PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Monitoring, Evaluation, and Reporting Indicator Reference Guide

MER 2.0 (Version 2.3)

September 2018

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Table of Contents

Tables & Figures

Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral
BF	breastfeeding
CBS	case-based surveillance
COD	cause of death
COP	PEPFAR Country Operational Plan
CQI	continuous quality improvement
CRVS	civil registration and vital statistics
CXCA	cervical cancer
DATIM	Data for Accountability, Transparency, and Impact
DQA	data quality assessment
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD	direct service delivery
EID	early infant diagnosis
EMR	electronic medical record
FSW	female sex worker
GARPR	UNAIDS Global AIDS Response Progress Reporting
GBV	gender-based violence
HCW	health care worker
HEI	HIV-exposed infant
HIVST	HIV self-testing
HRH	human resources for health
HTS	HIV testing services
IM	implementing mechanism
IP	implementing partner
L&D	labor and delivery
LTFU	lost to follow-up
KP	key populations
MAT	medication-assisted treatment
MER	monitoring, evaluation, and reporting indicators
MOH	Ministry of Health
MSM	men who have sex with men
OVC	orphans and vulnerable children
PEP	post-exposure prophylaxis
PEPFAR	United States President’s Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
POCT	point-of-care testing

PP	priority populations
PrEP	pre-exposure prophylaxis
PT	proficiency testing
PVLS	patient viral load suppression
PWID	people who inject drugs
SID	sustainability index
SIMS	site improvement through monitoring systems
STI	sexually transmitted infection
TA-SDI	technical assistance for service delivery improvement
TB	tuberculosis
TG	transgender people
TX	treatment
UNAIDS	Joint United Nations Programme on HIV/AIDS
USG	United States Government
VL	viral load
VMMC	voluntary medical male circumcision
WHO	World Health Organization

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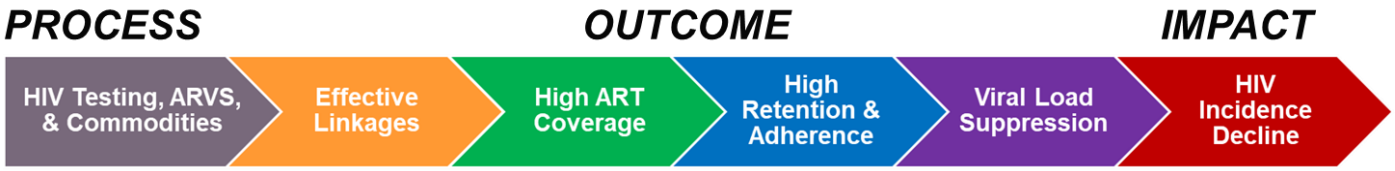
Overview

Over the past three years, site and population monitoring has effectively changed the way PEPFAR invests in communities to prevent HIV and reach epidemic control. PEPFAR is partnering with the international community to accelerate towards the UNAIDS 95-95-95 global goals: 95 percent of people living with HIV know their HIV status, 95 percent of people who know their HIV status are accessing treatment, and 95 percent of people on treatment have suppressed viral loads. Progress towards epidemic control will be successfully measured, in part, through an effective strategic information framework that not only monitors program outputs, but also key outcomes and programmatic impact.

Figure 1: PEPFAR Monitoring: Getting from Process to Impact



Given the global HIV progress over the past decade, planning, monitoring and resource allocation must occur at the subnational, community, and site levels in order to achieve the greatest impact. Collection and use of disaggregated data that characterizes the populations served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Consequently, the PEPFAR Monitoring, Evaluation, and Reporting (MER) indicators continue to evolve in order to reflect the progression of U.S. government (USG) support and global HIV response guidelines. Measuring the impact of support at national and regional above-site areas down to direct services at the site-level is paramount to PEPFAR's program implementation and monitoring approach.

The objectives of the MER guidance document are to streamline and prioritize indicators for PEPFAR programs; however, MER indicators are not an exhaustive list of all metrics that should be monitored by PEPFAR programs. PEPFAR programs should continually monitor and assess any acute programmatic issues and collect additional data to inform program improvement.

PEPFAR reviews MER indicators on an annual basis to ensure:

- indicators align with the programs planned for implementation and the expectations for both program monitoring and partner management practices;
- indicators reflect any new PEPFAR initiatives and/or emerging programmatic areas;
- indicators align with multilaterals and partner governments to avoid duplication of data collection, where possible; and
- continuous alignment within PEPFAR data streams (e.g., SIMS, expenditure reporting, SID etc.).

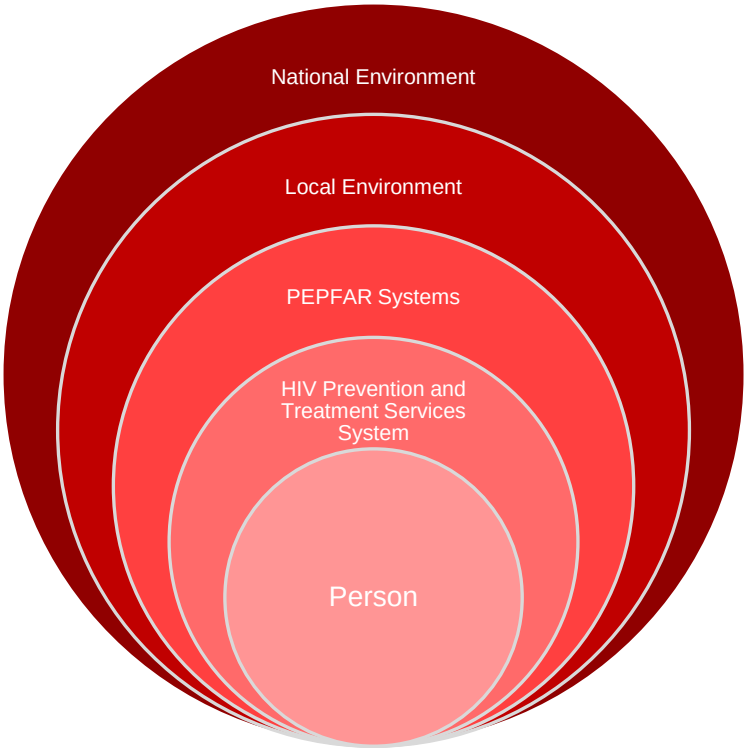
Specifically, in 2018, the following issues were taken into consideration:

- the need for further standardization of age, sex and key population disaggregations across the prevention and clinical cascades;
- the need to reduce data collection redundancies between indicators and ensure that the MER guidance and training materials reinforce the relationships within and between indicators;
- the need for enhancements to the data entry screens in DATIM to ensure better data quality; and
- the need for more input on MER changes from community stakeholders, technical experts, implementing partners, and PEPFAR field staff.

PERSON-CENTERED MONITORING

The latest iteration of the MER strives to drive program monitoring to a more patient-centered approach. Per the 2017 WHO Consolidated Guidelines on Person-Centred HIV Patient Monitoring and Case Surveillance, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of HIV tests or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

Figure 2: Patient-Centered Monitoring in PEPFAR



PEPFAR's commitment to person-centered monitoring is evidenced throughout this guidance document through:

- Indicators (i.e., HTS_RECENT) that allow programs to better understand clusters of recently-infected patients and spur programmatic action in order to intervene to stop active infections (i.e., through interventions such as index testing services and test & start).
- New types of outcome-focused cascade analyses (e.g., index testing, prevention).
- A modernized indicator to understand ART patient outcomes and retention in the era of differentiated care (i.e., TX_ML).
- A commitment to ensure data disaggregation by standard five-year age bands in order to further enhance programmatic focus on strengthening patient-level monitoring systems.
- Ensuring COP-funding for health information systems projects is impactful and supports: (1) interoperability between systems; (2) the adoption of standardized disaggregations; (3) shifts away from paper-based to electronic reporting; and (4) the adoption or expansion of HIV surveillance systems.

STANDARDIZED HEALTH DATA EXCHANGES & SURVEILLANCE SYSTEMS

At present, the majority of PEPFAR countries are limited to programmatic aggregate data and periodic surveys to describe the HIV care continuum. With greater emphasis on patient-centered monitoring comes a need to understand patient-level data beyond the aggregate indicators.

Because HIV programmatic aggregate data are not fully de-duplicated (though within antiretroviral treatment programs many are) and do not provide data on the number of people living with HIV or accurate data for total persons diagnosed. Periodic surveys offer individual de-duplicated data, denominators, and the 95-95-95 cascade, but are cross-sectional (one point in time) and are expensive to conduct.

Standardized health data surveillance systems offer countries a mechanism to complement aggregate reporting systems and surveys with quality HIV data that emphasizes individual de-duplicated data to more accurately report the 95-95-95 cascade.

These surveillance systems, when comprehensive, emphasize case finding and case reporting of new diagnoses including recent infections, identify if the newly diagnosed are linked to treatment and provide disaggregation by age, sex, geography, and risk. This in turn can trigger a public health response to effectively intervene and make the necessary adjustments from a surveillance and programmatic perspective to prevent new cases as countries strive to achieve and sustain epidemic control. There are several paths countries can take to obtain standardized health data exchanges and surveillance systems that track individual patients with the removal of duplicates by key HIV sentinel events [first HIV positive diagnoses (by new and chronic infection), first CD4 count (after diagnosis), antiretroviral treatment (ART) initiation, first viral load test, viral suppression

(follow up viral load tests), and death]. We describe two paths: (1) case-based surveillance (CBS) and (2) linkage of routine program data. Both approaches allow countries to monitor HIV cases longitudinally, providing real-time estimates of new diagnosis, treatment, and viral suppression by age, sex, and sub-national unit.

Many countries see the need and importance of standardized health data exchanges and surveillance systems but are not sure where to begin, what is needed, or do not have the requisite system attributes. For example, countries lack interoperability within their health systems infrastructure for data linkage between services to occur, methods to uniquely identify patients, and the important endpoint of mortality due to inadequate vital registration systems.

DISAGGREGATED MONITORING

Disaggregation of data is key to understanding if PEPFAR-supported services are reaching the intended beneficiaries and locations. Triangulation of routine program data with underlying geographic, demographic, and epidemiologic data is fundamental to PEPFAR planning, monitoring, and reporting processes. To ensure that no one in need of services in being left behind, PEPFAR requires the routine disaggregation of data by the following categories, where applicable:

Location: PEPFAR clinical indicators are disaggregated to the facility-level. Where services are provided in the community, data are reported at an intermediate community-level (e.g., ward, subdistrict, or district). PEPFAR analyses for planning and support focus on the subnational level (e.g., district).

Age: In order to advance the standardization of patient monitoring and routine health information systems, PEPFAR is adopting standardized reporting by five-year age bands. Beginning in FY19, PEPFAR program should report on the following standard age groups: <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and 50+. It is recommended that country teams review data on life expectancy and new infections to determine if it makes sense for your country to extend in-country and/or national reporting systems beyond the 50+ age band threshold

Sex: PEPFAR Indicators are disaggregated by biological sex (male or female), where applicable.

Key Populations: Reporting of key population disaggregations remains optional but is highly recommended for settings where it is safe to collect this data. The optional key populations disaggregations are: people who inject drugs, men who have sex with men, transgender people, female sex workers, and people in prison and other closed settings. Key populations disaggregations are incorporated into the following indicators: KP_PREV, HTS_TST, TX_NEW, PrEP_NEW, and PrEP_CURR. Disaggregations are not included for TX_CURR as an individual's status as a key population is subject to change over time.

The PEPFAR key populations reporting guidance is designed to avoid double-counting and ensure that the KP data reported can be meaningfully interpreted. Despite persons potentially falling into more than one KP disaggregate (e.g., an FSW who injects drugs, MSM that is currently incarcerated), implementing partners should be instructed to **report an individual in only one KP category** with which s/he is most identified. This guidance is applicable to KP_PREV and the KP disaggregates for HTS_TST, TX_NEW, PrEP_NEW, and PrEP_CURR. To better determine the KPs of interest for each indicator the key population classification document found in Appendix A.

Priority Populations: Disaggregation by priority population type is new with FY 2019 reporting. PP_PREV now includes a series of optional priority population types for reporting. Please note that reporting of the priority populations disaggregation is optional but is highly recommended.

Types of PEPFAR Support: To understand the level of support and the type of investments being provided, data are disaggregated by either direct service delivery (DSD) or technical assistance for service delivery improvement (TA-SDI). More information on these categories is provided in the section below.

DISAGGREGATION TYPES:

There are three categories of MER indicator disaggregations, which can be seen in the indicator reference sheets and the DATIM data entry screens.

Required Disaggregations: Required indicates that this indicator disaggregate is required for all countries that have programming for this area. This means that if the country supports a program area, defined by budget and targets set during the COP process, then it is required to report results.

Conditional Disaggregations: Conditional disaggregates include those for which some additional condition must be fulfilled. There are two main types of conditional indicator disaggregations:

a. Disaggregations for those programs that have received initiative-specific funds for special programming such as DREAMS. There is also one full indicator, AGYW_PREV, that is conditional and based on DREAMS funding.
b. Disaggregations that field teams have received permission or a waiver from their OGAC SI Advisor to report on such as reporting on the coarse age disaggregations instead of the finer age disaggregations. In this case reporting is considered conditional based on approval from OGAC.

Optional Disaggregations: Optional disaggregates should be completed by those for which the indicator is useful to determine the success of their program (e.g., KP or PP population disaggregations) or when it is both relevant and safe to enter the data at the site and/or community level (e.g., KP disaggregations for HTS, TST, PrEP_CURR, PrEP_NEW, and TX_NEW).

PEPFAR SUPPORT TO COMMUNITIES AND SITES

Completing the third full year of quarterly site-level monitoring by all PEPFAR implementing agencies and partners has provided granular data that demonstrate important differences in patient outcomes and site performance. These results should be used to prioritize resources, staff, and interventions among sites to determine the appropriate extent of support and monitoring needed based on site-level outputs and quality outcomes.

There are three categories of PEPFAR support that correspond to attained, scale-up, sustained and centrally supported areas. In areas where PEPFAR is supporting attained, scale-up, and sustained services the type of support should be categorized as Direct Service Delivery (DSD) or Technical Assistance-Service Delivery Improvement (TA-SDI).

In areas where PEPFAR support is not at the site level but is financial support at the national or subnational levels then this support should be characterized as Central Support (CS). DSD and TA-SDI include all sites receiving one or more PEPFAR-supported visits during the year. Importantly, site-level quarterly results and SIMS data should be analyzed and used to determine the number of program support visits needed each year to optimize the quality of HIV/AIDS services and impact. PEPFAR teams should work with implementing partners to ensure that programmatic data (including MER and SIMS results) are being used in this way. The key is to ensure that PEPFAR-supported sites receive the appropriate number of technical assistance visits based on their performance. Refer to the “PEPFAR-support definition” section within each indicator reference sheet for indicator-specific DSD and TA-SDI descriptions.

DSD: Individuals will be counted as receiving direct service delivery support from PEPFAR when BOTH of the below conditions are met: **Provision of key staff or commodities AND support to improve the quality of services through site visits** as often as deemed necessary by the partner and country team.

TA-SDI: Individuals will be counted as supported through TA-SDI when the point of service delivery receives support from PEPFAR that meets **the second criterion ONLY: support to improve the quality of services through site visits** as often as deemed necessary by the partner and country team.

1. PEPFAR is directly interacting with the patient or beneficiary in response to their health (physical, psychological, etc.) care needs by providing key staff and/or essential commodities for routine service delivery. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. Each indicator reference sheet includes a list of key staff and/or essential commodities that meet this condition.

AND/OR

2. PEPFAR provides an established presence at and/or routinized support for those services at the point of service delivery. Each indicator reference sheet includes a list of activities that count toward support for service delivery improvement.

SUPPORT IN CENTRALLY SUPPORTED AREAS: In areas where PEPFAR is providing solely financial support at the national, regional or district level, site level support will be through annual visits. However, to support government with quality monitoring, it is recommended that results reported through national health information systems should be jointly monitored with host country government on a quarterly basis. SIMS visits may be conducted at these sites if quality issues are identified.

While patient and beneficiary-support activities have transitioned to government or other support, PEPFAR continues to provide support for overarching activities, such as quality assurance and quality improvement (QA/QI) to ensure that patients continue to receive quality services. As such, PEPFAR will continue monitoring activities in centrally supported sites annually via the following indicators: HTS_TST, TX_CURR, TX_NEW, PMTCT_STAT, and PMTCT_ART. Due to the financial investments PEPFAR provides at the above-service delivery area in centrally supported sites and SNUs, it is important that results be provided to ensure that quality assurance initiatives are having the intended impact. PEPFAR programs should be focused on supporting the national program in their respective country to achieve 90% ART coverage (i.e., 95-95-95) for PLHIV; therefore, it is extremely important to understand the services provided to PLHIV across the entire country.

HOST COUNTRY NATIONAL PROGRAM

PEPFAR works closely with host countries, particularly with Ministries of Health, to jointly monitor the HIV response. Monitoring the host country HIV response is critical to understanding both the achievements and the gaps at the subnational level and by population. Host country data are used to inform PEPFAR programs and guide how PEPFAR resources are allocated at all levels. The key program areas for monitoring host country targets and results are: prevention of mother to child transmission programs, key populations, voluntary male medical circumcision and HIV diagnosis and treatment, including viral suppression.

Data are needed from both the national and subnational level. The subnational level is considered the organizational level in which the country team has prioritized their program (PSNU). Data on the host country national program is reported to PEPFAR for all subnational units, regardless of PEPFAR funding supporting these geographical areas; so that the total of the subnational results or targets should equal the total number of national results and targets.

Increasingly, individual-level surveillance data are critical to implement and used in conjunction with MOH to capture data from recent infections to deaths.

At the host country national level, to sufficiently monitor its national response, the host country government's national set of indicators should include the minimum set of harmonized global indicators (Global AIDS Response Reporting) and additional indicators that represent the needs of the country's program. The PEPFAR Country team should collaborate with the host country government and other stakeholders to make sure that PEPFAR reporting requirements are taken into consideration in the host country's national set. In constructing its own comprehensive set of requirements for monitoring the USG response in support of the host country national program, each PEPFAR country team will review all of the PEPFAR essential host country national indicators for applicability to the PEPFAR activities being conducted in the host country.

The PEPFAR host country national and subnational level indicators represent results obtained within the entire host country regardless of PEPFAR support. Both Standard Process and STAR Process Countries should report host country results at Q4 each fiscal year.

Host country results are also reported at the site-level for a subset of indicators. The majority of these facility-level indicators will be reported through the PEPFAR-MOH data alignment process. Standard Process COP Operating Units (i.e., Botswana, Burundi, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Ukraine, Vietnam, Zambia, and Zimbabwe) are required to complete the MOH data alignment process on an annual basis for the following indicators: HTS_TST, TX_CURR, TX_NEW, PMTCT_STAT, and PMTCT_ART.

Beginning in FY19, there will be one additional host country indicator reported at the facility level: HRH_STAFF_NAT. Please refer to the indicator reference sheet for HRH_STAFF_NAT for more details.

HOST COUNTRY TARGETS

Targets for the host country national and subnational indicators should be reported into DATIM during COP. Developing targets for the next year at the national and subnational data is an important step in understanding the national program and determining geographic investments (including host country, The Global Fund and other donors). When PEPFAR better understands the target setting process of the national program, then it is better placed to support the program and to fill necessary impactful programmatic gaps. Please describe the target setting process that the host country employs in the narratives and partnering donors). The national targets should cover the next calendar or fiscal year; the timeframe should be indicated in the narratives.

HOST COUNTRY RESULTS

At Q4 of the USG fiscal year, results from the host country systems should be reported up until the most recent month of collection and include 12 months of data. These may not align with end USG fiscal year results. These data should be collected continuously at the subnational level. Data should be in line with GARPR and UNAIDS reported data, where available, although may differ due to different reporting periods. In the narratives, please indicate what months the data include (e.g., October 2017-September 2018; or July 2017 to June 2018). Results should be consistently reported on the same time period to be able to monitor trends over time.

Table 1: Host Country indicators by reporting level, targets, and results

Host Country indicators by reporting level, targets, and results					
Host Country Indicator	Reporting Level			Results vs. Targets Requirements	
Indicator Name	*National*	*Subnational*	*Facility*	*Targets*	*Results*
DIAGNOSED	X	X			X
HTS_TST			X		
TX_NEW			X		
TX_CURR	X	X	X	X	X
VL_SUPPRESSION	X	X		X	X
PMTCT_STAT	X	X	X	X	X
PMTCT_ART	X	X	X	X	X
VMMC_CIRC	X	X		X	X
VMMC_TOTALCIRC	X	X		X	X
HRH_STAFF			X		X
KP_MAT	X	X			X

Red X: Designates those indicators collected through the annual MOH data alignment process

MER INDICATOR NARRATIVES

Three types of narratives are required as part of quarterly submissions: (1) IM level narratives, (2) technical area level narratives, and (3) host country results narratives. Specific requirements are defined for each type of narrative. In addition, guiding narrative questions were introduced for FY18 reporting to provide additional technical detail and continuity within the narrative submitted across PEPFAR countries.

GUIDING NARRATIVE QUESTIONS

Guiding narratives questions have been developed for each PEPFAR indicator to ensure that there is continuity in the technical information reported through the narratives and that this information will be most relevant to subject matter experts in triangulating the narrative data with the quantitative results.

Each indicator has 2-3 questions or prompts, included in the reference sheet, that should guide both implementing partners and USG technical area experts in the development and framing of both the IM and technical area narratives – in addition to the narrative requirements provided in the paragraphs below.

IMPLEMENTING MECHANISM (IM) NARRATIVES

Narratives are required each quarter. These narratives are an opportunity to convey additional context to accompany the quantitative results. IM level narratives are required for each reported indicator and should:

- Respond to the guiding narrative questions defined in the indicator reference sheet, as applicable.
- Describe current quarterly achievements as well as overall achievements against the fiscal year targets.
- Provide additional information related to specific data quality concerns or programmatic issues that may impact the assessment of partner performance. Indicate whether data quality assessments were conducted during the reporting period and the impact the assessment had on the results and program.
- If appropriate, reference specific site-level issues that were encountered during the reporting period that may prevent achievement of the IM target.
- Provide additional information that is useful for the interpretation of the results on an indicator-specific basis.
- Address any result discrepancies that cannot be reconciled after completing the Data Completeness and Logic Checks.
- Describe the nature of support the partner is providing that qualifies the results to be categorized as Direct Service Delivery (DSD) or Technical Assistance for Service Delivery Improvement (TA-SDI) in accordance with PEPFAR guidance.

TECHNICAL AREA NARRATIVES

Technical area level narratives summarize the PEPFAR OU's de-duplicated achievements against targets. These narratives should:

- Respond to the guiding narrative questions defined in the indicator reference sheet, as applicable.
- Provide additional information that would be useful for the interpretation of the results, including specific data quality concerns or programmatic issues that may impact the assessment of overall performance.
- Describe the nature of support the partners are providing that qualifies the results to be categorized as Direct Service Delivery (DSD) or Technical Assistance for Service Delivery Improvement (TA-SDI) in accordance with PEPFAR MER guidance.
- Describe the achievements in light of expected trajectories for the technical area.
- Provide information on data quality assessment (DQA) completion in the last 12 months.
- Address any data discrepancies that cannot be reconciled (at the interagency level) after completing the Data Completeness and Logic Checks.
- Address achievements by prioritization level and DSD and TA-SDI support. For example, is there an overlap between PEPFAR and the Global Fund in support for ART services?

HOST COUNTRY TARGETS & RESULTS NARRATIVES

National level indicator narratives provide an opportunity for teams to discuss the host country response beyond PEPFAR supported activities. For national indicators, both a justification and a source narrative are required for each indicator. Also take note that narratives for both National (_NAT) and Subnational (_SUBNAT) should be recorded in the _NAT narrative section in DATIM.

Justification Narrative

- How does the national number relate to the PEPFAR number?
- What proportion of results does PEPFAR contribute to the national response?
- If the PEPFAR result is larger than the national number, this should be described in detail.
- Note the actual reporting time frame for entered data.

Source narrative

- What is the source of these data?
- When were these data collected/calculated?

DATA QUALITY

Measuring the success of PEPFAR initiatives requires strong monitoring and evaluation (M&E) systems that produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part routine data management processes. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals are accurately monitored, and that decisions are based on strong evidence. Attention to data quality ensures that target-setting and results reporting are informed by valid and sensitive information, and that implanting partners and PEPFAR programs are thinking about and collecting and organizing this information in the same manner. In this way, attention to data quality leads to improved program performance and to more efficient resource management.

Over the past five years, efforts to ensure a data-driven approach to decision making has allowed global HIV programs to dramatically expand their results and impact in a budget-neutral environment. The combination of strengthened monitoring indicators, information regarding site and service delivery quality, site-specific program results, and a more detailed understanding of the geographic distribution of the burden of disease has allowed HIV programs to identify exactly where the HIV epidemic is occurring and where programs can maximize their impact in response.

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by PEPFAR are expected to have a data quality strategy in place. For example, data quality assessments should be done routinely conducted and action should be taken as a result of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the PEPFAR and host-country reporting systems as soon as possible. Standard operating procedures for routine data quality review should also be in place. Data should be routinely reviewed for errors before submission to ensure that the data passes the data quality checks outlined within the guidance and the Data Review Tool available in DATIM.

More specifically, as many countries are approaching the UNAIDS 95-95-95 goals, it is more important than ever to understand exactly how many people living with HIV are receiving treatment. Furthermore, it's imperative that countries understand the treatment gaps remaining by location and population to ensure that all PLHIV have equitable access to treatment and are virally suppressed and that scarce resources are allocated appropriately to areas with the greatest unmet need. As such, we are at a very important moment in the HIV response where accuracy of the data is essential in ensuring that programmatic decisions are made effectively. PEPFAR is committed to ensuring that the data collected through the MER is accurate and timely. It is essential to not only capture high-quality data, but to also continuously use and analyze the data to achieve maximum program impact.

SIMS IN RELATION TO MER 2.0

SIMS evaluates the quality of service delivery or program oversight to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these core essential elements (CEEs) highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. Site-level triangulation of MER and SIMS data can be used to contextualize performance and could be useful to determine if performance challenges at a site are due to issues related to the underlying quality of service provision. SIMS is currently undergoing revisions for FY19. Once complete, the following will be released: (1) an updated SIMS and MER Linkage Reference Table to describe which CEEs align with each MER indicator (2) an updated SIMS Implementation Guide, which will include recommendations on data triangulation across MER and SIMS data streams to inform strategies for improvement in programs and subsequent performance.

DREAMS-SPECIFIC GUIDANCE

In addition to required MER reporting, it is essential that all implementing partners in DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) SNUs report their results for and use data from all DREAMS-related indicators and their required disaggregations. The current list of DREAMS countries includes: Botswana, Cote d'Ivoire, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

DREAMS countries are encouraged to monitor interventions progress using custom indicators for program components that do not have existing MER indicators (e.g., contraceptive method mix, condom promotion and provision). Appendix C includes a full list of the DREAMS-related indicators reported for MER 2.0 and the required disaggregation for each indicator. Please note there are also specific reporting requirements for DREAMS narratives.

Key Updates and Changes: MER 2.2 to MER 2.3

Through the past 3 years of quarterly, site-level monitoring, PEPFAR programs have used data to improve implementation. Changes to the MER highlight key program areas (e.g., index testing services) that should be taken to scale. Tables 3 and 4 and Figure 4 on the following pages highlight the key details for the MER indicators.

INDICATOR TRAININGS:

Indicator training videos and content have been created by PEPFAR HQ technical area experts and uploaded on the MER DATIM support page. There is a training available for each technical area (e.g., TB, Treatment, HTS, HRH, etc.). Please note that the MER training videos are available to **both USG and implementing partner staff with access to DATIM**.

Training content is still being finalized and content is being uploaded to the DATIM support page on a rolling basis, once it becomes available. All training videos and associated training materials will be available by October 31, 2018.

Data entry screens reflecting the changes outlined in this guidance document are under development. Once finalized, screenshots will be captured on the DATIM support site at the following link: https://datim.zendesk.com/hc/en-us/articles/360001143166-DATIM-Data-Entry-Form-Screen-Shot-Repository.

NEW INDICATORS:

AGYW_PREV: AGYW_PREV is a semi-annual indicator introduced for reporting beginning in FY19. AGYW_PREV is a DREAMS-specific indicator to measure how many adolescent girls and young women (AGYW) are being served in the DREAMS program and whether all AGYW in DREAMS have received the intended layered services and interventions to ensure that they remain HIV-free.

CXCA_SCRN: CXCA_SCRN is a semi-annual indicator introduced for reporting beginning in Q4 of FY18. CXCA measures the percentage of HIV-positive women on ART screened for cervical cancer.

CXCA_TX: CXCA_TX is a semi-annual indicator introduced for reporting beginning in Q4 of FY18. CXCA_TX measures the percentage of cervical cancer screen-positive women who are also HIV-positive and on ART that were eligible for and received cryotherapy, thermocoagulation or LEEP.

HTS_INDEX: HTS_INDEX is now a standalone indicator to monitor and help guide PEPFAR programming for index testing services. Reporting for HTS_INDEX will begin in Q1 of FY19. HTS_INDEX is the first MER indicator to monitor PEPFAR programming related to HIV index testing services (often referred to as partner notification or contact tracing services). This indicator includes a cascade that will help to better understand the scale and fidelity of the index testing services provided by PEPFAR-supported programs.

HTS_RECENT: HTS_RECENT is a quarterly indicator introduced for reporting beginning in Q1 of FY19. Testing individuals that are newly diagnosed with HIV-1 for recent infection is an emerging programmatic area of emphasis for PEPFAR. HTS_RECENT measures the percentage of newly diagnosed HIV-positive persons aged ≥15 years with a test for recent infection result of 'recent infection' during the reporting period. As countries progress toward epidemic control, surveillance of newly diagnosed persons will ensure that interventions target those at highest risk of acquiring or transmitting HIV infection. One approach is to identify recent HIV infections, defined as those acquired within approximately the last one year. Incorporation of rapid tests for recent HIV-1 infection into routine HIV testing services will enable the establishment of a surveillance system to quickly detect, monitor, characterize, and intervene on recent infections among newly diagnosed HIV cases. Data collected from a recent infection surveillance system can also be used to fine-tune a country's programmatic response through prioritized programming and resource allocation.

PrEP_CURR: PrEP_CURR is a semi-annual indicator introduced for reporting beginning in FY19. PrEP_CURR measures the number of individuals receiving oral PrEP during the reporting period and is an important addition to the MER to help PEPFAR programs understand how many clients are being sustained on PrEP after initiation.

TX_ML: TX_ML is a semi-annual indicator introduced for reporting beginning in FY19. TX_ML is intended to drive improved tracing of patients to ensure patient outcomes are accurately documented. It is the first PEPFAR indicator to collect information on mortality among patients on ART and in care. The indicator also strives to better understand the magnitude of previously undocumented patient transfers.

NEW DISAGGREGATIONS:

HTS_TST: A new facility-based testing modality has been introduced: Post ANC1: Pregnancy/L&D/BF. Please refer to the HTS_TST indicator reference sheet for additional details.

PP_PREV: A new, optional priority populations type disaggregate was added to this indicator to capture the specific priority populations accessing prevention services. Age/sex-specific priority populations were not added to this disaggregate group (e.g., AGYW) because these can be calculated using the mandatory age/sex disaggregates collected within the indicator.

TX_TB: The denominator has been updated to include a new disaggregate for "positive result returned."

CHANGES IN REPORTING FREQUENCY:

See Table 4 for more details on indicator reporting frequency.

PrEP_NEW: The reporting frequency moves from quarterly to semi-annually in FY19 to align the prevention indicators.

TB_ART: The reporting frequency moves from semi-annually to quarterly in FY19 to align with the ART-related indicators and TB_STAT.

TB_STAT: The reporting frequency moves from semi-annually to quarterly in FY19 to align with HTS_TST.

TX_PVLS: The reporting frequency moves from annually to quarterly in FY19 to ensure that the treatment cascade can be reviewed quarterly and to emphasize the importance of regularly monitoring viral load coverage and suppression.

MODIFICATIONS TO EXISTING INDICATORS:

HRH_CURR: The reporting of HRH_CURR by the number of full-time equivalents is no longer required. HRH_CURR has been simplified to collect the total number of staff (regardless of FTE). In addition, a new data element has been added to capture the amount of funding spent on health care workers by cadre and support type.

PMTCT_EID: The denominator has been updated to include HIV+ pregnant women identified after ANC1, including those women who test positives later in pregnancy, at labor and delivery, and throughout the breastfeeding period. The positive results for these women will be captured under the newly added HTS modality, Post ANC1: Pregnancy/L&D/BF and will be summed with the positives (new and known) from ANC1 (i.e., PMTCT_STAT_POS) to obtain the total denominator.

MODIFICATIONS TO EXISTING DISAGGREGATIONS

OVC_HIVSTAT: The status type disaggregates have been modified. The sub-disaggregate under "No status reported" formerly called "Test not indicated" will now be "Test not required based on risk assessment" to simplify the language.

OVC_SERV: Age/sex and program status (i.e., active or graduated) disaggregations have been combined.

PMTCT_ART: Age disaggregations were added to the "maternal regimen type" disaggregate to align with PMTCT_STAT. Age disaggregations were not previously collected for PMTCT_ART.

PREP_NEW: The KP type disaggregation for this indicator has been updated. "Other key population" has been removed and replaced with "people who inject drugs" and "people in prisons and other closed settings" so that all key population disaggregate group options align between HTS_TST, TX_NEW, PrEP_CURR, and PrEP_NEW.

TB_ART: Age/sex and “ART status” disaggregations have been combined.

TB_PREV: Age/sex and “Type of TB preventive therapy by ART Start” disaggregations have been combined for both the numerator and the denominator.

TB_STAT: Age/sex disaggregations were updated from coarse-only to fine age bands to allow TB_STAT to auto-populate HTS_TST via the TB modality and to align with the age bands for TB_ART.

TX_TB: Age/sex and “ART Status” disaggregations have been combined for the numerator. Age/sex and “Start of ART by Screen Results” disaggregations have been combined for the denominator.

VMMC_CIRC: Age disaggregations were added to the “HIV Status and Outcome” disaggregate in order for VMMC HTS results to auto-populate into the HTS_TST indicator. Note that the age disaggregations align with HTS_TST to allow for auto-population. This means the <4 disaggregations differ slightly from the indicator itself.

RETIRED INDICATORS

TX_RET: Indicator has been removed in order to incorporate the new TX_ML indicator and strengthen reporting on TX_PVLS.

RETIRED DISAGGREGATIONS

OVC_SERV: The age/sex/service DREAMS-related disaggregate was removed and replaced with a new indicator, AGYW_PREV, to improve the tracking of layered services and interventions.

PMTCT_STAT: The age-only disaggregate was removed to minimize duplicative reporting. Age is already captured under the status and age disaggregate group.

TX_NEW: The “confirmed diagnosis of TB” disaggregate was removed as TB_ART results have moved to quarterly reporting.

INDICATOR DEFINITION CLARIFICATIONS

GEND_GBV: Clarifying language was added to the “disaggregate descriptions and definitions” section of the indicator to ensure that clients are not double-counted under the indicator.

OVC_SERV: Clarifying language added to this indicator reference sheet to better emphasize that only children (and their caregivers) that actually received one or more services in each of the preceding two quarters should be counted in this indicator. OVC that have registered for the program (i.e., been enrolled and assessed) but have not yet received any services should not be counted in the results. The purpose of this indicator is to assure that beneficiaries are being reached promptly and regularly with needed support.

In addition, illustrative eligible interventions that qualify a beneficiary to be counted as active have been added, for both children and caregivers. For services that are not captured in the list, local USG funding agency approval must be received in order to count these services toward active OVC status.

Next, minimum graduation benchmarks have been established to ensure that PEPFAR programs have aligned objectives for progressing children and their caregivers to a minimum level of stability. Children and caregivers in a household move from active to graduated status together when each has met the minimum benchmarks (reflecting the family-centered nature of OVC programming).

Lastly, clarifying language has been added to the indicator reference sheet regarding the calculation of annual totals and the timeframe of data submitted for Q4 disaggregates. Individuals should only be counted once at Q4 reporting (i.e., active, graduated, transferred, and exited disaggregates are mutually exclusive).

PMTCT_ART: Language has been added to clarify that only women initiating on treatment prior to pregnancy or during pregnancy (ANC) should be counted under PMTCT_ART. Women newly initiating or coming to the facility during L&D and breastfeeding should be counted under TX_NEW and/or TX_CURR, but not under PMTCT_ART.

PMTCT_STAT: Language has been added to clarify that subsequent testing events during pregnancy, labor and delivery, and breastfeeding will be reported under the new HTS_TST modality: Post ANC1: Pregnancy/L&D/BF. See the PMTCT_STAT and HTS_TST indicator reference sheets for further details.

TX_CURR: Language under the "How to Collect" section has been updated to better clarify PEPFAR reporting expectations in light of recent DQAs and to describe alignment with the new TX_ML indicator.

AGE DISAGGREGATIONS:

Data from the Population-Based HIV Impact Assessments (PHIA) has provided valuable insight into the progress many PEPFAR countries are making towards achieving the 95-95-95 goals in all ages and sexes. Significant disparities in incidence and viral suppression among adults ages 25-49-year led PEPFAR to reassess the required reporting age bands and further disaggregate the 25-49-year old age band into the following four age bands: 25-29, 30-34, 35-39, and 40-49 in FY18. Further review and analysis of age-disaggregated data during COP 2018 resulted in a shift towards disaggregation by standard five-year-age bands to align with the WHO guidance for electronic systems.

Reporting on the new MER 2.0 (v2.3) age bands will be introduced beginning in Q1 of FY 2019. As discussed in the previous MER guidance as well as in the FY 18 Consolidated Guidance for Data Collection and Use in PEPFAR and the COP 2018 PEPFAR Fiscal Year 2018 Country Operational Plan (COP) Guidance for Standard Process Countries, country teams were required to discuss any barriers or challenges to reporting the new finer age disaggregations during FY 18 to address these challenges in order to fully report on new finer age bands beginning in FY19. **Methods of extrapolating or estimating age disaggregated results data are not permitted.** If you have questions, contact your SI Advisor and SGAC_SI@state.gov. The table below describes the evolution of the standard, required age bands for PEPFAR reporting from FY 2015 through FY 2019. Note that there are some indicator-specific variations to these requirements.

Table 2: Evolution of PEPFAR Finer Age Bands for Results Reporting

<table>
<tr><th colspan="8">Evolution of PEPFAR Finer Age Bands for Results Reporting</th></tr>
<tr><th colspan="2">FY 2015 - 2016</th><th colspan="2">FY 2017</th><th colspan="2">FY 2018</th><th colspan="2">FY 2019</th></tr>
<tr><th>Age Band</th><th>Sex</th><th>Age Band</th><th>Sex</th><th>Age Band</th><th>Sex</th><th>Age Band</th><th>Sex</th></tr>
<tr><td><1</td><td>M / F</td><td><1</td><td>None</td><td><1</td><td>None</td><td><1</td><td>M / F</td></tr>
<tr><td>1-4</td><td>M / F</td><td rowspan="2">1-9</td><td rowspan="2">None</td><td rowspan="2">1-9</td><td rowspan="2">None</td><td>1-4</td><td>M / F</td></tr>
<tr><td>5-9</td><td>M / F</td><td>5-9</td><td>M / F</td></tr>
<tr><td>10-14</td><td>M / F</td><td>10-14</td><td>M / F</td><td>10-14</td><td>M / F</td><td>10-14</td><td>M / F</td></tr>
<tr><td>15-19</td><td>M / F</td><td>15-19</td><td>M / F</td><td>15-19</td><td>M / F</td><td>15-19</td><td>M / F</td></tr>
<tr><td>20-24</td><td>M / F</td><td>20-24</td><td>M / F</td><td>20-24</td><td>M / F</td><td>20-24</td><td>M / F</td></tr>
<tr><td rowspan="6">25-49</td><td rowspan="6">M / F</td><td rowspan="6">25-49</td><td rowspan="6">M / F</td><td>25-29</td><td>M / F</td><td>25-29</td><td>M / F</td></tr>
<tr><td>30-34</td><td>M / F</td><td>30-34</td><td>M / F</td></tr>
<tr><td>35-39</td><td>M / F</td><td>35-39</td><td>M / F</td></tr>
<tr><td rowspan="2">40-49</td><td rowspan="2">M / F</td><td>40-44</td><td>M / F</td></tr>
<tr><td>45-49</td><td>M / F</td></tr>
<tr><td>50+</td><td>M / F</td><td>50+</td><td>M / F</td><td>50+</td><td>M / F</td><td>50+</td><td>M / F</td></tr>
</table>

UPDATED DATIM FUNCTIONALITY:

AUTO-SUM NUMERATORS AND DENOMINATORS:

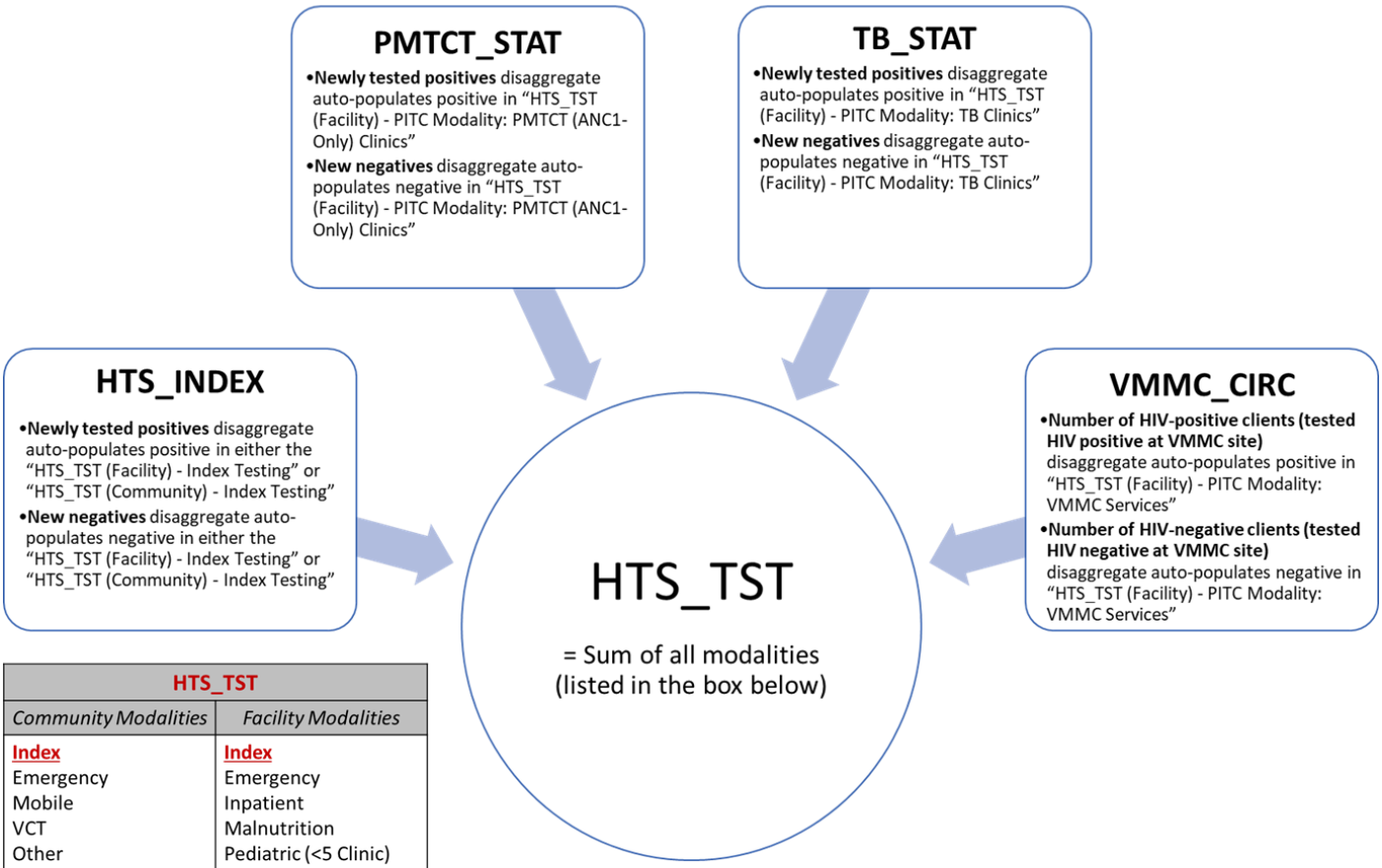
To reinforce data quality and reduce data entry, PEPFAR will begin to auto-sum the top-level numerators and denominators for most indicators in FY 2019. For example, the age/sex disaggregations for TX_CURR will be summed to obtain the total numerator for TX_CURR. **Implementing partner staff will not need to enter both a numerator and the age/sex disaggregations into DATIM.** Entering the age/sex disaggregations will auto-sum the numerator. In order to ensure completeness of reporting where age-related data is not collected fully, an option of 'unknown age' has been added to all indicators. Note that an 'unknown sex' option is not available. Data must be collected by sex, at a minimum, in order to be reported in DATIM. If you have questions about this requirement, contact your SI Advisor and SGAC_SI@state.gov.

In each indicator reference sheet, within the disaggregations section, the disaggregate group that will be used to auto-sum the numerator or denominator is highlighted in **BOLD** text. Not all indicators will auto-calculate.

AUTO-POPULATION OF HTS_TST MODALITIES:

New efforts to reduce data entry redundancy and reinforce the relationships between indicators are being instituted in this iteration of the MER guidance. The definitions for the PMTCT (ANC1), TB, VMMC, and index HIV testing services modalities have been aligned with their respective parent status indicators (i.e., PMTCT_STAT, TB_STAT, VMMC_CIRC, and HTS_INDEX). Results will no longer be entered for these modalities through the HTS_TST indicator directly but will instead be entered into the parent indicator and then auto-populated into HTS_TST. For example, results entered for TB_STAT newly tested positives will auto-populate into the TB modality for HTS_TST within DATIM. DATIM users will still see these modalities on the data entry screen but will no longer be able to enter data directly into the modalities. Once data is entered for the partner indicator, it will be copied into the relevant data entry form for the corresponding HTS modality. For further details, see the diagram below and review the HTS_TST reference sheet.

Figure 3: Auto-Population of HTS_TST from Associated Indicators



HTS_TST	
Community Modalities	*Facility Modalities*
Index	**Index**
Emergency	Emergency
Mobile	Inpatient
VCT	Malnutrition
Other	Pediatric (<5 Clinic)
	PMTCT (ANC1-Only)
	PMTCT (Post ANC1)
	STI
	TB
	VCT
	VMMC
	Other PITC

*Modalities in **red** feed into HTS_TST from their associated MER indicators as demonstrated in the diagram above.*

Table 3: Indicator Summary Table

Indicator Code	Indicator Group	Indicator Description	Reporting Frequency
AGYW_PREV	Prevention	Percentage of adolescent girls and young women (AGYW) that completed the DREAMS primary package of evidence-based services/interventions.	Semi-Annual
CXCA_SCRN	Testing	Percentage of HIV-positive women on ART screened for cervical cancer	Semi-Annual
CXCA_TX	Treatment	Percentage of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	Semi-Annual
EMR_SITE	Health Systems	Number of PEPFAR-supported facilities that have an electronic medical record system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	Annual
FPINT_SITE	Prevention	Number of HIV service delivery points at a site supported by PEPFAR that are providing integrated voluntary family planning services	Annual
GEND_GBV	Prevention	Number of people receiving post-gender-based violence clinical care based on the minimum package	Annual
HRH_CURR	Health Systems	Number of health workers who are working on HIV-related activities and are receiving any type of support from PEPFAR, as well as total spend on these workers	Annual
HRH_PRE	Health Systems	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	Annual
HTS_INDEX	Testing	Number of individuals who were identified and tested using Index testing services and received their results	Quarterly
HTS_RECENT	Testing	Percentage of persons aged ≥15 years newly diagnosed with HIV-1 infection who have a test for recent infection result of 'recent infection' during the reporting period	Quarterly
HTS_SELF	Testing	Number of individual HIV self-test kits distributed	Quarterly
HTS_TST	Testing	Number of individuals who received HIV Testing Services and received their test results	Quarterly
KP_MAT	Prevention	Number of people who inject drugs on medication-assisted therapy for at least 6 months	Annual
KP_PREV	Prevention	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	Semi-Annual
LAB_PTCQI	Health Systems	Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing (POCT) sites engaged in continuous quality Improvement (CQI) and proficiency testing (PT) activities.	Annual
OVC_HIVSTAT	Testing	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner.	Semi-Annual
OVC_SERV	Prevention	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	Semi-Annual

PMTCT_ART	Treatment	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy	Quarterly
PMTCT_EID	Testing	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	Quarterly
PMTCT_FO	Testing	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	Annual
PMTCT_HEI_POS	Testing	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	Quarterly
PMTCT_STAT	Testing	Percentage of pregnant women with known HIV status at antenatal care	Quarterly
PP_PREV	Prevention	Number of priority populations reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	Semi-Annual
PrEP_CURR	Prevention	Number of individuals, inclusive of those newly enrolled, that received oral antiretroviral pre-exposure prophylaxis to prevent HIV during the reporting period	Semi-Annual
PrEP_NEW	Prevention	Number of individuals who have been newly enrolled on oral antiretroviral pre-exposure prophylaxis to prevent HIV infection in the reporting period	Semi-Annual
SC_STOCK	Health Systems	Percentage of stock status observations from storage sites where commodities are stocked according to plan, by level in supply system	Semi-Annual
TB_ART	Treatment	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	Quarterly
TB_PREV	Prevention	Proportion of ART patients who completed a standard course of TB preventive therapy within the semiannual reporting period	Semi-Annual
TB_STAT	Testing	Percentage of new and relapse TB cases with documented HIV status	Quarterly
TX_CURR	Treatment	Number of adults and children currently receiving antiretroviral therapy (ART)	Quarterly
TX_ML	Treatment	Number of ART patients with no clinical contact since their last expected contact	Semi-Annual
TX_NEW	Treatment	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Quarterly
TX_PVLS	Viral Suppression	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	Quarterly
TX_TB	Treatment	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment.	Semi-Annual
VMMC_CIRC	Prevention	Number of males circumcised as part of the voluntary medical male circumcision for HIV prevention program within the reporting period	Quarterly

Table 4: Frequency of Reporting Table

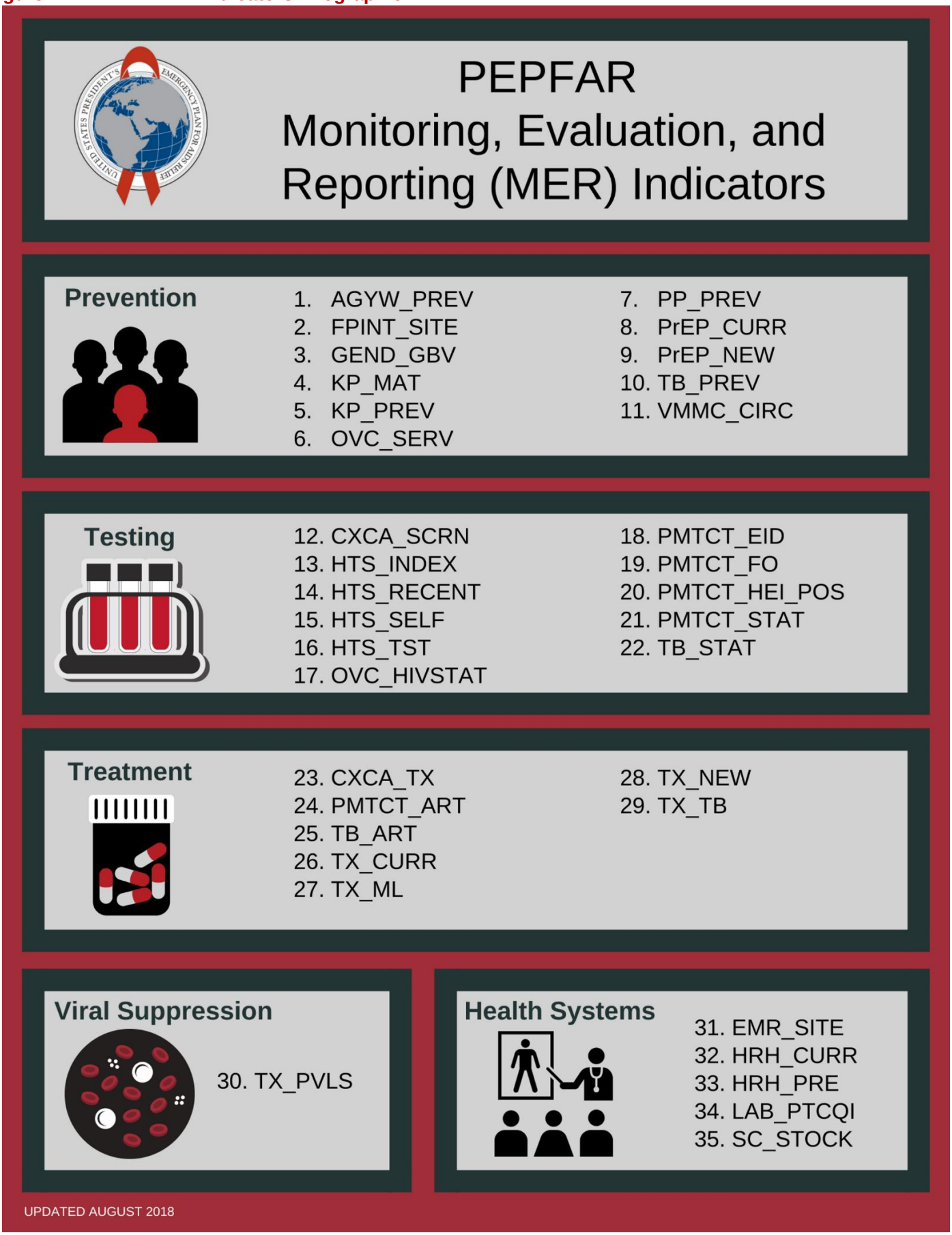
PEPFAR
MER Indicator Frequency Table

QUARTERLY	SEMI-ANNUAL	ANNUAL	HOST COUNTRY
HTS_TST Ⓕ Ⓒ	AGYW_PREV Ⓒ	EMR_SITE Ⓟ	DIAGNOSED Ⓝ Ⓢ
HTS_INDEX Ⓕ Ⓒ	CXCA_SCRN Ⓕ	FPINT_SITE Ⓟ	HRH_STAFF Ⓕ
HTS_RECENT Ⓕ Ⓒ	CXCA_TX Ⓕ	GEND_GBV Ⓕ Ⓒ	KP_MAT Ⓝ Ⓢ
HTS_SELF Ⓕ Ⓒ	KP_PREV Ⓕ Ⓒ	HRH_CURR Ⓕ Ⓒ Ⓐ	PMTCT_ART Ⓝ Ⓢ
PMTCT_ART Ⓕ	OVC_HIVSTAT Ⓕ Ⓒ	HRH_PRE Ⓐ	PMTCT_STAT Ⓝ Ⓢ
PMTCT_EID Ⓕ	OVC_SERV Ⓕ Ⓒ	KP_MAT Ⓕ	TX_CURR Ⓝ Ⓢ
PMTCT_HEI_POS Ⓕ	PP_PREV Ⓕ Ⓒ	LAB_PTCQI Ⓕ	VL_SUPPRESSION Ⓝ Ⓢ
PMTCT_STAT Ⓕ	PrEP_CURR Ⓕ	PMTCT_FO Ⓕ	VMMC_CIRC Ⓝ Ⓢ
TB_ART Ⓕ	PrEP_NEW Ⓕ		VMMC_TOTALCIRC Ⓝ Ⓢ
TB_STAT Ⓕ	SC_STOCK Ⓕ		
TX_CURR Ⓕ	TB_PREV Ⓕ		
TX_PVLS Ⓕ	TX_ML Ⓕ		
TX_NEW Ⓕ	TX_TB Ⓕ		
VMMC_CIRC Ⓕ			

Indicator Frequency & Type	
Quarterly	Report 3 months of results for these indicators, as instructed in the indicator reference sheet, at each quarterly reporting cycle.
Semi-Annual	Report 6 months of results for these indicators, as instructed in the indicator reference sheet, at the Q2 and Q4 reporting cycles.
Annual	Report 12 months of results for these indicators, as instructed in the indicator reference sheet, at the Q4 reporting cycle.
Host Country	Host country indicators (both targets and results) are reported annually. Host country targets are provided during COP and host country results are provided during Q4 reporting. Data for host country indicators should reflect both PEPFAR and other stakeholder achievements.

MER Reporting Levels			
Standard MER Indicator Reporting Levels		*Host Country Indicator Reporting Levels*	
Ⓐ	**Above-site-level**. Indicators collected at this level are reported at the OU (country)-level by implementing mechanism.	Ⓝ	**National-level.** Host Country indicators collected at this level are reported at the at the OU (country)-level in DATIM by USG staff. These data should encompass results for the entire host country, both PEPFAR and non-PEPFAR support.
Ⓒ	**Community-level**. Indicators collected at this level are reported at a larger geographic location, not a single structure. Each PEPFAR country team has defined its own community site area. These areas overlap with districts or other geographic entities (e.g., ward, county).	Ⓢ	**Subnational-level.** Host Country indicators collected at this level are reported at the PEPFAR priority subnational unit-level by USG staff. These data should encompass results for the entire host country, both PEPFAR and non-PEPFAR support.
Ⓕ	**Facility-level.** Indicators collected at this level are reported at fixed geographic points (sites) providing HIV-related services.	Ⓕ	**Facility-level.** Host Country indicators collected at this level are reported at fixed geographic locations (sites) providing HIV-related services. These data should be reported at PEPFAR-supported sites, but should encompass both PEPFAR and non-PEPFAR support at PEPFAR-supported sites.
Ⓟ	**Point of service delivery-level.** Indicators collected at this level are still reported at facilities, but focus even more granularly on service delivery points within a site where specific services are being provided (e.g., testing, treatment, PMTCT, VMMC, etc.).		

Figure 4: PEPFAR MER Indicators Infographic



How to read a PEPFAR indicator reference sheet

All indicators in this guidance are provided in a specific format to allow the reader to easily understand the specific requirements of each indicator. Please use this layout as a guide to understand how to read the reference sheets.

Indicator Code

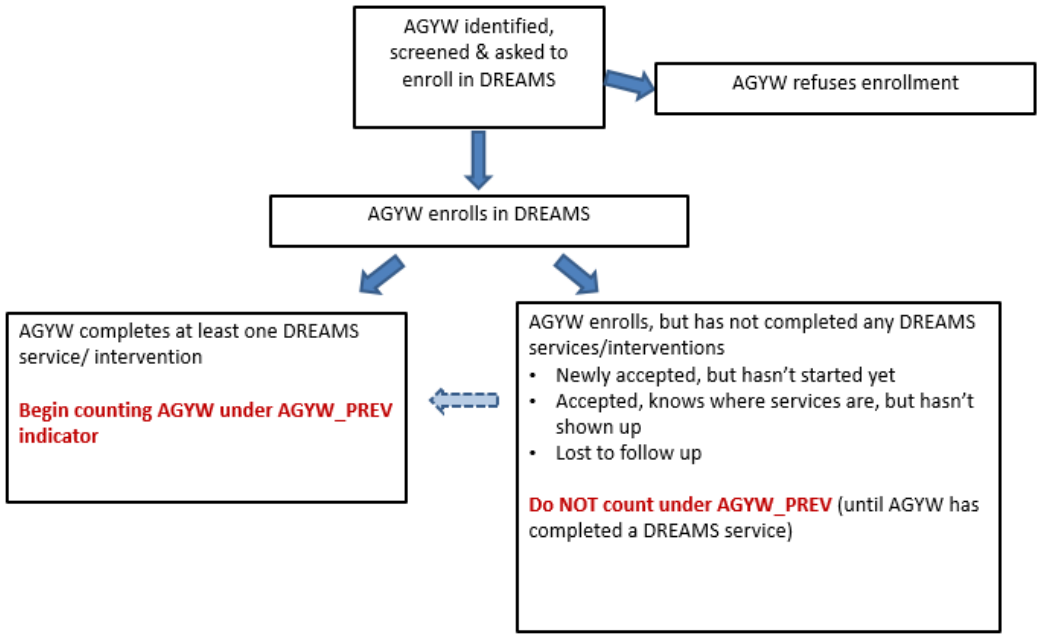
Description:	*Name of the indicator*	
Numerator:	*Name of the numerator*	*Descriptive information about the numerator*
Denominator:	*Name of the denominator*	*Descriptive information about the denominator*
Indicator changes (MER 2.0 v2.2 to v2.3):	*Highlights any changes that have occurred between MER 2.0 (versions 2.2 and 2.3). For changes prior to version 2.2, refer to the guidance from previous years.*	
Reporting level:	*Defines the level at which the indicator is reported: facility, community, and/or above-site*	
Reporting frequency:	*Defines the period at which the indicator is reported: quarterly, semi-annually, or annually*	
How to use:	*Defines how the data is used to monitor PEPFAR program activities*	
How to collect:	*Defines how the data is collected (highlighting data source, issues with double counting/deduplication, and important components of data collection that ensure data quality)*	
How to review for data quality:	*Outlines specific data quality considerations for the indicator*	
How to calculate annual total:	*Defines how annual totals are calculated for the indicator at the end of the fiscal year*	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Name of Numerator Disaggregate Group(s) [Disaggregate Requirements: (e.g., Required, Optional]	• *Disaggregations*
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	Name of Denominator Disaggregate Group(s) [Disaggregate Requirements: (e.g., Required, Optional]	• *Disaggregations*
Disaggregate descriptions & definitions:	*Describes and defines the disaggregates relevant to the indicator in greater detail*	
PEPFAR-support definition:	*Lists the indicator-specific definition for DSD vs. TA-SDI support that differ from the standard definitions outlined in the introduction section of the guidance*	
Guiding narrative questions:	*Lists the indicator-specific questions that implementing partners and USG country teams should address in the implementing mechanism and technical area summary narratives*	
Data Visualization & Use Examples:	*This section is included on the reference sheet for a highlighted subset of indicators and depicts example analyses or visualizations of the indicator's data. Examples are **not exhaustive** but are intended to be illustrative and informative. PEPFAR field teams and implementing partners are encouraged to continually innovate and improve upon any data visualizations provided here.*	

PREVENTION & SUPPORT INDICATORS

AGYW_PREV

Description:	Percentage of adolescent girls and young women (AGYW) that completed the DREAMS primary package of evidence-based services/interventions.	
Numerator:	Number of individual AGYW that have completed at least the DREAMS primary package of services/interventions at the time of reporting.	The numerator is the sum of the following age/sex/layering disaggregates: 1. Number of AGYW that have fully completed the DREAMS primary package of services/interventions but have not received any services/interventions beyond the primary package 2. Number of AGYW that have fully completed the DREAMS primary package of services/interventions AND at least one secondary service/intervention
Denominator: **[OPTIONAL]**	Cumulative number of individual AGYW enrolled in DREAMS that have ever completed at least one DREAMS service/intervention at the time of reporting.	Reporting on the denominator is optional.
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator. This indicator replaces and builds upon the service disaggregates of the OVC_SERV indicator that were previously used for DREAMS reporting.	
Reporting level:	Community (Reported by USG team, not implementing partners)	
Reporting frequency:	Semi-Annually	
How to use:	This indicator reflects program data on how many AGYW are being served in DREAMS and whether all AGYW in DREAMS have received the intended layered services/interventions to ensure that they remain HIV-free. Specifically, this indicator will measure how many AGYW have completed the DREAMS primary package of services/interventions, the primary package plus any secondary services/interventions, and how many have completed less than the primary package. **<u>Who is Captured Under AGYW_PREV:</u>** AGYW should only be counted under this indicator if they are enrolled in DREAMS AND have completed at least one DREAMS service/intervention. AGYW are not considered DREAMS beneficiaries if they have not actually completed a DREAMS service/intervention within the program. While a vulnerability assessment and/or enrollment screening may be a prerequisite to receiving a DREAMS service, the enrollment or screening by itself is not considered a qualifying DREAMS service under this indicator. Additionally, only AGYW who meet the country-specific eligibility criteria for DREAMS and are enrolled in DREAMS should be counted in this indicator (e.g., they have been screened for vulnerability and DREAMS participation, received a DREAMS passport or unique ID, etc.). AGYW and female OVC who are within the 10-24 age band but do not meet DREAMS criteria and have not been enrolled in DREAMS should not be counted in this indicator. They should instead be counted under other MER indicators such as OVC_SERV or PP_PREV as relevant to the definition of these indicators and the services that they receive. **<u>Defining the Country-Specific DREAMS Package:</u>** Each country is responsible for designating its own primary package of services/interventions for each DREAMS AGYW age band (10-14, 15-19 and 20-24) based on the DREAMS guidance. All 15 DREAMS countries will be required to submit a DREAMS Layering Table detailing their primary/secondary/contextual interventions for each age band for approval by OGAC on an annual basis during the COP process. For FY19, OGAC will	

	be reaching out to OUs for submission of their layering tables based on what was approved in COP18. Using the DREAMS Guidance and the DREAMS Layering Guidance, each DREAMS country should define the primary, secondary, and contextual package of DREAMS services/interventions for each AGYW age band (10-14, 15-19, and 20-24). • Primary services/interventions are defined as interventions that ALL AGYW in an age group should receive if they are enrolled in DREAMS in your country. • Secondary services/interventions are needs-based interventions that are part of your DREAMS core package but may not be received by all AGYW in that age group (i.e., only AGYW who experience violence should receive post-violence care). • Contextual interventions are those that are part of your DREAMS core package but cannot be linked to an individual AGYW (i.e., community mobilization). Note that these interventions should be included in your layering table but are not tracked as part of the AGYW_PREV indicator as, by definition, they are not linked to individual AGYW. **Using AGYW_PREV Results to Ensure Programmatic Layering:** The focus of this indicator is to track the layering of the country-specific DREAMS primary package of services/interventions, rather than tracking individual services/interventions themselves. Specific services received by AGYW will continue to be counted under PP_PREV, OVC_SERV, HTS_TST, PREP_NEW, PREP_CURR, PMTCT_STAT, GEND_GBV, KP_PREV, etc. as appropriate. Furthermore, AGYW enrolled in DREAMS and receiving DREAMS services should be counted under this indicator regardless of the budget code(s) funding the services that they received. For example, if an AGYW is enrolled in DREAMS and receives HIV testing, education support, and PrEP, she would be counted under HTS_TST, PREP_NEW, PREP_CURR, and OVC_SERV if she meets the definition of each respective indicator. She would also now be counted under AGYW_PREV to track if she has received the age-appropriate primary package of DREAMS services/interventions. Results from this indicator will be used to ensure that layering of DREAMS services is happening across agencies and partners within DREAMS districts and will be used to make programmatic decisions to ensure comprehensive, patient-centered prevention programming for AGYW. AGYW_PREV results will help field teams and HQ answer several essential questions related to DREAMS programming, quality, and reach. 1. How many unique clients is DREAMS serving? 2. Is layering happening as intended for all AGYW receiving DREAMS services? Are there specific services/interventions that are not reaching AGYW as intended? Are there specific SNUs where layering is stronger or weaker? Are there specific age bands where layering is stronger or weaker? 3. How does layering change over the time a girl is enrolled in DREAMS?
How to collect:	**This indicator should be reported only in SNUs where DREAMS-funded activities are occurring in the 15 DREAMS countries** (this includes countries previously referred to as DREAMS-like countries). **This indicator will be inputted in DATIM by the USG team, not individual IPs since this indicator involves data from multiple implementing partners over time**. It is recommended that one coordinating partner track layering data within an OU; however, since layering occurs between multiple implementing partners and across time and mechanisms the **USG team (DREAMS coordinator or DREAMS POC(s)) is best placed to input the data for AGYW_PREV.** Data collection requires reliable tracking systems that are designed to count the number of one-on-one encounters or participation in group interventions and that reduce double-counting of individuals in a reporting period. A unique identifier should be assigned to AGYW enrolled in DREAMS to track individual-level completion of DREAMS services across partners providing DREAMS services, where applicable. Data should be collected at every encounter/point of service and aggregated in time for PEPFAR reporting cycles.

	Examples of successful DREAMS layering data collection include the use of unique IDs, DREAMS passports or ID cards, and DHIS2 databases. It is a best practice to have one implementing partner that is responsible for the coordination of layering data systems; this partner then works across agencies and partners to ensure that all DREAMS services/interventions available to AGYW are captured within the system. Since layering occurs across partners, agencies, and over time, this indicator will be inputted by USG personnel (e.g., DREAMS coordinator or interagency DREAMS POCs). Services/interventions should only be counted towards primary package completion if the AGYW has completed that particular service/intervention. Countries should define service/intervention completion as part of their country-specific DREAMS Layering Table (e.g., country may count a multi-session intervention as complete after beneficiary has attended 80% of the sessions if that is what the instructions from the program developer indicate as completion). Do not count an intervention towards primary/secondary package completion for an individual AGYW until it has been completed. If an AGYW is enrolled in DREAMS and has received a secondary or contextual intervention but no primary interventions, then they should not be counted towards the numerator of this indicator but should still be in the denominator. **Determining the Denominator:** The AGYW_PREV denominator is optional. The denominator for this indicator is the total number of AGYW that have ever completed a DREAMS service/intervention at the time of reporting. Based on your program records and tracking system, determine the total number of AGYW who have been enrolled in the DREAMS program AND have completed a DREAMS service/intervention since its inception. The denominator will be cumulative over time and should continue to increase. As the definition of DREAMS "graduation" is currently being defined by HQ, the AGYW_PREV denominator will include AGYW that are currently, actively receiving DREAMS services and those that have completed DREAMS services in the past but are not currently active in DREAMS. The graphic below outlines the client flow for this indicator in more detail: 
How to review for data quality:	Data should be reviewed regularly for the purposes of program management, to monitor progress of layering, and to identify and correct any data quality issues. Potential data quality issues for AGYW_PREV:

<table>
<tr><td></td><td>Numerator is greater than the denominator. The total number of AGYW that have ever received a DREAMS service must be greater than the number of AGYW that have completed the DREAMS primary package of services/interventions.</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Layering and Time in DREAMS by Age/Sex [Required]</td><td>

Number of AGYW that have <u>fully completed the DREAMS primary package of services/interventions but have not received any services/interventions</u> beyond the primary package. Enrolled in DREAMS for…

0-6 month(s) by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
7-12 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
13-24 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
25+ months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F

Number of AGYW that have <u>fully completed the primary package of services/interventions AND at least one secondary service/intervention</u>. Enrolled in DREAMS for…

0-6 month(s) by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
7-12 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
13-24 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
25+ months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F

Number of AGYW that have <u>fully completed at least one DREAMS service/intervention but NOT the full primary package</u> of services/interventions. Enrolled in DREAMS for…

0-6 month(s) by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
7-12 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
13-24 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
25+ months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F

</td></tr>
<tr><td>Service Type [Optional]</td><td>

Violence Prevention
Education Support

</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex [Optional]</td><td>

10-14 F, 15-19 F, 20-24 F, 25-29 F

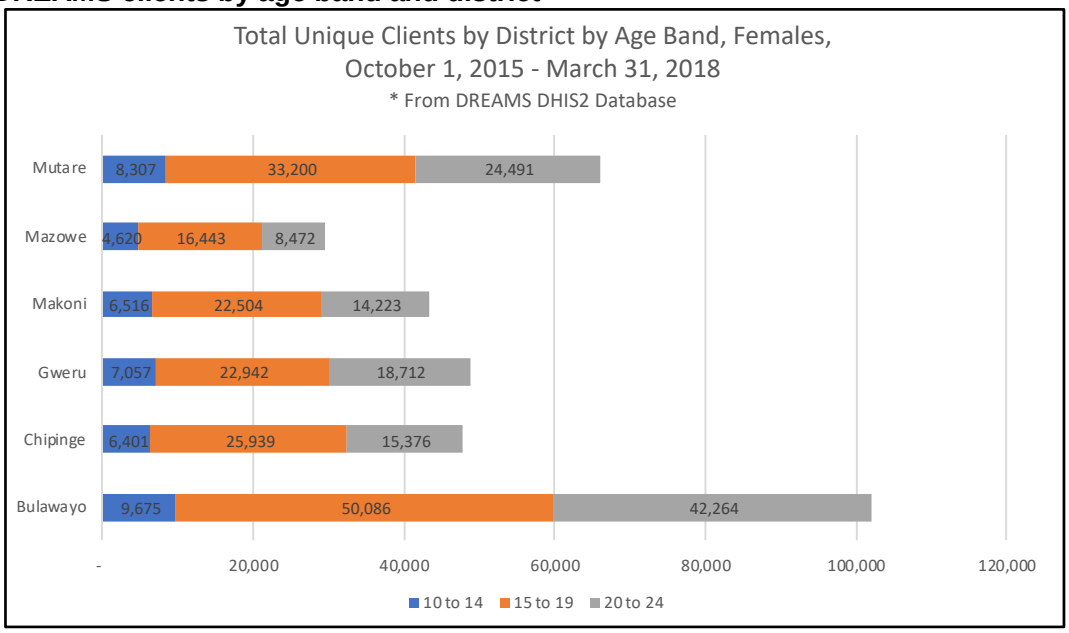
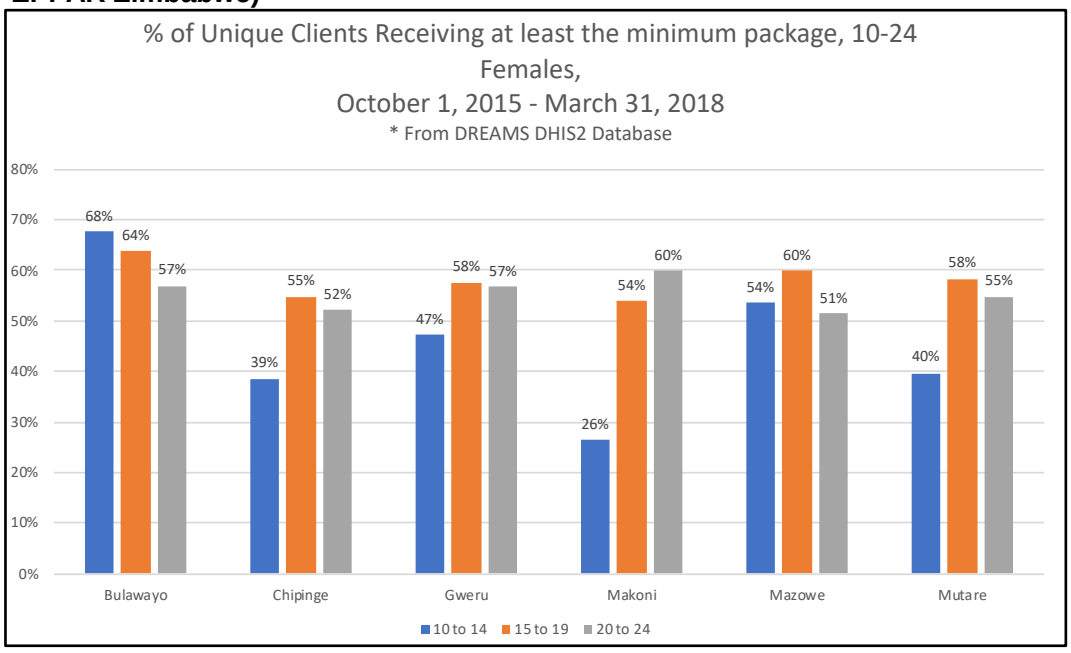
</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Numerator Disaggregates:

<u>Age/Sex/Layering/Time disaggregates [required]:</u>

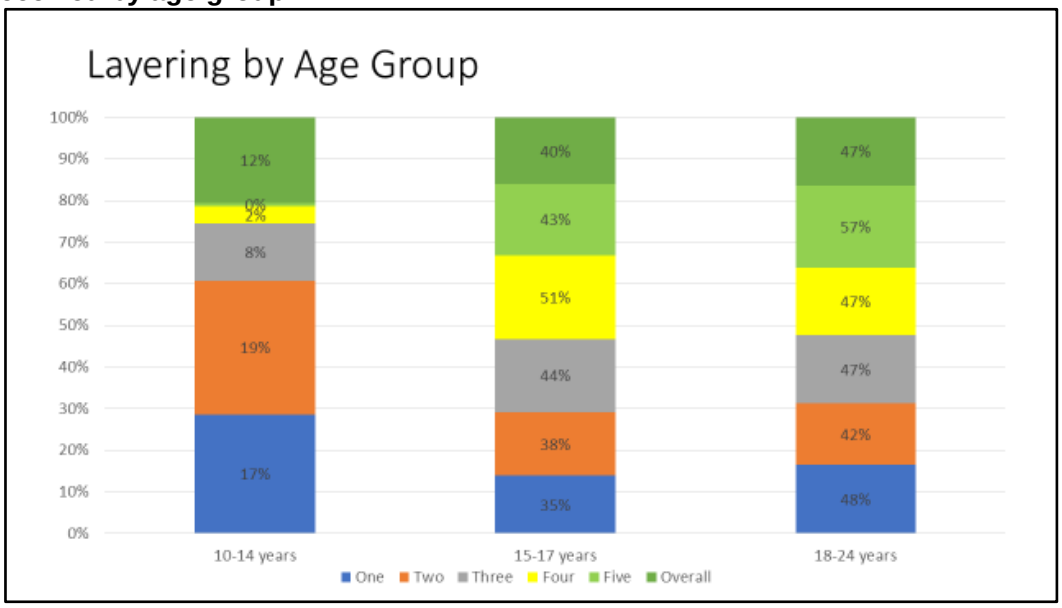
Age/Sex disaggregate: This should represent the current age of the AGYW at the time of last service delivery or the end of the current reporting period.
While the DREAMS Layering Table focuses on the DREAMS target age group of 10-24-year-old AGYW, the 25-29 age band is included here to account for AGYW who were 22-24-years-old when initially enrolled into DREAMS and have since aged out. DREAMS programming should not target 25-29-year-old AGYW unless explicitly approved in your COP.
Layering of services/interventions disaggregate: Countries should use their approved DREAMS Layering Tables to determine the makeup of the primary package of services/interventions reported in this indicator. A service should not be counted towards package completion until it is fully completed by the individual AGYW (see above).
Time in DREAMS disaggregate: Represents the time since completion of first service for each AGYW (e.g., 0-6 months disaggregate represents the number of AGYW who completed their second DREAMS service/interventions within 0-6 months of their first DREAMS service/intervention).

<u>Service disaggregates [optional]:</u>
</td></tr>
</table>

	○ Violence Prevention: Report the number of AGYW enrolled in DREAMS that received an evidence-based intervention focused on preventing violence within the reporting period. Interventions include: combination socioeconomic interventions; curriculum-based programs in schools, sports programs, or other community venues to change knowledge, skills and norms; parenting/caregiver programs that address violence prevention with parents, but also involve the AGYW. ○ Education Support: Report the number of AGYW enrolled in DREAMS who have received educational support to remain in, advance, and/or rematriculate in school within the reporting period. Interventions include: school block grants, individual bursaries, tuition, school fees, or fee exemption, support for uniforms and scholastic materials. **Denominator Disaggregates:** • **<u>Age/Sex disaggregate [optional]:</u>** ○ This should represent the current age of the AGYW at the time of last service delivery or the end of the current reporting period. ○ While the DREAMS Layering Table focuses on the DREAMS target age group of 10-24-year-old AGYW, the 25-29 age band is included here to account for AGYW who were 22-24-years-old when initially enrolled into DREAMS and have since aged out. DREAMS programming should not target 25-29-year-old AGYW unless explicitly approved in your COP.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for AGYW receiving HIV prevention services includes:</u> ongoing procurement of critical commodities such as condoms, teaching materials, or community promotion materials; funding for salaries of personnel delivering the individual, small group, or community-level intervention; stipends or incentives for volunteers; or paying for transportation of those staff to the point of Service delivery. Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>For AGYW receiving HIV prevention, ongoing support services service delivery improvement includes</u>: site supervision; training or assistance with monitoring and evaluation; QI/QC; and development of materials and protocols.
Guiding narrative questions:	Each OU should submit one narrative response, based on input from all agencies and implementing partners. 1. Describe your OU's approach to measuring layering and reporting on this indicator (e.g., unique identifiers, tracking individuals, analysis of coverage in small geographic areas). 2. If your OU was unable to report on this indicator, what actions are you taking to ensure you are able to report in the future? When do you anticipate being able to report on this indicator? 3. What challenges and/or data quality issues did you face in reporting on AGYW_PREV? 4. Were you able to report on the denominator? If so, how did you determine the number of AGYW that ever received a DREAMS service? If not, what were the barriers to reporting on the denominator for this indicator? 5. Describe your OU's approach to ensuring that partners are layering services and interventions for AGYW enrolled in DREAMS, including ensuring effective referral mechanisms and linkages have been established between clinical and community-based platforms? How have you sued the data for this indicator to inform your programming? 6. What are the challenges with implementing layering (i.e., AGYW subgroups who have difficulty participating in services/interventions, partners that have trouble with linking to services, etc.)?
General DREAMS narrative questions [Also collected in	Each OU should submit one narrative response, based on input from all agencies and implementing partners. 1. What methodology are you using to identify and target the most vulnerable adolescent girls and young women through your DREAMS program?

DATIM beginning in FY19]:	2. Are programs reaching the intended sub-populations with each of the country-specific DREAMS interventions/components of the core package? For example, if the goal for a parenting intervention was to reach parents of girls between the ages of 10 and 14 years did the program actually reach parents with girls that age? 3. How has engagement of these sub-populations changed since your last report? 4. What challenges have arisen in reaching these sub-populations since your last report? How are challenges being resolved, and are there any success stories to share since your last report?
Data Visualization & Use Examples:	**Example1: Zimbabwe DREAMS data representing cumulative total of unique DREAMS clients by age band and district**  **Example 2: Zimbabwe DREAMS data representing % of unique DREAMS clients that received at least the minimum package of DREAMS services (as defined by PEPFAR Zimbabwe)** 

Example 3: Uganda DREAMS data representing number of services AGYW have received by age group.



FPINT_SITE

Description:	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	
Numerator:	Number of service delivery points supported by PEPFAR that are providing fully integrated voluntary family planning services	Note: a service delivery point is NOT the same as a site. There can be numerous service delivery points within one site.
Denominator:	Number of total service delivery points at a site supported by PEPFAR	Not collected through the data entry screened, determined by number of sites reporting service delivery area.
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility by Service Delivery Point	
Reporting frequency:	Annually	
How to use:	This output indicator aims to measure progress towards integrating voluntary FP within the PEPFAR platform at the service delivery level. It captures information about whether FP integration is occurring at various HIV service delivery points within PEPFAR supported sites. Many PEPFAR sites will have numerous service delivery points within each site. For example, if one hospital receives PEPFAR support for both the HIV treatment department AND the ANC department, then the FPINT_SITE total for that one site is 2 service delivery points. This indicator will enable PEPFAR stakeholders to: • Gain a basic, but essential, understanding of whether FP services are being integrated in PEPFAR-supported service delivery points. • Identify gaps, including service contexts, countries, or regions with low levels of HIV/FP integration. Inherent within this indicator is the principle that integrated HIV/FP program activities must respect a client's right to make informed decisions about his or her reproductive life. This means that clients should have access to an appropriate and comprehensive range of contraceptive options; and/or to safer conception/pregnancy counseling depending upon their fertility desire and intentions. Judgements and personal opinions are not appropriate in a clinic setting. This indicator will be used to monitor coverage of HIV/FP integration at a global level. **Therefore, detailed information on completion of referrals, FP service uptake, types of contraceptive methods offered on site, and other critical components of integrated programs will not be captured through this indicator but should be maintained at the site or programmatic level.**	
How to collect:	**Definition: Voluntary Family Planning Service Provision** To be considered as a PEPFAR-supported service delivery point that directly provides fully integrated voluntary FP services, all 3 criteria below must be met. If a service delivery point provides fewer than 3 of the services noted below, it should not be counted under this indicator. The PEPFAR-supported HIV service delivery point must provide for all relevant clients, including partners in HIV discordant couples (as documented by standard operating procedures, guidelines, protocols, manuals and/or intake documents, etc.): 1. Assessment of voluntary FP needs through routine screening; 2. Provision of voluntary FP counseling (including safe pregnancy counseling for those wishing to become pregnant, or those who are pregnant); 3. Provision or referral of a broad range of modern contraceptive methods, in accordance with the National FP policy guidelines, for clients who voluntarily wish to delay or prevent pregnancy. It is very much preferred for methods to be available onsite. If	

referrals are given, they must include detailed information (e.g., facility location, hours of operation, etc.) about where methods can be accessed.

Assess Voluntary Family Planning Needs Through Screening (Number 1 above): In assessing FP needs, all clients as part of their routine care visit should be asked about their FP needs and practices. Depending upon the individual client and his or her needs, these can include: reproductive goals; prior pregnancies; living and family situation; FP knowledge; previously used FP methods and satisfaction with use; and any FP-related concerns. These needs should be assessed without expressing any personal biases about a client's preference.

Provide Voluntary Family Planning Counseling (including Safe Pregnancy Counseling) (Number 2 above): Quality voluntary FP counseling should cover a wide range of topics that are client and context specific, and that include both safe pregnancy counseling for individuals who wish to become pregnant as well as contraception for individuals who wish to avoid, space or delay pregnancy. "FP counseling" is not the same as "FP education". Depending upon the type of FP services that are offered at PEPFAR supported site; health providers or community mobilizers may provide EDUCATION and/or COUNSELING on FP.

Education activities may include distribution of printed materials, group health education and community outreach efforts among other interventions. Education helps to increase general knowledge on the benefits and importance of FP and increase support for FP use, as well as to link women and their partners to other FP services, including contraceptive method provision.

FP counseling is an interpersonal communication between the health provider and client where topics specific to the clients' needs are discussed to help them determine if they want to use FP and if so; to help them choose and use the FP method of their choice. HIV service providers or all levels can be trained and supported to develop or improve their skills at FP counseling. A wide array of FP counseling materials exist that can be used in PEPFAR settings; including national FP flipcharts, counseling cards and informational handouts

Provision or Referral of a Broad Range of Modern Contraceptive Methods (Number 3 above): Per U.S. Government legislation, and in line with national FP policies, a broad range of methods should be provided to clients, allowing them to choose the method most appropriate for them, either directly or through referral. For an SDP to be counted towards this indicator, at least three modern contraceptive methods should be available either on site or through referral. Emergency contraception is an important FP method that should be available in all HIV settings as part of FP and gender-based violence (GBV) services. Information on modern contraceptive methods can be found in the references listed at the end of this sheet. All referrals should include detailed information about where methods can be accessed (e.g., facility location, operating hours, etc.).

Special Considerations:

USG-supported FP and HIV/AIDS programs must adhere to the following principles:

- People living with HIV (PLHIV) and their partners should be provided with information on and be able to exercise voluntary choices about their health, including their reproductive health.
- The USG, including PEPFAR, supports a person's right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as use of FP methods, regardless of HIV/AIDS status.
- FP use should always be a choice, made freely and voluntarily, independent of the person's HIV status.
- The decision to use or not to use FP should be free of any discrimination, judgment, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.

<table>
<tr><td></td><td>

Access to and provision of health services, including antiretroviral treatment, for PLHIV should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of antiretroviral treatment and other drug interactions).
PLHIV who wish to have children should have access to safe and non-judgmental pregnancy counseling services.

</td></tr>
<tr><td>How to review for data quality:</td><td>FPINT_SITE counts the number of individual service delivery points (SDP) at a site with integrated FP services. It does not count the number of sites that integrate FP services. However, the number of sites can be extrapolated from the SDP data. See the definitions for SDP included above.

Denominator is greater than or equal to the Numerator: The total number of PEPFAR-supported service delivery points (the denominator) must be greater than or equal to the total number of PEPFAR-supported service delivery points that have integrated Family Planning (the numerator). (Note: this denominator is not collected through this indicator, therefore this data quality check would require triangulation with other indicators and additional data sources)</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A. Data is reported only once annually at Q4.</td></tr>
<tr><td>Disaggregations:</td><td>
Numerator Disaggregations:
<table>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Number of Service Delivery Points by Service Delivery Area [Required]</td><td>

HIV Testing Services service delivery points
Care & Treatment (includes pediatric and adolescent care and treatment) service delivery points
Antenatal Care and/or Maternity service delivery points
Priority Population Prevention service delivery points
Key Populations Service Delivery Points

</td></tr>
</table>
Denominator Disaggregations:
<table>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>
PEPFAR-Supported Service Delivery Point at a site
A PEPFAR-supported service delivery point uses PEPFAR funds to directly provide HIV-related services. It offers one or more HIV-related services including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART); screening and prophylaxis for opportunistic infections (OI); other health services for people living with HIV (e.g., positive health, dignity and prevention (PHDP), nutrition support, etc.), and prevention activities for priority populations (key populations and adolescent girls and young women). It can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point(s).
PEPFAR service delivery points for FP/HIV integration include the following:
1. HIV Testing services - includes counselling (pre-test information and post-test counselling); linkage to appropriate HIV services; and coordination with laboratory services to support quality assurance and the delivery of correct results. FP services can be made available with HIV testing services, especially for key populations and adolescent girls and young women as well as for HIV serodiscordant couples. (even if FP integration is targeting key or priority populations, if occurring in HTS the integration should be documented under HTS).
2. Care and Treatment (including Pediatric and Adolescent Care and Treatment Services) – this includes services where ART is initiated and monitored.
3. Antenatal and/or Maternity services - this includes FP education and healthy timing and spacing messages in the ANC setting (when a woman in pregnant and receiving PMTCT services and/or FP counseling and method provision post-partum.)
</td></tr>
</table>

	4. Priority Population Prevention services – this includes priority population programming, such as drop in centers and prevention sites focused on adolescent girls and young women (i.e., DREAMS). FP integration can also take place across the clinical cascade for priority populations, including care and treatment which would be recorded under care and treatment service delivery point. 5. Key Population Prevention services – this includes programming for Men who have sex with men, Transgender people, Sex workers, and People who inject drugs, such as drop in centers. FP integration can also take place across the clinical cascade for key populations, including care and treatment which would be recorded under care and treatment service delivery point.
PEPFAR-support definition:	The PEPFAR support categories of DSD and TA-SDI do not apply. To report results for this indicator, it is expected that PEPFAR provides support to the HIV service delivery area Definition: For this indicator, a "PEPFAR supported site" should include any facility site in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period. Definition: For this indicator, a "PEPFAR-Supported Service Delivery Point" at a site is a service delivery point that uses PEPFAR funds to provide HIV-related services. It offers one or more HIV-related services including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART) and TB/HIV services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). These can also include fixed locations and/or mobile operations offering routine and/or regularly scheduled services.
Guiding narrative questions:	1. Which service delivery points within supported facilities are providing integrated family planning services to people living with HIV or those at risk of acquiring HIV? (e.g., HIV prevention, HTS, C&T, PMTCT, KP, etc.) 2. What contraceptive services or methods are provided on site, and which contraceptive methods are provided through referral? Is there a tracking mechanism to ensure referrals are completed (e.g., that the client received the service)? 3. How do you ensure the quality of FP services offered at the site?

GEND_GBV

Description:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	
Numerator:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	This indicator DOES NOT include GBV prevention activities or non-clinical community-based GBV response.
Denominator:	N/A	N/A
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age/sex disaggregates updated. • Language added to the "disaggregate descriptions & definitions" section of the indicator to ensure that clients are not double-counted under this indicator.	
Reporting level:	Facility & Community	
Reporting frequency:	Annually	
How to use:	This indicator measures delivery of a basic package of post-GBV clinical services (including PEP and EC). NOTE: This indicator DOES NOT include GBV Prevention activities or non-clinical community-based GBV response (e.g., shelter programs, case management). This indicator will enable PEPFAR to: • To determine the number of individuals that are suffering from GBV and reporting to clinical partners. • To assess whether post-GBV clinical services are being used. • Gain an understanding of the uptake of post-GBV clinical services offered across PEPFAR countries. • Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. • Support efforts to assess the impact of post-GBV clinical services by correlating the reach (i.e., number of people served) of these services over time with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as survey data (DHS/PHIA/VACS). • Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.	
How to collect:	Data sources are standard program monitoring tools, such as forms, log books, spreadsheets and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of service delivery (i.e., ANC, PMTCT, ART, etc.) and aggregated in time for PEPFAR reporting cycles. The indicator can be generated by counting the number of persons receiving post-GBV clinical care, disaggregated by the age group and sex of the client receiving the service, as well as the type of service (sexual violence or emotional/physical violence) and PEP provision (see below for disaggregation information). To adequately capture the provision of these services, logs and monitoring forms will need to be used wherever the services are offered. These forms will need to track both the outcome of the initial assessment and the provision of referrals or services. For PEP specifically, registries should collect both the administration of the PEP as well as its completion and the patient's adherence. **Special considerations:** As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows:	

<table>
<tr><td></td><td>

Do no harm
Privacy, confidentiality, and informed consent
Meaningful engagement of people living with HIV (PLHIV) and GBV survivors
Accountability and M&E

</td></tr>
<tr><td>How to review for data quality:</td><td>Numerator ≥ subtotal of each of the disaggregation: The number of people receiving post-GBV clinical care should be greater or equal to the sum of each individual disaggregate group.

Total sexual violence numerator ≥ PEP age/sex disaggregates for the same reporting period.</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A. Data is reported only once annually at Q4.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Violence Service Type by Age/Sex [Required]</td><td>Sexual Violence by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
Physical and/or Emotional Violence by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of People Receiving Post-Exposure Prophylaxis (PEP) Services by Age/Sex (Disaggregate of the Sexual Violence Service Type) [Required]</td><td>Received PEP by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Violence Service Type Disaggregate Definitions:
Sexual violence (post-rape care): Although guidelines for post-rape care will vary from country to country, in addition to treatment of serious or life-threatening medical issues (e.g., lacerations, broken bones) and the necessary forensic interviews and examinations, the minimum package of post-rape care services should always begin with an assessment of the client's specific needs. The following represents the Minimum Package for post-rape care services that must be in place to count under this indicator:
Provision of Clinical Services: (all of the following must be in place, including relevant commodities, and ability to count individuals—independent of whether individuals use the specific service)
Rapid HIV testing with referral to care and treatment as appropriate
Post exposure prophylaxis (PEP) for HIV -- if person reached within the first 72 hours
STI screening/testing and treatment
Emergency contraception, if person is reached in the first 120 hours. PEPFAR funds cannot be used to procure EC. EC is legal in all PEPFAR countries except Honduras, so should be available in all countries except for Honduras
Counseling (other than counseling for testing, PEP, STI and EC)
Physical and/or emotional violence (other Post-GBV care): GBV can take many forms and includes physical and emotional violence. The following services should be available for persons who have experienced GBV that is not sexual. If a client experiences both sexual and physical and/or emotional violence, the client should be counted under the sexual violence disaggregate-only. However, the client should receive the appropriate services as defined under both packages. Services should</td></tr>
</table>

	always begin with an assessment of the client's specific needs and include, as appropriate. The following represents the Minimum Package for other post-GBV care services that must be in place to count under this indicator: • Provision of Clinical Services: (all the following must be in place and available to count persons—independent of whether people use the specific service) • Rapid HIV testing with referral to care and treatment as appropriate (Please note that individuals should also be counted under the MER HIV testing and counseling indicator (i.e., # of individuals who received HIV testing and counseling services and received their results). • STI screening/testing and treatment • Counseling (other than for HIV counseling and testing) **For both Sexual violence and Physical and/or emotional violence: These** cannot be counted for the indicator alone, however where applicable should be offered: • Longer-term psycho-social support (e.g., peer support groups) • Legal counsel • Police • Child protection services • Economic empowerment **Number of People Receiving Post-exposure prophylaxis (PEP) Services Description:** PEP service provision should only be counted under this indicator if the individual receives PEP treatment (i.e., drugs) in accordance with international and/or national protocols, guidelines, etc., and if the individual **completes** the full course of treatment. If an individual is provided with PEP, completes the full course of treatment (and meets the other criteria detailed within this indicator reference sheet) the individual should be counted under this GBV care indicator. The individual should not be additionally counted under other MER treatment indicators (e.g., # of individuals new on ART; # of individuals ever on ART, etc.) PEP is intended to prevent HIV infection, while other MER treatment indicators monitor ARV provision to those who are HIV positive.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for GEND_GBV includes</u>: ongoing procurement of commodities (e.g., ARVs, rapid HIV test kits, STI testing or treatment commodities) or funding of salaries (partial or full) for HCW actively delivering the components of GBV care in accordance with international or national protocols or guidelines [i.e., physicians, nurses, and other health care workers who can assess GBV and provide treatment and appropriate referrals. <u>Ongoing support for GEND_GBV service delivery improvement includes</u>: mentoring and supportive supervision, training, guidance development, site level QA/QI, regular assistance with monitoring and evaluation functions and data quality assessments, or commodity consumption forecasting and supply management.
Guiding narrative questions:	1. How are GBV cases identified in the community and/or at the facility? If cases are identified at the community, how are they referred to a facility for post-GBV clinical care? 2. Of those coming in for services who are screened and disclose sexual violence, what proportion receive PEP? What proportion of those who disclose sexual violence refuse PEP? 3. Is site level data on the type of violence disclosed collected? If so, please provide available data in the narratives on the proportion that disclose physical and/or emotional violence, and of those choose to receive services. 4. What proportion of clients experienced both sexual and physical/emotional violence? a. Note: If clients experience both sexual and physical/emotional violence, they should only be counted under sexual violence to ensure that there is no duplication.

KP_MAT

Description:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months	
Numerator:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months within the reporting period	This indicator provides information on the total number of individuals who have been on treatment for at least 6 months within the reporting period.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility	
Reporting frequency:	Annually	
How to use:	When proper and sufficient dosage is administered, medication-assisted therapy (MAT) is highly effective in reducing opioid use and the injecting behaviors that put opioid-dependent people at risk for HIV. In addition, MAT can help improve retention for those who are on ART. Therefore, all people who are dependent on opioids should be offered and have access to this service. The implementation of MAT programs should facilitate and enhance access to HIV-specific services for PWID including HIV testing services, linkages to ARV treatment programs, PMTCT for female PWID, and a range of other prevention and harm reduction services. Implementing partners providing MAT referrals-only should not use this indicator unless it the services being provided meet the KP_MAT_TA requirement outlined in the PEPFAR-support definitions below. Please refer to the "KP_PREV" indicator to see if the services provided meet reporting criteria for that indicator as well.	
How to collect:	This indicator provides information on the total number of individuals who have been on medication-assisted therapy (e.g., methadone, buprenorphine, or buprenorphine/naloxone to treat drug dependency) for at least six months within the reporting period. Consequently, data for this indicator can be generated by counting the number of individuals who are currently receiving MAT or received at least 6 months of MAT in the reporting period in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. Count all individuals who have completed at least 6 months of MAT even if they drop-out, die, or are otherwise lost to follow-up, as long as they completed the minimum of 6 months MAT within the reporting period. Do not count individuals who initiate treatment too late in the reporting period to be able to reach a minimum of 6 months by the time of reporting.	
How to review for data quality:	This indicator makes use of program data as part of an on-going cohort. The MAT register and/or patient-level data can be used to determine the number of people starting MAT in the defined period, as a cohort, and the number of those who are still in treatment 6 months and who were on MAT for at least six months during the reporting period. Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues.	
How to calculate annual total:	N/A. Data is reported only once annually at Q4.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Sex	• Male • Female
	Denominator Disaggregations:	

	Disaggregate Groups	Disaggregates
	N/A	N/A
Disaggregate descriptions & definitions:	N/A	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used: <u>Provision of key staff or commodities for PWID on MAT includes</u>: procurement of methadone or any other medication assisted options for the treatment of opioid dependence, or funding for salaries of personnel delivering the service (i.e., HCW, program managers). Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>Ongoing support for MAT services for PWID service delivery improvement includes</u>: mentoring and supportive supervision, training, MAT guidance development, site level QA/QI, regular assistance with monitoring and evaluation functions and data quality assessments, or MAT consumption forecasting and supply management.	
Guiding narrative questions:	1. Were the individuals who initiated MAT too late in this reporting period (at least 6 months prior) excluded from the results?	

KP_PREV

Description:	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	
Numerator:	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	The numerator can be generated by counting the number of unique individuals from an activity who are reached with prevention interventions designed for the intended key population.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Denominator has been removed.	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	This indicator provides information on the total number of unique individuals that have received individual-level and/or small-group level intervention(s). This indicator will help determine the reach of key populations and may help understand the relative saturation (coverage) of PEPFAR-supported KP prevention programs when reliable population size estimates are available. Small-group intervention is defined as less than or equal to 25 individual attendees in one setting. HIV testing services (HTS) or referring an individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this indicator. A partner may count an individual (with unknown HIV serostatus or self-identified as HIV negative) as having received a prevention activity if they have provided, offered, or referred to HTS AND at least one additional listed prevention activities below (outside of HTS) during the reporting period. If an individual is already known to be HIV positive at the time of the outreach, s/he should receive at least one of the interventions listed in the table (outside of HTS) to qualify as being counted under this indicator. The table below lists the prevention interventions that a partner may offer in addition to HTS (or HTS referral).	

Prevention Interventions for Key Populations
• **Offer or refer to HTS* (Required)**
• Targeted information, education, and communication (IEC)
• Outreach/Empowerment
• Condoms
• Lubricant
• Offer or refer to STI screening, prevention, and treatment
• Link or refer to ART
• Offer or refer to prevention, diagnosis, treatment of TB
• Offer or refer to screening and vaccination for viral hepatitis
• Offer or refer to Reproductive Health (Family Planning; PMTCT), if applicable
• Refer to medication-assisted therapy (MAT), if applicable
• Offer or refer to needle syringe program (NSP), if applicable

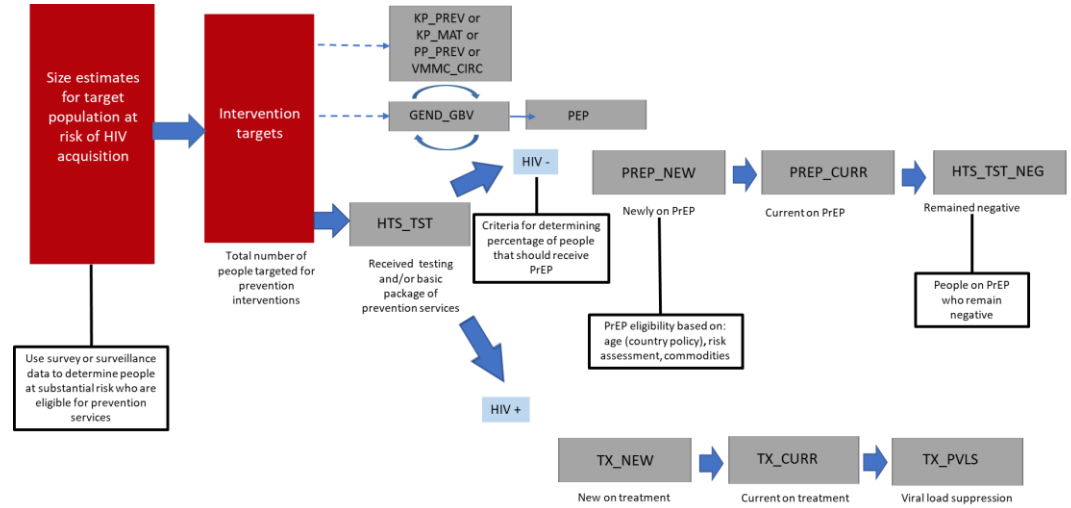
	*Partner should also report the number of individuals tested under the indicator "HTS_TST" if HTS was conducted (and results were given) as part of the outreach activity. If it was a documented complete HTS referral to the facility, it can be counted as HTS_TST_TA. Please refer to the HTS_TST indicator definition sheet for details.
How to collect:	Tracking systems must be able to reduce double-counting of individuals in a reporting period. The numerator can be generated by counting the number of de-duplicated individuals who were reached and had completed the appropriate prevention intervention(s) designed for the intended key population. For example, this means that when a unique individual receives HTS referral plus condoms and lubricant at more than one occasion during the reporting period, **the person is counted only once** for being reached for this indicator. Furthermore, **de-duplication of all returning beneficiaries within the Q3-Q4 reporting period (April 1 – September 30) will also need to take place in Q4 reporting if they had already been counted under KP_PREV in Q1-Q2 of the same fiscal year**. For example, if an individual had received prevention interventions under KP_PREV through PEPFAR-supported program in January 2017 and was counted as being reached in FY17 Q2 reporting cycle, and this same individual was later reached with prevention services again by PEPFAR-supported program in June 2017, that individual should NOT be reported again in the FY17 Q4 reporting period. This de-duplication is critical to accurately track the **ANNUAL** number of unique individuals reached by PEPFAR within a given fiscal year. Trend analysis of past performance of KP_PREV data will be adversely affected with the change in frequency of KP_PREV reporting from annually to semi-annually if this de-duplication is ignored (i.e., annual number of KP_PREV reported within the same fiscal year would be inflated as the same individual would be counted twice if this de-duplication does not occur at Q4 reporting). If possible, a unique identifier can be assigned. The use of a unique identifier can help programs monitor the frequency of contact/outreach of a single individual over time (i.e., Beneficiary A with unique identifier AW0901 had four documented outreach visits in FY17 but was only counted once under KP_PREV in FY17).

How to review for data quality:	Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues. Potential data quality issues with KP_PREV are:
	• Numerator
	  ○ The Numerator is = to the sum of the disaggregation: The number of KP reached with individual and/or small-group level preventive interventions should be equal to the sum of KP disaggregates.
	  ○ Despite persons potentially falling into more than one KP disaggregate (e.g., FSW who injects drugs), implementing partners should be instructed to report an individual in only one KP category with which s/he is most identified.

How to calculate annual total:	Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
KP Type [Required]	• MSM who are SW; • MSM who are not SW; • TG who are SW; • TG who are not SW; • Female SW; • PWID male; • PWID female; • People in prisons and other closed settings
Testing Services [Required]	• KP known positive; • KP was newly tested and/or referred for testing;

		• KP declined testing and/or referral
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	Testing Services Disaggregates Definitions: • **Known Positive:** Persons within each key population type for whom HIV testing is not indicated because they are known to be HIV-positive. HIV-positive test results should be verified, if possible, for all persons accessing HIV prevention services during the reporting period. Implementing partners should maintain records (without personally identifiable information) on whether the HIV-positive client is linked to treatment. Patients tested positive in previous reporting periods should be counted as Known Positives. • **Newly Tested and/or Referred for Testing:** Persons within each key population type for whom HIV testing is indicated because they do not know their HIV status or their last HIV-negative test was more than 3-6 months ago (or more/less frequently as indicated by National Guidelines) should either be offered an HIV test on site or given information about where and when they can access an HIV test at another nearby clinic. Every attempt should be made to ensure the client is linked with HIV testing services that are KP-friendly, and where possible the completed referral should be documented (i.e., the client accessed HIV testing). Note: Persons who access testing and whose results are newly tested HIV-positive in the reporting period should also be counted under "newly tested" even if they return for additional prevention services during that reporting period. • **Declined Testing and/or Referral:** Persons who, after explaining the benefits of HIV testing and the reason for testing every 3-6 months (or more/less frequently as indicated by National Guidelines), decline to be tested on-site or referred to a site where HIV testing is offered. Although every attempt should be made to support key populations with HIV testing as part of the package of HIV prevention services and to provide HIV testing on site or KP-friendly sites, programs should also respect the autonomy of clients to decline this service. Clients who decline testing and/or referral can still receive other prevention services, as long as the benefits of HIV testing were explained and testing or a referral for testing was offered.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for KP receiving HIV prevention services include</u>: ongoing procurement of critical commodities such as test-kits, condoms, lubricants, or funding for salaries of personnel providing any of the prevention package components (i.e., peer navigators, outreach workers, program managers). Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>Ongoing support for HIV prevention among KP improvement includes</u>: mentoring and supportive supervision; training; organizational strengthening; QA/QI; program design like development of training curricula, prevention guidance development, or standard operating procedures (SOPs) and follow-up to ensure fidelity to the program design; regular assistance with monitoring and evaluation functions and data quality assessments; or condom forecasting and supply management.	
Guiding narrative questions:	1. Did the IMs de-duplicate all returning beneficiaries in Q3-Q4 who have already been counted in Q1-Q2 of this fiscal year? If not, why not? 2. Are there mechanisms in place (i.e., unique identifier) in which IMs can de-duplicate multiple outreach encounters within a fiscal year? What are these mechanisms? If mechanisms are not in place, how does the IM report individuals and not encounters within the fiscal year? 3. Do the testing service disaggregations equal the total number of KP_PREV reported? If not, why not? 4. What were the barriers in collecting testing service disaggregations for this indicator?	

Data Visualization & Use Examples:	HIV Prevention Cascade: 

OVC_SERV

Description:	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	
Numerator:	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	The numerator is the sum of the following Program Participation Status disaggregates: 1. Active beneficiaries (children and caregivers) 2. Graduated beneficiaries (children and caregivers graduated in the reporting period)
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Clarifying language added to this indicator reference sheet. Only children (and their caregivers) that actually received one or more services in each of the preceding two quarters should be counted in this indicator. OVC that have registered for the program (i.e., been enrolled and assessed) but have not yet received any services should not be counted in the results. A beneficiary enrolled for the first time during the reporting period must receive at least one service during the previous quarter. The purpose of this indicator is to assure that beneficiaries are being reached promptly and regularly with needed support. • Illustrative eligible interventions that qualify a beneficiary to be counted as active have been added, for both children and caregivers (see Appendix D). The illustrative lists while comprehensive, are not exhaustive. For services that are not captured in the list, local USG funding agency approval must be received in order to count these services toward active OVC status. • Requirements for active status defined by several, potentially overlapping, categories of recipients: child beneficiaries, caregiver beneficiaries, and DREAMS participants aged 10-17. • Minimum graduation benchmarks have been established to ensure that PEPFAR programs have aligned objectives for progressing children and their caregivers to a minimum level of stability. Children and caregivers in a household move from active to graduated status together when each has met the minimum benchmarks (reflecting the family-centered nature of OVC programming). • Clarifying language has been added to the indicator reference sheet regarding the annual total and the timeframe of data submitted for Q4 disaggregates. Individuals should only be counted once by each partner at Q4 reporting (i.e., the active, graduated, transferred, and exited disaggregates are mutually exclusive), with graduated and active categories taking precedent. • Program participation status (active or graduated) will be collected by age/sex. Age bands have been revised for those 18 and older from 18-24 M/F to 18+M or 18+F, and for those <10 to <1, 1-4, and 5-9. • DREAMS specific disaggregates (OVC_SERV age/sex/service) have been removed to align with the new AGYW_PREV indicator.	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	PEPFAR is mandated to care for children orphaned or made vulnerable by HIV. Mitigating the impact that HIV is having on children and the families that support them is integral to a comprehensive HIV response. It is important to note that the definition of “affected” children includes, but is not limited to, children living with HIV and children at risk of HIV infection. PEPFAR recognizes that individuals, families, and communities are affected by HIV in ways that may hinder the medical outcomes of HIV-positive persons as well as the emotional and physical development of children orphaned or made vulnerable by HIV/AIDS. A variety of services (per Technical Considerations 2017) are supported through PEPFAR to mitigate these effects in order to improve health and well-being outcomes of children and adults to contribute to epidemic control. The goal of OVC programs is to build stability and resiliency	

	in children and families who are exposed, living with, at risk of, or affected by HIV/AIDS. This is achieved through rigorous case management and provision of and access to health and socio-economic interventions. This indicator is a direct (output) measure of the number of individuals receiving PEPFAR OVC program services for children and families affected by HIV/AIDS. The total numerator of this indicator is disaggregated by Program Participation Status "active" to track the number of OVC and caregivers actively enrolled in an OVC program and receiving services, and "graduated" to track the number of OVC and caregivers graduating from PEPFAR OVC programs. Graduation requires that each child and caregiver in the household achieve a global set of minimum benchmarks. These graduation benchmarks purposefully set a high standard for children and caregivers to exit the program in a stable situation. Partners may include additional benchmarks based on local criteria for achieving stability. Additional disaggregates for "transferred out to a PEPFAR-supported partner", "transferred out to a non-PEPFAR supported partner", and "exited without graduation", while not included in the total numerator, capture critical information on the differing situations of children who have left the program and track the movement of children and their caregivers between PEPFAR and host-country programs that provide a sustainable response to OVC needs. Transfers to host-government services for unstable households in geographic areas not prioritized by PEPFAR should be counted as transfers to non-PEPFAR supported programs. Illustrative eligible interventions have been added to this guidance to ensure that children (and their caregivers) counted as "active" receive substantive, timely, and regular support based on a needs assessment after enrollment. See Appendix D.
How to collect:	Data sources include PEPFAR OVC program registers and other records of program data generated by implementing partners. Implementing partners' registers need to record names of children and caregivers, likely requiring use of a unique ID system, who meet the criteria for "active beneficiary" or "graduated" to generate the numerator total and disaggregates included in this indicator. Each individual should be counted only once under OVC_SERV in the reporting period. In addition to counting active and graduated beneficiaries, implementing partners should record whether children or caregivers "transferred out to a PEPFAR-supported partner", "transferred out to a non-PEPFAR supported partner", or "exited without graduation." The program participation status and transfer/exit disaggregate categories are mutually exclusive. All agencies receiving HKID funding are required to report on this indicator. Please note that there is specific guidance related to graduation. PEPFAR guidance for graduation from an OVC project includes the following eight benchmarks (see Appendix E for additional details and definitions). Reporting scenarios and frequently asked questions for OVC reporting are included in Appendix F.
How to review for data quality:	Review PEPFAR OVC implementing partners' results to ensure that there is no double counting. Review IP and site results for deviations from one period to the next which may indicate rapid exit and entry of beneficiaries or high sudden graduation rate in one, versus another period. Age/sex disaggregates will auto-sum the total numerator.
How to calculate annual total:	To calculate data for annual results for OVC_SERV: Sum the reported number of Q4 Active (children and caregivers who received services in each of the preceding two quarters (Q3 + Q4)) + Q4 Graduated (all OVC that graduated from the OVC program in the fiscal year). Q4 OVC_SERV = (Active Q4) + (Graduated Q4)

<table>
<tr><td></td><td colspan="2">Individuals should only be counted once by each partner at Q4 reporting. Program participation status at the end of Q4 should take precedence for where to count an individual (i.e., if a beneficiary was counted as exited without graduation at Q2 but had met the criteria to be counted as active at Q4 then they should be reported at Q4 only under the active category and not in the total reported for exited without graduation).</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Program Participation Status (active or graduated) by Age/Sex [Required]</td><td>• Active (Report the number of children and caregivers that received at least one service in each of the preceding two quarters OR received at least one service in the preceding quarter if registered during the reporting period) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18+ F/M
• Graduated (At Q2: Report the number of children and caregivers that graduated from the OVC program in previous two quarters. At Q4: Report the number of children and caregivers that graduated from the OVC program in the past four quarters.) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18+ F/M</td></tr>
<tr><td>Exited or Transferred [Required]
Disaggregate should be reported into DATIM for exited or transferred, even if no numerator (active + graduated) values are reported.</td><td>• Transferred out to a PEPFAR-supported partner (At Q2: Report the number of children and parents/caregivers that transferred out to a PEPFAR-supported partner in the past two quarters. At Q4: Report the number of children and parents/caregivers that transferred out to a PEPFAR supported partner in the past four quarters.)
• Transferred out to a non-PEPFAR supported partner (At Q2: Report the number of children and parents/caregivers that transferred out to a non-PEPFAR-supported partner in the past two quarters. At Q4: Report the number of children and parents/caregivers that transferred out to a non-PEPFAR supported partner in the past four quarters.)
• Exited without graduation (At Q2: Report the number of children and caregivers that exited in the past two quarters. At Q4: Report the number of children and parents/caregivers that exited in the past four quarters and did not return to active status (i.e., those who are exited without graduation as of the last day of the reporting period)</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Program Participation Status Definitions:
• “Active beneficiary” <u>is an individual, a child or caregiver, who has received at least one PEPFAR OVC program service in each of the preceding two quarters. New beneficiaries registered during the reporting period can be counted as active only if they have received at least one service in the last quarter</u>. For OVC_SERV, a caregiver fulfills the role of parent or guardian, and there should be no more than two caregivers per child beneficiary. While adults or household members who are not caregivers fulfilling the role of parent or guardian may indirectly benefit from program support or access a one-time service, they should not be counted as that does not meet the intention of increasing primary caregivers’ access to critical services and support.</td></tr>
</table>

Active OVC_SERV beneficiaries include several, potentially overlapping, categories of recipients with the following requirements:

1. Child beneficiary ("OVC") aged 0-17 (note: children aged 18 to 20 and still completing secondary education may be included per the PEPFAR OVC 2012 Guidance):
    a. Has a case plan developed (or updated) in last 12 months
    b. Continues to be monitored at least quarterly, but as often as is necessary according to the child's safety, schooling, stability, and health status. Monitoring includes establishing contact in person, or virtually where needed, to ensure that the case plan is progressing, and documentation of this contact is recorded in the case plan.
    c. Has received directly from the project, was facilitated to obtain, or has a completed referral for at least one intervention in each of the preceding two quarters (see Appendix D for illustrative eligible interventions for children ages 0-17; if a service is not included on this list seek approval from local USG funding agency). Intake assessment, enrollment, subsequent assessments including HIV risk assessment, case plan development, and case plan monitoring are considered critical administrative processes rather than services but remain critical to ensuring provision of needs-based services in a timely manner.
2. Caregiver beneficiary (primarily aged 18+) of an OVC (child/adolescent aged 0-17 or 18-20 still enrolled in secondary education) who has met the following criteria:
    a. Has received directly from the project, was facilitated to obtain, or has a completed referral for at least one caregiver intervention in each of the preceding two quarters (see Appendix D for illustrative examples).
    b. In addition, select services, including parenting, household economic strengthening, and food security interventions (specified in Appendix D in the caregiver and child column), qualify both the caregiver and OVC to be counted as active.
3. DREAMS participant aged 10-17
    a. A DREAMS participant who is not otherwise actively enrolled in an OVC program must receive a DREAMS service/intervention that is also included in the list of OVC_SERV illustrative services (Appendix D). However, they are not required to have an OVC case plan.

- **"Graduation"** is defined as when a household enrolled in a PEPFAR OVC program is deemed to have become more stable and is no longer in need of project-provided services. For caregivers and children 17 or under (or aged 18- 20 and completing secondary education for OVC program beneficiaries) to be counted as an individual graduated in DATIM, all child and all caregiver beneficiaries in a household must meet all applicable (age and HIV status specific) graduation benchmarks established by PEPFAR for improving stability in the household. For the purposes of graduation, a household is defined as all children in the household less than age 18 years and their caregiver(s) (not to exceed two people fulfilling the role of parent or guardian). PEPFAR guidance for graduation from an OVC project includes the following eight benchmarks (see Appendix E for additional details and definitions), which align with the illustrative services in Appendix D.

Graduation Benchmarks:

DOMAIN: HEALTHY

- BENCHMARK: All children, adolescents, and caregivers in the household have known HIV status or test not required based on risk assessment
- 1.2.1. (a) BENCHMARK: All HIV+ children, adolescents and caregivers in the household with a viral load result documented in the medical record and/or laboratory information systems (LIS) have been virally suppressed for the last 12 months.
  OR If viral load testing or viral load testing results are unavailable at clinic treating HIV+ beneficiaries, then:

	○ 1.2.1. (b) BENCHMARK: All HIV+ children, adolescents, and caregivers in the household have adhered to treatment for 12 months after initiation of antiretroviral therapy ○ 1.3.1. BENCHMARK: All adolescents 10-17 years of age in the household have key knowledge about preventing HIV infection ○ 1.4.1. BENCHMARK: No children < 5 years in the household are undernourished **DOMAIN: STABLE** ○ BENCHMARK: Caregivers are able to access money (without selling productive assets) to pay for school fees and medical costs for children aged 0-17 **DOMAIN: SAFE** ○ BENCHMARK: No children, adolescents, and caregivers in the household report experiences of violence (including physical violence, emotional violence, sexual violence, gender-based violence, and neglect) in the last 6 months ○ 3.1.2. BENCHMARK: All children and adolescents in the household are under the care of a stable adult caregiver **DOMAIN: SCHOOLED** ○ BENCHMARK: All school-age children and adolescents in the household regularly attend school and progressed in school during the last year **Exited or Transferred Disaggregate Definitions:** • **"Transferred out to a non-PEPFAR-supported partner"** is defined as when a child or caregiver beneficiary has transitioned to programs that are not PEPFAR funded. These could include country-led services or other donor funded programs. • **"Transferred out to a PEPFAR-supported partner"** is defined as when a child or caregiver beneficiary has transitioned from the support of one PEPFAR partner to another PEPFAR-partner. • **"Exited without graduation"** is defined as when a child or caregiver has not received program services in each of the past two preceding quarters or is lost-to-follow up, re-located, died, or the child has aged-out of the program without the household meeting graduation benchmarks from PEPFAR OVC program. Program participation status categories (i.e., active, graduated, exited without graduation, transferred out to a non-PEPFAR-supported partner, and transferred out to a PEPFAR-supported partner) are mutually exclusive such that an individual should be counted under only one category, per partner, per reporting period.
PEPFAR-support definition:	Modifications to standard definition of DSD and TA-SDI related to eligible goods and services: <u>Provision of key staff or eligible goods/services for OVC beneficiaries receiving care and support services in the community includes</u>: For beneficiaries of OVC services, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group or community level activity (e.g., psychosocial support, child protection services, education, etc.). Partial salary support may include stipends or incentives for volunteers/para-social workers or paying for transportation of those staff to the point of service delivery. For goods or services to be eligible, goods or services (e.g., bursaries, cash transfers, uniforms) can either be paid for out of the implementing partner's budget or be provided as a result of the IP's efforts to leverage and mobilize non-project resources. For example, an IP may help beneficiaries fill out and file forms necessary for the receipt of government provided cash transfers, social grants, or bursaries for which they are eligible. Given the focus on long-term local ownership, IP's are encouraged to mobilize goods and services whenever possible. <u>For care and support services, ongoing support for OVC service delivery for improvement includes</u>: the development of activity-related curricula, education materials, etc., supportive supervision of volunteers, support for setting quality standards and/or ethical guidelines, and monitoring visits to assess the quality of the activity, including a home visit, a visit to a

	school to verify a child's attendance and progress in school or observation of a child's participation in kids' clubs.
Guiding narrative questions:	1. Please explain reasons and context for highest/lowest performing partners' performance (i.e., results/target) for OVC_SERV total numerator and OVC_SERV <18, including any programmatic shifts or monitoring updates that were made as a result of the change in indicator guidance for MER v2.3. 2. Please explain results by Program Participation Status: a. For active beneficiaries, were there any interventions that were provided and approved by local USG funding agency that were not included in the illustrative examples (Appendix D)? b. For graduation, were any of the benchmarks especially challenging to achieve or monitor? If so, which? 3. Please explain results by exited/transferred: a. How many beneficiaries exited without graduation? Please explain the reasons for exiting without graduation and try to quantify with percentages if possible. Are there certain partners with higher rates of exiting without graduation? How are you managing this with the partner(s)? b. How many beneficiaries were transferred? To whom (e.g., other NGOs, government support, etc.). Where were beneficiaries transferred? Please provide disaggregates for beneficiaries transferred to specific sources of support.

PP_PREV

Description:	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	
Numerator:	Number of priority populations reached with standardized HIV prevention intervention(s) that are evidence-based	The numerator is the number of individuals from each priority population reached with HIV prevention interventions during the reporting period. For the purposes of reporting, the team will sum the numbers reached in each of the priority populations and report that total (details of the priority populations reached should be explained in the narratives).
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age/sex disaggregates updated. • Denominator has been removed. • Optional priority populations disaggregation category added to the numerator.	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	The indicator represents PEPFAR-supported programming only and helps to determine PEPFAR's reach to priority populations. It may also help inform coverage of PEPFAR-supported programming for priority populations when reliable population size estimates are available. **Priority populations:** Priority populations should be defined by each country in the indicator narrative and must have a documented HIV prevalence or incidence greater than the general population of the country. Groups that might be counted as priority populations include: • Adolescent girls and young women (determined using the reported age/sex disaggregations) • Adult men women (determined using the reported age/sex disaggregations) • Clients of sex workers • Displaced persons • Fishing Communities • Military and other uniformed services • Mobile Populations • Non-injecting drug users **Package of interventions:** Together with the IP, the country team designs a set of interventions for each of the priority populations. In a defined catchment area for the specific priority population, all prevention interventions may not be offered by one IP. However, all required intervention must be available in the catchment area for the priority population. Interventions must adhere to written protocols, include goals and activities, and be designed to promote adoption of key behaviors that support HIV prevention and service uptake among the priority population(s). The interventions should comprise multiple encounters with the same individuals or groups. HIV testing services (HTS) or referring an individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this indicator.	

The table below lists the interventions that must be offered in addition to HTS (or HTS referral).

Required Interventions for Adult Populations	Required Interventions for Youth Populations
• Promotion of relevant prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.	• Promotion of relevant youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
• Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.	• Information, education and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.
• Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.	• Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
• Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.	• Condom and lubricant (where feasible) promotion, skills training, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other youth-friendly, community-based service outlets.
	• Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

How to collect:

Data collection requires reliable tracking systems that are designed to count the number of one-on-one encounters or participation in group interventions and that reduce double-counting of individuals in a reporting period. Data should be collected at every encounter/point of service and aggregated in time for PEPFAR reporting cycles. This indicator only counts those interventions at the individual and/or group level.

A partner may count an individual (with unknown HIV sero-status or self-identified as HIV negative) as having received a prevention intervention if they have provided HTS and/or referral to HTS **AND** at least one of the other listed prevention interventions during the reporting period. If an individual is already known to be HIV positive at the time of service delivery, s/he should receive at least one of the interventions listed in the table (outside of HTS) to qualify as being counted under this indicator.

Tracking systems must be able to reduce double-counting of individuals in a reporting period. **An individual will be reported when he/she first receives any of the required interventions in the reporting period; if the same individual receives any subsequent interventions during the same reporting period they will be reported as a returning beneficiary and not counted again in the reporting period.**

Furthermore, **de-duplication of all returning beneficiaries within the Q3-Q4 reporting period (April 1 – September 30) will also need to take place in Q4 reporting if they had already been counted under PP_PREV in Q1-Q2 of the same fiscal year**. For example, if an individual had received prevention interventions under PP_PREV through PEPFAR-supported program in January 2017 and was counted as being reached in FY17 Q2 reporting cycle, and this same individual was later reached with prevention services again by PEPFAR-supported program in June 2017, that individual should **NOT** be reported again in the FY17 Q4 reporting period. This de-duplication is critical to accurately track the **ANNUAL** number of unique individuals reached by PEPFAR within a given fiscal year.

<table>
<tr><td></td><td>Trend analysis of past performance PP_PREV data will be adversely affected with the change in frequency of PP_PREV reporting from annually to semi-annually if this de-duplication is ignored (i.e., annual number of PP_PREV reported within the same fiscal year would be inflated as the same individual would be counted twice if this de-duplication does not occur at Q4 reporting).

If possible, a unique identifier should be assigned to program participants or names can be collected to track individual participation in the prevention interventions/sites.

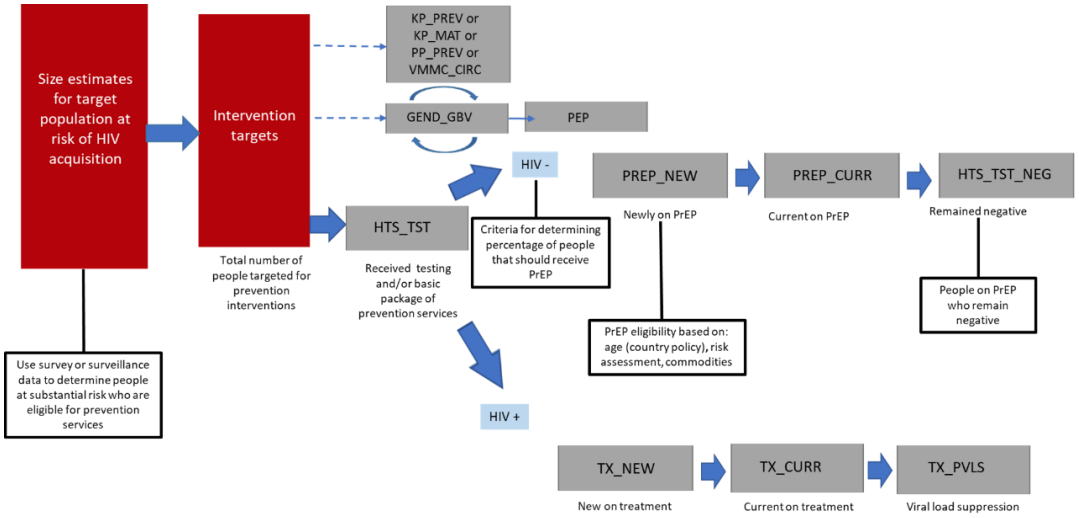
Site (facility and community) level system should maintain accurate registers for each individual priority population and sum these individual populations when reporting this indicator.</td></tr>
<tr><td>How to review for data quality:</td><td>Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues.

Testing services disaggregates should not exceed the numerator.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex
[Required]</td><td>• 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Testing Services
[Optional]</td><td>• Known positive;
• Newly tested and/or referred for testing;
• Declined testing and/or referral</td></tr>
<tr><td>Priority Population Type
[Optional]

<u>Note that AGYW and adult men are NOT listed here as these population groups can be ascertained using the age/sex disaggregate group found above</u>.</td><td>• Clients of sex workers
• Displaced persons (e.g., refugees)
• Fishing communities
• Military and other uniformed services (including police, border guards, and security workers)
• Mobile Populations (e.g., migrant workers, truck drivers)
• Non-injecting drug users
• Other Priority Population Type (Describe in the narrative)</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Testing Services Disaggregates Definitions:
• Known Positive: Persons within each key population type for whom HIV testing is not indicated because they are known to be HIV-positive. HIV-positive test results should be verified, if possible, for all persons accessing HIV prevention services during the reporting period. Implementing partners should maintain records (without personally identifiable information) on whether the HIV-positive client is linked to treatment. Patients tested positive in previous reporting periods should be counted as Known Positives.
• Newly Tested and/or Referred for Testing: Persons within each key population type for whom HIV testing is indicated because they do not know their HIV status or their last HIV-negative test was more than 3-6 months ago (or more/less frequently as indicated by National Guidelines) should either be offered an HIV test on site or given information about where and when they can access an HIV test at another nearby clinic. Every attempt should be made to ensure the client is linked with HIV testing services that are PP-friendly, and where possible the completed referral should be documented (i.e., the client accessed HIV testing). Note: Persons who access testing and whose results are</td></tr>
</table>

	newly tested HIV-positive in the reporting period should also be counted under "newly tested" even if they return for additional prevention services during that reporting period. • **Declined Testing and/or Referral:** Persons who, after explaining the benefits of HIV testing and the reason for testing every 3-6 months (or more/less frequently as indicated by National Guidelines), decline to be tested on-site or referred to a site where HIV testing is offered. Although every attempt should be made to support key populations with HIV testing as part of the package of HIV prevention services and to provide HIV testing on site or PP-friendly sites, programs should also respect the autonomy of clients to decline this service. Clients who decline testing and/or referral can still receive other prevention services, as long as the benefits of HIV testing were explained and testing or a referral for testing was offered.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for priority populations receiving HIV prevention services includes: ongoing procurement of critical commodities such as condoms, teaching materials, or community promotion materials; funding for salaries of personnel who deliver components of the intervention; or paying for transportation of those staff to the point of Service delivery. Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For priority populations receiving HIV prevention, ongoing support services service delivery improvement includes: site supervision; training or assistance with monitoring and evaluation; QI/QC; and development of materials and protocols.
Guiding narrative questions:	1. Please indicate how GEND_NORM activities are being tracked and reported by specifying in the narrative which of the three following options was used: a. GEND_NORM is tracked as a custom indicator, meets PP_PREV criteria, and is being included in PP_PREV results. Report the GEND_NORM results in the narrative. b. GEND_NORM is a custom indicator but results are not included in PP_PREV reporting. Report the GEND_NORM results in the narrative. c. Reporting under PP_PREV alone and not using GEND_NORM as a custom indicator. 2. Please help us understand what is being tracked or counted under PP_PREV: a. Describe the types of activities or interventions that are being provided to beneficiaries. b. If a specific evidence-based intervention or curriculum is being implemented, please provide the name. c. Specify the priority populations counted under PP_PREV and if priority populations are either receiving the intervention themselves or indirectly benefiting from intervention, based on other beneficiaries' receipt or access to the intervention. 3. PP_PREV requires that "HIV testing services (HTS) or referring an individual to HTS (at least once during the reporting period) unless the individual self-identifies as HIV positive. a. Are you tracking the number of HTS referrals generated through PP_PREV activities? If so, please provide the number. b. If you are not tracking the HTS referrals please state so and provide an approximation. 4. If PP_PREV increased or decreased by >25% since the last reporting period, please explain the reasons (e.g., budget changes, changes to how curriculum-based interventions are tracked, activities included in PP_PREV that were previously counted elsewhere, etc.).
Data Visualization & Use Examples:	

HIV Prevention Cascade:



PrEP_CURR

Description:	Number of individuals, inclusive of those newly enrolled, that received oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV during the reporting period	
Numerator:	Number of individuals that received oral PrEP during the reporting period	N/A
Denominator:	N/A	N/A
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	Tenofovir-containing oral PrEP reduces the risk of HIV acquisition among numerous populations when taken consistently. WHO guidelines recommend offering oral PrEP to those at substantial risk of HIV infection, (incidence rate of 3 per 100 persons per year). This level of elevated risk has been seen among sero-discordant couples with inconsistent condom use when the partner living with HIV is not virally suppressed, men who have sex with men (MSM), transgender (TG) women, sex workers (SW) of all genders, and people who inject drugs (PWID), as well as adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. PEPFAR supports WHO guidelines on the use of PrEP as part of a package of comprehensive structural, biomedical and behavioral prevention services. In most settings, PrEP will be integrated into existing prevention or treatment services for the target population. As PEPFAR continues to scale up PrEP service delivery, monitoring the PrEP cascade will be important to understand which populations are using this prevention intervention, as well as their length of time using it and their HIV outcome. Understanding the PrEP cascade by population will help improve implementation strategies for those in highest incidence communities initiating PrEP and the retention strategies to support them to stay on PrEP.	
How to collect:	The numerator can be generated by counting the number of individuals that have received PrEP during the reporting period, in accordance with national guidelines or WHO standards, including both those individuals newly initiating on PrEP and those continuing to receive PrEP. PREP_CURR reflects all persons receiving PrEP during the reporting period. • An individual newly initiating on PrEP will be counted under both PREP_NEW and PREP_CURR during the reporting period. • If an individual tests positive at his or her three-month PrEP follow-up appointment and is then initiated on PEPFAR-supported treatment in the same reporting period, that individual could be counted as PREP_CURR in addition to TX_NEW and TX_CURR (given successful transfer into the ART program) within that reporting period. They would not be counted under PREP_CURR in subsequent reporting periods. • The reporting level for this indicator is the facility level only. If PrEP is being provided at community-based sites, these sites should be connected to or have a relationship to a clinical facility. The community sites providing PrEP programming should count the number of individuals currently on PrEP being served through the community service delivery point, and then those data should be reported through the facility connected to that community site. **Key Populations:** Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery. NOTE: In accordance to PrEP guidance, all persons at substantial risk of HIV infection are eligible for PrEP, including adolescent girls and young	

<table>
<tr><td></td><td>women and sero-discordant couples. Therefore, not all PrEP beneficiaries are expected to fall within the KP disaggregates, so the total disaggregations for KP do not have to sum to the numerator total. Both KP-specific and clinical partners have the option to complete these KP disaggregates, but only if safe to maintain these files and to report. As this indicator spans over more than one reporting period, please confirm KP status at each clinical visit as part of routine monitoring for patient-centered care.</td></tr>
<tr><td>How to review for data quality:</td><td>Numerator ≥ PREP_NEW numerator for the same reporting period (quarter). Numerator ≥ subtotal of three-month test result disaggregate group. Numerator ≥ subtotal of KP population type disaggregate group.</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator. Results are cumulative at each reporting period and should include anyone who received PrEP at ANY TIME during the reporting period.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex [Required]</td><td>• 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Three-month Test Result [Required]</td><td>• Positive
• Negative
• Less than three months since PrEP initiation</td></tr>
<tr><td>Key Population Type [Optional]</td><td>• People who inject drugs (PWID)
• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People in prison and other closed settings</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>• Age is defined as the age at the time of the visit during the reporting period.
• Three-Month Test is defined as the HIV testing result received by those individuals who present for their three-month follow-up PrEP visit.
  ○ There is also a disaggregate within the indicator to record the result for those individuals who take an HIV test when they were initiated on PrEP less than three months previously (Positive/negative/Less than three months since PrEP initiation).
  ○ For comprehensive clinical monitoring patients should be receiving two tests within each six-month reporting window.</td></tr>
<tr><td>PEPFAR-support definition:</td><td>Standard definition of DSD and TA used.

Provision of key staff or commodities for PrEP services includes: ongoing procurement of critical commodities (excluding HTS commodities) such “tenofovir-containing PrEP” which could be TDF alone, TDF/FTC, or TDF/3TC or funding for salaries of personnel providing any of the prevention package components (i.e., clinicians, outreach workers, program managers). Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted.

Ongoing support for HIV prevention among PrEP services includes: mentoring and supportive supervision; training; organizational strengthening; QA/QI; program design like development of training curricula, PrEP guidance development, or standard operating procedures (SOPs) and follow-up to ensure quality of care; regular assistance with monitoring and evaluation functions and data quality assessments; or supply chain management</td></tr>
<tr><td>Guiding narrative questions:</td><td>1. What support does PEPFAR provide at this site in terms of staffing, commodities and laboratory services?
2. How are you tracking and/or finding individuals who have discontinued PrEP?</td></tr>
</table>

	3. What reasons are individuals citing for discontinuing their use of PrEP?

PrEP_NEW

Description:	Number of individuals who have been newly enrolled on antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	
Numerator:	Number of individuals who have received (oral) antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection	The numerator is generated by counting the number of people newly enrolled in oral PrEP (including WHO specified regimens "tenofovir-containing PrEP" which could be TDF alone, TDF/FTC, or TDF/3TC) during the reporting period, in accordance with the demonstration project guidance or the nationally approved protocol (or WHO/UNAIDS standards).
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age/sex disaggregates updated. • KP disaggregations updated to align with other KP-related indicators.	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	The indicator measures the ongoing growth of PrEP services. This measure is critical to assess progress in the program's response to the epidemic in specific geographic areas, and the uptake and utility of PrEP among persons at substantially increased risk of HIV infection. This indicator permits monitoring trends in use but does not attempt to distinguish between different modes or regimens of PrEP or to measure the cost, quality or effectiveness of PrEP provided. These will each vary within and between countries and are liable to change over time. PrEP has been shown to reduce incident infections among several populations including serodiscordant heterosexual couples, MSM, FSW, and transgender people (TG). The WHO now recommends that oral PrEP containing tenofovir should be offered as an additional prevention choice for people at substantial risk, defined as HIV incidence > 3/100 person-years.	
How to collect:	The numerator can be generated by counting the number of people who are newly enrolled on PrEP in the reporting period, in accordance with national guidelines (or WHO/UNAIDS standards). NEW is a state defined by an individual's beginning in a PrEP program. It is expected that the characteristics of new clients are recorded at the time they newly initiate into a program. Patients are "new" on PrEP only if they are naive to antiretroviral therapy for prevention of HIV infection and have not received oral or topical prophylaxis previously in any program. Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery. NOTE: In accordance to PrEP guidance, not all PrEP beneficiaries are expected to fall within the KP disaggregates, therefore the total disaggregations for KP does not have to sum to the numerator total. Both KP-specific and clinical partners have the option to complete these KP disaggregation, but only if safe to maintain these files and to report.	

<table>
<tr><td>How to review for data quality:</td><td colspan="2">Numerator ≥ subtotal of the age/sex disaggregation: The total number people newly enrolled on PrEP (numerator) should be greater or equal to the subtotal of the age/sex disaggregate group.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum results across quarters.</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex [Required]</td><td>• 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Key Population Type: [Optional]</td><td>• People who inject drugs (PWID)
• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People in prison and other closed settings</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Age Description: Age is defined as the age at the time of initiation of PrEP. For example, if a 19-year-old woman begins PrEP and then shortly after turns age 20, she will still be counted under NEW in the 15-19 F age/sex category.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA used.

<u>Provision of key staff or commodities for PrEP services includes</u>: ongoing procurement of critical commodities such “tenofovir-containing PrEP” which could be TDF alone, TDF/FTC, or TDF/3TC or funding for salaries of personnel providing any of the prevention package components (i.e., clinicians, outreach workers, program managers). Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted.

<u>Ongoing support for HIV prevention among PrEP services includes</u>: mentoring and supportive supervision; training; organizational strengthening; QA/QI; program design like development of training curricula, PrEP guidance development, or standard operating procedures (SOPs) and follow-up to ensure quality of care; regular assistance with monitoring and evaluation functions and data quality assessments; or supply chain management</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. Roughly what proportion of those offered PrEP at the site agrees to start PrEP?
2. Of those initiating PrEP, how many are estimated to continue at one and three months?
3. What strategy is used to determine PrEP eligibility at the site:
a. Screening tool?
b. All clients considered at risk and eligible?
c. Client request?</td></tr>
</table>

TB_PREV

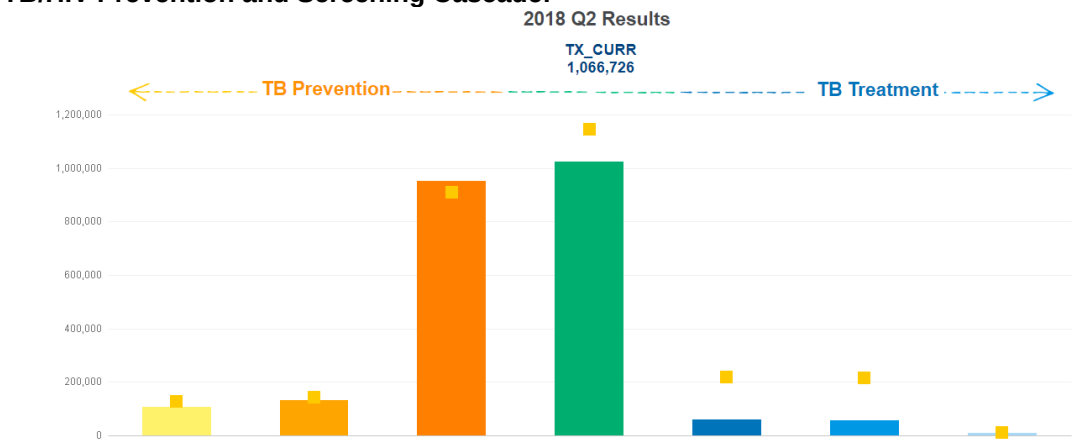
Description:	Proportion of ART patients who completed a standard course of TB preventive therapy within the semiannual reporting period	
Numerator:	Number of ART patients who completed a course of TB preventive therapy during the reporting period (for continuous IPT programs, this includes the patients who have completed the first 6 months of isoniazid preventive therapy (IPT))	The numerator can be generated by counting the number of PLHIV on ART who are documented as having received at least six months of IPT or have completed another standard course of TB preventive therapy.
Denominator:	Number of ART patients who are expected to complete a course of TB preventive therapy during the reporting period (for programs using continuous IPT, this includes only the patients who are scheduled to complete the first 6 months of therapy)	The denominator can be generated by counting the total number of patients who are scheduled to complete a course of TB preventive therapy (or at least 6 months of IPT for those who are on a prolonged or continuous regimen) in the semiannual reporting period.
Indicator changes (MER 2.0 v2.2 to v2.3):	• Numerator disaggregates have been changed to capture Age/Sex by Type of TB preventive therapy (TPT) by ART Start. • Denominator disaggregates have been changed to capture Age/Sex by Type of TB preventive therapy (TPT) by ART Start.	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator measures the performance of HIV programs in scaling up TB preventive therapy, with the goal of preventing progression to active TB disease among PLHIV and decreasing ongoing TB transmission in this population. As part of a cascade from TX_CURR to TB screening (captured in TX_TB), this indicator will inform programs on the pace of scale-up, and the proportion will allow for monitoring of cohorts through completion of therapy. Disaggregates on type of therapy will inform programs on their relative use of different regimens, and the timing of ART will allow the clinical cascade to focus on those who are newly entering care, which will better demonstrate program performance, particularly in countries that have already provided TB preventive therapy for many of their PLHIV in care.	
How to collect:	The numerator can be generated by counting the number of PLHIV on ART who are documented as having received at least six months of IPT or have completed another standard course of TB preventive therapy. This should include the patients who completed a shorter alternative course, such as 3 months of isoniazid and rifapentine (3HP), as well as those who are on prolonged or continuous IPT who have completed their first 6 months of therapy during the semiannual reporting period. **Importantly, programs should ensure that patients on continuous therapy are counted only once, and not repeated in future calculations.** The denominator can be generated by counting the total number of patients who are scheduled to complete a course of TB preventive therapy (or at least 6 months of IPT for those who are on a prolonged or continuous regimen) in the semiannual reporting period. **For IPT:** • Patients who are taking a standard 6-month course of IPT would be expected to complete therapy if they started IPT in the previous reporting period; therefore, all patients who started IPT at any time in the previous 6-month reporting period (i.e., the 6 months before the start of the current reporting period) should be included in the denominator. The few patients who start and complete IPT in the same reporting would also be included. • Patients who are taking prolonged (9- or 12-month) or continuous IPT would also be expected to complete the first 6 months of IPT if they started IPT in the previous	

<table>
<tr><td></td><td>reporting period; therefore, all patients who started prolonged or continuous IPT in the previous 6-month reporting period should be included. The few patients who start and complete 6 months of IPT in the same reporting would also be included.

For alternative regimens:
• Patients who are taking a 3-month regimen of isoniazid and rifapentine would be expected to complete therapy in this reporting period if they started on therapy at any time starting 3 months prior to the start of the current reporting period to 3 months prior to the end of the current reporting period; all such persons should be included in the denominator.
• Patients who are taking a 4-month course of rifampicin would be expected to complete therapy in this reporting period if they were started on therapy at any time starting 4 months prior to the start of the current reporting period to 4 months prior to the end of the current reporting period; all such persons should be included in the denominator.

These data elements can be collected from the ART register or from separate TB screening (presumptive TB) or IPT registers.</td></tr>
<tr><td>How to review for data quality:</td><td>Only one disaggregation type is used for age (coarse disaggregations).
Data Element ≥ subtotal of each of the disaggregations.</td></tr>
<tr><td>How to calculate annual total:</td><td>When analyzing this data in conjunction with data on TB screening for ART patients (TX_TB), it is preferred to analyze it as a snapshot indicator and use the result reported at Q4. However, one could analyze the TB_PREV numerator independently of other data and sum the results across Q2 and Q4 to calculate the total number of ART patients who completed a course of TB preventive therapy during the fiscal year.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex by Type of TB Preventive Therapy (TPT) by ART Start: [Required]</td><td>• IPT by newly enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• IPT by previously enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• Alternative TPT regimen by newly enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• Alternative TPT regimen by previously enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex by Type of TB Preventive Therapy (TPT) by ART Start: [Required]</td><td>• IPT by newly enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• IPT by previously enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• Alternative TPT regimen by newly enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• Alternative TPT regiment by previously enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Type of TB Preventive Therapy (TPT) by ART Start Descriptions:
• IPT/Newly enrolled on ART: Among those who completed 6 months of IPT, the patients who started IPT and ART in the previous reporting period.
• IPT/Previously enrolled on ART: Among those who completed 6 months of IPT, the patients who started IPT in the previous reporting period, but who started ART prior to the previous reporting period (i.e., patients who were on ART prior to the reporting period when they started IPT).
• Alternative TPT regimen/Newly enrolled on ART: Among those who completed an alternative regimen (e.g., 3-month INH and rifapentine), the patients who started the regimen and ART in the current or the previous reporting period</td></tr>
</table>

	• Alternative TPT/Previously enrolled on ART: Among those who completed an alternative regimen (e.g., 3-month INH and rifapentine), the patients who started the regimen in the current or the previous reporting period, but started ART prior to previous reporting period
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for routine HIV-related services includes: ongoing provision of critical re-occurring costs or commodities (such as ARVs, TB preventive therapy and diagnostic/screening tests) or funding of salaries or provision of Health Care Workers for HIV clinic services. Staff responsible for maintaining patient records in both HIV and TB clinics are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. Ongoing support for patients receiving routine HIV-related services includes: training of HIV service providers, clinical mentoring and supportive supervision of staff at HIV sites, infrastructure/renovation of facilities, support of HIV service data collection, reporting, data quality, QI/QA of HIV services support, ARV and IPT consumption forecasting and supply management, support of lab clinical.
Guiding narrative questions:	1. Roughly what proportion of all PLHIV on treatment have already completed TB preventive therapy prior to this reporting period? 2. If TB preventive therapy was not provided to all PLHIV in care (and for who active TB disease was ruled out), what are the main reasons for limited scale-up? 3. Roughly what proportion of patients who received TB preventive therapy were treated with the 6-month (or longer) isoniazid regimen? 4. If completion rates were less than 85%, what are the main reasons why? 5. If less than 80% of newly enrolled PLHIV who screened negative for TB disease were started on TPT, what are the main reasons why?
Data Visualization & Use Examples:	**TB/HIV Prevention and Screening Cascade:**



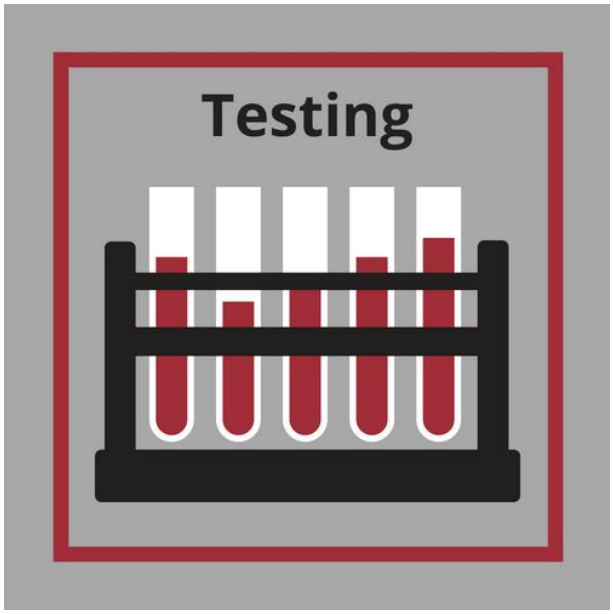
Fiscal Year	Fiscal Quarter	Completed TB preventive therapy - TB_PREV Numerator	Expected to complete TB preventive therapy - TB_PREV Denominator	Screened negative - TX_TB Denominator NEG	ART patients screened for TB - TX_TB Denominator	Screened positive - TX_TB Denominator POS	Specimen sent - TX_TB Denominator Specimen	Started on TB therapy - TX_TB Numerator
2018	Q2	105,563	130,561	951,639	1,022,769	57,978	56,273	9,330
	Target	128,033	141,955	909,864	1,143,713	219,190	216,128	9,476

VMMC_CIRC

Description:	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period	
Numerator:	Number of males circumcised	The numerator can be generated by counting the number of males circumcised.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age disaggregations updated. • Age disaggregations added to the "HIV Status and Outcome" disaggregate in order for VMMC results to auto-populate into HTS_TST.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator tracks the number of male circumcisions conducted during the reporting period and assists in potentially determining coverage of circumcision in the population over time. The total number of males circumcised indicates a change in the supply of and/or demand for VMMC services. Additionally, disaggregations are required and are used to evaluate whether prioritized services have been successful at reaching the intended population (by age, HIV status, and circumcision technique), targets have been achieved, and whether modeling inputs should be adjusted. An additional level of disaggregation below the circumcision technique level is required for follow-up status, since post-operative clinical assessments are part of good clinical care and low follow-up rates may indicate a problem in program quality.	
How to collect:	The numerator can be generated by counting the number of males circumcised as part of the VMMC for HIV prevention program. This information can generally be found in VMMC Register, or client medical records maintained by each program/site/service provider.	
How to review for data quality:	Disaggregations for HIV status and outcome and circumcision technique should be equal to (but not exceed) the numerator. The circumcision technique by follow-up status disaggregate should be less or equal to the circumcision technique disaggregate.	
How to calculate annual total:	Sum results across quarters.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Age [Required]	• 0-60 days, 2 months - 4 years, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
	HIV Status and Outcome by Age [Required] ***Underlined portions auto-populate into the VMMC HTS_TST modality.***	• Number of HIV-positive clients (tested HIV positive at VMMC site) by: <1 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age • Number of HIV-negative clients (tested HIV negative at VMMC site) by: <1 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age • Number of clients with indeterminate HIV status or not tested for HIV at site (regardless of previous documentation) by: <1 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
	Circumcision Technique [Required]	• Surgical VMMC • Device-based VMMC
	Circumcision Technique/Follow-up Status (Sub-disaggregation of the VMMC circumcision technique disaggregation) [Required]	• Surgical VMMC: Followed-up within 14 days of surgery • Surgical VMMC: Did not follow-up within 14 days of surgery or did not follow-up within the reporting period • Device-based VMMC: Followed-up within 14 days of device placement.

		• Device-based VMMC: Did not follow-up within 14 days of device placement or did not follow-up within the reporting period
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	N/A	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for VMMC include: medical instruments, supplies, or medicines needed for the VMMC procedure, or funding for salaries for HCW who deliver VMMC services. Ongoing support for VMMC service delivery improvement includes: training of VMMC service providers; clinical mentoring and supportive supervision of HCW at VMMC sites; infrastructure/facility renovation; support of VMMC service-related data collection, reporting, data quality assessments (DQA); CQI/EQA of VMMC services at point of service delivery; or commodities consumption forecasting and supply chain management support.	
Guiding narrative questions:	1. Is the age distribution of males 60% or more 15+ years of age? • Is this age distribution getting older as compared to previous quarters? 2. If OU is using compression collar type device for VMMC • Are they adhering to WHO Guidelines for tetanus immunization? • Were there any tetanus AEs reported? 3. What proportion of clients are returning for follow-up (should be at least 80%)? 4. What barriers are there to further scaling up VMMC services?	

TESTING INDICATORS



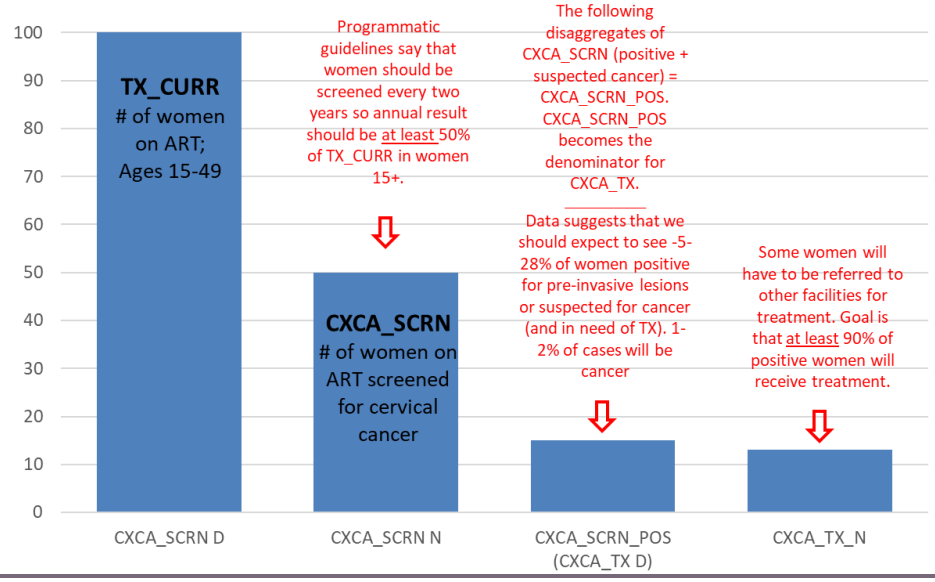
CXCA_SCRN (including CXCA_SCRN_POS)

Description:	Percentage of HIV-positive women on ART screened for cervical cancer	
Numerator:	Number of HIV-positive women on ART screened for cervical cancer	The numerator captures the number of individual HIV-positive women on ART who received a screening test for cervical cancer.
Denominator:	Number of HIV-positive women ages 15-49 on ART at PEPFAR-supported sites	See TX_CURR for more details.
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator is vital for understanding and estimating the demand for screening services and forecasting and planning for the resources required to meet that demand and the resulting treatment needs. Disaggregation enhances sensitivity of this indicator in order to help identify the need for further outreach, as well as trigger further situational investigation at lower levels of the health system. For VIA, the benchmark of 5%-25% screen-positivity for women (aged 30-60) screened for the first time should be used when monitoring performance. (WHO, 2013; ACCP, 2004)	
How to collect:	The primary data sources for this indicator are registers or logbooks in use at the point of cervical cancer screening service delivery at PEPFAR supported ART sites. Client and facility level data collection tools should include the data elements required for disaggregation. Data for the numerator should be generated by counting the total number of HIV-positive women on ART who received a cervical cancer screening test. For the purposes of this indicator, “screened” is defined as receiving the tests necessary to determine the need for treatment of precancerous lesions – or referral for suspected invasive cervical cancer. • For programs using a VIA based test-and-treat strategy, the number of women receiving a VIA result should be counted here. • For programs using a test-triage-treat strategy (e.g., HPV test with VIA triage, with treatment only if the woman is VIA positive), the following should be counted: ○ The number of women who received a negative result on the initial screening test (e.g., HPV test) The number of women who received BOTH a positive result on the initial screening test (e.g., HPV test) AND either a positive (or suspected cancer) or negative result on the triage test (e.g., VIA) should be counted here. Only completed screenings should be counted under this indicator – screening tests that were not completed due to cervicitis or other issue, should not be counted. Screening visits where cancer is suspected based on initial speculum examination, prior to the application of acetic acid, should be counted as ‘completed screenings’. This is because the **defined purpose** of the screening was **fulfilled** (i.e., to identify individuals with increased probability of having either the disease itself or a precursor of the disease).	
How to review for data quality:	The numerator for this indicator should not be larger than TX_CURR among women 15+.	
How to calculate annual total:	Sum results across reporting periods for the numerator. Denominator (TX_CURR) is a snapshot indicator.	
	Numerator Disaggregations:	

<table>
<tr><td rowspan="4">Disaggregations:</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Screening Visit Type and Result by Age [Required]</td><td>• 1st time screened (Negative, Positive, Suspected Cancer) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• Rescreened after previous negative (Negative, Positive, Suspected Cancer) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• Post-treatment follow-up (Negative, Positive, Suspected Cancer) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>See TX_CURR.</td><td>See TX_CURR.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Result:
• Negative
  ○ Indicates that neither a lesion, nor any indication of invasive cervical cancer were visualized during the VIA test.
• Positive (CXCA_SCRN_POS)
  ○ Indicates the visualized presence of aceto-white lesion on the cervix following the application of acetic acid.
  ○ In practice, women with a positive result are further differentiated into ‘eligible for cryotherapy’ and ‘ineligible for cryotherapy’, based on the size and location of the lesion.
  ○ Women with fulminating masses or other indication of suspected cervical cancer are not counted under this disaggregate.
• Suspected Cancer
  ○ Indicates the visualized presence of a fulminating mass, or other clinical indicator suspicious for invasive cervical cancer.

In practice, women with a VIA screening (or triage) test result of “positive” or “suspected cancer” are both considered screen-positive (or triage-positive); however, for the purposes of monitoring, screen-positive results are separated into precancerous lesions (“positive” disaggregate) and suspected cancer (“suspected cancer” disaggregate) because the care pathways for each are different. Precancerous lesions may be treated immediately with outpatient procedures, whereas suspected cancer requires further evaluation (colposcopy, biopsy, diagnosis) before treatment options can be considered. Clinical definitions can be found in Comprehensive cervical cancer control: a guide to essential practice [WHO, 2014].

Screening Visit Type
• 1st Time screening
  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the screening-naïve HIV-positive population – only women being screened for the first time in their lifetime should be counted under this disaggregate
• Rescreening after previous negative result
  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received a negative result on their most recent screening test
  ○ WHO recommends that HIV-positive women or women of unknown HIV status who receive a negative cervical cancer screening test result be rescreened every 3 years; however, the results of PEPFAR modelling exercises led to the current PEPFAR recommendation of a screening interval (for women with a negative result) of every 2 years for HIV positive women.
  ○ As a program matures, countries should consider adding an additional performance indicator which measures whether women that should return for routine rescreening in a given time period are returning in that time period (e.g.,</td></tr>
</table>

	number of rescreened women in a given time period, over the number of women who were expected to be rescreened in the same time period) • Post-treatment follow-up screening ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received precancerous lesion treatment due to a positive screening result on their last screening test ○ Some national guidelines require post-treatment follow-up screening at intervals other than or in addition to 1 year (e.g., 6 months and 12 months) – programs should use additional indicators to monitor the additional follow-up time points, and this should be noted in the narrative.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. For cervical cancer screening services, direct service delivery includes: ongoing procurement of critical screening related commodities or requisite materials such as specula, acetic acid, bright white light source (bulbs/lamp, or torch/batteries), or other consumables (cotton swabs, exam gloves, gauze, etc.), or funding for salaries of screening service providers including program managers, supervisors, and/or coordinators. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For cervical cancer screening services, ongoing support for service delivery improvement includes: clinical mentoring/supportive supervision, VIA training, guidance development, infrastructure/renovation of facilities, site level QI/QA, routine support of M&E and reporting, or commodities consumption forecasting and supply management.
Guiding narrative questions:	1. Are there any barriers you face encouraging HIV-positive women on ART to get screened for cervical cancer and, if so, what would be helpful to overcome these barriers? 2. Please provide the context for how real-time (or near real-time) imaging technologies are in use at your sites. For instance, do you have the option to send images to a central location for review? If so, do they provide feedback while the client is still at your site or does the delay in processing necessitate a return visit for the client? 3. For areas where VIA is not the preferred screening test (i.e., where HPV testing or Pap smear are more common), describe the challenges in promoting and scaling up this option.
Data Visualization & Use Examples:	**HIV/Cervical Cancer Cascade:** 

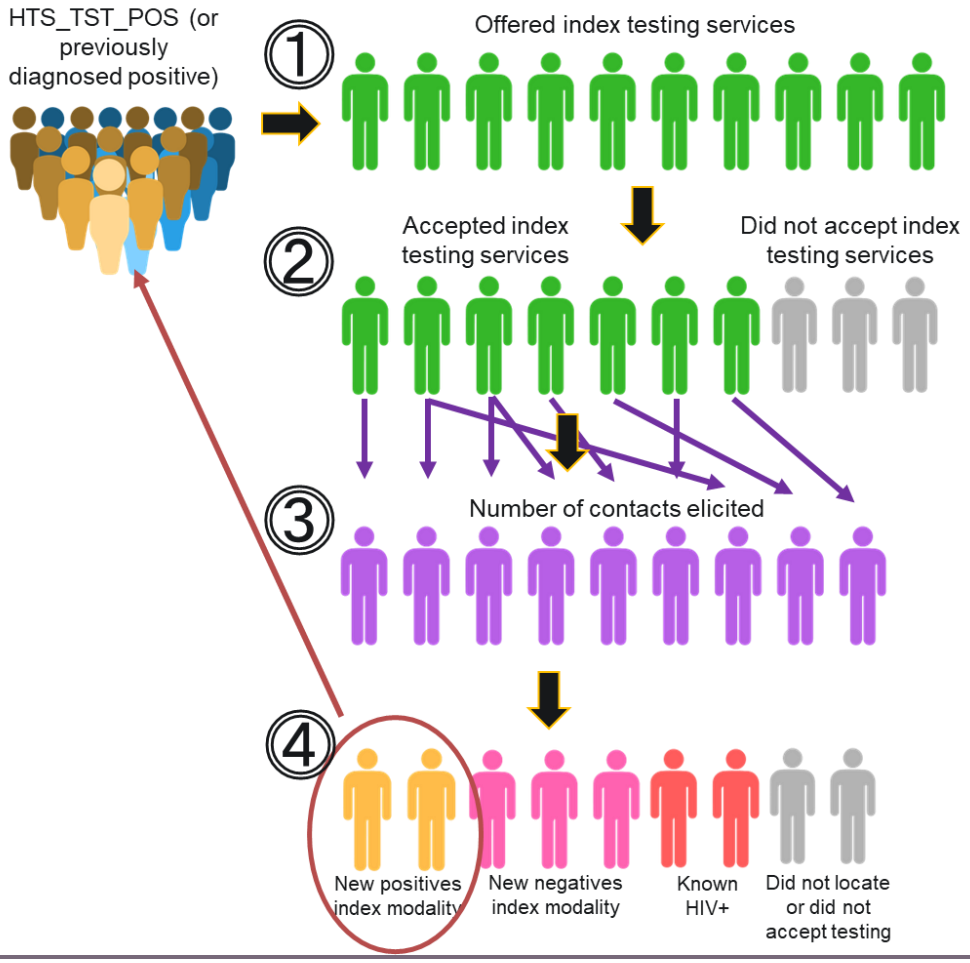
HTS_INDEX

Description:	Number of individuals who were identified and tested using Index testing services and received their results	
Numerator:	Number of individuals who were identified and tested using Index testing services and received their results	This indicator aims to monitor the scale and fidelity of implementation of HIV index testing-related services
Denominator:	N/A	There is no official denominator. However, this indicator represents a cascade and the collected disaggregations serve as both numerators and denominators when analyzing the index testing cascade.
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This is the first MER indicator to monitor PEPFAR programming of HIV Index Testing services (often also referred to as Partner Notification Services or contact tracing etc.). Index testing, also referred to as partner testing/partner notification services, is an approach whereby the exposed contacts (i.e., sexual partners, biological children and anyone with whom a needle was shared) of an HIV-positive person (i.e., index client), are elicited and offered HIV testing services. In this context, index testing refers to any HIV testing of the contacts of an index client (i.e., a person known to be HIV positive). **Only the following persons count as contacts: current or past sexual partner(s), biological children /parents (if index case is child) or anyone with whom a needle was shared.** Biological children reported under HTS_INDEX should only include children of an HIV-positive mother. Children of male-index clients (fathers) should only be included when the biological mother is HIV-positive, she is deceased, or her HIV status is not known or not documented. Conversely, if the index client is the child, his/her mother should be tested, and if the mother is HIV-positive or deceased, the father should be tested as well. In addition, all biologic siblings of the index child should be tested. In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease. Every newly diagnosed individual becomes a subsequent index client from whom to elicit contacts. Like HTS_TST and HTS_SELF, HTS_INDEX is reported at the facility and community levels. Testing of persons who have not had exposure through an index client, such as neighbors or family members (e.g., children of HIV-negative mother, grandparents, etc.) not born to the index, should not be reported under HTS_INDEX. Testing of non-contacts should be reported under the modality that best reflects the service delivery point where testing occurred. For example, if HIV testing were conducted in a mobile clinic, unexposed contacts would be reported under the 'Mobile' modality of HTS_TST. All index testing services must meet WHO's 5C minimum standards, including consent, counseling, confidentiality, correct test results, and connection to HIV prevention (for both HIV-positive and HIV-negative individuals), and HIV care and treatment (often referred to as 'linkage', for HIV-positive individuals). The 5 C's are essential for all HTS, especially in the context of identifying contacts for HIV testing. Additionally, all index clients should be screened for Intimate Partner Violence (IPV) per WHO guidelines. An index client should not feel as if they are required to provide contacts in order to receive any services. HTS_INDEX is separated into several steps (1-4 below) that are aligned with core components of index testing implementation. These steps are part of a cascade of implementation that begins with an offer of index testing services to the index client and ends in provision of an HIV test (and results) to the contacts named by the index client. This	

final step 4 (and the age sex disaggregates) will **auto-populate** into the 'Index' modality in HTS_TST for either facility or community.

The steps are:

1. **How many index clients were offered index testing services? This** is the number of index clients (newly diagnosed positive or previously known positives who may or may not be on ART) who were offered (e.g., counseled on) index testing services (regardless of whether or not those services were accepted by the index client).
2. **How many index clients accepted index testing services? This** is the number of index clients who accepted (e.g., agreed to) provision of index testing services by a provider (including, counseling on index testing, elicitation of current or past sexual partners/partner notification etc.).
3. **How many contacts did the index client provide?** This is the number of contacts provided by the index client as a result of accepting index testing services. The index client provides the age (<15 or >15) and sex (male or female) of the contact(s). Since the index client 'self-reports' these data, the contact's recorded age and/or sex does not need to be corrected in Step 3 if differing age/sex information is collected in Step 4. As mentioned above, contacts are only sexual partners, biological children/parents, and anyone with whom a needle was shared.
4. **How many contacts were tested for HIV and received their results?** Of those tested and received their results, how many tested positive and negative? This is the number of contacts who were tested for HIV and received their results (positive and negative). The positive and negative disaggregations do not include the contact's self-reported status; only the actual provision of an HIV test to the contact. However, please note that previous or known positives are also recorded as "known positive" in Step 4. Known positives should not be retested.



	Reporting and use of this indicator should not preclude any other data collection or indicators that may be used to monitor implementation, effects, and outcomes related to HIV index testing services. That is, other data may need to be collected and used by the program to ensure efficient and effective implementation of index testing services either at the facility or community level. For example, to have a more accurate denominator for contacts tested, programs may also collect information about the number of contacts reached among the contacts elicited. Furthermore, of those contacts reached, how many agreed to test for HIV. Programs may also wish to disaggregate the numbers of contacts reached and tested by the four different approaches to index testing (e.g., client, dual, contract, and provider) to see which approaches are most effective. Programs could also track the number of newly diagnosed partners and children linked to HIV treatment.
How to collect:	The suggested data source is a designated HIV Index Testing Services register or logbook. This will allow easier collection of the data for each step in the index testing cascade shown above (see Steps 1-4 above). Alternatively, existing HTS registers, log books, and reporting forms already in use to capture HTS can be revised to include the steps mentioned above and the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems, and non-governmental organization records. Other important considerations for reporting on high-fidelity index testing services: • For a contact to be counted under Step 4, he/she must be tested for HIV and receive their result or be a known positive. That contact could either self-report a known exposure to someone with HIV as their reason for testing, have an index testing referral letter/card/coupon given to them from their HIV-positive partner/family member (client-referral approach), or have been identified during the elicitation process and contacted by a provider. For example, if someone comes to a facility or mobile unit and requests an HIV test and reports a known exposure to someone with HIV as their reason for testing, that person should be counted under HTS_INDEX. Further, that individual's HIV diagnosis must be confirmed using a nationally validated testing algorithm. For example, an HIV-positive rapid HIV test performed at the community- or facility- level must be confirmed with a second and third (in some contexts) test, which may be performed at the same site or at a different facility. If the confirmatory test is performed at a different facility, then this may entail follow-up by implementing partners to confirm the diagnosis before reporting on the Step 4. • For children <1, only if serologic tests used for diagnostic purposes should be reported under HTS_INDEX. Serologic tests for screening infants should be excluded (including tests to look for HIV exposure at age 9 months or another time point). For example, you may use the HTS_INDEX <1 disaggregate to report negative diagnostic results if a serologic-based test is used to confirm the absence of HIV infection in infants <1-year-old who have not breastfed for at least 3 months prior to testing. However, since diagnosis of HIV infection in infants is typically based on virologic and not serologic tests, the general expectation is not to see results in the "< 1" disaggregate of the HTS_INDEX indicator. HIV virologic testing of HIV-exposed infants should be counted under PMTCT_EID. • Programs that utilize the 'dual-referral' approach (i.e., the provider/counselor sits with an index client and their partner(s) to assist with disclosure and/or partner testing) may want to offer re-testing to the index client to protect his or her safety. In this case, the index client's test result should NOT be counted again under HTS_INDEX or HTS_TST. Individuals who undergo couples testing (i.e., neither partner knows their status) should be counted under HTS_TST and the appropriate service delivery modality should be indicated (e.g., ANC). • The partner elicitation process of index testing is a continuous process. Providers/counselors should follow local SOPs to determine when PLHIV are asked again about any new partners or previous partners that may not have been disclosed by the index client previously. • Retesting for verification of HIV positive status before or at antiretroviral (ART) initiation should not be counted under HTS_INDEX. Retesting for verification is primarily conducted as a quality assurance activity to avoid misdiagnosis and to ensure those

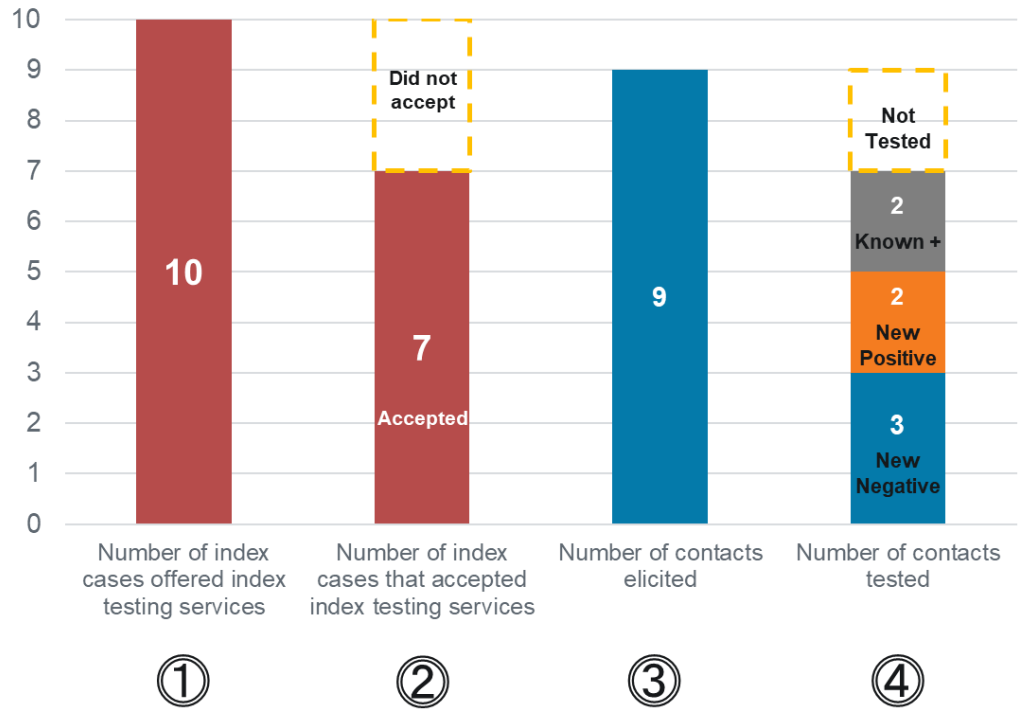
<table>
<tr><td></td><td>initiated on ART are indeed HIV positive. Therefore, retesting for verification should only be conducted for persons who have received an HIV diagnosis, but have not yet been initiated on ART.

Please refer to HTS_TST for information on Data Quality and reporting considerations that would also apply here.

Key Populations:
Provision of data (on any of the steps outlined above) specific to key populations (FSW, MSM, Transgender people, PWID, and people in prisons and other closed settings) who were tested and received their results should be included but not disaggregated into a separate ‘KP’ disaggregate. That is, there is no separate Key Population disaggregate requested (unlike HTS_TST). The first priority of data collection and reporting of testing for the index client and their contacts, particularly key populations, must be to do no harm. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations. Please refer to the KP_PREV and PP_PREV indicator reference sheets for more information on working with KPs.</td></tr>
<tr><td>How to review for data quality:</td><td>Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify implementation and data quality issues.

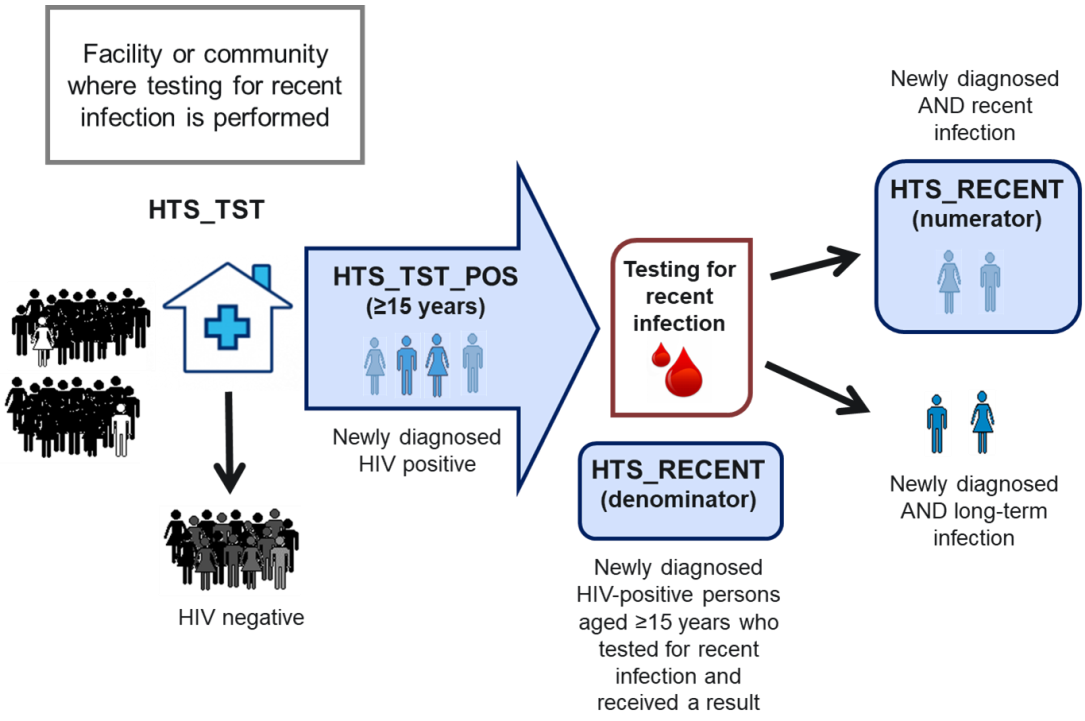
In addition, data reported under each step can be compared to the previous step where it makes programmatic sense. Potential scenarios include: (1) Generally speaking, the number of contacts who were tested for HIV (Step 4) should not be greater than the number of contacts provided (Step 3). Note: testing of a contact of an index client, who was not part of a formal index testing elicitation strategy, may be counted under Step 4 if that contact discloses that his/her sexual or needle-sharing partner is a known positive. (2) Additionally, it is possible for the number of contacts provided by the index client (Step 3) to be greater than the number of index clients who accepted index testing services (Step 2). However, if the number of contacts provided (step 3) is lower than the number of index clients accepting services (step 2), then most index clients are naming zero contacts, which may suggest an issue with the elicitation process.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Number of index cases offered index testing services by age/sex [Required]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of index cases that accepted index testing services by age/sex [Required]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of contacts elicited by HIV status and age/sex [Required]</td><td>• <15 F/M, 15+ F/M, Unknown Age F/M
(Note that because disaggregation is contacts elicited from index cases, finer age bands may not be known and are not required)</td></tr>
<tr><td>Number of <u>contacts tested by test result</u> and age/sex [Required]

<u>Underlined portions auto-populate into the INDEX HTS_TST modality.</u></td><td>• <u>New positives by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u>
• <u>New negatives by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u>
• Known positives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
</table>
</td></tr>
</table>

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	Please refer to the stepwise process outlined in the "how to use" and "how to collect" sections for more details.	
PEPFAR-support definition:	Standard definitions of DSD and TA-SDI apply. <u>For HTS services, direct service delivery includes</u>: ongoing procurement of critical HTS related commodities such as rapid HIV test kits or requisite materials (lancets, capillary tubes), samples and materials for proficiency testing, other HIV diagnostic commodities, or funding for salaries of HIV testing service providers including counselors, laboratory technicians, program managers, and/or community health workers. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>For HTS services, ongoing support for service delivery improvement includes</u>: clinical mentoring/supportive supervision, HTS training, HTS guidance development, routine support of HTS M&E and reporting, or HIV test kits consumption forecasting and supply management.	
Guiding narrative questions:	1. For Step 1, how many previously known positives (versus newly identified positives) were offered index testing services? 2. For Step 3, how many contacts were not contacted due to Intimate Partner Violence (IPV) risk? How many contacts were successfully reached, and how? Of contacts reached, how many reported already knowing they were HIV-positive? 3. Discuss the contribution of index testing to overall HIV testing conducted within the OU. What are the challenges or facilitators to scaling index testing services over other modalities reported under HTS_TST? Please describe approaches for testing contacts (such as, client-referral, provider referral, contract referral, and/or dual referral) and/or quantify any estimation of linkage to treatment from diagnosis.	
Data Visualization & Use Examples:	**Index Testing Cascade:** 	

HTS_RECENT

Description:	Percentage of persons aged ≥15 years newly diagnosed with HIV-1 infection who have a test for recent infection result of 'recent infection' during the reporting period	
Numerator:	Number of newly diagnosed HIV-positive persons aged ≥15 years with a test for recent infection result of 'recent infection' during the reporting period	HTS_RECENT should be reported alongside HTS_TST at facilities/communities where tests for recent infection have been incorporated as a supplemental test in addition to the country-approved HIV diagnostic testing algorithm
Denominator:	Number of newly diagnosed HIV-positive persons aged ≥15 years with a test for recent infection result during the reporting period	N/A
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	As countries progress toward epidemic control, surveillance of newly diagnosed persons will ensure that interventions target those at highest risk of acquiring or transmitting HIV infection. One approach is to identify recent HIV infections, defined as those acquired within approximately the last one year. Incorporation of rapid tests for recent HIV-1 infection into routine HIV testing services will enable the establishment of a surveillance system to quickly detect, monitor, characterize, and intervene on recent infections among newly diagnosed HIV cases. Data collected from a recent infection surveillance system can also be used to fine-tune a country's programmatic response through prioritized programming and resource allocation. Recommended use of this indicator is described below. For additional information on recent infection surveillance, please refer to the PEPFAR guidance on recent infection testing, template protocol on establishing recent infection surveillance, and the emerging technology page on pepfarsolutions.org. • **Surveillance**: Determination of the percentage of 'recent infection' among newly diagnosed HIV-positive persons aged ≥15 years will enable the identification of geographic areas and/or demographic categories that may benefit from intensified prevention and testing activities. The percentage of recent infection may also be used to monitor epidemic trends in recent infection over time. • **Programmatic Response:** The number and percentage of 'recent infection' by facility/community can be used to identify areas with ongoing transmission to quickly target education, prevention, and testing resources to increase case finding and interrupt transmission. Disaggregation by age, sex, pregnancy status, and key population (optional) can further identify subpopulations at higher risk to inform program planning and implementation. Changes over time should be monitored to assess program impact. • **Proxy Incidence:** While tests for recent infection that incorporate a rapid test for recent infection among newly diagnosed HIV-positive individuals are not currently being used to estimate population-level incidence, a proxy measure of annual incidence among HTS clients aged ≥15 years may be calculated to assess impact of HIV programs on the epidemic using: HTS_RECENT (Numerator) / [# of persons aged ≥15 years testing negative + HTS_RECENT (Numerator)]. This estimate can be annualized using the assay's mean duration of recent infection. To reflect the population of HTS clients, this proxy measure of incidence should be weighted to account for newly diagnosed HIV-positive persons aged ≥15 years that do not accept recency testing. Once weighted, it may serve as a standardized indicator for monitoring the epidemiological impact of	

	programs over time. Note that incidence among HTS clients may not be generalizable to the broader population given that the population of undiagnosed PLHIV are not reflected. • **Implementation:** The denominator of this indicator may be used to monitor the rollout of testing for recent infection. In addition, a crude estimate of testing coverage may be calculated using: HTS_RECENT (Denominator)/HTS_TST_POS (≥15 years). Tests for recent infection should be performed as a supplementary test for persons who are confirmed positive for HIV-1 through the national HIV testing algorithm. While the results of tests for recent infection may be provided to patients along with counseling messages, results are not intended to affect clinical management. Please see the diagram below that describes the HTS_RECENT data flow in more detail. 
How to collect:	Data for this indicator are reported at both the facility and community levels. HTS_RECENT should be reported alongside HTS_TST at facilities/communities where tests for recent infection have been incorporated as a supplemental test in addition to the country-approved HIV diagnostic testing algorithm. If the facility/community implementing partner (IP) refers specimens to a laboratory or hub facility for testing for recent infection, the indicator should be reported by the facility/community IP where the specimen was collected. Similarly, if the facility/community IP refers specimens for viral load testing as part of a RITA, the indicator should be reported by the facility/community IP where the specimen for the test for recent infection was collected. Electronic case-based surveillance systems that incorporate test for recent infection results should be used to collect and report data for this indicator. Where those systems do not exist or do not include test for recent infection results, existing HTS registers, log books and reporting forms that have been modified to incorporate test for recent infection results may be used. If neither case-based surveillance systems nor existing HTS tools are options, registers, log books, and reporting forms specifically designed for test for recent infection results should be used to collect and report data. If guidelines specify that viral load testing be conducted alongside the test for recent infection as part of a recent infection testing algorithm (RITA), the RITA result must be used. Viral load testing should be incorporated at facilities/communities with ready access to viral load testing or sample referral networks but is not required at facilities/communities that do not have this infrastructure in place to avoid delay in the rollout of rapid testing for recent infection.

<table>
<tr><td></td><td>NOTE: Country guidelines may vary in reference to the time point and setting at which testing for recent infection is conducted. HTS is recommended, but other service delivery points may be considered if the test for recent infection is conducted within a short period of initial HIV diagnosis. Ideally, the test for recent infection should be conducted on the same time as diagnosis.

Data for this indicator are collected and reported regardless of whether or not test results have been returned to the patient.

NOTE: If country guidelines indicate that test for recent infection results are to be returned to the patient, it is the responsibility of the implementing partner to do so in a timely manner and in-line with country guidelines.

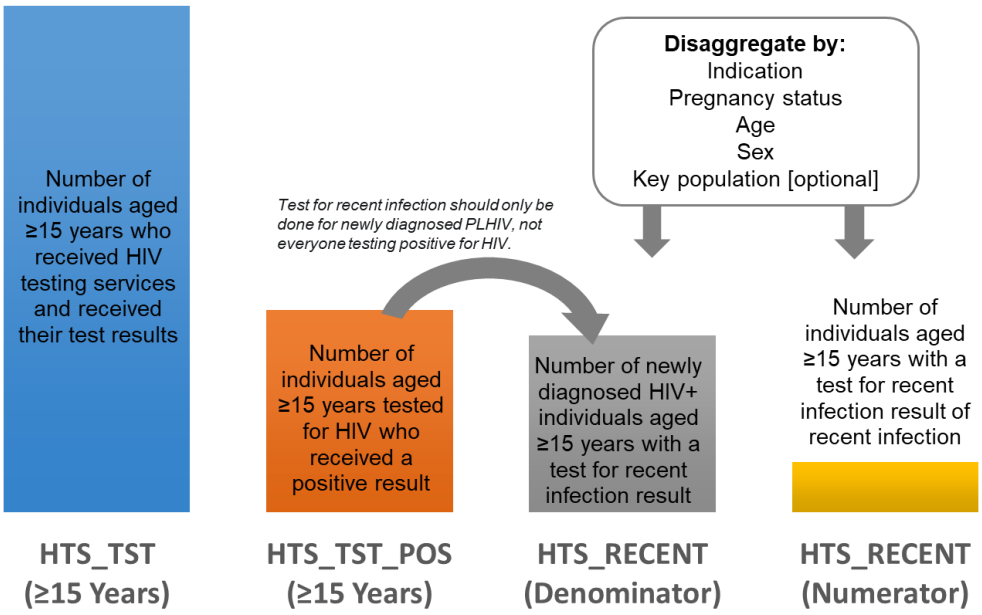
Key Populations:
Information on tests for recent infection and test for recent infection results should be reported by key population (PWID, MSM, TG, FSW, and people in prison or other closed settings). Importantly, reporting on this disaggregate is optional.

See Appendix A: Key Population Classification Document, to inform identification of key populations at HTS service delivery. However, reporting of key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple key population categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE key population disaggregation category to avoid double-counting.

Note: Both key population-specific and clinical partners have the option to complete these disaggregations, but only if it is safe to maintain these files and report. Age and sex data on key populations receiving tests for recent infection will not be reported. Please refer to the KP_PREV indicator reference sheets for more information on working with KPs.

The first priority of data collection and reporting of HTS among key populations must be to do no harm. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.</td></tr>
<tr><td>How to review for data quality:</td><td>• HTS_TST_POS (≥15 years) ≥ HTS_RECENT (Denominator); The number of persons aged ≥15 years who received HIV testing services and received a positive result should be greater than or equal to the number of persons aged ≥15 years with a test for recent infection result.
• HTS_RECENT (Denominator) ≥ HTS_RECENT (Numerator): The number of persons aged ≥15 years with a test for recent infection result should be greater than or equal to the number of persons aged ≥15 years with a result of ‘recent infection’.
• HTS_RECENT (Denominator) = subtotal of each disaggregate group: The number of persons aged ≥15 years with a test for recent infection result should be equal to the sum of each individual disaggregation group (Age/Sex/Indication).</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters for both the numerator and denominator.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Indication by Age/Sex [Required]</td><td>• Assay: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• RITA: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Not Documented: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
</table>
</td></tr>
</table>

	Indication by Pregnancy Status [Required]	• Pregnant Assay • Pregnant RITA • Pregnant Not Documented
	Key Population Type [Optional]	• People who inject drugs (PWID) • Men who have sex with men (MSM) • Transgender people (TG) • Female sex workers (FSW) • People in prison and other closed settings
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	Indication by Age/Sex [Required]	• Assay: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • RITA: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Not Documented: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Indication by Pregnancy Status [Required]	• Pregnant Assay • Pregnant RITA • Pregnant Not Documented
	Key Population Type [Optional]	• People who inject drugs (PWID) • Men who have sex with men (MSM) • Transgender people (TG) • Female sex workers (FSW) • People in prison and other closed settings
Disaggregate descriptions & definitions:	**Indication:** • Assay: Refers to a test for recent infection result based solely on a rapid test for recent infection. • RITA: Refers to a test for recent infection result based on a recent infection testing algorithm. The specific RITA is defined by country guidelines and may include a viral load test. • Not Documented: Indication of test result (assay or RITA) was not documented in the data source used for reporting. **Pregnant:** • Pregnancy status is defined as the status at the time when the test for recent infection was conducted, not at the time of reporting. **Age:** • Age is defined as the age at the time when the test for recent infection was conducted, not at the time of reporting.	
PEPFAR-support definition:	Standard definitions of DSD and TA-SDI apply. <u>For HTS services, direct service delivery includes</u>: ongoing procurement of critical HTS related commodities such as rapid HIV test kits or requisite materials (lancets, capillary tubes), samples and materials for proficiency testing, other HIV diagnostic commodities, or funding for salaries of HIV testing service providers including counselors, laboratory technicians, program managers, and/or community health workers. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>For HTS services, ongoing support for service delivery improvement includes</u>: clinical mentoring/supportive supervision, HTS training, HTS guidance development, routine support of HTS M&E and reporting, or HIV test kits consumption forecasting and supply management.	
Guiding narrative questions:	1. For countries electing to use a RITA with viral load testing, please explain if HTS_RECENT (denominator) does not reflect the implementation of tests for recent	

	infection (e.g., pending RITA result due to turnaround time for viral load testing). What proportion of POCT are using RITA? 2. If HTS_RECENT (denominator) does NOT equal HTS_TST_POS (≥15 years), please explain why. Note that newly diagnosed PLHIV infected with HIV-2 who are not co-infected with HIV-1 should not be tested for recent infection.
Data Visualization & Use Examples:	**HIV Recency Testing Cascade:** 

HTS_SELF

Description:	Number of individual HIV self-test kits distributed	
Numerator:	Number of individual HIV self-test kits distributed	This indicator aims to monitor trends in the distribution of HIV self-test kits within a country at the lowest distribution point.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age disaggregates updated.	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This is the first MER indicator to monitor PEPFAR programming of HIV self-testing approaches and distribution HIV self-test kits. HIV self-testing refers to a process in which a person collects his or her own specimen (oral fluid or blood), performs an HIV test, and then interprets the results. This is often done in a private setting, either alone or with a trusted person. HIV self-testing is a **screening test** and requires self-testers with a reactive (preliminary positive) result to receive further testing from a trained provider using a validated national testing algorithm. HIV self-testing approaches range from unassisted self-testing (with limited or no instruction provided) to directly assisted self-testing (where a testing provider demonstrates how to use the self-test kit). Self-test kits can be distributed in various ways (i.e., by providers or outreach workers, over-the-counter, etc.). Secondary distribution of HIV self-test kits may also occur (e.g., to partners of ANC attendees, or clients of FSWs). This indicator aims to monitor trends in the distribution of HIV self-test kits within a country at the lowest distribution point (i.e., between the distributer and the intended user(s)/recipient). The implementation of HIV self-testing programs should facilitate and enhance access to and uptake of HIV testing services for populations where HIV test uptake is low and undiagnosed HIV infection is high (i.e., men, adolescents/young adults, and key populations).	
How to collect:	The suggested data source is a (newly developed) HIVST (HIV self-test) register or logbook. This will minimize any potential confusion with HTS_TST data collection and reporting since HIV self-testing is only a screening test and should not be reported under HTS_TST which only includes diagnostic testing. If a standalone HIVST register or logbook is not possible, revise existing HTS registers, log books, and reporting forms already in use to include very clear labels to indicate self-testing to prevent information entered in an HTS register from being counted and reported under HTS_TST or HTS_TST_POS. Note that one individual can receive multiple self-test kits (e.g., one for themselves and one for their partner or partners). **Data for the numerator should be generated by counting the number of individual HIV self-test kits distributed and <u>NOT</u> the number of individuals receiving an HIV self-test kit.** Number of self-test kits distributed should be captured and reported at the lowest distribution point. The lowest distribution point refers to the individual/site giving out self-test kits and capturing data for monitoring purposes. This is to prevent double counting between the various higher supply chain levels. **<u>For example</u>**, the central warehouse distributes 500 self-test kits to an implementing partner doing outreach for KPs. The implementing partner gives their peer outreach workers a total of 50 self-test kits to give out during an outreach event. The outreach workers return from their event having given out 30 self-test kits. In this scenario, the lowest distribution point would be the outreach workers who are capturing the monitoring data. Therefore, the number of tests kits distributed would be 30. Each of these lowest distribution counts should be rolled up (aggregated) to create the numerator for this indicator.	

	The disaggregation by type of self-testing provides information about the proportion of test kits distributed through each model (i.e., directly assisted vs. unassisted self-testing). Further disaggregation by "number of tests distributed to a person by age/sex" (for both directly assisted and unassisted self-testing) and "test kit distributed for use by" (for unassisted self-testing) can provide information about what subpopulations are receiving HIVST kits and who the test kit is intended for use by (i.e., self, sex partner, other) in the unassisted model. The findings can support national government and PEPFAR programs to assess how efficient different distribution approaches are at reaching target populations. These data may also be useful for projecting programmatic commodities (e.g., self-test kits) and systems needs (e.g., staffing resources). It is important to note that for the purposes of this indicator, it is assumed that the tests distributed to individuals and counted in the directly assisted self-testing model are the used by individuals that received them so the disaggregation for "test kit distributed for use by" is not requested in the directly assisted model. Please refer to the example clarification below for additional details. **For example**, if an 18-year-old female reports to a testing site and receives a one-on-one testing demonstration for herself – the test for herself will be reported as directly assisted and you would provide the age/sex disaggregation data for one test kit distributed in the 15-19-year-old age band. When she leaves the clinic, she takes two additional test kits along with her: one for her sex partner and one for her friend to use at a later time. The two test kits for her sex partner and friend would be counted as unassisted. For the age/sex breakdown under unassisted, 2 tests would go in the 15-19-year-old female age band because two tests were distributed to the female in that age band. **The reporting follows the distribution of the test kits and not the age/sex demographics of the end user of the self-test kit.** For the "test kit distributed for use by" disaggregate, you would indicate a '1' in the 'sex partner' disaggregate for the test she planned to distribute to her sex partner and a '1' in the 'other' disaggregate for the test she planned to distribute to her friend. It is understood that registers and procedures for HIVST are still relatively new in many PEPFAR countries and specific distribution methods (e.g., vending machines) may not always allow for collection of detailed data on self-test kit distribution. As such, the only required disaggregate for this indicator will be for the type of self-testing (i.e., directly-assisted vs. unassisted). In addition, age/sex demographic information for test kits distributed using the directly-assisted self-testing model will also be required as these individuals should have received an in-person HIV test kit demonstration and demographic information should be collected at that time Note: Although not required, implementing partners should attempt to document and report information about actual use of self-test kits. This includes who used the test kit, the test result from the self-test and linkage to retesting (if result is reactive), particularly when directly assisted HIVST occurs. Methods used may include request the return of the kits or follow up calls to determine outcomes. This information can further inform whether HIVST services are reaching individuals who may be HIV-positive and if those individuals are retesting to confirm their diagnosis. For more information on HIV self-testing, please refer to the "WHO Guidelines on HIV Self-Testing and Partner Notification" released in December 2016. To review a repository of country-specific guidance and polices related to HIV self-testing, please visit the HIV Self-Testing Research and Policy Hub.
How to review for data quality:	Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues. For example, the number of test kits distributed should not be greater than the number of test kits a provider allocated during the reporting period. Pay careful attention to the number of HIVST kits distributed at pharmacies and online. **Implementing partners should review their data to ensure that HTS_SELF is not reported under HTS_TST (or HTS_TST_POS) results.** Furthermore, data should be reviewed to ensure the numerator does not include the number of HIV self-tests performed

<table>
<tr><td></td><td>or used, nor does it reflect a definitive diagnosis (which would be reported under HTS_TST).

The “directly-assisted” disaggregate should be reviewed to see if additional information was collected related to: 1) test result (negative or reactive) and 2) linkage for repeat testing to confirm a reactive self-test result. While not required for this indicator, this information should be collected by implementing partners as part of routine program monitoring.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Type of self-testing [Required]</td><td>• Directly-assisted
• Unassisted</td></tr>
<tr><td>Number of Test Kits Distributed to a Person by Age/Sex
[Required for Directly Assisted; Optional for Unassisted]</td><td>• Directly-assisted by: 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Unassisted by: 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of Test Kits Distributed to Key Populations
[Optional for both Directly Assisted and Unassisted]</td><td>• People who inject drugs (PWID): Directly-assisted, Unassisted
• Men who have sex with men (MSM): Directly-assisted, Unassisted
• Transgender people (TG): Directly-assisted, Unassisted
• Female sex workers (FSW): Directly-assisted, Unassisted
• People in prison and other closed settings: Directly-assisted, Unassisted</td></tr>
<tr><td>Test kit distributed for use by [For Unassisted Only; Reporting Optional if data are available]</td><td>• Unassisted self-testing by:
○ Self
○ Sex Partner
○ Other</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Type of self-testing:
• Directly assisted HIVST refers to trained providers or peers giving individuals an in-person demonstration before or during HIVST of how to perform the test and interpret the test result (WHO, 2016).
• Unassisted HIVST refers to when individuals self-test for HIV and only use an HIVST kit with manufacturer-provided instructions for use. In addition to reporting the total number of HIV self-test kits distributed to individuals, the HTS_SELF indicator includes several disaggregates to characterize aspects of distribution (WHO, 2016).
Test kit distributed for use by [For Unassisted Only; Reporting]:
• Self: Individual that HIV self-test kit was distributed to intends to use the test kit on him- or herself.
• Sex Partner: Individual that HIV self-test kit was distributed to plans to further distribute the self-test kit for use on his or her sexual partner(s).
• Other: Individual that HIV self-test kit was distributed to plans to further distribute the test kit to an individual that is not themselves or one of their sex partners (e.g., relative, friend)</td></tr>
<tr><td>PEPFAR-support definition:</td><td>Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for the distribution of HIVST kits includes</u>: ongoing procurement of HIVST kits or funding for salaries of providers who distribute or directly assist with HIVST including counselors, laboratory technicians, program managers, and</td></tr>
</table>

	community health workers. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For HIVST, ongoing support for service delivery improvement includes: clinical mentoring/supportive supervision, HIVST training, HIVST guidance development, site level QI/QA, routine support of HIVST M&E and reporting, or HIVST kit consumption forecasting and supply management.
Guiding narrative questions:	1. Describe the process/methods and challenges for tracking distribution of test kits. 2. Describe process/methods and challenges for tracking use of self-test kits. 3. Describe process/methods and challenges for tracking linkage of individuals for repeat testing to confirm a reactive self-test result.

HTS_TST (including HTS_TST_POS)

Description:	Number of individuals who received HIV Testing Services (HTS) and received their test results	
Numerator:	Number of individuals who received HIV Testing Services (HTS) and received their test results	The numerator captures the number of individuals who received HIV Testing Services (HTS) and received their test results. At a minimum, this means the person was tested for HIV and received their HIV test results
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age/sex disaggregates updated. • One new HTS facility testing modality added: PMTCT (Post ANC1: Pregnancy/L&D/BF). • Clarifying language is included to • Connections to other indicators described in the guidance are further cemented by creating direct data entry screen links between HTS_TST and associated testing indicators. Testing data entered in DATIM for HTS_INDEX, PMTCT_STAT, TB_STAT, and VMMC_CIRC will auto-populate the HTS_TST indicator, as appropriate. Manual data entry of results into the index, PMTCT (ANC-1), TB, and VMMC modalities will no longer be possible in DATIM. Data will first need to be entered into the associated testing indicator.	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This indicator is intended to monitor trends in the uptake of HTS (regardless of the service delivery modality and population group) within a country. The disaggregation by test result provides information about the proportion of persons testing HIV positive and the effectiveness of HTS programs in identifying people living with HIV (PLHIV) over time. Further disaggregations are intended to monitor access to and uptake of HTS by population (age, sex, and test result), HTS setting and service delivery modality. The findings can support national governments and PEPFAR programs to determine the coverage and identify gaps in HTS services. These data may also be useful for projecting programmatic commodities and system needs such as HIV test kits and other staffing resources, although the numerator reflects the number of individuals tested, not the number of tests performed. Please reference the WHO Consolidated Guidelines on HIV Testing Services for information "relevant to the provision of HTS and…issues and elements for effective delivery of HTS that are common in a variety of settings, contexts and diverse populations". http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/	
How to collect:	Existing HTS registers, log books, and reporting forms already in use to capture HTS can be revised to include the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems and non-governmental organization records. Data for the numerator should be generated by counting the total number of individuals who received HTS and their test results. Note: Although several other MER indicators (see below) may report on the HIV status of individuals, actual testing of individuals must be reported under HTS_TST. Thus, any persons who are newly tested as part of the programs linked to the indicators listed below (i.e., PMTCT, TB, VMMC, Prevention services) must be reported under one of the HTS_TST modalities, unless otherwise indicated below. • PMTCT_STAT (data from PMTCT_STAT auto-populates to HTS_TST PMTCT ANC1-Only modality) • TB_STAT (data from TB_STAT auto-populates to HTS_TST TB modality)	

- VMMC_CIRC (data from VMMC_CIRC auto-populates to HTS_TST VMMC modality)
- HTS_INDEX (data from HTS_INDEX auto-populates to HTS_TST Index modality)
- PrEP_CURR
- PP_PREV
- KP_PREV
- OVC_HIVSTAT

Importantly, if a site does not report on TB_STAT, VMMC_CIRC, or PMTCT_STAT, any HIV testing conducted in locations related to VMMC, PMTCT or TB should be reported under the 'Other PITC' modality of HTS_TST.

For an individual to be counted under this indicator, that individual's HIV diagnosis must be confirmed using a nationally validated testing algorithm. For example, an HIV-positive rapid HIV test performed at the community- or facility- level must be confirmed with a second test, which may be performed at the same site or at a different facility. If the confirmatory test is performed at a different facility, then this may entail follow-up by implementing partners to confirm the diagnosis before reporting on this indicator. The implementing partner who first identified and tested the individual should report on HTS_TST under the appropriate modality; however, that implementing partner must ensure that the diagnosis of the individual tested is confirmed. Only a confirmed diagnosis (positive or negative) counts under HTS_TST regardless of the modality used for reporting. Similarly, simply only confirming the diagnosis of an individual who has already been tested (as per the national testing algorithm) does not fulfill the requirements for reporting on HTS_TST regardless of the modality used.

For children <1, only if serologic tests are used for diagnostic purposes should they be reported under HTS_INDEX. Serologic tests for screening infants should be excluded (including tests to look for HIV exposure at age 9 months or another time point). For example, if the partner/program uses serologic-based testing to confirm absence of HIV infection in infants <1-year-old who have not breastfed for at least 3 months prior to testing, you may use the HTS_INDEX <1 disaggregate to report negative diagnostic results for such cases. However, since diagnosis of HIV infection in infants is based on virologic and not serologic tests, the general expectation is not to see results in the "< 1" disaggregate of the HTS_INDEX indicator. HIV virologic testing of HIV-exposed infants should be counted under PMTCT_EID and PMTCT_HEI_POS.

Retesting for verification of HIV positive status before or at antiretroviral (ART) initiation should not be counted under HTS_TST since testing of this individual will have already been counted at the point of the initial diagnosis. Retesting for verification is primarily done as a quality assurance activity to avoid misdiagnosis and to ensure those initiated on ART are indeed HIV positive. Therefore, retesting for verification should only be performed for persons who have received an HIV diagnosis but have not yet been initiated on ART. While retesting for verification should not be recorded as HTS_TST or HTS_TST_POS, these data should nevertheless be tracked and rates of discordancy monitored.

Key Populations (KPs):
Provision of information (tested, tested positive, tested negative) on KPs (FSW, MSM, Transgender people, PWID, and people in prisons and other closed settings) who were tested and received their results should be reported, where possible, under the KP disaggregate However, reporting on this disaggregate is optional. Importantly, the KP disaggregate is NOT a HTS_TST modality. That is, regardless of whether the KP disaggregate is used for reporting or not, all KP testing should be reported under the appropriate modality. For example, a community site keeps secure and safe records of all key populations tested at that site. This community site has determined it can report on the KP disaggregate in a safe and confidential way. Of the 100 individuals KPs who were tested and received their results (including confirmation of diagnosis) at this site, the community

site reports 100 under the appropriate modality (in this case, VCT) AND reports 100 under the KP disaggregate.

See Appendix A: Key Population Classification Document, to inform identification of key populations at HTS service delivery. However, reporting of key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple key population categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE key population disaggregation category to avoid double-counting.

Note: Both key population-specific and clinical partners have the option to complete these disaggregations, but only if it is safe to maintain these files and report. Age and sex data on key populations receiving tests for recent infection will not be reported. Please refer to the KP_PREV indicator reference sheets for more information on working with KPs.

The first priority of data collection and reporting of HTS among key populations must be to do no harm. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.

Note the misalignment of reporting frequency between HTS_TST [quarterly] and KP_PREV [semi-annually] and the differences in the process of de-duplication of individuals (HTS_TST is de-duplicated within the quarter, whereas KP_PREV is de-duplicated within the fiscal year). For example, if a KP is reached and tested more than once within the fiscal year, s/he will only be counted once under KP_PREV but could be counted multiple times under HTS_TST KP disaggregation during same the fiscal year if the KP was tested multiple times in different quarters. However, if a KP is tested multiple times within the same quarter, s/he should be deduplicated (i.e., only be counted once in the quarter). Please be cognizant of such limitations when interpreting KP_PREV, HTS_TST, and HTS_TST_POS cascade data by key populations.

Data Systems and Tools
When developing or modifying existing monitoring and evaluation systems and tools to collect and report on this indicator, the following information should be considered (* designates data elements that are required for HTS_TST reporting in DATIM):

1. This indicator counts the number of individuals tested not the number of tests conducted. All efforts should be made to ensure data are collected on individuals tested vs. number of tests conducted through de-duplication. Within HTS registers, collecting data on the following variables should be considered to help in these efforts:
    a. Retesting status: new tester, re-tester (i.e., tested in the last 3 months), retesting to verify an HIV-positive diagnosis before ART initiation
    b. HIV testing services - *HIV test results, date of HIV test, receipt of HIV test results, previously tested during the reporting period
    c. Demographic - Client's Unique ID, name, *sex, and *age at time of HTS services
    d. Date HIV-positive individual was linked to treatment
    e. Site - *site name and ID, district, region, province, and *service delivery modality
2. Using unique identifiers for individuals is one way to account for retesting and avoid double reporting if electronic systems are available to easily link data through these unique identifiers. Another approach is to record information about prior testing on the HTS client register.
3. For an individual to be counted under HTS_TST, their HIV diagnosis must be confirmed using a nationally validated testing algorithm. For example, an HIV-positive rapid HIV test performed at the community- or facility- level must be confirmed with a second test, which may be performed at the same site or at a different facility. If the confirmatory test is performed at a different facility, then this may entail follow-up by implementing partners to confirm the diagnosis before reporting on this indicator. The implementing partner who first identified and tested the individual should report on HTST_TST under

<table>
<tr><td></td><td colspan="2">the appropriate modality; however, that implementing partner must ensure that the diagnosis of the individual tested is confirmed. That is, only a confirmed diagnosis (positive or negative) counts under HTS_TST regardless of the modality used for reporting. Similarly, simply only confirming the diagnosis of an individual who has already been tested (as per the national testing algorithm) does not fulfill the requirements for reporting on HTS_TST regardless of the modality used.
4. Note: Retesting for verification of HIV positive status before or at antiretroviral (ART) treatment initiation is only done for persons who have already been diagnosed HIV-positive as per the national HIV testing guidelines. All clients diagnosed HIV-positive should be retested for verification before or at ART initiation with a new specimen and preferably a second operator using the same national HIV testing strategy. Retesting for verification is primarily done as a quality assurance activity to avoid misdiagnosis and to ensure those initiated on ART and treatment services are indeed HIV positive. Thus, HIV testing conducted to verify status should not be counted under HTS_TST, since their initial HIV diagnosis will have already been counted at the point of the initial receipt of the HIV diagnosis (as per the national HIV testing guidelines).
5. Patient level Deduplication: adding “has patient been tested in the last 3 months” to the HTS facility and community registers can help implementing partners de-duplicate at the reporting level.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Only one age disaggregation type is used for age/sex/test result received: The number of individuals newly receiving ART must be disaggregated by age and sex. If possible, the full age/sex disaggregations should be used. If the full age/sex disaggregations are not possible, then, and only then, should the aggregated age/sex disaggregations be used. Do NOT complete both age/sex disaggregations.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum results across quarters.</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>HTS Modality and Result by Age/Sex (Community-Level HTS Reporting) [Required]

<u>Underlined modalities auto-populate for their respective parent indicators.</u></td><td>• <u>Index (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u>
• Mobile (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• VCT (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Other Community Testing Platform (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>HTS Modality and Result by Age/Sex (Facility-Level HTS Reporting) [Required]

<u>Underlined modalities auto-populate for their respective parent indicators.</u></td><td>• <u>Index (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u>
• Emergency (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Inpatient (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
</table>

		• Malnutrition (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M • Pediatric <5 Clinic (by Positive/Negative result) by: <1 F/M, 1-4 F/M • PMTCT [ANC1-Only] (by Positive/Negative result) by: <1 F, 1-4 F, 5-9 F, 10-14 F, 15-19 F, 20-24 F, 25-29 F, 30-34 F, 35-39 F, 40-44 F, 45-49 F, 50+ F, Unknown Age F • PMTCT [Post ANC1: Pregnancy/L&D/BF] (by Positive/Negative result) by: <1 F, 1-4 F, 5-9 F, 10-14 F, 15-19 F, 20-24 F, 25-29 F, 30-34 F, 35-39 F, 40-44 F, 45-49 F, 50+ F, Unknown Age F • STI (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • TB (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VCT (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • TB (Positive/Negative): <1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15_19 F, 20-24 M, 20-24 F, 25-29 M, 25-29 F, 30-34 M, 30-34 F, 35-39 M, 35-39 F, 40-49 M, 40-49 F, 50+ M, 50+ F; • VMMC (by Positive/Negative result) by: <1 M, 1-4 M, 5-9 M, 10-14 M, 15-19 M, 20-24 M, 25-29 M, 30-34 M, 35-39 M, 40-44 M, 45-49 M, 50+ M, Unknown Age M • Other PITC (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Result by Key Population Type [Optional]	• People who inject drugs (PWID) by Positive/Negative • Men who have sex with men (MSM) by Positive/Negative • Transgender people (TG) by Positive/Negative • Female sex workers (FSW) by Positive/Negative • People in prison and other closed settings by Positive/Negative
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	**Disaggregates: Service Delivery Modality** In addition to reporting the total number of individuals tested and receiving their test results and the total type of test results received (negative, positive), HTS_TST data should be disaggregated by service delivery modality, and then also by age/sex/test result within each service delivery modality. Service delivery modalities can reflect a reason for testing (index, STI), as well as, the location/place of testing (e.g., inpatient ward, VCT drop-in center). For example, STI and Index in this context refer to a reason a person is seeking or being offered an HIV test i.e., the person suspects he/she may have an STI or the person is a contact of an index client (see modalities below for more details). In either case (STI or index), that person should be reported under either STI or index even if he/she were tested for HIV any other location or setting (inpatient, VCT, drop-in center). That is, reporting the reason for testing as either STI or Index takes precedence over all other modalities. A single person should only be counted once under any given modality. **Service delivery modalities are defined as:**	

Community-based testing: Applies to any testing done outside of a designated health facility. Within community-based testing, the following disaggregates are available:

A. **Index:** Importantly, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information). Index testing, also referred to as partner testing/partner notification services, is an approach whereby the exposed contacts (i.e., sexual partners, biological children and anyone with whom a needle was shared) of an HIV-positive person (i.e., index client), are elicited and offered HIV testing services. That is, in this context, Index testing refers to any HIV testing of contacts of an index client (i.e., a known positive). **Only the following persons count as contacts: current or past sexual partner(s), biological children /parents (if index case is child) or anyone with whom a needle was shared. Biological children reported under HTS_INDEX should only include children of an HIV-positive mother and children of male-index clients (fathers) whose biological mother is HIV-positive, deceased, or her HIV status is not known or not documented**. Conversely, if the index client is the child, his/her mother should be tested, and if positive or deceased, the father should be tested as well. In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease, and every newly identified positive becomes a subsequent index client from whom to elicit contacts. While testing the contacts of an index client may occur in mobile, VCT or other community testing venue, this testing should be reported under HTS_INDEX. That is, if an individual could be reported under both HTS_INDEX and another HTS_TST modality, that individual should only be reported once under HTS_INDEX. Again, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information).

B. **Mobile:** Testing in Mobile ad hoc or temporary testing locations, such as community centers, schools, workplaces, and includes testing in mobile unit such as tents and vans. Testing related to VMMC services is not included here and should be reported under facility based VMMC modality.

C. **VCT (Voluntary Counseling and Testing):** Includes testing conducted in standalone VCT center that exists outside of a designated health facility (e.g., drop-in-center, wellness clinic where HTS services are provided, testing sites aimed at key populations, etc.).

D. **Other community platforms:** Includes all community-based modalities not captured above (e.g., ad hoc testing campaign that does not satisfy the mobile testing definition) and community-based OVC testing) should be entered under this modality.

Facility-based testing: Applies to any testing occurring inside a designated health facility. Within the facility-based testing, the following disaggregates are available:

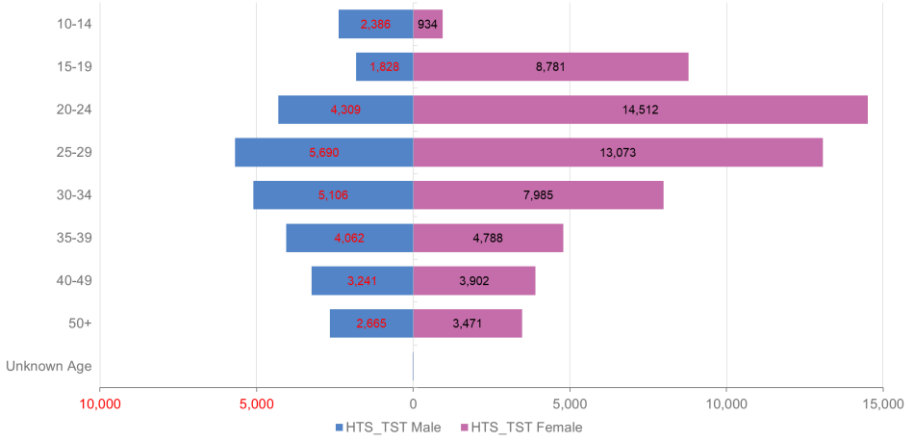
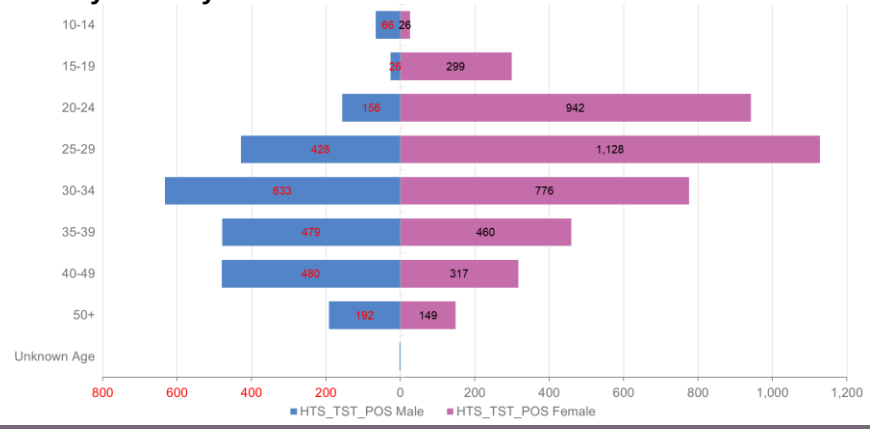
A. **Index:** Importantly, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information). Index testing, also referred to as partner testing/partner notification services, is an approach whereby the exposed contacts (i.e., sexual partners, biological children and anyone with whom a needle was shared) of an HIV-positive person (i.e., index client), are elicited and offered HIV testing services. That is, in this context, Index testing refers to any HIV testing of contacts of an index client (i.e., a known positive). Only the following persons count as contacts: current or past sexual partner(s), biological children /parents (if index case is child) or anyone with whom a needle was shared. Biological children reported under HTS_INDEX should only include children of an HIV-positive mother and children of male-index clients (fathers) whose biological mother is HIV-positive, deceased, or her HIV status is not known or not documented. Conversely, if the index client is the child, his/her mother should be tested, and if positive or deceased, the father should be tested as well. In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease, and every newly identified positive becomes a subsequent index client from whom to elicit contacts. While testing the contacts of an index client may occur in mobile, VCT or other community testing venue, this testing should be reported under HTS_INDEX. That is, if an individual could be reported under both HTS_INDEX and another HTS_TST modality, that individual

should only be reported once under HTS_INDEX. Again, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information).

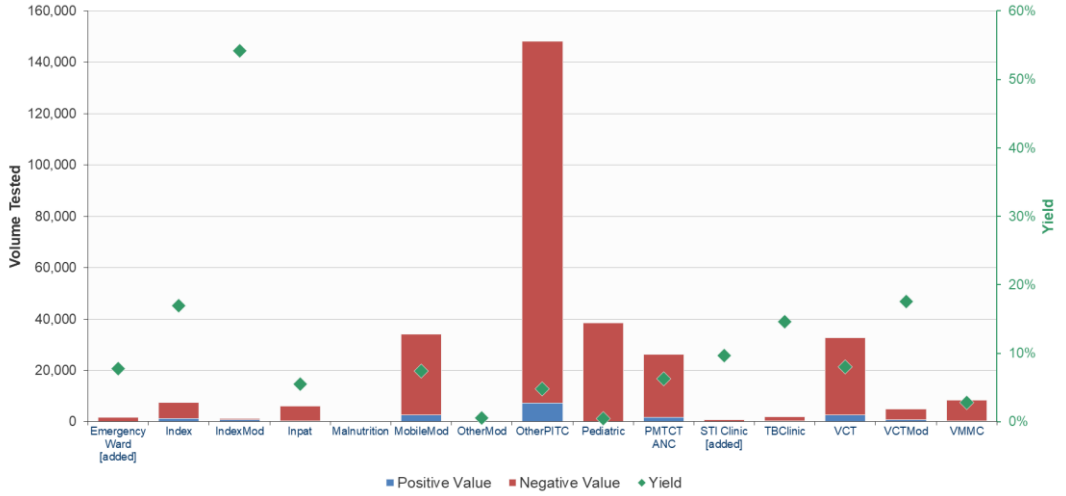
B. Provider Initiated Counseling and Testing (PITC):
    a. **Emergency:** Includes persons tested or seen in a designated emergency department or ward for the immediate care and treatment of an unforeseen illness or injury.
    b. **Inpatient:** Includes PITC occurring among those patients admitted in the inpatient and surgery wards.
    c. **Malnutrition:** Clinics and inpatient wards predominately dedicated to the treatment of malnourished children. While this service delivery modality may be part of either inpatient or outpatient services, if an individual could be reported under both malnutrition and another service delivery modality, report an individual only once and under malnutrition. However, the biological children of female index cases should be classified under the Index testing modality.
    d. **Pediatric <5 Clinic:** Includes PITC occurring in the pediatric <5 clinic only. This modality refers only to children tested in the <5 clinic. Children tested for any other reason should be counted under the respective modality where their testing occurred. Note that this modality does not include virologic testing, which is reported under PMTCT_EID, nor rapid HIV testing used to identify HIV exposed infants. This modality should also not include children of index cases who should be classified under the Index modality or malnourished children who should be classified under Malnutrition.
    e. **PMTCT (ANC1 Only):** Pregnant women tested at their 1st antenatal care clinic (ANC) for their current pregnancy (who are also reported under PMTCT_STAT) are reported under this modality. Refer to PMTCT_STAT reference sheet for guidelines on data collection. Individuals counted under PMTCT_STAT who already knew their status should not be reported under HTS_TST.
    f. **PMTCT (Post ANC1: Pregnancy/L&D/BF):** Includes pregnant or breastfeeding women who receive a test POST ANC1, this includes women who are tested later in pregnancy (>ANC2), during labor & delivery (L&D), and while breastfeeding.
    g. **STI:** Includes persons seen in a designated STI clinic as well as patients seen in the OPD for STI symptoms. This includes suspect and confirmed STI cases. HIV testing may take place in an STI clinic, an OPD, a co-located VCT or other setting. However, if the reason for the HIV testing is the individual is either a suspect or confirmed STI case, then the test should be reported under the STI modality.
    h. **TB:** Includes persons referred for HIV testing because they are a confirmed or a presumptive TB case. HIV testing may have taken place in a TB clinic, a co-located VCT or other setting. However, if the reason for the HIV test is that the client is a TB case or a TB suspect, then it should be classified under the TB modality. Refer to TB_STAT for guidelines on data collection for TB.
    i. **Other PITC:** This includes any other provider-initiated testing and counseling that is not captured in one of the other testing modalities listed above. For reporting purposes, this includes testing of patients triaged to other clinics within the OPD that see patients for routine/chronic care (i.e., eye, dental, dermatology, diabetes, etc.). This does not include patients seen in the OPD for emergency care or an STI. Those patients should be classified under the emergency and STI modalities, respectively.

C. **VMMC:** This modality includes HIV testing for males conducted as part of VMMC programs in both facility and mobile outreach programs. Testing is recommended through the VMMC program, although not mandatory. Refer to VMMC_CIRC for guidelines on data collection for VMMC.

D. **VCT:** Refers to a clinic specifically intended for HIV testing services that is co-located within a broader health care facility. This data can typically be found in the VCT register. This should not include testing of patients referred by providers from other clinical services within the facility (TB, ANC, Inpatient, emergency, etc.). Even though the actual test may be administered in the VCT clinic, report those individuals under the

	serviced delivery modality from which they were referred. This modality should also not include testing of exposed partners and exposed family members of an index case, who should be reported under the Index disaggregate.
PEPFAR-support definition:	Standard definitions of DSD and TA-SDI apply. <u>For HTS services, direct service delivery includes</u>: ongoing procurement of critical HTS related commodities such as rapid HIV test kits or requisite materials (lancets, capillary tubes), samples and materials for proficiency testing, other HIV diagnostic commodities, or funding for salaries of HIV testing service providers including counselors, laboratory technicians, program managers, and/or community health workers. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>For HTS services, ongoing support for service delivery improvement includes</u>: clinical mentoring/supportive supervision, HTS training, HTS guidance development, routine support of HTS M&E and reporting, or HIV test kits consumption forecasting and supply management.
Guiding narrative questions:	1. Please describe and/or specify any processes or data available for determining rates of retesting (not including verification testing) of both HIV positives and negatives. 2. Please describe processes/methods and/or quantify any estimation of linkage to treatment from diagnosis. 3. Please describe and/or quantify (proportions retested prior to ART, concordance or discordance rates) verification testing occurring prior to ART initiation to minimize misdiagnosis. 4. Please describe processes/methods for capturing new service delivery modalities (STI and Emergency) and any challenges with accurately capturing these modalities.
Data Visualization & Use Examples:	**HTS Age/Sex Pyramid by Number Tested:**  **HTS Age/Sex Pyramid by Number Positive:** 

HTS Positives, Negatives and Yield by Testing Modality:



OVC_HIVSTAT

Description:	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner.	
Numerator:	Number of orphans and vulnerable children (<18 years old) with HIV status reported, disaggregated by HIV status	Data sources for this indicator include HIV test results that are self-reported by OVC (or their caregivers), results of HIV Risk Assessments conducted by implementing partners, registers, referral forms, client records, or other confidential case management and program monitoring tools that track those in treatment and care.
Denominator:	Number of orphans and vulnerable children reported under OVC_SERV (<18 years old, total numerator including active and graduated)	Denominator is not collected again as part of this indicator, but is collected under the indicator OVC_SERV.
Indicator changes (MER 2.0 v2.2 to v2.3):	• Clarifications have been made to the indicator reference sheet to highlight risk assessment. The disaggregate under "No status reported" formerly called "Test not indicated" will now be "Test not required based on risk assessment" to simplify the language and will no longer be included under the "No status reported to implementing partner" category. HIV positive OVC for whom ART status is not documented will be reported under "Reported HIV Positive -- Not currently receiving ART or ART status unknown" and OVC for whom HIV status is missing will be reported under "HIV Status Unknown."	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	This indicator will be tracked through routine program monitoring semi- annually through the POART process. Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC beneficiaries, to assess their risk of HIV infection, and to facilitate access and retention in ART treatment for those who are HIV positive. When the implementing partner determines that the child is at risk of HIV infection, the program should refer children for testing and counseling services. When the implementing partner knows the HIV status, the program should ensure that the children are linked to appropriate care and treatment services as an essential element of quality case management. OVC programs should also play an important role in family-centered disclosure, for those who are HIV positive. • This indicator is NOT intended to be an indicator of HIV tests performed or receipt of testing results, as these are measured elsewhere and confirmed test results are frequently unavailable to community organizations due to health facility concerns about patient confidentiality. • This indicator is NOT intended to imply that all OVC beneficiaries require an HIV test. OVC with known positive or negative status do not need to be tested. OVC with unknown HIV status should be assessed for risk, and if determined to be at risk, should be referred or otherwise supported, to access HTS. For younger children who are determined not to be at risk ("test not required based on risk assessment") reassessment of risk will only be needed in cases where their risk situation changes (i.e., in cases of child sexual abuse). Older children whom the IP thinks may be sexually active should be assessed every reporting period. An HIV risk assessment should always occur prior to HIV testing to determine if a test is required. • Status disclosure to the implementing partner is NOT a prerequisite for enrollment or continuation in an OVC program. OVC programs serve persons of positive, negative, and unknown HIV status appropriate to their needs and vulnerability to HIV. This indicator ensures that IPs are regularly providing outreach to caregivers to identify children's HIV	

	status, encouraging family disclosure, and linking to care and treatment services as needed. • This indicator captures if implementing partners are tracking the self-reported HIV status of the OVC that they serve and enrollment in ART for those who are positive. Testing results for OVC who are referred for testing should be reported under HTS_TST based on the service delivery point where they are tested. • This indicator also captures if implementing partners are tracking if the OVC that they serve who report to be HIV positive are successfully linked to and retained in treatment and care. ART treatment status should be recorded both at the time of enrollment as well as at regular intervals at least once during the reporting period. • Since this is not a testing indicator, HIV positivity yield should NOT be calculated based on this indicator. Yield calculations should only be made by testing partners. • A helpful way to assess OVC_HIVSTAT performance is to create a category of known status/risk (by combining those reported positive, negative, and those who have been risk assessed and found to not require a test) and compare this with OVC_SERV <18. This analysis encourages programs to actively follow-up on all instances of "HIV status unknown" by targeting instances of missing data, nondisclosure, and issues with reporting timing. While OVC_HIVSTAT as a percentage of OVC_SERV <18 historically intended to identify gaps in IP tracking of HIV status of OVC, this updated way of reviewing the data provides insight into OVC with known status and identifies where additional follow-up is needed for those with unknown status. • This indicator is a subset from OVC_SERV. Only OVC who were reported under OVC_SERV <18 should be included in the denominator for this indicator. • DREAMS beneficiaries under 18 who are reported under OVC_SERV should also be reported under OVC_HIVSTAT where feasible.
How to collect:	Data sources for this indicator include HIV test results that are self-reported by OVC (or their caregivers), results of HIV Risk Assessments conducted by implementing partners, registers, referral forms, client records, or other confidential case management and program monitoring tools that track those in treatment and care. Implementation of the HIV risk assessment should be integrated into case management and on-going case monitoring, and should not be conducted separately, if possible. This will vary by partner and project. The partners should work out a timeline based on their experience of how long referral completion and status disclosure usually takes and factor that into their case management processes. Implementing partners will record the OVC beneficiary's self-reported HIV status semi-annually. **Reporting Scenarios:** **Q1.** Daniel reports to the community health worker (CHW) that he is negative, but his last test was two years ago. Is Daniel still reported as "Negative", or as "No Status", and needs to be risk assessed? **A1.** Based on their knowledge of the child from case management records, if the CHW believes that the child has no risk of HIV infection (i.e., no one in the household is HIV+, they are not exposed to violence, child is not sexually active yet) then getting another test done is not necessary and would report them as negative. This applies mainly to younger children under age 12 (depends on average age of sexual debut in the country). For adolescents, we recommend getting risk assessed if the test was not conducted in the reporting period. In that same scenario, what if the CHW decides to administer the HIV Risk Assessment to Daniel and finds that an HIV test is not indicated, how should that be reported? This should be reported as "Test Not Required Based on Risk Assessment" because once the CHW decides to conduct a risk assessment, this means that the child's status is in question and that should be captured as No Status. **Q2.** Elizabeth reports to the CHW that she is negative and had an HIV test within the past 6 months, but the CHW knows that she was recently exposed to something that could put her at high risk (e.g., GBV, sexually active), what should the CHW do?

<table>
<tr><td></td><td colspan="2">A2. Because the CHW thinks that Elizabeth may be at risk of HIV infection, the CHW would conduct the risk assessment and she is no longer reported as “Reported HIV Negative”. If found at risk (e.g., GBV exposure) then she should be referred for testing. If determined to be Test Not Required Based on Risk Assessment Elizabeth would be captured as “Test Not Required Based on Risk Assessment”.

If she completes the testing within the reporting period and the caregiver is willing to disclose the result of the test, her response would be captured accordingly.
If she is risk assessed and referred for testing but her caregiver is not able/willing to complete the test or disclose the status within the reporting period it is captured as “No HIV Status”. Hopefully by the following reporting period, the caregiver will have completed the referral and disclosed the child's status so it can be captured as positive or negative. It is understandable that the whole process from risk assessment to referral completion and disclosure may not be completed within 6 months and there be movement from “No HIV Status” to “Reported HIV positive” or “Reported HIV Negative” in future reporting periods.

Q3. What do we do when a caregiver refuses to disclose their status and the status of their child or refuses to complete an HIV test – even when the HIV risk screening tool indicates that their child is at high risk of HIV infection?
A3. A caregiver should never be forced to disclose their or their child’s status, the results of an HIV test, or to complete an HIV test. HIV status and completion of an HIV test are not required for enrollment in an OVC program. If a child is believed to be at high risk of HIV and the caregiver is reluctant to disclose results or complete a test, OVC programs should attempt to facilitate a meeting with the caregiver, and persons specially trained on HIV disclosure. OVC programs may also consider enlisting the support of community members with whom the caregiver has greater trust. Until the client chooses to disclose test results, status under OVC_HIVSTAT should be recorded as “No HIV Status.”

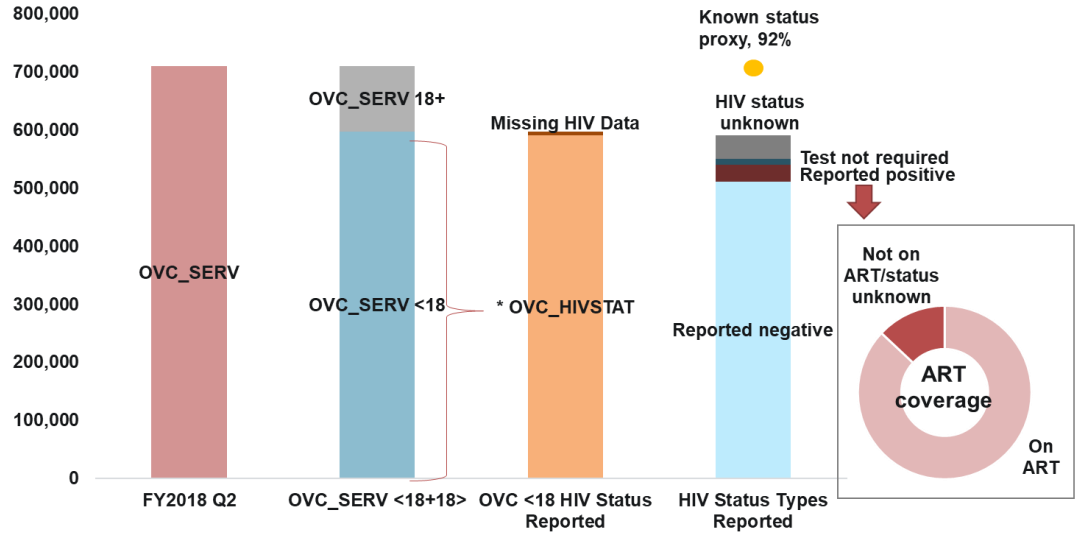
Q4. How do we report on HIV exposed infants who are still too young to have had their final HIV status testing?
A4. Because HIV-exposed infants may be tested at multiple points prior to receiving a final HIV status, we recommend that they be counted as "no status" until such time that the clinic determines their final status as positive (infected) or negative (not infected). A note can be entered in DATIM in the narrative section indicating the number of children entered as "no status" that are HIV-exposed (i.e., infants during the reporting period who were of undetermined status). It is important for all HIV-exposed infants and their caregivers to be facilitated to make appointments deemed necessary by the clinic.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">The OVC_HIVSTAT total numerator should equal OVC_SERV<18 results total numerator, including active and graduated. Review any site with the following reporting issues: 1) numerator greater than 100% of OVC_SERV <age 18, and 2) very low coverage of OVC_HIVSTAT (defined as OVC_HIVSTAT numerator divided by OVC_SERV <18) which provides data on reporting of status.

Missing data should be documented under “HIV status unknown” or “Reported HIV positive-Not currently receiving ART or ART status unknown.” Potential reasons for missing data may include: 1) IP was not able to collect information from all caregivers of OVC_SERV<18 within the reporting period, 2) IP was not able to locate all the caregivers of OVC_SERV<18 (e.g., relocated, migrant work).</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Status Type [Required]</td><td>• Reported HIV positive to implementing partner
  ○ Currently receiving ART
  ○ Not currently receiving ART or ART status unknown
• Reported HIV negative to implementing partner</td></tr>
</table>

<table>
<tr><td></td><td></td><td>• Test not required based on risk assessment
• No HIV status reported to the implementing partner (HIV status unknown)</td></tr>
<tr><td></td><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>See OVC_SERV.</td><td>See OVC_SERV.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Status Type Disaggregate Definitions:
• “Reported HIV positive to IP” includes beneficiaries <age 18 who report to the IP that they are HIV positive based on an HIV test conducted during or prior to the reporting period (regardless of where the test occurred). All beneficiaries <age 18 who report to the IP that they are HIV positive based on an HIV test conducted during or prior to the reporting period (regardless of where the test occurred) should be reported as “currently receiving ART” or “not currently receiving ART or ART Status Unknown.” This also includes beneficiaries <age 18 who report that they are HIV positive based on an HIV test conducted during previous project reporting periods. OVC entered in either category as “Reported HIV positive– currently receiving ART” or “Reported HIV positive– not currently receiving ART or ART Status Unknown” in the previous reporting period should be followed in the current reporting period and their current ART treatment status noted.
• “Reported HIV negative to IP” includes beneficiaries <age 18 who report that they are HIV negative to the IP based on an HIV test conducted during the reporting period (regardless of where the test occurred). For a child who reports multiple tests within the current period, use most recent test. For beneficiaries entered as “Reported HIV negative to IP” in a previous reporting period—if the IP believes the child’s risk has not changed in the last six months, they should continue to report the child as negative during the current reporting period. However, if the IP believes that the child has recently been exposed to risk of HIV infection (e.g., sexual violence) or if an adolescent has become sexually active, then the IP should conduct the HIV risk assessment. Potential outcomes reported after the HIV risk assessment include 1) the child is tested and reported as HIV positive and either currently receiving ART or not receiving ART or ART status unknown, or 2) the child is tested and reported as HIV negative, 3) the child is reported as “No HIV Status reported to the IP”, or 4) the child is reported as “Test not required based on risk assessment.”
• “Test not required based on risk assessment” includes beneficiaries (OVC_SERV<age 18) who based on a risk assessment made by the implementing partner do not require a test during the reporting period (formerly known as test not indicated). (Consensus Conference Technical Report on the Role of OVC Programs Supported by PEPFAR in Extending Access to HTS includes further information on determining whether a test is required).
• “No HIV status reported to the IP” (HIV status unknown) includes all beneficiaries <age 18 who do not fit in the above categories and who report to the IP that they do not know their HIV status or for whom HIV status is missing. Potential scenarios for reporting a child in this category include:
○ Caregiver chooses to not disclose whether the child has been tested and his/her current HIV status in the reporting period
○ Caregiver refuses to let the IP conduct a risk assessment on the child in the reporting period.
○ Caregiver recommended by IP to have child tested base on risk assessment but refuses to test the child in the reporting period OR does take child to test but doesn't report results to IP in the reporting period.
○ The IP is still in the process of convincing the caregiver to get the child assessed, tested and/or disclosure of status. IPs may not be positioned to report within the reporting period this would be captured under No HIV Status Reported to the IP. The IP should monitor these children and provide services to encourage referral completion and disclosure in the next reporting period.
○ The IP has not collected HIV Status for the child; HIV status is missing.</td></tr>
</table>

	We recommend that IPs aim to move a newly enrolled OVC with HIV Status Unknown through the assessment cascade within the reporting period. A newly enrolled child would initially be considered "HIV Status Unknown" until he/she is risk assessed. If the OVC is found to not be at risk at present, he/she will be noted as "Test not required based on risk assessment." If the OVC is found to be at risk, he/she will be referred for HIV testing and then the program will work with the guardian to disclose the results until he/she can be reported as "Reported HIV Negative", "Reported HIV Positive – currently on ART" or "Reported HIV Positive – not currently on ART or ART status unknown". For children reported as "HIV Status Unknown" in the previous reporting period, the IP should ensure that child is risk assessed, referred for testing if needed, and supported to disclose new test results. Children reported as "Test not required based on risk assessment" with no changes in their risk situation for the past six months, don't need to be reassessed. If the IP believes the child's risk situation has changed in the last six months, then the child should be reassessed by the implementing partner to determine whether testing is indicated and the results entered as outline above, and the child should receive appropriate follow-up.
PEPFAR-support definition:	Modifications to standard definition of DSD and TA-SDI related to eligible goods and services: <u>Provision of key staff or eligible goods/services for OVC beneficiaries receiving care and support services in the community include</u>: For beneficiaries of OVC services, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group or community level activity (e.g., psychosocial support, child protection services, education, etc.). Partial salary support may include stipends or incentives for volunteers/para-social workers or paying for transportation of those staff to the point of service delivery. For goods or services to be eligible, goods or services (e.g., bursaries, cash transfers, uniforms) can either be paid for out of the implementing partner's budget or be provided as a result of the IP's efforts to leverage and mobilize non-project resources. For example, an IP may help beneficiaries fill out and file forms necessary for the receipt of government provided cash transfers, social grants, or bursaries for which they are eligible. Given the focus on long-term local ownership, IP's are encouraged to mobilize goods and services whenever possible. <u>For care and support services, ongoing support for OVC service delivery for improvement includes</u>: the development of activity-related curricula, education materials, etc., supportive supervision of volunteers, support for setting quality standards and/or ethical guidelines, and monitoring visits to assess the quality of the activity, including a home visit, a visit to a school to verify a child's attendance and progress in school or observation of a child's participation in kids clubs.
Guiding narrative questions:	1. If the sum of reported HIV negative + reported HIV positive + Test not required based on risk assessment is less than 90% of OVC_SERV <18, please explain why such a high proportion are being reported in the category of "HIV Status Unknown" (i.e., the performance metric described in the "how to use" section). Are there certain partners that are struggling with reporting or understanding the disaggregates? How is the Mission responding? 2. Please explain the breakdown of those reported under "HIV Status Unknown." What percentage of caregivers refused to disclose a child's HIV status? What percentage represents those who have been referred for testing but do not yet have results? What percentage represents missing data where an implementing partner failed to document the child's HIV status? 3. For children reported as "Reported HIV Positive - not currently on ART or ART Status Unknown", what efforts are being undertaken in response? Are there certain partners with low ART coverage, why? Is this an issue related to community case management? Or are partners having a hard time collecting timely confirmation of treatment status (i.e., missing)?

Data Visualization & Use Examples:	OVC_HIVSTAT Cascade:



PMTCT_EID

Description:	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	
Numerator:	Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period	The numerator is a measure of sample collection for virologic testing. Throughout the reference guide the term "received a first virologic test" specifically means "had a first sample collected for virologic testing." Age refers to age at specimen collection
Denominator:	PMTCT_STAT_POS + HTS_TST_POS from the Post ANC1: Pregnancy/L&D/BF modality. (see PMTCT_STAT & HTS_TST reference sheets)	Calculated indicator, sum of: PMTCT_STAT POS: 1) Newly Tested Positive, 2) Known Positive at entry (see PMTCT_STAT reference sheet for more details) and HTS_TST_POS: Post ANC1: Pregnancy/L&D/BF modality (see HTS_TST reference sheet for more details)
Indicator changes (MER 2.0 v2.2 to v2.3):	• Denominator is updated to include women identified as positive after ANC1, including later in pregnancy, at L&D, and throughout the breastfeeding period. These women are reported under the newly added HTS modality: Post ANC1: Pregnancy/L&D/BF.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This percentage is a proxy measure, relying on PMTCT_STAT_POS + HTS_TST_POS (Post ANC1: Pregnancy/L&D/BF) as a proxy denominator for total number of HEI. Reviewing infants with a first virologic test (N) against this proxy denominator should be done with caution; see assumptions and limitations in the data quality section below.	
How to collect:	This indicator measures the extent to which HIV-exposed infants receive a first virologic HIV test to determine their HIV status by 12 months of age. The indicator is disaggregated by the age of the infant at the time of sample collection, specifically between birth and 2 months and between 2 and 12 months of age. Only samples collected for the first virologic test for each HIV-exposed infant should be counted in this indicator, including dried blood spots (DBS) and samples collected for POC testing (e.g., Alere, Xpert). Even though there is ongoing exposure of infants to HIV (through breastfeeding), this indicator only measures access to a first test, and not access to all the recommended HIV tests throughout breastfeeding. HIV status of infants at the end of the breastfeeding period and the outcomes of the PMTCT program are measured in PMTCT_FO. The positive results of HIV infant virologic testing are collected under the PMTCT_HEI_POS indicator. Please see the reference sheet for PMTCT_HEI_POS for more information. Implementing partners should report on all infants whose samples were collected for a first virologic test, even if no test result has been recorded in the patient record/register at the time of reporting. This indicator should be collected from the clinical source (i.e., HIV-exposed infant registers or patient records) to ensure unduplicated patient counting. HIV-exposed infant registers should be used to count exposed infants and samples collected for virologic testing. (If available, information could come from electronic systems). If the standard report does not contain all the required information, individual patient files should be used. Additional supporting information for this indicator can be obtained from standard laboratory information systems (i.e., DNA PCR or POC/near POC log books or electronic systems) however, it will be important to ensure that repeat tests of the same sample or HIV-infected infants receiving a confirmatory virologic HIV test result are not counted twice.	

<table>
<tr><td></td><td>A virologic test is a test used for HIV diagnosis in infants up to 18 months of age. The most commonly used form of virologic testing or nucleic acid testing (“NAT”) is HIV DNA PCR on dried blood spots (DBS) but this indicator also includes samples collected for POC testing. Three other types of testing should not be reported: 1) Serologic testing of children should not be reported in this indicator. (See HTS_TST for additional details). 2) Virologic tests conducted with the purpose of confirming the diagnosis of HIV, 3) Virologic tests used for clinical monitoring of children on ART, such as viral load quantification. Additionally, only the first sample collected should be counted for each infant, even if they have had more than one virologic test done.

The numerator is divided into first sample collected between birth and 2 months of age and first sample collected between 2 and 12 months of age. The 0-2 month and 2-12-month age periods are based on age at collection of sample, not on date of result return to the facility or caregiver. It is likely that at the time of reporting there will be samples that have been collected but for which no result is documented in the register or patient record.</td></tr>
<tr><td>How to review for data quality:</td><td>Infant testing coverage (PMTCT_EID / PMTCT_STAT_POS + HTS_TST_POS from the Post ANC1: Pregnancy/L&D/BF modality) is a proxy calculation, relying on PMTCT_STAT_POS + HTS_TST_POS from the Post ANC1: Pregnancy/L&D/BF modality as a proxy denominator for the total number of HIV exposed infants (HEI). Reviewing infants with a first virologic test (N) against these denominator results) should be done carefully—see assumptions and limitations below. Review of outlier percentages for testing coverage by age band is recommended (e.g., review high and low outliers for 0-≤2-month testing coverage disaggregate).

Assumption: the total number of HIV positive pregnant and breastfeeding women, and therefore HEI, does not significantly vary quarter by quarter. We would not expect all the women reported under PMTCT_STAT_POS to have given birth to the infants reported under PMTCT_EID. However, despite that time period mismatch, the assumption is that the total number of HIV positive women (estimated HEI) does not vary significantly quarter by quarter, so it is reasonable to compare infants tested to the STAT_POS & HTS_TST_POS PostANC1: Pregnancy/L&D/BF denominator from the same reporting time period.

See the PMTCT_HEI_POS indicator reference sheet for a description of considerations and limitations in calculating proxy positivity for HEI (PMTCT_HEI_POS / PMTCT_EID).</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Infant Test by Age at Sample Collection [Required]</td><td>• Infants who had a first virologic test (sample collected) between birth and 2 months of age (0-≤2mo);
• Infants who had a first virologic test (sample collected) between 2 and 12 months of age.</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>See PMTCT_STAT and HTS_TST.</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Infant Test by Age at Sample Collection: For the numerator to be calculated, implementing partners are required to report:
• Infants who had a first virologic test (sample collected) between birth and 2 months of age (0-≤2mo): Age at the time the sample is collected should be reported.
• Infants who had a first virologic test (sample collected) between 2 and 12 months of age: Age at the time the sample is collected should be reported.</td></tr>
<tr><td>PEPFAR-support definition:</td><td>Standard definition of DSD and TA-SDI used.

Provision of key staff or commodities for PMTCT includes: commodities such as test kits, ARVs including infant prophylaxis, lab commodities, or funding for salaries of health care workers.</td></tr>
</table>

	Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.
Guiding narrative questions:	1. Provide context for low EID testing coverage by geographic area or partner/implementing mechanism, including any planned activities/remedial actions. For example, PMTCT_EID is lower than previous quarters due to a stock out of DBS reagent. 2. Provide additional monitoring data related to: turn-around time of virologic test results back to the facility and results returned to caregiver.

PMTCT_FO

Description:	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	
Numerator:	Number of HIV-exposed infants with a documented outcome by 18 months of age disaggregated by outcome type. (Note: Collection of 18 month visit outcomes is recommended at 24 months of age, see additional explanation to the right.)	Calculated indicator in DATIM, sum of: HIV-infected, HIV-uninfected, HIV-final status unknown, died without status known. It is recommended to wait to collect the 18 month visit outcomes until the patient is 24 months old for the following reasons: 1) this allows for children who present several months late to their 18 month visit to be included in the numerator and 2) cohort reporting is easiest when monthly reporting by facilities is used and where the birth month and the reporting month are the same calendar month (i.e., for infants born in January 2012, their 24 month reporting month would be January 2014, rather than using the 18 month reporting month of July 2013).
Denominator:	Number of HIV-exposed infants who were born 24 months prior to the reporting period and registered in the birth cohort.	Only those HIV-exposed infants registered in the birth cohort at any time between 0 and 18 months of age (including transfers-ins) who were born 24 months prior to the reporting period are included in the denominator.
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility	
Reporting frequency:	Annually	
How to use:	In settings where national guidelines support breastfeeding of HIV-exposed infants, antibody testing of all HIV-exposed children at 18 months of age and/or 6 weeks after cessation of breastfeeding is recommended to determine final HIV status ('final outcome'/FO) of HIV-exposed children. To accomplish this goal, it is recommended to identify infants at birth or at the first infant follow-up visit and track them through the end of the breastfeeding period. This indicator measures progress toward ensuring that all infants born to HIV-positive women have an outcome documented. In settings where a mother-infant register is utilized and/or it is common practice for HIV-infected women to breastfeed less than or more than 18 months please describe in the narrative the final outcome time point.	
How to collect:	To report on this indicator PEPFAR supported sites would ideally use registers or facility held cards for HIV exposed infants that collect longitudinal information on follow-up and are organized by birth month of infants. This methodology is referred to as birth cohort reporting. Two examples of birth cohort reporting: 1. In Kenya, this indicator was first piloted by PEPFAR and the Ministry of Health in Western Kenya and is currently integrated into the national HIV summary reporting tool. Data from the facility HIV exposed infant longitudinal follow-up register, which organizes infants by birth-month cohorts, are aggregated into a report summarizing outcomes for infants reaching 24 months of age during each month. 2. In Malawi, clinic staff complete monthly follow up reporting forms as part of the national quarterly supervision visits using data collected directly from HIV-exposed infant cards which are kept in a binder that is organized by birth month (no HIV exposed register is used).	

As an example, for those infants born in FY 2015, the outcomes would be reported in FY 2017.

FY 2019 (Report results for the entire 12-month reporting period for these indicators at the Q4 reporting cycle)												
Reporting Month (FY19)	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
Birth Month (FY17)	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP

Both approaches allow a paper-based health facility records to quickly identify the number of HIV-exposed infants registered in the birth cohort at any time between 0 and 18 months of age (denominator).

How to review for data quality:

By design this indicator should equal 100% if all outcomes are known regardless of outcome type. This allows for facilities to check that all HIV-exposed infants have an outcome assigned to them during the reporting process. Data utilization requires reviewing the disaggregated data to understand the specific outcomes of interest. In settings where HIV-exposed infant registers do not allow for documentation of all disaggregated outcomes, country teams should report only on available disaggregates even if the aggregate indicator is less than 100%, however this should be specified in the narrative.

The denominator should include those "Transferred In" and those "Transferred Out" as long as for "Transferred In" there is documentation that HIV-exposed infants were registered at their original site in the birth cohort at any time between 0 and 18 months of age and were born 24 months prior to the reporting period. "Transferred Out" should be reported under HIV status unknown. The inclusion of Transfers-In/Out provides a quality check to ensure that all exposed infants have an outcome assigned to them during the reporting process such that the sum of the numerator disaggregation equals the denominator. However, this may lead to outcomes for >100% of HIV positive pregnant women (PMTCT_STAT_POS) identified at a site so this comparison should not be used as a logic check.

How to calculate annual total:

N/A. Data is reported only once annually at Q4.

Disaggregations:

Numerator Disaggregations:

Disaggregate Groups	Disaggregates
Outcome Type [Required]	• HIV-infected • HIV-uninfected • HIV-final status unknown • Died without status known

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
N/A	N/A

Disaggregate descriptions & definitions:

Outcome Type:

For the numerator to be calculated, implementing partners are required to report:

- HIV-infected: Number of HIV-exposed infants identified as HIV-infected at any point during follow-up. HIV-infected includes infants and children with diagnostic virologic or serologic confirmation of HIV-infection (DNA PCR before 18 months; rapid test at 18 months) and those with a presumptive HIV diagnosis where DNA PCR is not available. Site should also maintain data on HIV infected infants and whether they are linked or not linked to ART services, or whether they have no information on patient linkage to ART programs.

	• HIV-uninfected: Number of HIV-exposed infants with a negative 18-month antibody test documented. Based on national guidelines, countries should determine if "HIV-uninfected" includes infants with a documented negative antibody test that was done at least 6 weeks after cessation of breastfeeding but before 18 months of age.
	• HIV final status unknown: Sum of the following disaggregates (not reported in DATIM but should be documented at site level)
	  ○ In care but no test done: Number of HIV-exposed infants who attended 18-month visit but no antibody test result is documented (unknown FO)
	  ○ Lost to follow-up: Number of HIV-exposed infants who did not attend the 18-month visit (unknown FO)
	  ○ Transferred out (unknown FO): Number of HIV-exposed infants who transferred out between 0 and 18 months without confirmation of HIV-infection (unknown FO)
	• Died without status known: Number of HIV-exposed infants who are documented to have died without confirmation of HIV-infection between 0 and 18 months. Note: HIV-exposed infants who are HIV infected and later confirmed to have died or transferred out during follow-up are still counted under HIV infected and not died or transferred out.
	
	Every infant in a given cohort should be assigned one outcome only.

PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for PMTCT include:</u> commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers. <u>Ongoing support for PMTCT service delivery improvement includes</u>: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.

Guiding narrative questions:	1. Provide context for PMTCT_FO results (e.g., PMTCT_FO not equal to 100%, low or high rate of HIV-uninfected infants) and describe how this data being use for program management?
	2. Provide context on:
	  • The status of birth cohort monitoring in your operating unit, geographic area or partner/implementing mechanism, including any planned activities.
	  • The data source used for reporting, and any key information about data quality that is important for interpretation of results (see MER reference sheet for examples).
	  • The number and proportion of PEPFAR-supported PMTCT sites implementing cohort monitoring and able to (1) report on PMTCT_FO and (2) longitudinally track mothers to assess retention/viral suppression

PMTCT_HEI_POS

Description:	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	
Numerator:	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	This indicator excludes confirmatory testing. It includes 2 required sets of disaggregations: 1) disaggregation by age for positive infants based on the infant's age at specimen collection for virologic testing; 2) Confirmation of ART initiation, also disaggregated by age at specimen collection.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures how many HIV-infected infants are identified in a reporting period, disaggregated by age at sample collection and ART initiation status. Identification is by virologic HIV testing: DNA PCR testing of dried blood spots (DBS) or point of care (POC) (e.g., Alere, Xpert) virologic testing. Infants are defined as a child aged between 0 days (newborn) and 12 months of age, and age disaggregation is based on the infant age at the time of sample collection. The infant age reported should not be based on how old the infant was when the result was available to the site but when the sample was collected. This indicator can include infants identified as HIV-infected on any virologic test by 12 months of age and is not limited to infants identified as HIV-infected on their first virologic test. Infants may be HIV-uninfected on their first virologic test, but at a later age be identified as HIV-infected, and they should be counted in this indicator as long as they were aged 0 - 12 months at the time of subsequent sample collection. Confirmatory testing (collection of a second sample for repeat virologic testing after the first virologic test is positive) is excluded. Positive Infants and Linkage to ART: PMTCT_HEI_POS will be used to track how many positive infants are identified in a reporting period, and the "ART initiation confirmed" disaggregate can be compared to PMTCT_HEI_POS positive infants to describe rates of linkage to ART for HIV-infected infants (PMTCT_HEI_POS_ART / PMTCT_HEI_POS). The age disaggregate will also help describe linkage rates for very young infants (0-2mo). The proportion of positive infants confirmed as initiating ART can be used to help identify sites with potential successes or challenges in documentation, linkage, and/or initiation of infected infants. Comparison to TX_NEW age <1: the disaggregate for PMTCT_HEI_POS infants confirmed as initiating ART (sum of 0-2 and 2-12 months) could be compared to "infants <1-year-old initiated on ART (TX_NEW <1)." However, equal values for PMTCT_HEI_POS_ART and TX_NEW age <1 may not be expected, as each indicator may not be counting the same infants. The ART initiation disaggregate within HEI_POS will allow us to report a linked infant ART initiation outcome for each positive infant reported. For more information, see section on "How to review for data quality." Proxy positivity: When quarterly time period results are aggregated, PMTCT_HEI_POS (numerator) may be able to be compared to PMTCT_EID (numerator) for a proxy positivity calculation. This comparison will provide a poor proxy for positivity for sites or areas with a high percent of test results that are unknown. Combining quarters of data for both PMTCT_HEI_POS and PMTCT_EID for this comparison may reduce the portion of test	

	results that are unknown, especially for infants whose sample was collected near the end of a reporting period. It is also important to note that infants reported under HEI_POS will not be exactly the same as infants reported through PMTCT_EID in the quarterly time period for several reasons: 1) PMTCT_EID is limited to first virologic tests whereas HEI_POS reports infants identified on a first or subsequent test 2) PMTCT_EID is limited to infants with a first virologic test sample collected during the reporting period; whereas PMTCT_HEI_POS includes infants whose positive diagnosis was established during the reporting period, but their sample could have been collected in the prior period. Birth cohort monitoring: HIV status of infants at the end of the breastfeeding period and the outcomes of the PMTCT program are measured in the PMTCT Final Outcome indicator, PMTCT_FO. This indicator reports HIV-infected infants identified by virologic HIV testing on any sample collected by 12 months of age: DNA PCR testing of dried blood spots (DBS) or point of care (POC) (e.g., Alere, Xpert) virologic testing. **Limitations and Considerations:** • This indicator does not collect infants with a negative virologic test result or the number of infants whose test result is unknown. As such, "percent unknown" cannot be calculated through the MER indicator, though it is still an important metric for program monitoring. Notifying caregivers of infant test results remains important. • The infants reported as tested under the revised PMTCT_EID indicator are not necessarily the same infants whose positive results would be reported under the new HEI_POS indicator. Dividing HEI_POS by PMTCT_EID will not provide a precise measure of positivity; however, a proxy positivity could be calculated over a longer time period. See "How to Review for Data Quality" for more information.
How to collect:	This indicator should be collected from the clinical source (i.e., HIV-exposed infant registers or patient records) to ensure unduplicated patient counting and patient care. HIV-exposed infant registers should be used to count HIV-infected infants whose results were returned in the reporting period and the age at the time of sample collection. (If available, information could come from electronic systems). If the standard report does not contain all the required information, individual patient files should be used. Additional supporting information for this indicator can be obtained from standard laboratory information systems (i.e., DNA PCR or POC/near POC log books or electronic systems) however, it will be important to ensure that repeat tests of the same sample or HIV-infected infants receiving a confirmatory virologic HIV test result are not counted twice. Only HIV-infected infants identified as infected by a virologic HIV test on a sample collected when they were between ages 0 through 12 months should be included in this indicator. Infants who initially were identified negative from a first virologic test but who were later identified as HIV-infected after a later virologic test should be included, as long as the infant was still aged 12 months or less at the time of sample collection. Currently, the most commonly used form of virologic testing or nucleic acid testing ("NAT") is HIV DNA PCR on dried blood spots (DBS) but this indicator also includes HIV-infected infants identified through POC testing (e.g., Alere, Xpert). Serologic testing or "rapid" testing cannot diagnose HIV infection in infant and so infants with a positive serologic test result and either no virologic test result or a negative virologic test result should not be included; however, infants with a positive serologic test and a positive virologic test result should be included. The numerator is divided into HIV-infected infants who had their diagnostic sample collected for virologic testing between birth and 2 months of age and those whose diagnostic sample was collected between 2 and 12 months of age. The 0- ≤2 month and 2-12-month time periods are based on age at sample collection for virologic HIV testing, not on date of result available to the facility or caregiver. HIV-infected infants should be reported in the quarterly time period in which they are identified, even if the sample was collected/sent in the previous quarter; their age should be reported by age at the time of collection of the sample that produced the positive result, and not the age when the result was available to the site.

<table>
<tr><td></td><td>Example scenario to clarify time period and age: an infant has a DBS collected in quarter 3, aged 11 months. Due to long turnaround times, the positive result returns to the site in quarter 4 and staff now identify him/her as HIV-infected at 13 months old. This infant should be counted in quarter 4 as HIV-infected, and his/her age should be reported as 11 months (2-12mo age band).

ART initiation: An additional disaggregate of the numerator is that the HIV positive infant is confirmed as having initiated ART. An HIV-infected infant reported as “ART initiation confirmed” should have documentation of an ART regimen in their record. An HIV-infected infant whose record includes documentation of “referred to ART” or an ART clinic number without evidence of receipt of an ART regimen should not be reported as “ART initiation confirmed.” ART does not include infant ARV prophylaxis regimens for PMTCT.</td></tr>
<tr><td>How to review for data quality:</td><td>Linkage and ART Initiation:
Compare the PMTCT_HEI_POS ART initiation confirmed (disaggregate) to the PMTCT_ HEI_POS numerator to calculate linkage to ART. Significantly <100% or >100% linkage of HIV-infected infants to ART may reflect referrals to different sites, program weakness, or poor data quality and requires review to confirm.
TX_NEW comparison: HEI_POS_ART disaggregate is expected to be close in value to TX_NEW age <1; however, some discrepancies could be expected and significant discrepancies should be reviewed to confirm. These values may differ in part because the age disaggregate definitions for these indicators differs. TX_NEW age is based on age at ART initiation, while PMTCT_HEI_POS is based on age at virologic sample collection. Scenario: An infant’s virologic sample was collected when the infant was 11 months old near the end of Q1. The infant’s positive result was available to the site in Q2 and she started ART in Q2 at 13 months of age. Under PMTCT_HEI_POS in Q2, she would be reported as “Positive, ART initiation confirmed, age 2-12mo;” however, under TX_NEW in Q2 she would be reported in the 1-9-year age group.
Proxy positivity: it is useful to review proxy positivity (PMTCT_HEI_POS / PMTCT_EID) across sites or locations to identify potential outliers for further review. Summing multiple quarters of data is recommended, as quarter-specific comparisons may provide a less accurate proxy. See “How to use” section for more considerations.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Infant age at virologic sample collection, for positive infants [Required]</td><td>Positive, 0 to ≤2 months
Positive, 2 to 12 months</td></tr>
<tr><td>Positive, confirmed initiated ART by age at virologic sample collection [Required]</td><td>Positive, confirmed initiated ART, 0-2 months of age
Positive, confirmed initiated ART, 2-12 months</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Description of infant age at virologic sample collection for positive infants: For the numerator to be calculated, implementing partners are required to report:
HIV-infected infants identified in a quarter, disaggregated by the age at time of sample collection: 0-2 months of age, or between 2-12 months of age. These values will auto-sum to the numerator.
Description of positive, confirmed initiated ART by age at virologic sample collection:
Implementing partners are required to note HIV positive infants, disaggregated by age 0-≤2months and between 2-12 months, who are confirmed as initiating ART by:</td></tr>
</table>

	a. Positive, confirmed ART initiation, infant was between 0-2 months of age at age time of virologic sample collection b. Positive, confirmed ART initiation, infant was between 2-12 months of age at time of virologic sample collection
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PMTCT include: commodities such as test kits (e.g., including but not limited to DBS bundles or collection kit, POC/near POC sample collection kits and testing devices), ARVs including infant prophylaxis, lab commodities; or funding for salaries of health care workers. Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.
Guiding narrative questions:	1. Describe the data source used for reporting on this indicator, and any key information about data quality that is important for interpretation of quantitative results. 2. Linkage: (PMTCT_HEI_POS confirmed initiated ART (disaggregation) / PMTCT_HEI_POS total numerator). Please describe rates of linkage of positive infants (including young infants, ages 0-2 based on age of virologic sample collection) by subnational area. Please provide context for areas with low linkage rates, and describe activities aimed at improving infant ART initiation.

PMTCT_STAT (including PMTCT_STAT_POS)

Description:	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)	
Numerator:	Number of pregnant women with known HIV status at first antenatal care visit (ANC1) (includes those who already knew their HIV status prior to ANC1)	The numerator is the sum of the following two data elements: 1. The number of women with a previously known HIV status (both known HIV positive and known negative) attending their first ANC visit (ANC1) for a new pregnancy over the last reporting period. 2. The number of women attending ANC1 who were tested for HIV and received results
Denominator:	Number of new ANC clients in reporting period	N/A
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age disaggregates updated. • Removal of separate age-only disaggregate to reduce reporting redundancy. • Addition of "Recent Negative at Entry" disaggregate to account for clients at ANC1 who recently tested negative and are currently ineligible for testing (according to national guidelines) at ANC1. • Language added to clarify that subsequent testing events during pregnancy and breastfeeding will now be reported under a new HTS modality: Post ANC1: Pregnancy/L&D/BF (see HTS_TST reference sheet for additional information).	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR-supported antenatal care (ANC) know their HIV status and those newly testing positive are initiated on ART.	
How to collect:	The data source is the ANC register. There is a risk of double counting as a pregnant woman could be tested multiple times during one pregnancy; therefore, partners should ensure a data collection and reporting system is in place to minimize double counting, including a longitudinal ANC register (meaning a register that is able to record all information about one pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy). Subsequent testing during pregnancy and breastfeeding will be counted in the new HTS modality: Post ANC1: Pregnancy/L&D/BF. There is also a risk of undercounting if those women who already knew their HIV status prior to attending ANC are not documented, therefore the ANC register should at a minimum should document both "previously known positive" and "newly tested positive". It may be appropriate to report "known negative" women under the "Recent Negative" disaggregate if national guidelines do not require retesting women known to be HIV negative (often women tested in the last 3 months, however exact timing depends on local guidelines). See disaggregate definitions below for additional information. Women reported under the "Newly Tested Positive" and "New Negative" disaggs will auto-populate the HTS_TST ANC1 modality. Women who are tested later in pregnancy, during L&D, and/or during breastfeeding should be reported under the HTS_TST Post ANC1: Pregnancy/L&D/BF modality.	
How to review for data quality:	The % should never be above 100% at a site, and therefore review of the method of data collection and correction of any errors at sites with greater than 100% coverage is important to ensuring data quality for this indicator. Retesting of HIV-negative women during pregnancy, at L&D and through the postpartum period is an important program strategy is collected under the HTS_TST Post ANC1:	

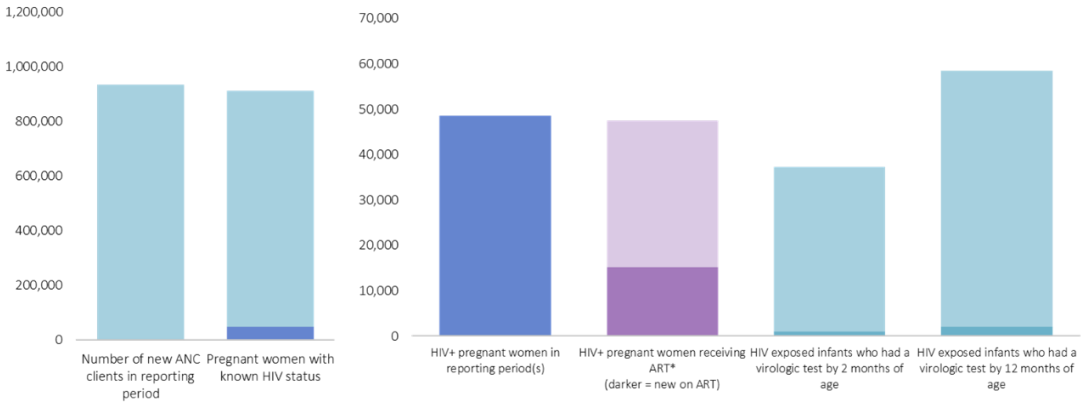
<table>
<tr><td></td><td>Pregnancy/L&D/BF modality. Please see the HTS_TST reference sheet for more information on collecting this information.</td></tr>
<tr><td>How to calculate annual total:</td><td>Assuming site level records avoid double counting (as described above) across the annual reporting cycle, sum numerator and denominator across all reporting periods for the annual result.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Status and Age
[Required]

Underlined portions auto-populate into the PMTCT (ANC1-ONLY) HTS_TST modality.</td><td>• Known Positives: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• Newly Tested Positives: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• New Negatives: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• Recent Negatives at Entry: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age
[Required]</td><td><10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Status and Age:
• Known Positive at entry: Number of pregnant women attending ANC for a new pregnancy who were tested and confirmed HIV-positive at any point prior to the current pregnancy should be reported as known positive at entry. Pregnant women with known HIV status attending ANC for a new pregnancy may not need retesting if they are already on ART, or they may be required to be retested prior to initiating ART based on national guidelines. Known positives who are re-tested and confirmed to be HIV positive prior to initiating ART should still be documented as known positive at entry.
• Newly Tested Positive: The number of women attending ANC1 who were tested for HIV and received a positive result. Women who tested negative prior to this pregnancy and are tested again at ANC1 for this new pregnancy should be counted in this indicator.
• New Negatives: The number of women attending ANC1 who were tested for HIV and received a negative result. Women who are tested negative prior to this pregnancy and are tested again at ANC1 should be counted in this indicator.
• Recent Negative at entry: Number of pregnant women attending ANC for a new pregnancy who recently tested HIV negative and are not eligible – according to country clinical guidelines - for another HIV test at ANC1. For example, women who tested negative within three months of attending ANC1 may not be recommended for testing per country clinical guidelines. This is expected to be a less utilized disaggregate.</td></tr>
<tr><td>PEPFAR-support definition:</td><td>Standard definition of DSD and TA-SDI used.

Provision of key staff or commodities for PMTCT includes: commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers.

Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.</td></tr>
<tr><td>Guiding narrative questions:</td><td>1. Provide context for poor performance in PMTCT_STAT coverage (Numerator/Denominator = STAT coverage) by geographic area, age, or partner/implementing mechanism, including any planned activities/remedial actions.
2. For areas where age disaggregates are NOT completely reported, describe challenges for collecting and/or plan and timeline for collection.</td></tr>
</table>

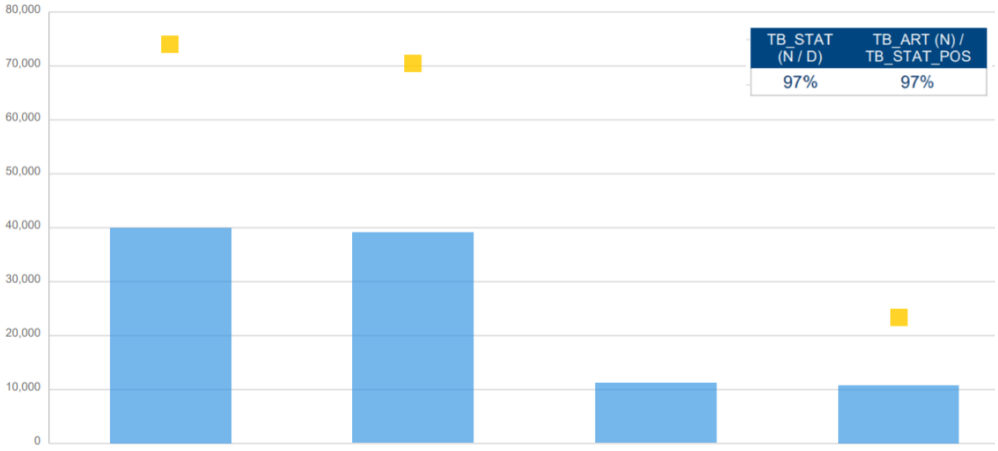
Data Visualization & Use Examples:	**Uptake of ANC Testing and PMTCT Treatment Linkage to EID Cascade:**



TB_STAT (including TB_STAT_POS)

Description:	Percentage of new and relapse TB cases with documented HIV status	
Numerator:	Number of new and relapsed TB cases with documented HIV status, during the reporting period	The numerator can be generated by counting the number of new and relapsed TB cases with documented HIV test results during the reporting period.
Denominator:	Total number of new and relapsed TB cases, during the reporting period	The denominator can be generated by counting the number of new and relapse TB cases during the reporting period.
Indicator changes (MER 2.0 v2.2 to v2.3):	• Reporting frequency has changed from semi-annual to quarterly. • Age disaggregations have changed from coarse ages to fine ages to allow for TB_STAT to auto-populate HTS_TST via the TB modality.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures the performance of the TB program in ensuring that TB cases know their HIV status.	
How to collect:	The numerator and denominator can be obtained from basic management unit TB registers as well as additional data collection sources (i.e., HIV testing registers) that may contain relevant information (i.e., HIV test results, enrollment in HIV care programs). Programs should modify the register as needed to easily capture this information (<1 F, <1 M, 1-4 F, 1-4 M, 5-9 F, 5-9 M, 10-14 F, 10-14 M, 15-19 F, 15-19 M, 20-24 F, 20-24 M, 25-29 F, 25-29 M, 30-34 F, 30-34 M, 35-39 F, 35-39 M, 40-44 F, 40-44 M, 45-49 F, 45-49 M, 50+ F, 50+ M, Unknown age F, Unknown age M) and (Known HIV-positive at service entry). The data source is the TB register. There is a risk of double counting as TB patients could be tested multiple times during their TB treatment, therefore partners should ensure a data collection and reporting system is in place to minimize double counting. There is also a risk of undercounting if those patients who already knew their HIV status prior to attending TB clinic are not documented, therefore the TB register at a minimum should document "Known HIV-positive at service entry; Newly tested HIV-positive; Tested HIV negative."	
How to review for data quality:	Only one disaggregation type is used for age and gender (fine age and gender disaggregations) • Denominator ≥ Numerator. • Numerator ≥ subtotal of each of the disaggregations. • Denominator ≥ subtotal of each of the disaggregations	
How to calculate annual total:	Sum results across quarters for both the numerator and denominator.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Status by Age/Sex [Required] ***Underlined portions auto-populate into the TB HTS_TST modality.***	• Known Positives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Newly Tested Positives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M 49 M, 50+ F, 50+ M, Unknown Age F/M • New Negatives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**

	Age/Sex [Required]	• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
Disaggregate descriptions & definitions:	N/A	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for TB cases receiving HIV-related services includes</u>: funding of test kits, ARVs, ARTs, and lab commodities or funding of salaries or provision of Health Care Workers for TB/HIV-related services. Staff responsible for maintaining patient records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. <u>Ongoing support for TB cases receiving HIV-related services includes</u>: training of TB/HIV service providers, clinical mentoring and supportive supervision of staff at TB/HIV sites, infrastructure/renovation of facilities, support of TB/HIV service data collection, reporting, data quality, QI/QA of TB/HIV services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow up/retention, support of other TB/HIV programs.	
Guiding narrative questions:	1. If coverage for this indicator is less than 90%, please explain why. 2. Please describe how the denominator was determined. 3. Describe the sources for the data that you are reporting (i.e., are the data from just PEPFAR-supported facilities or do the data reflect national-level data, including those from non-PEPFAR supported facilities)?	
Data Visualization & Use Examples:	**TB_STAT and ART Cascade:**	



Fiscal Year	Fiscal Quarter	New/Relapsed TB cases TB_STAT Denominator	TB cases with HIV status TB_STAT Numerator	TB cases with positive HIV status TB_STAT_POS	HIV-positive TB cases on ART TB_ART Numerator
2018	Q2	40,027	39,025	11,220	10,862
	Target	73,967	70,510		23,309

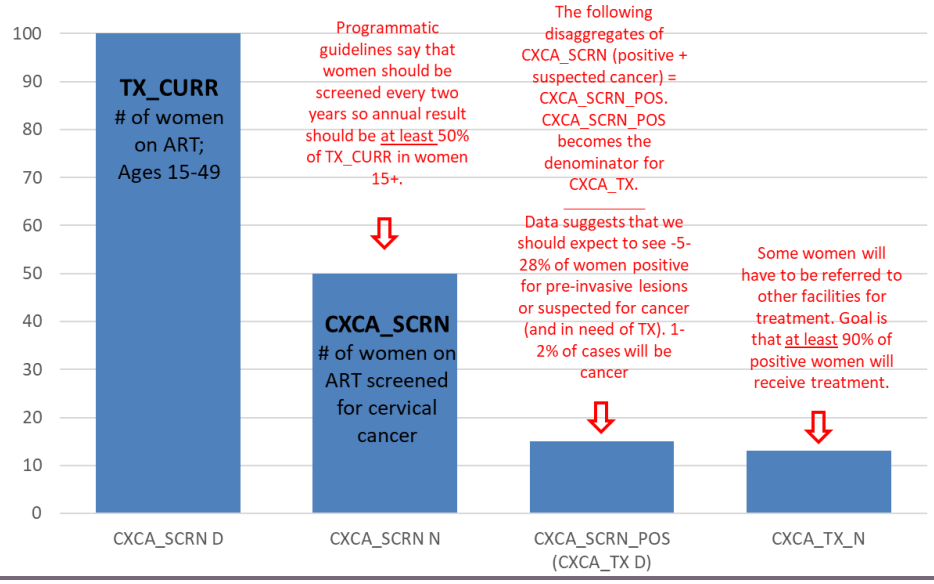
TREATMENT INDICATORS

CXCA_TX

Description:	Percentage of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	
Numerator:	Number of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	The numerator captures the number of individual HIV-positive women on ART who required treatment for precancerous cervical lesions, who received that treatment.
Denominator:	Number of HIV-positive women on ART at PEPFAR supported sites who are eligible for cryotherapy, thermocoagulation or LEEP	See CXCA_SCRN_POS.
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	It is vital that all HIV-positive women on ART requiring treatment for precancerous lesions receive the treatment for which they are eligible. The purpose of this indicator is to monitor whether women requiring (and eligible for) treatment for precancerous lesions received treatment. The globally accepted benchmark of at least 90% eligible for treatment of precancerous lesions receiving treatment should be used when monitoring performance (WHO, 2013; ACCP, 2004).	
How to collect:	The primary data sources for this indicator are registers or logbooks in use at the point of precancerous lesion treatment service delivery. Client and facility level data collection tools should include the data elements required for disaggregation. Data for the numerator should be generated by counting the total number of HIV-positive women on ART who received precancerous lesion treatment (cryotherapy, thermocoagulation or LEEP or other) who were eligible for that treatment. Challenges may arise in counting when women are referred for LEEP, but who are found eligible for cryotherapy (or thermocoagulation) upon presenting at the LEEP service delivery point. It is vital that facility level data collection and program monitoring tools capture the data elements necessary to identify this key performance issue, which can lead to data quality issues for this indicator.	
How to review for data quality:	The numerator for this indicator should not be larger than CXCA_SCRN and should be equal to 100% or less of the CXCA_SCRN_POS disaggregate (not including suspected cancer).	
How to calculate annual total:	Sum results across both reporting periods for the numerator.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Screening Visit Type and Treatment Type by Age [Required]	• 1st time screened (cryotherapy, thermocoagulation or LEEP) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age • Rescreened after previous negative (cryotherapy, thermocoagulation or LEEP) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age

<table>
<tr><td></td><td></td><td>• Post-treatment follow-up (cryotherapy, thermocoagulation or LEEP) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
<tr><td></td><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>See CXCA_SCRN_POS.</td><td>See CXCA_SCRN_POS.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Treatment Type
• Cryotherapy
○ The primary outpatient ablative treatment for small precancerous cervical lesions.
○ By applying a highly cooled metal disc (cryoprobe) to the cervix and freezing the abnormal areas (along with normal areas) covered by it, cryotherapy eliminates precancerous areas on the cervix by freezing.
• Thermocoagulation
○ An outpatient ablative treatment for small precancerous cervical lesions that is used instead of cryotherapy in some settings.
○ It uses electricity to generate temperatures of 100–120 °C for ablation of cervical lesions and can be used for all stages of cervical cancer.
• LEEP
○ The primary outpatient treatment for large precancerous cervical lesions.
○ The removal of abnormal areas from the cervix and the entire transformation zone, using a loop made of thin wire powered by an electrosurgical unit; the loop tool cuts and coagulates at the same time; this is followed by use of a ball electrode to complete the coagulation.

Screening Visit Type
• 1st Time screening
○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the screening-naïve HIV-positive population – only women being screened for the first time in their lifetime should be counted under this disaggregate.
• Rescreening after previous negative result
○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received a negative result on their most recent screening test.
○ WHO recommends that HIV-positive women or women of unknown HIV status who receive a negative cervical cancer screening test result be rescreened every 3 years; however, the results of PEPFAR modelling exercises led to the current PEPFAR recommendation of a screening interval (for women with a negative result) of every 2 years for HIV-positive women.
○ As a program matures, countries should consider adding an additional performance indicator which measures whether women that should return for routine rescreening in a given time period are returning in that time period (e.g., number of rescreened women in a given time period, over the number of women who were expected to be rescreened in the same time period).
• Post-treatment follow-up screening
○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received precancerous lesion treatment due to a positive screening result on their last screening test.
○ Some national guidelines require post-treatment follow-up screening at intervals other than or in addition to 1 year (e.g., 6 months and 12 months) – programs should use additional indicators to monitor the additional follow-up time points, and this should be noted in the narrative.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.</td></tr>
</table>

	For precancerous cervical lesion treatment services, direct service delivery includes: ongoing procurement of critical treatment related commodities such as carbon dioxide or nitrous oxide gas or requisite materials (cryotips, specula, spatulas and swabs, exam gloves, etc.), or funding for salaries of precancerous lesion treatment service providers including program managers, supervisors, and/or coordinators. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For precancerous cervical lesion treatment services, ongoing support for service delivery improvement includes: clinical mentoring/supportive supervision, cryotherapy, thermocoagulation or LEEP training, guidance development, infrastructure/renovation of facilities, site level QI/QA, routine support of M&E and reporting, or commodities consumption forecasting and supply management.
Guiding narrative questions:	1. Please describe challenges with the provision of same day treatment and/or with the return of women who postpone precancerous lesion treatment. 2. At sites where both thermocoagulation and cryotherapy are offered, what if any context is given by women choosing one treatment option over the other?
Data Visualization & Use Examples:	**HIV/Cervical Cancer Cascade:** 

PMTCT_ART

Description:	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	
Numerator:	Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy	Auto-Calculated indicator in DATIM, sum of: 1) New on life-long ART, 2) Already on life-long ART at the beginning of the current pregnancy
Denominator:	**PMTCT_STAT_POS** (see PMTCT_STAT)	Collected as part of PMTCT_STAT. Calculated indicator in DATIM, sum of: 1) New Positives, 2) Known Positive at entry (**see PMTCT_STAT, Disaggregate Group Positivity Status for more details**)
Indicator changes (MER 2.0 v2.2 to v2.3):	• Added language to clarify that only women initiating on treatment prior to pregnancy or during pregnancy (ANC) should be counted under PMTCT_ART. Women newly initiating or newly coming to the facility during L&D or breastfeeding should not be counted under PMTCT_ART. • Age disaggs added to align with PMTCT_STAT.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR-supported antenatal care (ANC) know their HIV status and are initiated on ART.	
How to collect:	Data source is the ANC or PMTCT register depending on country context (in many high HIV prevalence settings information on the number of women receiving ART regimens is integrated into the ANC register). There is a risk of double counting as a pregnant woman receiving ART at ANC should have multiple visits for each pregnancy therefore partners should ensure a data collection and reporting system is in place to minimize double counting of the same pregnant women across visits including a paper based longitudinal ANC or PMTCT register (meaning a register that is able to record all information about 1 pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy) or an electronic medical record/patient tracking system. There is also a risk of undercounting if those women who already on ART prior to attending ANC are not documented, therefore the ANC register should document both “New on ART” and “Already on ART at the beginning of the current pregnancy”. Note: Those women reported in PMTCT_ART including newly enrolled on ART and already on ART at the beginning of pregnancy should also be reported in the TX_NEW and TX_CURR indicators, respectively. Women who are already on ART should not be counted in TX_NEW. PMTCT_ART is about initiation of ART (yes/no) or already on ART (yes/no). This will most likely be captured at ANC1 but may be captured at a future ANC visit. Women initiated on ART during L&D or breastfeeding should not be reported under PMTCT_ART but should still be reported under TX_NEW.	
How to review for data quality:	Review any site with over 100% coverage or very low coverage to ensure they reflect expected results. In general, services should be reported at the site where they are delivered (however PMTCT_ART- “already on treatment” and PMTCT_STAT_POS “known positive at entry” are exceptions, see details under description of disaggregate below). Therefore, coverage at site level must be understood within the context of the service delivery model at that site. For example, in local areas where ART is integrated into ANC and low volume PMTCT sites are only testing for HIV and then referring women to other facilities for ART, the expectation is that for one individual PMTCT_STAT_POS (newly tested) will be documented at one facility and PMTCT_ART (new on ART) would be documented at another facility leading to the appearance of greater than >100% coverage at one site and 0% coverage at another.	
How to calculate annual total:	Sum results across quarters for both the numerator and denominator.	

<table>
<tr><td rowspan="4">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Maternal Regimen Type and Age [Required]</td><td>• New on ART by: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• Already on ART at the beginning of current pregnancy by: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>N/A</td><td>See PMTCT_STAT_POS.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Maternal Regimen Type:
For the numerator to be calculated, implementing partners are required to report:
• The number of HIV-positive pregnant women newly initiated on ART should only be counted in a regimen category if she actually received the regimen. Referral alone for ART should not be counted. Additionally, a woman who temporarily stopped ART and has started again during the same pregnancy should not be counted as new on treatment.
• The number of HIV-positive pregnant women already on ART at beginning of pregnancy: May be counted even if ART is continuing to be received at another facility. For example, a woman, who is already on treatment, becomes pregnant and enrolls in ANC/PMTCT because she is HIV-positive but is continuing to receive her ART at a nearby treatment clinic should be counted within this disaggregate. However, if a woman was initiated on ART at another facility during this pregnancy and then transfers-in to the ANC site, she should not be counted (since she was already counted at the first ANC site for this pregnancy).</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

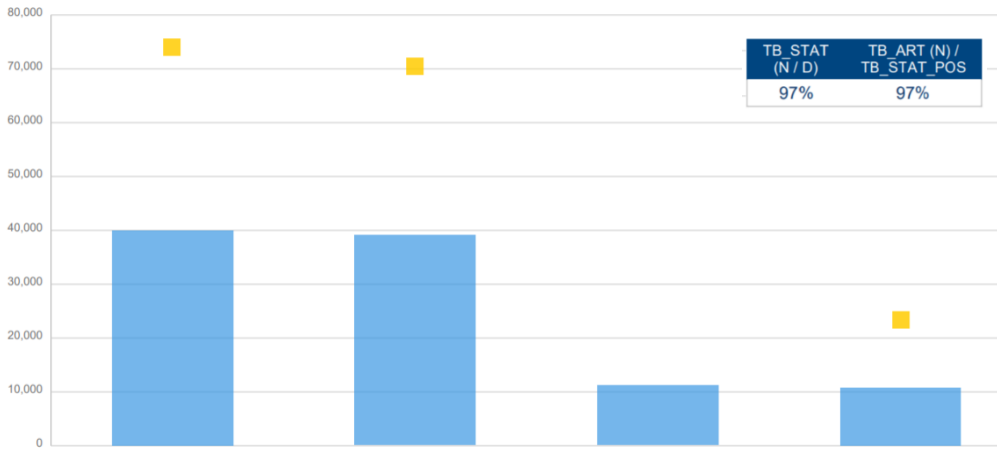
Provision of key staff or commodities for PMTCT include: commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers.

Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. Provide context for low PMTCT_ART coverage (PMTCT_ART / PMTCT_STAT_POS = ART coverage) by geographic area or partner/implementing mechanism, including any planned activities/remedial actions.
2. Describe activities related to ensuring retention through the breastfeeding period. If additional data available in country, describe retention rates or rates of LTFU among pregnant women continuing or starting ART as of ANC1.
3. Explain any differences in PMTCT_ART coverage among newly identified HIV positive women initiating ART compared to known positives already on ART.</td></tr>
</table>

TB_ART

Description:	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	
Numerator:	Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period	The numerator is generated by counting the total number of TB patients (new and relapse TB cases) with documented HIV-positive status during TB treatment who are newly initiated or already on ART.
Denominator:	**TB_STAT_POS (see TB_STAT)**: Number of registered TB cases with documented HIV-positive status during the reporting period.	Denominator is not collected as part of this indicator, but is TB_STAT_POS.
Indicator changes (MER 2.0 v2.2 to v2.3):	• Reporting frequency has changed from semi-annual to quarterly. • Numerator disaggregates have been changed to capture Age/Sex by ART Status.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator will measure the extent to which programs effectively link HIV-infected TB patients to appropriate HIV treatment. The HIV status of TB patients is often determined at the TB clinics (and will be captured with TB_STAT), but ART for TB cases is frequently provided by the HIV program. Therefore, provision of ART for this population often implies successful linkage between the TB and HIV program, which should be followed from TB_STAT_POS to TB_ART.	
How to collect:	The numerator is generated by counting the total number of TB patients (new and relapse TB cases) with documented HIV-positive status during TB treatment who are newly initiated or already on ART.	
How to review for data quality:	Only one disaggregation type is used for age/sex. Numerator ≥ subtotal of each of the disaggregation.	
How to calculate annual total:	Sum results across quarters.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	ART Status by Age/Sex [Required]	• New on ART: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Already on ART: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	TB_STAT_POS (See TB_STAT).	TB_STAT_POS (See TB_STAT).
Disaggregate descriptions & definitions:	**Age Description:** Age is defined as the age at the date of initiation on ART or current age, not the age at the date of reporting. **ART Status Definition:** This disaggregation should distinguish those who started ART during the reporting period (this should also be reported under TX_NEW) from those who were already on it at the beginning of the reporting period.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for TB cases receiving HIV-related services includes: funding of test kits, ARVs, ARTs, and lab commodities or funding of salaries or provision of Health Care Workers for TB/HIV-related services. Staff responsible for maintaining patient	

	records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. Ongoing support for TB cases receiving HIV-related services includes: training of TB/HIV service providers, clinical mentoring and supportive supervision of staff at TB/HIV sites, infrastructure/renovation of facilities, support of TB/HIV service data collection, reporting, data quality, QI/QA of TB/HIV services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow up/retention, support of other TB/HIV programs.
Guiding narrative questions:	1. If % coverage for TB_ART / TB_STAT_POS is less than 90%, please explain why. 2. Describe the sources for the data that you are reporting (i.e., are the data from just PEPFAR-supported facilities or do the data reflect national-level data, including those from non-PEPFAR supported facilities)? As above, please describe the sources of the data you are reporting.
Data Visualization & Use Examples:	**TB_STAT and ART Cascade:**



Fiscal Year	Fiscal Quarter	New/Relapsed TB cases TB_STAT Denominator	TB cases with HIV status TB_STAT Numerator	TB cases with positive HIV status TB_STAT_POS	HIV-positive TB cases on ART TB_ART Numerator
2018	Q2	40,027	39,025	11,220	10,862
	Target	73,967	70,510		23,309

TX_CURR

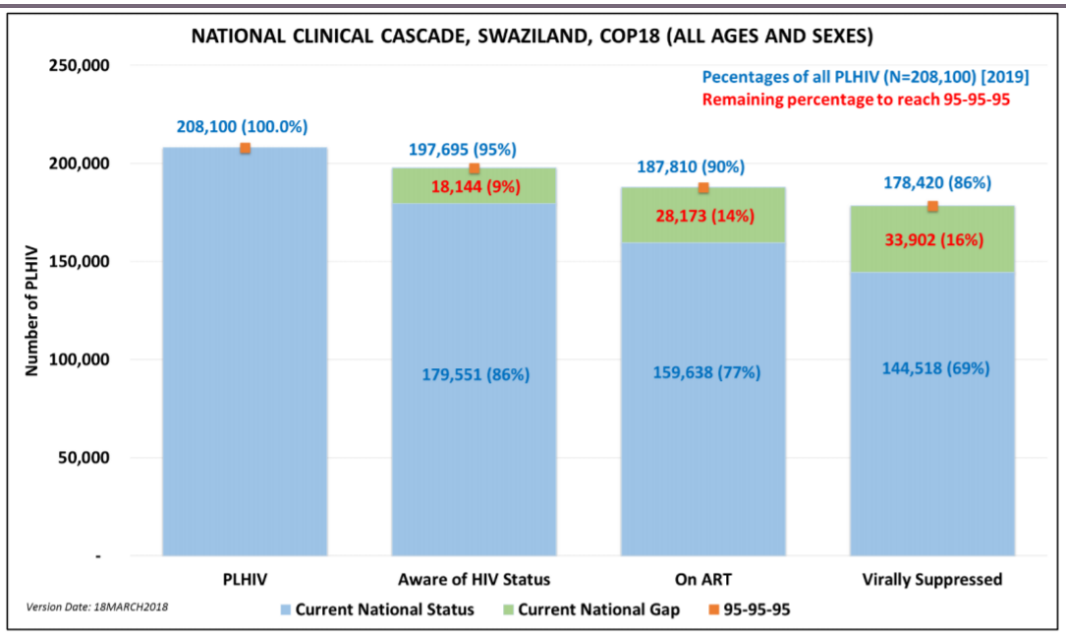
Description:	Number of adults and children currently receiving antiretroviral therapy (ART)	
Numerator:	Number of adults and children currently receiving antiretroviral therapy (ART)	Count the number of adults and children who are currently receiving ART.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age/sex disaggregates updated. • Language under the "How to Collect" section updated to clarify which individuals are counted under this indicator.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures the ongoing scale-up and uptake of ART and retention in ART programs as a critical step in the HIV service cascade and assesses progress towards coverage of ART for all eligible HIV-positive individuals when reviewed against the number of PLHIV that are estimated to be eligible for treatment. It allows us to track the response to the epidemic in specific geographic areas and among specific populations as well as at the national level.	

How to collect:	This indicator should be collected from facility ART registers/databases, program monitoring tools, and drug supply management systems.
	
	Count the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period.
	• Patients on ART who initiated or transferred-in during the reporting period should be counted.
	• Patients that pick up several months of antiretroviral drugs at one visit should also be counted as long as they have received enough ARVs to last to the end of the reporting period.
	• However, if it is determined that a patient has died, they should immediately be removed from the TX_CURR results.
	• HIV-positive pregnant women who are eligible for and are receiving antiretroviral drugs for their own treatment are included. HIV-positive pregnant women initiating lifelong ART through PMTCT (Option B+) will count as "current" on ART under this indicator. These include HIV-infected pregnant women who:
	  ○ Have newly initiated ART during the current pregnancy
	  ○ Are already on ART at the beginning of the current pregnancy
	
	Patients excluded from the current on ART count are patients who died, stopped treatment, transferred out, or are lost to follow-up. **Patients who have not received ARVs within four weeks of their last missed drug pick-up should not be counted.** Patients do not need to qualify as lost to follow-up before tracing efforts commence. Efforts to trace patients that have missed a clinical visit or drug pick-up should begin immediately following a missed clinical contact. TX_ML describes the PEPFAR-recommended patient tracing process in more detail.
	
	This indicator should be reported from both PEPFAR-supported sites in the private or public sector. Patients currently receiving treatment from mobile clinics can be reported in two ways. Firstly, if the mobile clinic is associated (receives commodities, reports to, is staff by) a nearby health facility, then these individuals should be reported by that facility. Secondly, if a mobile clinic is stationary for more than 2 reporting periods, it should be added to the PEPFAR facility list with geocodes and data should be reported for this mobile clinic directly.
	
	DO NOT include: Patients who receive ARVs for post-exposure prophylaxis (PEP) or short-term ART only for prevention (PrEP) should not be reported in this indicator.	

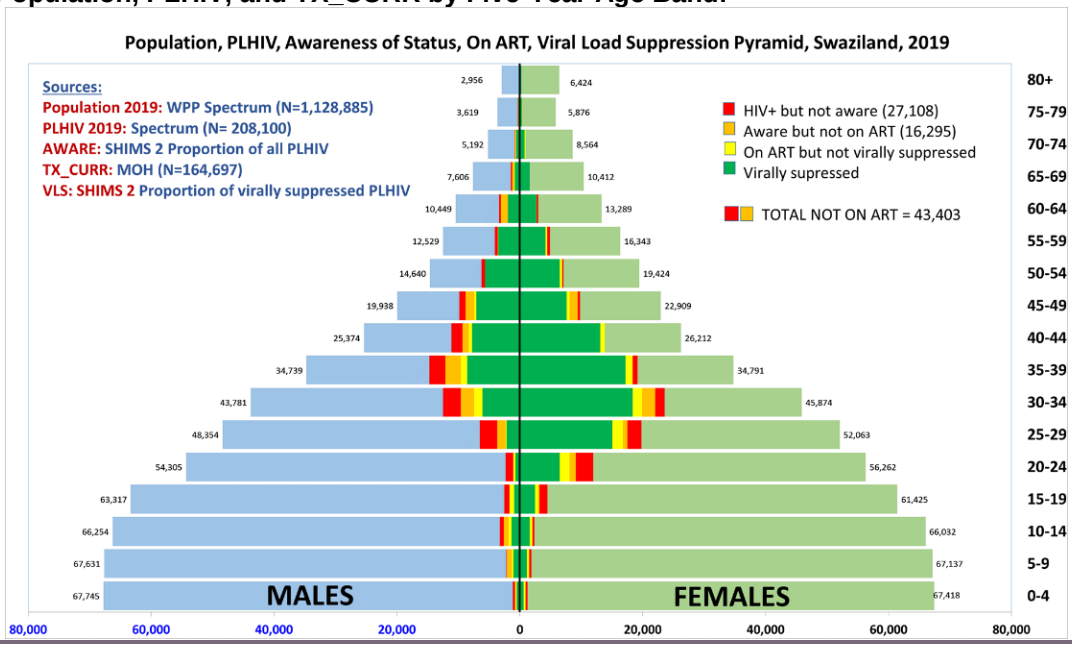
<table>
<tr><td>How to review for data quality:</td><td colspan="2">• Confirm that TX_CURR ≥ TX_NEW
• Net new of TX_CURR between reporting periods should be less than TX_NEW in that time period</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex [Required]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>N/A</td><td>N/A</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">For age /sex disaggregates:
CURRENT is a state defined by treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Age represents an individual's age at the end of the reporting period or when last seen at the facility. For example, a 14-year-old child will be counted as currently receiving treatment in the <15 age category at the end of reporting period "A". During reporting period "B" the child turns age 15 and so at the end of this reporting period the child will be counted under the 15+ age category.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

Provision of key staff or commodities for PLHIV receiving ART includes: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver HIV treatment services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted.

Ongoing support for PLHIV receiving ART service delivery improvement includes: clinical mentoring and supportive supervision of staff at HIV sites providing ART, support for quality improvement activities, patient tracking system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. What percentage of clients are picking up their ART drugs on a quarterly basis? On a semi-annual basis?
2. What percentage of clients are being seen for clinical follow-up visits on a quarterly basis? On a semi-annual basis? On an annual basis?</td></tr>
<tr><td>Data Visualization & Use Examples:</td><td colspan="2">Eswatini 95-95-95 Cascade Example:</td></tr>
</table>



Population, PLHIV, and TX_CURR by Five-Year Age Band:



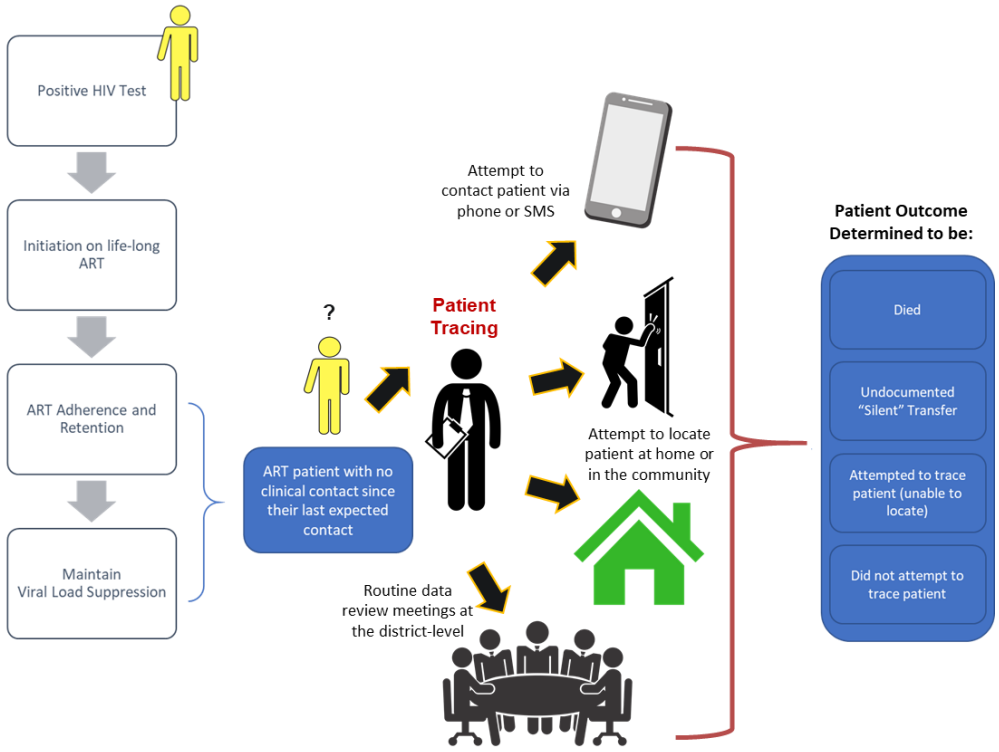
TX_ML

Description:	Number of ART patients with no clinical contact since their last expected contact	
Numerator:	Number of ART patients with no clinical contact since their last expected contact	Clinical contact is defined as any clinical interaction with the patient, such as clinical assessment by a healthcare worker or provision of medication.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	New indicator	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	TX_ML is intended to drive improved tracing of patients to ensure patient outcomes are known and that appropriate programmatic action is being taken to locate patients that have missed clinical visits. From a public health perspective, treatment adherence and retention are essential to achieve and maintain viral suppression and ultimately reduce or eliminate disease transmission. Not uncommonly, patients who are lost-to-follow up, may have died or have self-transferred to another health care facility; it is important to understand and make these distinctions as they require different programmatic interventions. Serious attempts should be made to reengage any patient that has not returned for clinical services or drug pick-up and return them to treatment, and mortality data should be analyzed and investigated to determine causes of death amenable to programmatic intervention. Lastly, this indicator is intended to support the civil registration and vital statistics systems (CRVS) of PEPFAR-supported countries and help improve mortality and cause-of-death reporting in both health and civil registration systems. This is the first time PEPFAR will collect mortality information through routine program data. Mortality is an essential measure to assess the impact of the health sector more broadly, and the HIV program in particular. Mortality data should be compared between sites and districts as well as by age and sex to determine the geographic and demographic areas where intensified interventions are most needed. Particularly, determining the cause-of-death (COD) or conditions experienced at the time of death among PLHIV can be used to help identify programmatic gaps and focus resources on interventions aimed at reducing preventable deaths. This is also the first time that PEPFAR has tried to understand the magnitude of “silent transfers” across the treatment program. Active tracing of clients who are LTFU to identify those that have been linked to treatment at another facility is needed. It’s important to note that this is not a cohort monitoring indicator. TX_ML is meant to inform TX_CURR and help to better understand what is happening with the ART patient population.	
How to collect:	When a patient has missed their most recent expected clinical contact, the clinic or other related staff should attempt to reach and reengage the patient as soon as possible. Through the reaching and reengagement process, the patient’s outcome should be documented as follows: 1. Died (confirmed) 2. Previously undocumented patient transfer (confirmed) 3. Traced patient (unable to locate) 4. Did not attempt to trace patient Clinical contact is defined as reporting to the clinic for ART pick-up or clinical assessment, or a documented community visit with community health worker or peer from an ART refill	

group. Attempts to reach and re-engage patients into treatment should be made as soon as a patient misses a clinical visit.

The numerator for this indicator will be calculated by summing the following categories of LTFU patients (if collected): patient died, previously undocumented patient transfer, traced but un-located patient, untraced patient. Documented patient transfers will not be collected as part of this indicator, as these patients have an explained outcome and would not be expected to have had clinical contact.

The graphic below describes the indicator flow in more detail:



Monitoring mortality:
A robust civil registration system that provides high quality, directly measured HIV-related mortality data is the best way to monitor mortality. As recommended in the United Nations Statistics Division (UNSD), Principles and Recommendations for a Vital Statistics System for every death, civil registration systems should collect information such as date and cause of death (COD), age, sex and place of residence.

Any time activities to reach and reengage patients on treatment are conducted and it is concluded that an ART patient has died, the death should be reported into the formal civil registration system if it is established that this has not already been done. Where it has been done, in settings where death registration systems are active, it may be possible to link existing civil registration records of death and COD with ART patient records to ascertain those LTFU.

PEPFAR teams should work collaboratively with their Ministries of Health in conjunction with civil registration authorities (often located within Ministries of Interior or Home Affairs) to enhance civil registration and vital statistics systems and to establish consistent procedures for collecting and linking mortality data (i.e., to ensure the same data elements are collected for matching purposes). WHO guidance is available to help countries establish or strengthen civil registration systems. CDC has a team dedicated to strengthening CRVS systems internationally, within the National Center for Health Statistics (NCHS), which is available to provide technical assistance.

	Deaths among ART patients that occur in the health facility: Deaths occurring within the health facility should be immediately recorded in the ART register and/other relevant tracking register, which may or may not already include cause of death. The Medical Certificate of Death and Cause of Death (MCCD) should be filled to ascertain COD and is also a data source for obtaining mortality-related data for patients who died in the facility. If filled according to WHO/ICD guidelines, and coded correctly, the underlying cause of death (UCOD) will be identified. When filled correctly, the MCCD will also include a sequence of events leading to the immediate cause of death. It will also list conditions that are not in the causal chain but are related to the cause of death. If these are entered electronically (through the WHO DHIS mortality module or alternative electronic system), these fields (Part I, a-d, and Part II) can all be coded and/or searched. MCCD forms are typically embedded in national death reporting forms, which include demographic information and other country-specific requirements for registration. Completed death reporting forms should be sent to the national registration authorities for legal registration. Even without COD, recording and reporting all deaths among HIV-infected patients, and the general population, as well as knowing mortality rates, etc., is valuable. ***Deaths among ART patients that occur outside the health facility:*** Deaths that occur outside the facility should be confirmed by unambiguous report of family or close acquaintance (i.e., it should not be presumed). COD in community settings is commonly ascertained through verbal autopsy. Verbal autopsy is a method of gathering health-information about a patient that has died in order to determine their probable COD; it typically includes an interview with a caregiver to elicit known diagnoses, signs, and symptoms experienced by the deceased as well as an open narrative describing the circumstances of the death. Where a system for verbal autopsy is in place, PEPFAR teams should coordinate with local authorities to identify the best COD information available (e.g., reported conditions, open narrative, probable COD assigned). Where such a system is not in place, verbal autopsy could be introduced or, for purposes of this indicator, unvalidated family reporting can be accepted to determine cause of death. For more information on verbal autopsy, see the WHO verbal autopsy standards. **Caveats:** It is widely acknowledged that even where reporting is required, mortality data, especially cause of death, are often underreported or inaccurate. Where high quality MCCD is available, PEPFAR teams can expect to find UCOD according to the standard definitions provided. However, where systems are weak, teams may need to use whatever COD information is available for reference to best describe conditions co-existing at the time of death. For verbal autopsy, it should also be noted that since verbal autopsy results are generally considered valid only at the population level, teams are likely to be able to elicit information about conditions coexisting at the time of death rather than a specific UCOD. For reference, the National Center for Health Statistics at CDC compiled a status table, found in Appendix G, that describes the completeness of mortality and COD reporting in several PEPFAR countries. **Additional Considerations:** Please note that this indicator is only collecting information on deaths and silent transfers among PLHIV that are on treatment. It is **not** intended to collect deaths among PLHIV that are not linked to care and receiving treatment services. As described earlier, TX_ML is meant to inform TX_CURR and help to better understand outcomes of the ART patient population.
How to review for data quality:	Program data collected on mortality should be routinely triangulated with facility-based mortality surveillance and mortality data from other studies or sources. Patient trackers, tracing logs, missed appointment reports, and other available sources should be routinely checked. These comparisons will help programs understand where efforts are required to better improve and/or ensure completeness of reporting.

<table>
<tr><td></td><td>Indicators narratives should describe this triangulation and note any data caveats. For additional information on the quality of mortality and cause of death data, please see the resources below.
WHO Analyzing mortality levels and causes-of-death http://www.who.int/healthinfo/anacod/en/
CRVS Knowledge Gateway Learning Centre: Modules 4 & 5 https://crvsgateway.info/Learning-Centre~22</td></tr>
<tr><td>How to calculate annual total:</td><td>There should be no annual total. Data for this indicator are intended to provide context for TX_CURR results but the numerator should not be summed across reporting periods due to the active movement and potential reclassification of patients. For example, a patient that is lost in Q2 could (hopefully) be reengaged in services at Q4. In addition, it could be determined that a patient that was lost at Q2 is deceased at Q4. For that reason, the numerator should not be summed.

However, the disaggregation for confirmed deaths can be summed across reporting periods.</td></tr>
<tr><td>Disaggregations:</td><td><table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Outcome by Age/Sex [Required]</td><td><u>Died</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
<u>Previously undocumented patient transfer</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
<u>Traced patient (unable to locate)</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
<u>Did not attempt to trace patient</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F</td></tr>
<tr><td>Cause of death by age/sex (sub-disaggregate of the ‘died’ outcome above) [Optional]</td><td>HIV disease resulting in <u>TB</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
HIV disease resulting in <u>cancer</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
HIV disease resulting in <u>other infectious and parasitic disease</u> by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
Other HIV disease, resulting in other diseases or conditions leading to death by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
Other natural causes: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
Non-natural causes: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-</td></tr>
</table></td></tr>
</table>

		39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F • **Unknown Cause** by <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	**Outcome definitions:** • **Died:** Patient was confirmed as dead by direct observation or by unambiguous report of family or close contact (neighbors, co-workers, etc.); it should not be presumed. • **Previously undocumented patient transfer:** Patient transferred to another health facility, but the patient transfer was not previously documented at the originating health facility; this is also known as a "silent transfer." Silent transfers should be confirmed by verifying with the health facility where the patient receives care. • **Traced patient (unable to locate):** Exhaustive attempts (e.g., phone calls, home visits, triangulation with other health facilities) were made to locate the patient, but patient was still not located through these efforts. Exhaustive attempts means completing more than 3 attempts to contact or locate the patient using multiple methods. • **Did not attempt to trace patient:** No attempt was made to trace the patient during the reporting period. **Cause of Death Reporting:** Through the standard MCCD form and ICD coding guidelines, the objective is to identify the underlying cause of death (UCOD). The UCOD is (a) the disease or injury that initiated the chain of morbid events leading directly to death, or (b) the circumstances of the accident or violence that produced the fatal injury. Appendix H describes the ICD codes associated with the cause of death categories outlined below. **Cause of death definitions:** • HIV disease resulting in TB: Any patient with known or presumed TB (pulmonary and/or extra-pulmonary) at the time of death without another identified COD • HIV disease resulting in other infectious and parasitic disease: Any patient who died from any infectious cause other than TB; this includes infections not otherwise specified • HIV disease resulting in cancer: Any patient with known or presumed cancer at the time of death • Other HIV disease, resulting in other diseases or conditions leading to death: Any patient who died from a non-infectious, non-malignant cause that was related to HIV, such as acute HIV infection syndrome, (persistent) generalized lymphadenopathy, hematological and immunological abnormalities, etc. • Other natural causes: Any patient who died from natural causes (including certain cancers and infections, etc.) that were not directly related to HIV disease. • Non-natural causes: Any patient who died from non-natural causes (e.g., trauma, accident, suicide, war, etc.) • Unknown Cause: Patients in whom cause of death was truly not known	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PLHIV receiving ART include: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver HIV treatment services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic)	

	can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. Ongoing support for PLHIV receiving ART service delivery improvement includes: clinical mentoring and supportive supervision of staff at HIV sites providing ART, support for quality improvement activities, patient tracking system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management.
Guiding narrative questions:	1. Describe patient tracing efforts in more detail. When does patient tracing occur (e.g., within 1 week of missed contact, within 4 weeks of missed contact, etc.)? 2. What percentage of LTFU patients received an active follow-up visit during the reporting period? 3. What is being done to address facilities with above average mortality? Or a higher than average number of patients who were untraceable? 4. Please describe how HIV mortality program data are linked to CRVS systems and plans to improve linkages. 5. Please describe the state of death registration in the country and plans to improve it. Describe the completeness and accuracy of the data in more detail. a. In addition, describe the death registration coverage rate (typically defined as the number of registered deaths out of the number of estimated deaths) as well as the cause of death registration coverage rate. b. What proportion of health facility-based deaths are registered? Receive a COD? What proportion of community-based deaths are registered? Receive a COD?

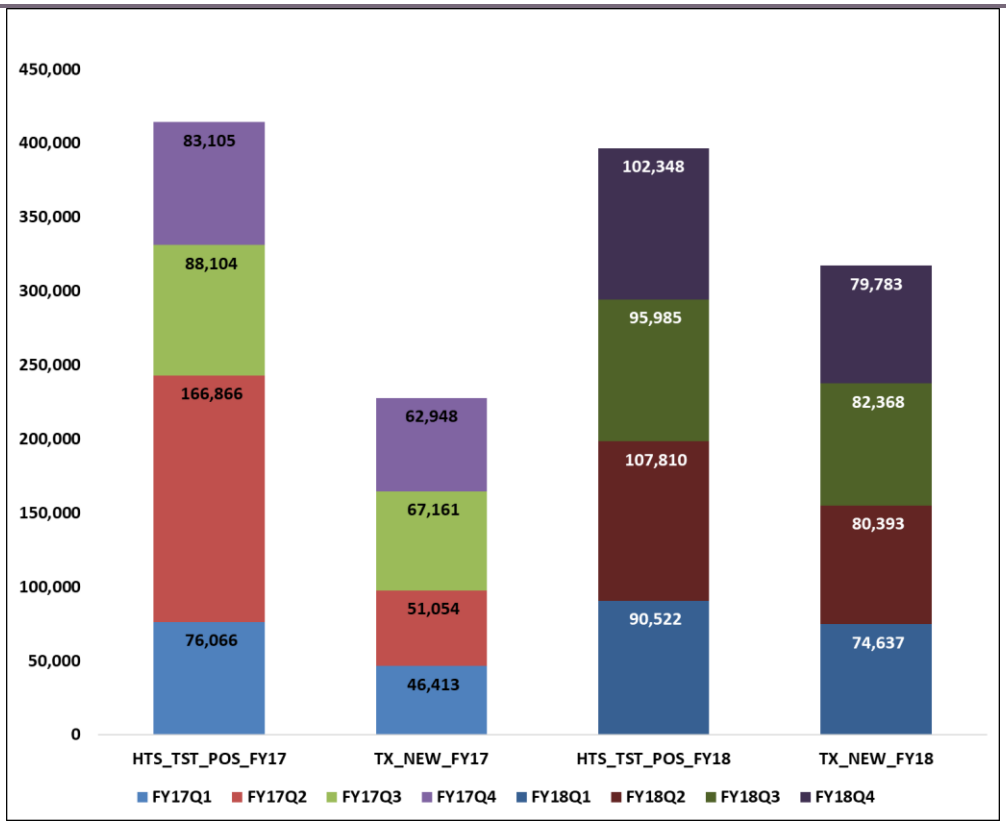
TX_NEW

Description:	Number of adults and children newly enrolled on antiretroviral therapy (ART)	
Numerator:	Number of adults and children newly enrolled on antiretroviral therapy (ART)	The indicator measures the ongoing scale-up and uptake of ART programs.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Age/sex disaggregates updated. • Pregnancy disaggregation removed due to confusion with this disaggregation and PMTCT_ART. However, the breastfeeding disaggregate was retained.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	The indicator measures the ongoing scale-up and uptake of ART programs. This measure is critical to monitor along with number of patients currently on ART in relation to the number of PLHIV that are estimated to be eligible for treatment to assess progress in the program's response to the epidemic in specific geographic areas and populations as well as at the national level. This is particularly critical in the context of current revisions to country-specific ART eligibility. Reporting the number of new patients enrolled on ART at both the national and overall PEPFAR program levels is critical to monitoring the HIV services cascade, specifically the successful linkage between HIV diagnosis and initiating ART. Disaggregation of new on ART by age/sex at ART initiation, pregnancy status at ART initiation, and breastfeeding status at ART initiation is important to understand the percentage of new ART initiations coming from priority populations.	
How to collect:	Facility ART registers/databases, program monitoring tools, or drug supply management systems. • The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards). • Patients who known to transfer in from another facility, or who temporarily stopped therapy and have started again should not be counted as new patients. • **NEW is a state defined by an individual initiating ART during the reporting period. It is expected that the characteristics of new clients are recorded at the time they newly initiate life-long ART. For example, patients who receive post-exposure prophylaxis (PEP), short term ART only for prevention (PrEP), or ART starter pack alone should not be used to count individuals reached with this indicator.** BF disaggregation: Women who initiate ART while breastfeeding should be counted under this indicator but not in PMTCT_ART. Key population disaggregation* see Appendix A to support the identification of key populations at ART initiation. However, reporting of key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which s/he is most identified in order to avoid double-counting. NOTE: both KP-specific and clinical partners have the option to complete these disaggs, but only if safe to maintain these files and to report.	
How to review for data quality:	• Numerator ≥ subtotal of each disaggregation: The total number of adults and children newly enrolled on ART should be greater or equal to the sum of all of the age/sex disaggregations and pregnancy/ breastfeeding status. • Confirm that TX_CURR ≥ TX_NEW.	

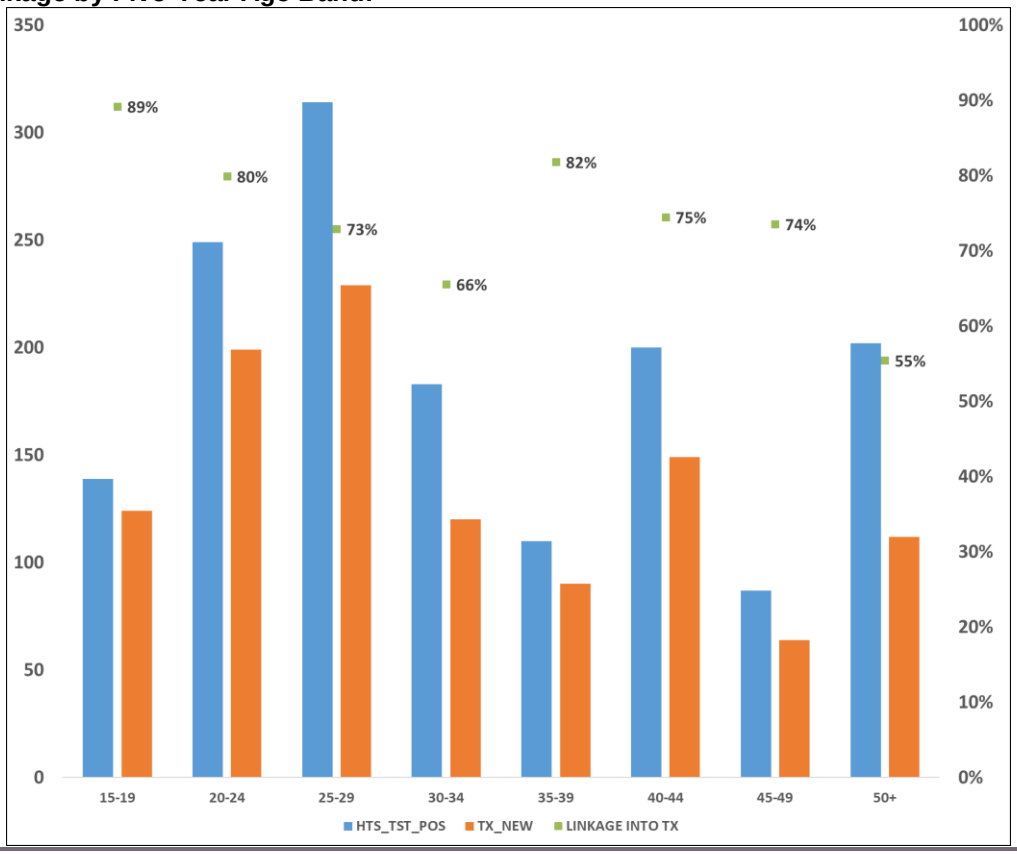
<table>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum results across quarters</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Breastfeeding status at ART initiation
[Required]</td><td>• Breastfeeding at initiation of ART</td></tr>
<tr><td>Key Population Type
[Optional]</td><td>• People who inject drugs (PWID)
• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People in prison and other closed settings</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td colspan="2">N/A</td><td>N/A</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Age/Sex: Age is defined as the age of the patient at the date of initiation on ART, not the age at the date of reporting.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for PLHIV receiving ART includes</u>: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver HIV treatment services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted.

<u>Ongoing support for PLHIV receiving ART service delivery improvement includes</u>: clinical mentoring and supportive supervision of staff at HIV sites providing ART, support for quality improvement activities, patient tracking system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. If TX_NEW does NOT equal HTS_TST_POS, explain why.
2. If TX_NEW result is markedly different from targets, explain why.</td></tr>
<tr><td>Data Visualization & Use Examples:</td><td colspan="2">Stacked Linkage Cascade Example:</td></tr>
</table>



Linkage by Five-Year Age Band:



TX_TB

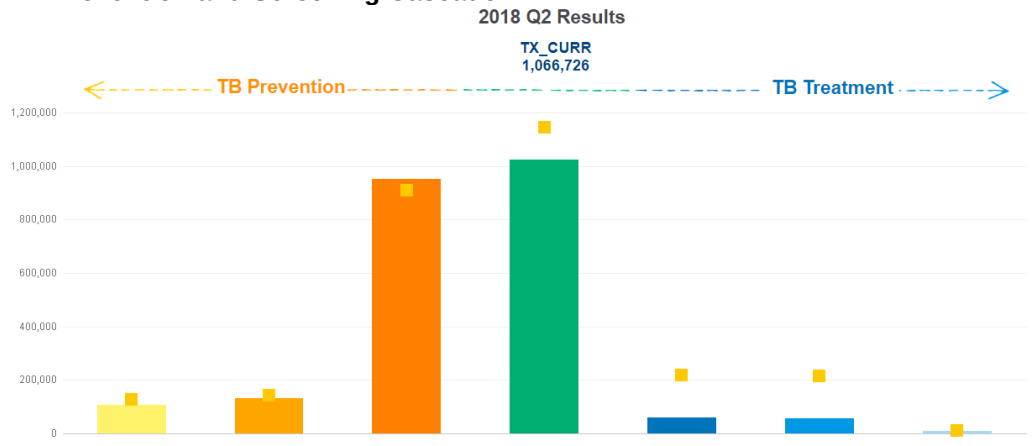
Description:	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment.	
Numerator:	Number of ART patients who were started on TB treatment during the semiannual reporting period.	The numerator can be generated by counting the number of screened ART patients who were diagnosed with TB and started on anti-TB therapy during the reporting period.
Denominator:	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	The denominator can be generated by counting the number of ART patients who were screened for TB symptoms at least once during the reporting period.
Indicator changes (MER 2.0 v2.2 to v2.3):	• Numerator disaggregates have been changed to capture current/new on ART by age/sex. • Denominator disaggregates have been changed to capture newly enrolled vs. previously enrolled on ART by screen results by age/sex. • Denominator disaggregate has been added: "positive result returned."	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator documents the TB screening of ART patients as well as the proportion who were diagnosed and started on TB therapy. The disaggregates demonstrate the cascade from screening to testing and can be used to identify gaps and challenges in TB diagnostic activities among ART patients.	
How to collect:	The denominator can be generated by counting the number of ART patients who were screened for TB symptoms at least once during the reporting period. This includes newly enrolling ART patients as well as those previously started on ART. The numerator can be generated by counting the number of screened ART patients who were diagnosed with TB and started on anti-TB therapy during the reporting period. These data should be captured in ART registers as well as additional data collection sources (e.g., facility-based TB screening registers or forms, TB specimen registers, TB microscopy result registers, GeneXpert data collection systems) that may contain relevant information (e.g., TB screening results, TB specimen testing results). Programs should modify the register as needed to easily capture this information. Documentation of symptom screening is generally collected in patient charts but may also be collected in another aggregate partner-generated data source. Screening for TB and/or initiation of anti-TB therapy might not happen at the same time that ART is started. For PLHIV new to HIV care, those who are diagnosed with TB are usually started on anti-TB therapy before they initiate ART (e.g., 2-8 weeks as per current recommendations). Regardless of when they occur relative to ART initiation, TB screening and initiation of TB therapy should be included for all patients who were currently on ART or who started ART at any time during the reporting period. Further information on how to use and collect these data is provided by WHO in the following guidelines: "Latent Tuberculosis Infection: Updated and Consolidated Guidelines for Programmatic Management."	
How to review for data quality:	Only one disaggregation type is used for age (coarse disaggregates). Numerator ≥ subtotal of each of the disaggregations.	
How to calculate annual total:	It is preferred to analyze this indicator as a snapshot indicator (i.e., the result reported at Q4) when viewing this data in conjunction with TB_PREV data; in other words, when one is analyzing the PEFPAR TB/HIV Screening Cascade. The TX_TB Denominator should not be summed over the semiannual time periods since it is a snapshot indicator that captures a clinical event (screening), not unique patients. However, note that the TX_TB Numerator, if	

<table>
<tr><td></td><td colspan="2">analyzed on its own, could be summed across semiannual time periods to conclude the number of ART patients who were started on TB treatment during the fiscal year.</td></tr>
<tr><td rowspan="9">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>ART Status (Current/New on ART) by Age/Sex [Required]</td><td>• Number of patients starting TB treatment who newly started ART during the reporting period: <15 F/M, 15+ F/M, Unknown Age F/M
• Number of patients starting TB treatment who were already on ART prior to the start of the reporting period: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Start of ART by Screen Result by Age/Sex [Required]</td><td>• New on ART/Screen Positive: <15 F/M, 15+ F/M, Unknown Age F/M
• New on ART/Screen Negative: <15 F/M, 15+ F/M, Unknown Age F/M
• Previously on ART/Screen Positive: <15 F/M, 15+ F/M, Unknown Age F/M
• Previously on ART/Screen Negative: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td>Specimen Sent [Required]</td><td>Number of ART patients who had a specimen sent for bacteriologic diagnosis of active TB disease.</td></tr>
<tr><td>Diagnostic Test (Disaggregation of Specimen Sent) [Required]</td><td>• GeneXpert MTB/RIF assay (with or without other testing)
• Smear microscopy only
• Additional test other than GeneXpert</td></tr>
<tr><td>Positive Result Returned [Required]</td><td>Number of ART patients who had a positive result returned for bacteriologic diagnosis of active TB disease.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Age/Sex/Start of ART by Screen Result:
• Age/Sex/New on ART/Screen Positive: The number of patients who started ART in the reporting period and who screened with least one positive symptom during the reporting period.
• Age/Sex/New on ART/Screen Negative: The number of ART patients who started ART in the reporting period and who had all negative symptom screens during the reporting period.
• Age/Sex/Previously on ART/Screen Positive: The number of patients who were on ART prior to the reporting period and who had at least one positive symptom screen during the reporting period.
• Age/Sex/Previously on ART/Screen Negative: The number of ART patients who were on ART prior to the reporting period and who had all negative symptom screens during the reporting period.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for routine HIV-related services includes</u>: ongoing provision of critical re-occurring costs or commodities (such as ARVs, TB preventive therapy and diagnostic/screening tests) or funding of salaries or provision of Health Care Workers for HIV clinic services. Staff responsible for maintaining patient records in both HIV and TB clinics are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included.

<u>Ongoing support for patients receiving routine HIV-related services includes</u>: training of HIV service providers, clinical mentoring and supportive supervision of staff at HIV sites, infrastructure/renovation of facilities, support of HIV service data collection, reporting, data quality, QI/QA of HIV services support, ARV and IPT consumption forecasting and supply management, support of lab clinical.</td></tr>
</table>

Guiding narrative questions:	1. If the denominator does not roughly equal TX_CURR (i.e., if not all patients are being screened for TB disease regularly), please describe the main reasons. 2. If there are issues with reporting the disaggregations, please describe. 3. If there are issues with performance (e.g., if specimens are not sent for all persons who screened positive for TB symptoms, or if the numerator doesn't equal positive specimen returned), what are they and how can they be addressed? 4. Are the patients in the numerator all receiving care from PEPFAR-supported sites? Are they receiving TB and HIV care from the same site? 5. Describe access to GeneXpert testing for ART patients who screen positive for TB.
Data Visualization & Use Examples:	**TB/HIV Prevention and Screening Cascade:**



Fiscal Year	Fiscal Quarter	Completed TB preventive therapy - TB_PREV Numerator	Expected to complete TB preventive therapy - TB_PREV Denominator	Screened negative - TX_TB Denominator NEG	ART patients screened for TB - TX_TB Denominator	Screened positive - TX_TB Denominator POS	Specimen sent - TX_TB Denominator Specimen	Started on TB therapy - TX_TB Numerator
2018	Q2	105,563	130,561	951,639	1,022,769	57,978	56,273	9,330
	Target	128,033	141,955	909,864	1,143,713	219,190	216,128	9,476

VIRAL SUPPRESSION INDICATORS

TX_PVLS

Description:	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	
Numerator:	Number of ART patients with suppressed VL results (<1,000 copies/ml) documented in the medical or laboratory records/LIS within the past 12 months	If there is more than one VL result for a patient during the past 12 months, report the most recent result. Only patients who have been on ART for at least 3 months should be considered.
Denominator:	Number of ART patients with a VL result documented in the medical or laboratory records/LIS within the past 12 months.	Only patients who have been on ART for at least 3 months should be considered.
Indicator changes (MER 2.0 v2.2 to v2.3):	• Frequency of reporting updated from annual to quarterly. The reporting period still covers a 12-month period and may include data from the previous fiscal year. • Data source hierarchy for indicator reporting is established. • Guiding narrative questions updated.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	**VL SUPPRESION OUTCOMES:** This indicator monitors the proportion of documented viral load results from adult and pediatric ART patients who have been on ART for at least 3 months (or according to national guidelines) with a suppressed result (<1,000 copies/ml). This allows ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression. This indicator will provide data on patients who have a viral load (VL) test in the past 12 months and the percentage who were virally suppressed at the most recent test. **VL TESTING COVERAGE:** Comparison of the denominator for this indicator with the result for TX_CURR from 6 months earlier (i.e., two quarters prior) can be used to crudely estimate VL testing coverage supported by PEPFAR. For example, a comparison may be made between the FY19 Q1 denominator for TX_PVLS and FY18 Q3 TX_CURR, given that patients newly initiating ART and included in TX_CURR in FY18 Q4 and FY19 Q1 may not be eligible for a viral load test. In calculating this estimate, it is important to ensure that individuals, not tests are being reported for TX_PVLS. Analyzing both VL testing coverage and suppression rates by geography, sub-population, and implementing mechanisms is essential for program management and quality of care. Real-time review of VL results should trigger an immediate response to follow-up on patients who are not suppressed (i.e., VL ≥1000).	
How to collect:	This indicator should be collected from clinical sources (e.g., electronic or paper patient records), where possible, to ensure de-duplicated patient counting and receipt of results to inform patient care. Ideally, data for this indicator should be collected from an electronic medical records system (EMR) to minimize data collection errors and ensure that results are informing patient care. If data collection from an EMR is not possible, indicator data may be collected from paper-based registers or reports that reflect the VL results. If standard patient registers do not contain all the required information, individual patient records should be reviewed. If a clinical source does not exist or does not contain the desired information, data may be extracted from an electronic laboratory information system (LIS). VL results from an LIS must be linked to back to the individual patients and their record at sites.	

NOTE: If patient-linked VL results from LIS is used for reporting, it is incumbent that the implementing partner ensure this information is transcribed into the patient record for timely VL results utilization/patient management.

The data source used for reporting on this indicator should be specified and data reported should be de-duplicated and used to inform patient care at sites. If the LIS is used, please explain why clinical sources could not be used to report on this indicator in the narrative (see guiding narrative question section below).

VL results should be reported for patients who have been on ART for at least 3 months (or according to national guidelines). It is important to ensure that the data sources used to collect and aggregate data are updated to be able to report VL results data for patients who have been on ART for at least 3 months.

The indicator reporting frequency is now quarterly. The reporting period still covers a 12-month period and may include data from the previous fiscal year (see visual below). For example, when reporting data in FY19 Q1, country teams will be required to report data for FY18 Q2+ FY18 Q3+FY18 Q4+ FY19 Q1.

	FY18									FY19								
	FY18 Q2			FY18 Q3			FY18 Q4			FY19 Q1			FY19 Q2			FY19 Q3			FY19 Q4		
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
FY19 Q1 reporting	FY19 Q1 12 MONTHS																				
FY19 Q2 reporting				FY19 Q2 12 MONTHS																	
FY19 Q3 reporting							FY19 Q3 12 MONTHS														
FY19 Q4 reporting										FY19 Q4 12 MONTHS											

Both only VL tests with recorded results and VL results that are linked back to patients should be included in the numerator and denominator of this indicator.

This indicator should be reported for all PEPFAR-supported treatment sites (i.e., from all reporting TX_CURR). VL monitoring result utilization should be promoted for individual patient, site, and program use. If a PEPFAR-supported treatment site (i.e., a site that has reported TX_CURR) has not collected any samples for VL testing, “0” should be entered for both the numerator and denominator.

Where more than one result is available for the reporting period, the most recent result should be reported. Programs should describe the method(s) of data collection and the results de-duplication methodology utilized in their narratives.

How to review for data quality:

- Denominator ≥ Numerator: The number of VL results from adults and children on ART must be greater than or equal to the number of VL results from adult and pediatric ART patients with a VL <1,000 copies/ml.
- Numerator ≥ subtotal of each disaggregation: The total number of VL results from adult and pediatric ART patients with a VL <1,000 copies/ml should be greater than or equal to the sum of all of the results disaggregated by age/sex, pregnancy/breastfeeding status, and test indication.
- TX_CURR ≥ TX_PVLS (D): TX_CURR should be greater than or equal to the number of adults and children on ART with VL results

How to calculate annual total:

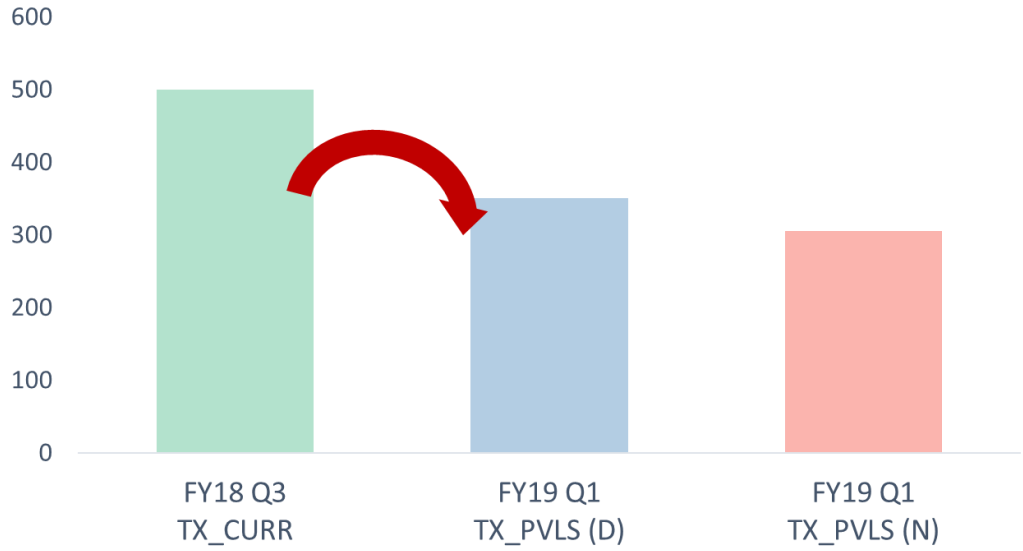
This is a snapshot indicator. Results are cumulative at each reporting period.

Disaggregations:

Numerator Disaggregations:

Disaggregate Groups	Disaggregates
Indication by Age/Sex [Required]	• Routine by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M

		• Targeted by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Not Documented by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Indication by Pregnant/Breastfeeding [Required]	• Pregnant Routine; • Pregnant Targeted; • Pregnant Not Documented; • Breastfeeding Routine; • Breastfeeding Targeted; • Breastfeeding Not Documented
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	Indication by Age/Sex [Required]	• Routine by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Targeted by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Not Documented by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Indication by Pregnant/Breastfeeding [Required]	• Pregnant Routine; • Pregnant Targeted; • Pregnant Not Documented; • Breastfeeding Routine; • Breastfeeding Targeted; • Breastfeeding Not Documented
Disaggregate descriptions & definitions:	**Indication Disaggregate Definitions:** • *Routine:* Refers to VL tests obtained at standard intervals following ART initiation to monitor virologic response to ART (testing frequencies and interval are dependent on the National guidelines but should be recommended to occur at least annually for patients on ART) and includes follow-up VL tests done after an initial VL result of VL≥1000. • *Targeted:* refers to viral load tests ordered based on a specific clinical indication, (e.g., concern about disease progression or failure to respond to ART). • *Not documented:* not indicated in the patient file, registry, or log book whether this test was targeted or routine. If any data are reported here, an explanation is required in the narrative section including a description of plans to address missing data so in the future, data are reported under routine or targeted.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for PLHIV on ART who receive VL monitoring includes</u>: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver VL monitoring services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>Ongoing support for PLHIV receiving ART VL monitoring improvement includes</u>: clinical mentoring and supportive supervision of staff at HIV sites providing ART and VL monitoring services, support for quality improvement activities, patient tracking, enhanced adherence counseling system support, routine support of VL related M&E and reporting, VL related commodities consumption forecasting and supply management	

Guiding narrative questions:	1. Briefly describe the VL testing algorithm used in country. Please ensure that the description includes any differences in the VL monitoring algorithm for different sub-populations (e.g., pregnant women, breastfeeding women, children etc.). 2. Clarify how the program is able to ensure that only patients who have been on ART for at least 3 months are being reported. If reporting a different duration (e.g., only patients who have been on ART for at least 6 months), please specify. 3. Specify and briefly describe the data sources used to report on this indicator (e.g., EMR, LIS, DHIS2 etc.). If the LIS is used, please explain why clinical sources could not be used to report on this indicator. 4. What efforts are made to ensure individuals, not tests are being reported (e.g., processes of de-duplicating data to reflect unique individuals being tested and outcomes). Please describe the de-duplication methodology used, if applicable. 5. Clarify definition of how country is reporting on routine vs. targeted tests. If there were lower-than-expected numbers of routine or targeted VL testing, please explain. 6. Please describe the overall coverage of VL testing in the country, with any differences by region or age. 7. If any data are reported in the 'not documented' or 'not known' disaggregation, please explain why and include plans to address for next reporting cycle. 8. Describe any association of ART regimen type with TX_PVLS.
Data Visualization & Use Examples:	**Viral Load Coverage and Suppression Cascade:** 

HEALTH SYSTEMS INDICATORS

EMR_SITE

Description:	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	
Numerator:	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery points: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	Answer recorded separately for each service delivery point (or area).
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility by service delivery point (or area).	
Reporting frequency:	Annually	
How to use:	This indicator can be used as a cross-sectional indicator at Q4. It can be used to better understand PEPFAR's investments in Strategic information and to support a broader understanding of data quality challenges for other indicators. Timely access to up-to-date patient information plays a vital role in the provision of effective clinical care by health professionals. Diagnosis and treatment can be improved if health professionals have easy access to accurate and comprehensive medical records of patients.	
How to collect:	**Definition of an Electronic Medical Record (EMR):** An EMR is a longitudinal electronic record of an individual patient's health information that can assist health professionals with decision-making and treatment. Data found in a record may include patient demographics, past medical history, vital signs, examination and progress notes, medications, allergies, immunizations, laboratory test results, other test results. It can also support the collection of data for other uses such as quality management, public health disease surveillance and reporting. EMR can include real-time point-of-care data entry as well as retrospective data entry. An EMR is a digital version of a paper chart that contains key information in a patient's medical history from one service delivery point or site. The implementing partner should indicate whether the PEPFAR-supported service delivery areas have implemented and are actively using an electronic medical record system to assist clinical service provision or patient/program monitoring and reporting. Specifically, for PEPFAR reporting a minimum of 6 months of retrospective data should be included in the EMR. (For example, an ART EMR set up in September 2018 to contain at least 6 months of retrospective data (current patients that have been enrolled on ART) could be counted in the reporting at FY18 APR. **Individual service delivery area/point EMR versus Integrated Health EMR:** EMRs are typically for all health areas, but PEPFAR is interested in better understanding whether EMRs are available for the service delivery areas where PEPFAR focuses its work. If a service delivery area is incorporated in a larger integrated health EMR, then it should be included this indicator. If two or more service areas are in an integrated EMR, both areas should be included in this indicator. A site service delivery area should be reported under this indicator if the EMR is on site (i.e., server and computer entry screen or there is a central server at a hub facility, that includes all data from all the "spokes" for that facility's catchment area. As long as the data for patient management and reporting comes from the EMR system as one source.	

<table>
<tr><td></td><td>For example, if services are integrated, for example EID service delivery is integrated into treatment services, then as long as EID data is captured in the treatment services EMR (or a separate EMR for EID is available within these services), then the EMR could be counted under both the treatment and EID service delivery areas.

Registries:
Some sites maintain types of e-Registers (which might provide basic functionality like reporting, default tracing, etc.). However, <u>if these e-Registers do not capture longitudinal clinical information, they should not be included in this indicator</u>.</td></tr>
<tr><td>How to review for data quality:</td><td>If a site does not report for a specific service delivery area (e.g., the site is not a PEPFAR-supported ART site reporting TX_CURR), then it should not be included as having an EMR in that service delivery area (e.g., EMR for C&T services – N/A should be selected in this case).</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A. Data is reported only once annually at Q4.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Service Delivery Area [Required]</td><td>• HIV Testing Services: (yes, no, N/A)
• Care & Treatment (includes Pediatric and Adolescent Care and Treatment Services: (yes, no, N/A)
• Antenatal and/or Maternity Services: (yes, no, N/A)
• Early Infant Diagnosis and/or Under Five Clinic (not Pediatric ART Services): (yes, no, N/A)
• TB/HIV Services: (yes, no, N/A)</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Service Delivery Area:
• HIV Testing services: includes counselling (pre-test information and post-test counselling); linkage to appropriate HIV services; and coordination with laboratory services to support quality assurance and the delivery of correct results.
• Treatment services: includes services where ART is initiated and monitored.
• Antenatal/maternity services: HIV Testing and treatment in an ANC and/or maternity setting
• EID services: HIV testing and care for infants of HIV positive women, often linked to <5 children services and/or maternity services, but can also be part of an ART clinic, but with its own EMR EID
• TB/HIV services: includes routine screening, diagnosis, treatment, and prevention of TB among PLWHA or routine HIV testing and counseling and appropriate referral in persons with TB</td></tr>
<tr><td>PEPFAR-support definition:</td><td>The PEPFAR support categories of DSD and TA-SDI do not apply to this indicator. To report results for this indicator, it is expected that PEPFAR provides support to the HIV service delivery area. <u>PEPFAR did not have to support the development of the EMR in order for it to be counted. EMRs supported by other donors or Ministries of Health should be included in this indicator.</u> It is highly recommended that service delivery areas that have functional EMRs use these both for patient management as well as reporting.

Definitions:
What is a PEPFAR supported site for the purpose of this indicator?
“PEPFAR supported site” for the purpose of this indicator should include any facility in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period.

What is a PEPFAR-Supported Service Delivery area at a site for the purpose of this indicator?</td></tr>
</table>

	PEPFAR-supported facility-based service delivery area uses PEPFAR funds to provide HIV-related services at service delivery points within the facility. It offers one or more HIV-related services including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART) and TB/HIV services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). These can also include fixed locations and/or mobile operations offering routine and/or regularly scheduled services.
Guiding narrative questions:	1. In the narrative, implementing partners should describe the primary EMR(s) in use for each the service delivery areas within the sites they support. Indicate the platforms that these EMRS were created on and who the primary partner, developer, or donor is that is responsible for maintaining these EMRs at the sites.

HRH_CURR

Description:	Number of health workers who are working on HIV-related activities and are receiving any type of support from PEPFAR, as well as total spend on these workers	
Numerator:	Number of health workers at this facility site who are working on HIV-related activities (e.g., prevention, treatment) and are receiving any type of support from PEPFAR, as well as total spend on these workers	This indicator is reported at the facility, community, and above-site levels.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	• Reporting the indicator by number of full-time equivalents (FTEs) is no longer required as the indicator has been simplified to collect the total number of staff by cadre category and support type. • A new data element has been added to collect the total funding spent by cadre and support type.	
Reporting level:	Facility, Community, and Above-Site	
Reporting frequency:	Annually	
How to use:	Many countries experience HRH shortages and/or imbalances by population density (e.g., HRH shortages in rural areas) that are not related to population health needs, including HIV epidemiology. Addressing density and distribution of HRH is important in increasing access to HIV services where they are needed. In many PEPFAR countries, there are overall shortages of HRH, particularly in rural and remote areas, leading to insufficient numbers of health workers according to internationally recommended levels (2.3 doctors, nurses, midwives/1,000 population). There are also countries where there is large overproduction of health workers, with medical unemployment in urban areas, and at the same time with shortages in rural areas. Furthermore, different types of health workers receive different types and amounts of support that may vary by geographic location, cadre, workload, and other factors. Understanding the ways in which different cadres are supported is important for mobilizing differential models of service delivery under different circumstances. This indicator measures the number of PEPFAR-supported health workers who contribute to providing HIV services at facility and community sites. It allows us to track our level of support and continuously calibrate it based on impact. It also allows us, over time, to measure the transition from PEPFAR support to host country support.	
How to collect:	Data on total numbers of positions supported should be tracked by implementing partner's record-keeping systems, for example, personnel databases, human resources records, and financial records that show salary or stipend payments, including information on non-monetary support to volunteers. Leverage the same records and systems partners already use to report dollar amounts for work plans and financial reporting, to identify PEPFAR support of HRH. For non-monetary supported personnel, partners should cross-reference expense reports and registers against the cadre types who received the corresponding non-monetary benefits. For example, receipts showing transportation allowances were provided to attend meetings could be cross-referenced with the attendance listed in the minutes for community lay workers. Facility and community workers are reported by IM, Site ID, facility and community site affiliation, and cadre type. All PEPFAR-supported workers at the facility and community should be reported. How to document: 1. Identify all facility and community sites where you work.	

	2. Identify and count the number of health workers (individuals) you support at each site. 3. Group these health workers into their most appropriate, mutually exclusive cadre (doctor, nurse, lay counselor, laboratory cadres, pharmacy cadres, etc.). 4. List the total number of workers by each cadre under the "total # of de-duplicated staff by cadre" column. This numerator is entered separately in DATIM, separate from the disaggregates described below. 5. List all types of monetary and non-monetary support that were provided to health workers at any of those sites in the current fiscal year (as incentive or compensation for time spent on HIV services at those sites). 6. It is possible for one worker to receive more than one type of support. In such cases individual staff person can be listed under more than one type of support. It is possible for the disaggregates to exceed the numerator for each cadre. However, note that the entries under "total # of de-duplicated staff by cadre" column should be the actual number of workers supported by PEPFAR. 7. Salary support includes base salary. 8. Stipend includes any amount paid that is above the standard base salary, allowances, and financial benefits such as health insurance, social security benefits, fringe benefits, etc. For example, a health worker that works out of standard business hours such as a weekend, and PEPFAR pays for weekend hours only. 9. Assign those types of support to the health workers identified on your site lists and then create a matrix of supported health workers by cadre and support type: 10. Non-monetary support should be reported even if you provide only non-monetary support, with no salary or stipend. 11. Above-site support may include Ministry of Health or other government staff who work at the district or provincial level, or at the national level, including Ministry of Health office, National Reference Laboratories, or at national research centers not otherwise providing HIV services directly to beneficiaries.
How to review for data quality:	Sites reporting on HRH_CURR should be reporting DSD results for the indicators that the HRH are supporting. HRH_STAFF_NAT should be greater than or equal to HRH_CURR at each individual site (facility-level only) where these data are reported. HRH_STAFF_NAT includes all staff at PEPFAR-supported sites (i.e., staff that are both PEPFAR-supported AND non-PEPFAR supported). The total number of workers reported under the column "total # of de-duplicated staff by cadre" cannot be higher than the sum of disaggregates. However, it can be lower than the sum of disaggregates.
How to calculate annual total:	N/A. Data is reported only once annually at Q4. **Fill out total # of de-duplicated staff entry form first**, and then complete the disaggregates. Data should capture health workers for whom PEPFAR provided support in the same reporting period (fiscal year), and who have not been transitioned by the end of the fiscal year. Unfilled positions or vacancies should not be included.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Cadre category by type of support and total spend provided by PEPFAR (Facility & Community-Level) (Both service and non-service delivery) [Required]	• Clinical Cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Laboratory Cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Pharmacy Cadre by number of workers supported and total spend for: salaried staff; staff receiving

		stipends/allowances; staff receiving non-monetary support • Management Cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Social Service Cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Lay Cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Other HCWs by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support
	Cadre category by type of support and total spend provided by PEPFAR (Above-Site-Level) (Non-service delivery) [Required]	• Management (Central Level) by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Management (Subnational Unit Level) by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Epidemiologist/Surveillance: Management (Central Level) by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Laboratory cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Pharmacy cadre by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support • Other by number of workers supported and total spend for: salaried staff; staff receiving stipends/allowances; staff receiving non-monetary support
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	**Cadre Category (Facility & Community-Level; Both service and non-service delivery):** • **Clinical workers** are those who provide a direct clinical service to clients: Clinical professionals, including doctors, nurses, midwives, clinical officers, medical and nursing assistants, auxiliary nurses, auxiliary midwives, and testing and counseling providers. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals. • **Laboratory workers** are those who conduct laboratory tests, collect blood or samples at a lab, and relay the results to a clinician for diagnostic purposes. This category includes cadres such as laboratorians, lab technicians, phlebotomists, and lab managers. • **Pharmacy workers** are those who dispense ARVs at a facility or community center and help with forecasting and supply chain logistics to ensure there are no stock-outs. It	

includes but not limited to pharmacists, pharmacy assistants, and pharmacy technicians based at a facility.

- **Management workers** are those who provide support to the site for administrative needs but not directly provide services to clients: Facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support.
- **Social service workers** are those who have advanced training in social services and provide services directly to clients: Social service workers including social workers, child and youth development workers, social welfare assistants.
- **Lay workers** are those who have non-clinical training and provide services directly to clients: Health workers who provide important services for the continuum of care within facilities and/or communities. These include but are not limited to adherence support, mother mentors, cough monitors, expert clients, lay counselors, peer educators, community health workers and other community-based cadres.
- **Other HCWs**: workers who do not fit into any of the categories above (e.g., data capturers, data clerks, security guards, cleaners, etc.).

Cadre Category (Above-Site-Level; non-service delivery):

- **Management central level** are those staff supporting management functions at national level. Examples may be development and implementation of policies, guidelines, quality standards, health or HIV budgeting and financing. The work of these staff has a national scope and affect all (or multiple) districts or regions.
- **Management sub-national unit** are those staff supporting management functions for one geographic area at the sub-national level. Examples may include district-level health planning and coordination, district-level quality improvement, training or mentoring (e.g., district health office, provincial coordinating authority)
- **Laboratory workers** are those staff providing monitoring and supportive supervision, and in-service training to facility-based lab workers. These may include laboratory QI specialists, lab accreditation specialists at the PSNU or OU level, and secondments for the lab branch in a Ministry of Health.
- **Pharmacy workers** are those managing various stages in the supply chain process, including forecasting and logistics above the service delivery level. It includes but not limited to pharmacy managers, staff at a drug warehouse involved in supply chain logistics, pharmacists based at the SNU level, and senior pharmacists/ secondments based at a Ministry of Health.
- **Epidemiologist/Surveillance** staff are those collecting and/or analyzing HIV epidemiologic data at the above-service delivery area level. This may include making national or district-level estimates of PLHIV or key populations, incidence modeling, ANC or sentinel surveillance, integrated behavioral and biological surveys, drug resistance estimates.
- **Other types of staff** not covered by the above categories (e.g., data capturers, data clerks, security guards, cleaners, etc.).

Type of Support Provided by PEPFAR to the Staff: For each cadre category supported by PEPFAR at the site level and above site level (both service and non-service delivery) report the total amount spent for the workers across four categories.

- **Salary:** Total amount of salary support provided by PEPFAR, even if the health worker receives partial support from sources other than PEPFAR. PEPFAR salary support is any ongoing monetary contribution bench marked toward a total salary which is benchmarked toward, a government salary scale or international salary standard. A salary is characterized by being disbursed at regularly scheduled intervals in expected denominations.
- **Stipend/Allowances:** Total amount spent for each cadre on stipends and allowances. Stipends and allowances are separate from base salary. Stipend payments are not necessarily commensurate with, nor benchmarked toward, a government salary scale or international salary standard. These include one-time and supplementary payments, for example, for overtime worked due to HIV case burden, and financial benefits such

	as social security fund and health insurance. Payment could be made at regular intervals or intermittently depending on agreement. • **Non-monetary support only:** Total amount spent on only non-monetary forms of support that do not involve currency, in connection with or in support of the provision of HIV services. These include mobile phone credits, general modes of transportation like bicycle or motorbike, job aids or equipment that can be used outside of HIV or in other jobs (such as in private practice), or other in-kind support. Include volunteers who work on HIV and receive only non-monetary support from PEPFAR.
PEPFAR-support definition:	No additional requirements needed outside of the standard definition.
Guiding narrative questions:	1. For all categories of workers, including other, please provide description of specific cadres in the narrative. 2. Please include descriptions of what type types of non-monetary support are captured (e.g., mobile phone credits, equipment, bicycles, etc.). 3. Please confirm that workers listed as under non-monetary receiving only non-monetary support (not in addition to salary or stipend)?

HRH_PRE

Description:	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	
Numerator:	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	The numerator is the sum of new health workers from the host country who graduated from a pre-service training institution within the reporting period with full or partial PEPFAR support. Individuals may be in pre-service training over a number of years but can be counted as graduated when they have completed their program. Graduates do not need to attend a formal ceremony – completing the program and receiving documentation is sufficient.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Above-Site	
Reporting frequency:	Annually	
How to use:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up health services. The lack of a sufficient workforce in countries presents a serious challenge to every area of health. The data will tell us the number of new health workers who are available to enter the health workforce each year as a result of PEPFAR support.	
How to collect:	Training under this indicator is defined as “pre-service” training – the training of “new” health workers (see definition below). Training generally occurs prior to the individual entering the health workforce in his or her new position (with the exception of certain training that may occur on-the job but that prepares health workers to function as a new cadre or with an expanded scope of practice in the health system). A health worker who advances to a higher cadre (e.g., a clinical assistant who completes training to become a clinical officer) shall be counted as a “new” health worker for the purposes of this indicator. The HRH goal is to expand the number of workers in the workforce and increase access to care through the advancement of current workers to higher level cadres through additional training and education. Pre-service training institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre’s entry into the workforce. “In-service” and “continuing education” training should not be included in the count for this indicator but continue to be encouraged. These types of training may be captured by other indicators within program areas (e.g., supply chain). In order to count, the duration of training must meet or exceed a minimum of 6 months. For example, community health workers who receive a 3-month training course cannot be counted here. The training duration may be a combination of classroom and practical field time to arrive at six months. A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The	

<table>
<tr><td></td><td>duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above.

Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted.

Successful completion of training may be documented by diploma, certificate or other evidence of completion of the program and subsequent eligibility to enter service.

Individuals not meeting these documented requirements should not be counted in this indicator.

“Health workers” refers to individuals involved in safeguarding and contributing to the prevention, promotion and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. This is not an exhaustive list of all health workers and position titles may vary from country to country. For the purposes of this indicator, health workers may include the following but is not limited to:
• Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, medical technologists, and psychologists. They usually have a tertiary education and most countries have a formal method of certifying their qualifications.
• Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counselors. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.
• Workers in a health ministry, hospital and facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support.
• Social service workers including social workers, child and youth development workers, social welfare assistants.

PEPFAR support includes funding in the areas of curriculum development, teacher training and support, tuition/scholarships, infrastructure, materials/equipment, and practica/internships. For example, full or partial support of student tuition or scholarships, teacher salaries, and expansion/refurbishment of pre-service training facilities could all count under this indicator depending on the investment.

Data sources: MOH Human Resource Information Systems (HRIS), pre-service training institutions, Ministry of Education, Public Service, and/or private sector HRIS, Ministry of Social Welfare HRIS, professional boards and councils, alumni or graduate networks.</td></tr>
<tr><td>How to review for data quality:</td><td>N/A</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A. Data is reported only once annually at Q4.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>By Cadre:
[Required]</td><td>• Doctors
• Nurses
• Midwives
• Social Service Workers
• Laboratory Professionals
• Other</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
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Disaggregate descriptions & definitions:	As a service delivery area indicator, the PEPFAR support categories of DSD and TA-SDI do not apply. To report results for this indicator, it is expected that PEPFAR provides support for this activity as defined below. New health worker graduates of pre-service training institution or program will be counted as PEPFAR supported when PEPFAR is supporting the training of new health worker graduates, including: • Tuition and fees - At least 50% of the students' tuition and fees were or will be provided by PEPFAR for at least six months of their education • Curriculum development - The students received or will receive training where PEPFAR curriculum development was essential to qualify them for their trained role • Infrastructure - The students received or will receive six months or more of education at an institution that could not have supported their education without PEPFAR-supported infrastructure improvements (classrooms, dormitories, utilities) • Faculty support - The students received or will receive six months of more of education at an institution that could not have supported their education without one or more faculty members present and qualified due to PEPFAR support • Practica / internship support - The students would not have received or will not receive adequate practica or internship training without PEPFAR support (including transportation to or sufficient resources at the practicum facility) • Materials / equipment - The students would not have received or will not receive education without materials or equipment (including books and supplies) provided by PEPFAR • PEPFAR educational programs (for non-university-based training institutions) - The students received or will receive their education in a PEPFAR-funded, non-university-based education program for one or more courses without which they would not graduate or be qualified for the intended role • Please refer to the HRH flowchart and worksheet for further information (https://www.pepfarii.net/twg/hrh/SitePages/Home.aspx)
PEPFAR-support definition:	No additional requirements needed outside of the standard definition.
Guiding narrative questions:	1. For each cadre, describe nature of education (university, professional school), types of certification/accreditation (e.g., RN, LPN, ADN, BSN, NP, PA). 2. For each cadre, describe how training is leading to employment and service gap filling and aligned to reaching HIV epidemic control.

LAB_PTCQI

Description:	Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing (POCT) sites engaged in continuous quality Improvement (CQI) and proficiency testing (PT) activities.	
Numerator:	• Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites engaged in CQI activities. • Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites engaged in PT activities. • Number of specimens received for testing at all PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites within a testing category.	The numerator is generated by counting the number of PEPFAR-supported laboratory-based testing and point-of-care testing sites for each testing category by their level of engagement in CQI and PT activities; and the number of specimens received for testing at laboratory-based testing and point-of-care testing sites within each testing category.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility	
Reporting frequency:	Annually	

How to use:	• **Monitoring Engagement in CQI and PT:** CQI and PT programs are critical to ensure efficient and quality assured laboratory testing. Monitoring testing sites' levels of engagement in CQI and PT enables the identification of facilities, geographic areas, and implementing partners that may benefit from additional support related to laboratory quality. Engagement in CQI and PT may also be used to monitor progress over time (e.g., progress toward laboratory accreditation) and maintenance of quality assured laboratory testing.
	  ○ **Recommendations for engagement in CQI and PT are outlined below. Implementing partners reporting data that do not meet these recommendations should be prepared to provide detailed explanations and action plans.**
	  ▪ 100% of laboratory-based testing sites participating in CQI and PT.
	  ▪ 100% of HIV Viral Load and IVT/EID laboratory-based testing sites working towards accreditation.
	  ▪ >70% of POCT sites, particularly HIV serology/diagnostic testing sites, participating in CQI and PT; with the goal of all POCT sites participating in CQI and PT.
	  ▪ Year-over-year increases in the proportions of testing sites achieving higher levels of engagement in CQI (e.g., an increase in the proportion of accredited testing sites as compared to the previous year). Once saturation is achieved, it is critical that this indicator be used to monitor maintenance of CQI and PT programs.
	  ▪ >90% of testing sites that conduct a test passing PT for that testing category
	• **Providing Context for Testing Results:** Levels of engagement in CQI and PT may be used to provide context for testing results at the facility, SNU, or OU levels. Testing results reported in an SNU where a low percentage of testing sites are engaged in CQI, for example, may infer a lower degree of confidence than if the SNU had a high percentage of testing sites engaged in CQI. Please note that enrollment and achievement in CQI and PT programs are proxy indicators for laboratory quality and provide an indication of quality practices rather than a direct measurement of testing quality at the site.
	• **Monitoring Availability of Laboratory Services:** The number of specimens received for each testing category assesses the extent to which PEPFAR-supported laboratories and/or POCT sites are maintaining or expanding laboratory services. The number of specimens received may also be used to monitor the capacity of testing sites and scale-up efforts over time.	

	• **Assessing the Clinic-Lab Interface:** The number of specimens received for testing may be used in conjunction with other indicators to monitor the clinic-lab interface.
How to collect:	**Which facilities are counted?** Collect data for the LAB_PTCQI indicator, both laboratory and POCT, at facilities with PEPFAR-supported laboratories or POCT sites. A PEPFAR-supported laboratory or testing site is defined as a facility that receives direct service delivery (DSD) or technical assistance for service delivery improvement (TA-SDI) from PEPFAR, is the recipient of specimens from PEPFAR-supported clinics, and/or receives proficiency testing panels via PEPFAR support. See definitions for 'laboratory' and 'POCT site' below. **How many laboratory-based testing sites are in the facility?** A facility may have one laboratory-based testing site (e.g., HIV Viral Load laboratory-based testing site), multiple laboratory-based testing sites with different testing categories (e.g., HIV Serology/Diagnostic and HIV Viral Load laboratory-based testing sites), and/or multiple laboratory-based testing sites with the same testing category (e.g., Two HIV Viral Load laboratory-based testing sites - each under a distinct entity/department within the facility). **How many POCT sites are in the facility?** A facility may have one POCT site (e.g., HIV Rapid Test POCT site), multiple POCT sites with different testing categories (e.g., HIV Rapid Test POCT site and CD4 POCT site), and/or multiple POCT sites with the same testing category (e.g., Two HIV Serology/Diagnostic test POCT sites – one associated with the PMTCT program and the other associated with the TB program). **Where can data for this indicator be found?** Data on engagement in CQI and PT can be obtained from program records of PEPFAR-funded partners. Additionally, laboratory-based testing and POCT site-level documentation can be used to assess CQI engagement and PT results. Data on the number of specimens received for testing can be obtained from specimen registers/log books and/or laboratory information systems (LIS). **How are data interpreted and reported (Laboratory-Based Testing)?** Identify the level of engagement in CQI activities for each laboratory-based testing site by choosing one of the following: • Performs this test but does not participate in CQI (see definition of 'CQI participation' below). • Performs this test and participates in CQI but has not been externally audited (see definition of 'external audit' below). • Performs this test, participates in CQI, and has been externally audited, but does not meet full accreditation standards (see definition of 'accreditation' below). • Performs this test, participates in CQI, has been externally audited, and is fully accredited. Identify the level of engagement in PT activities for each laboratory-based testing site by choosing one of the following: • Performs this test but does not participate in PT (see definition of 'PT participation' below). • Performs this test, participates in PT, but did not pass the last round (see definition of 'passing PT' below). • Performs this test, participates in PT, and passed the last round. Sum the number of specimens received for testing at all laboratory-based testing sites within a testing category. See definition for 'specimens received for testing'. **How are data interpreted and reported (Point-of-Care Testing)?** Identify the level of engagement in CQI activities for each POCT site by choosing one of the following: • Performs this test but does not participate in CQI. • Performs this test and participates in CQI but has not been externally audited.

- Performs this test, participates in CQI, has been externally audited, and achieved a score of 0-1 (≤ 59%).
- Performs this test, participates in CQI, has been externally audited, and achieved a score of 2-3 (60%-89%).
- Performs this test, participates in CQI, has been externally audited, and achieved a score of 4-certified (≥ 90%).

Identify the level of engagement in PT activities for each POCT site by choosing one of the following:

- Performs this test but does not participate in PT (see definition of 'PT participation' below).
- Performs this test, participates in PT, but did not pass the last round (see definition of 'passing PT' below).
- Performs this test, participates in PT, and passed the last round.

Sum the number of specimens received for testing at all POCT sites within a testing category. See definition for 'specimens received for testing'.

DEFINITIONS (LABORATORY-BASED TESTING SITES):

Laboratory:

A. Having dedicated physical laboratory infrastructure
B. Having dedicated trained laboratory professionals performing testing
C. Conducting laboratory testing in one or more of the following areas:
    a. Diagnosis of HIV infection with rapid test kits, EIA, WB or other molecular methods
    b. Infant Virologic Testing / Early Infant Diagnosis (IVT/EID)
    c. HIV viral load
    d. TB diagnostics: Xpert, AFB, or culture
    e. CD4 testing
    f. Others, including:
        - Blood bank screening and/or cross-matching
        - Hematology
        - Clinical chemistry
        - Serology
        - Microbiology
        - Malaria infection diagnostics
        - STI diagnostics
        - OI (Opportunistic Infection) diagnostics, including Cryptococcal antigen

Note: If a point-of-care assay (such as a rapid diagnostic test or Pima CD4) is performed at a laboratory-based testing site, as defined above, data should be reported in the laboratory portion of the indicator LAB_PTCQI indicator.

Laboratory-based testing site:
A point within a facility (with a PEPFAR-supported laboratory) that performs one of the tests defined in the testing categories within a laboratory.

Blood centers/banks:
Perform any service involved in blood donor recruitment, blood and plasma collection, testing, processing, storage, and distribution of blood and blood products. Stand-alone blood center/banks conducting testing such as screening and/or cross-matching are considered laboratories for this indicator.

CQI Participation:
CQI activities implement, improve, or maintain a Quality Management System (QMS). A functioning QMS is essential to provide accurate and reliable results with safety, efficiency, monitoring, and accountability throughout the testing process.
A laboratory-based testing site is counted as participating in CQI if they are engaged in activities within the testing category that are supported by a locally, nationally, regionally or internationally recognized CQI or accreditation preparedness program.
Examples of recognized programs:

A. Strengthening Laboratory Management Towards Accreditation (SLMTA)
B. Other established programs that utilize an auditing process such as WHO AFRO Stepwise Laboratory Quality Improvement Process Towards accreditation (SLIPTA) stepwise processes or CDC/PAHO Caribbean Laboratory Quality Management System Stepwise Improvement Process towards Accreditation (CDC/PAHO LQMS-SIP).
C. Locally-recognized basic laboratory quality management system programs
D. Locally-recognized laboratory mentorship programs
E. Participation in laboratory accreditation programs based on recognized laboratory standards such as African Society for Blood Transfusion (AfSBT), College of American Pathologists (CAP), or International Organization for Standardization (ISO).

External Audit:
Refers to a documented assessment conducted by a qualified external auditor. External audits can either be those for accreditation or those to assess readiness for accreditation such as WHO AFRO Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) and CDC/PAHO Caribbean Laboratory Quality Management System Stepwise Improvement Process towards Accreditation (CDC/PAHO LQMS-SIP). Internal assessments and audits, including those conducted as part of a training program curriculum; do not count towards this indicator.

Accreditation:
Refers to accreditation by a national, regional or internationally recognized accreditation body, such as College of American Pathologists (CAP), International Organization for Standardization (ISO) accreditation programs, regional accreditation bodies such as the South African National Accreditation System (SANAS), African Society for Blood Transfusion (AfSBT), or other approved accreditation organizations. A laboratory-based testing site is assessed by a standardized set of criteria defined by an acceptable national, regional, or international organization. Accreditation certificates are a formal recognition that a laboratory is competent to perform clinical testing. Laboratory-based testing site accreditation status must be current.

PT Participation:
Defined as enrollment/participation in a local, national, regional, and/or international external quality assurance or proficiency testing program at any time during the reporting period.

Passing PT:
A laboratory-based testing site is counted as passing PT if the last scheduled and completed PT panel was received within the reporting period and was scored as acceptable, successful, or satisfactory by the PT provider. Be aware that scoring systems between PT providers and across test categories may differ. All testing sites that are enrolled in PT should receive a score from the PT provider for each round of PT that is distributed, regardless of whether or not the site reported results.

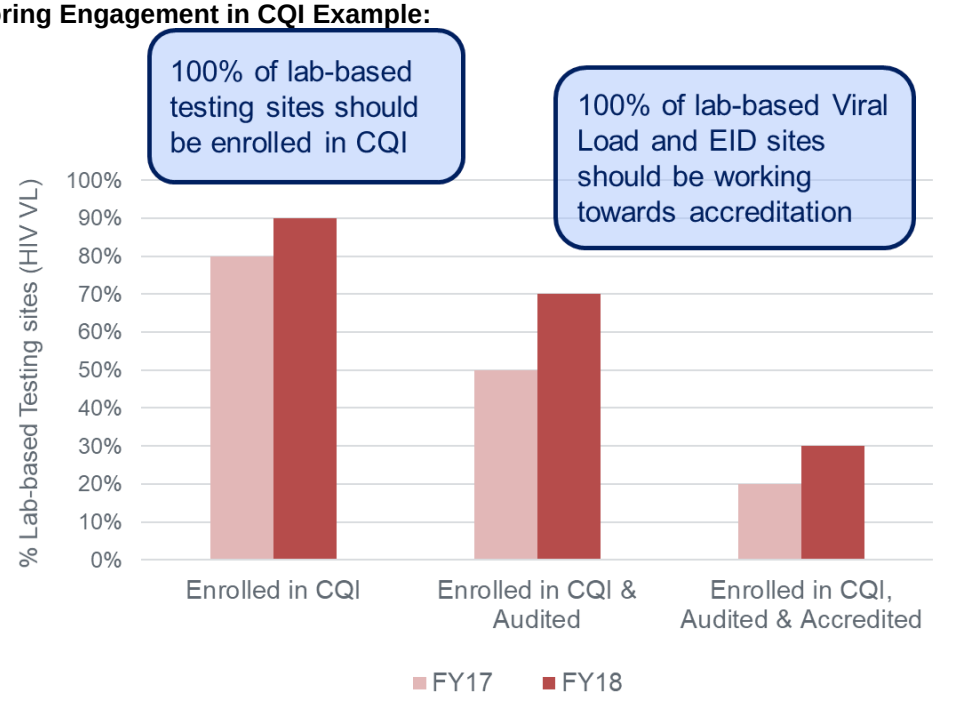
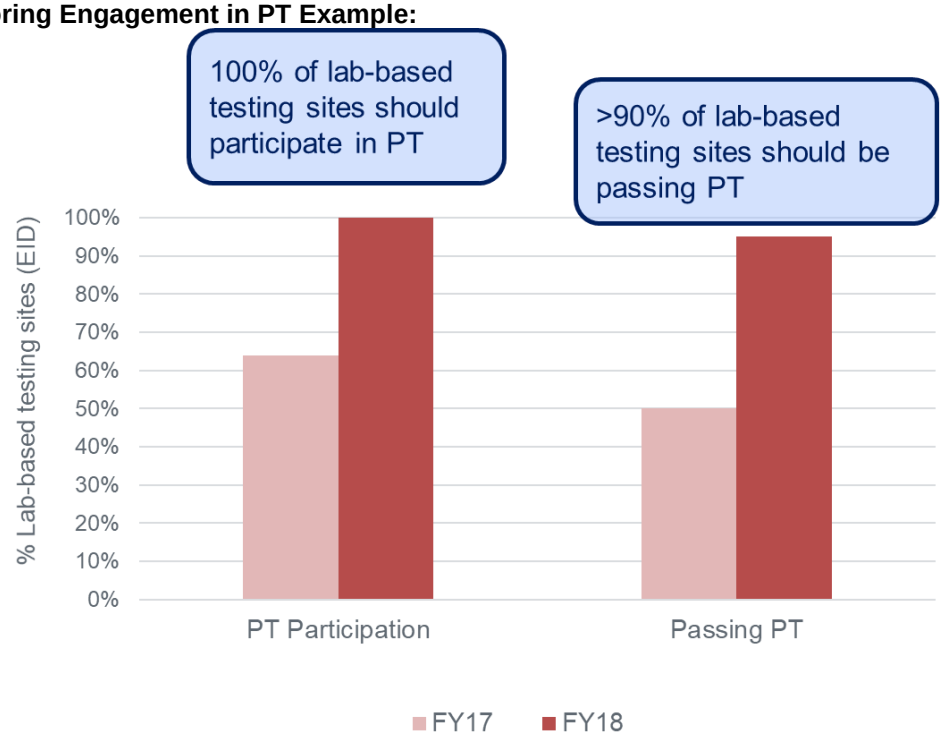
Specimen received for testing:
A specimen is received for testing if its arrival at the laboratory-based testing site was recorded in a register/log book and/or LIS within the reporting timeframe. A specimen received for testing may or may not have been tested/analyzed.

DEFINITIONS (POINT-OF-CARE TESTING SITES):

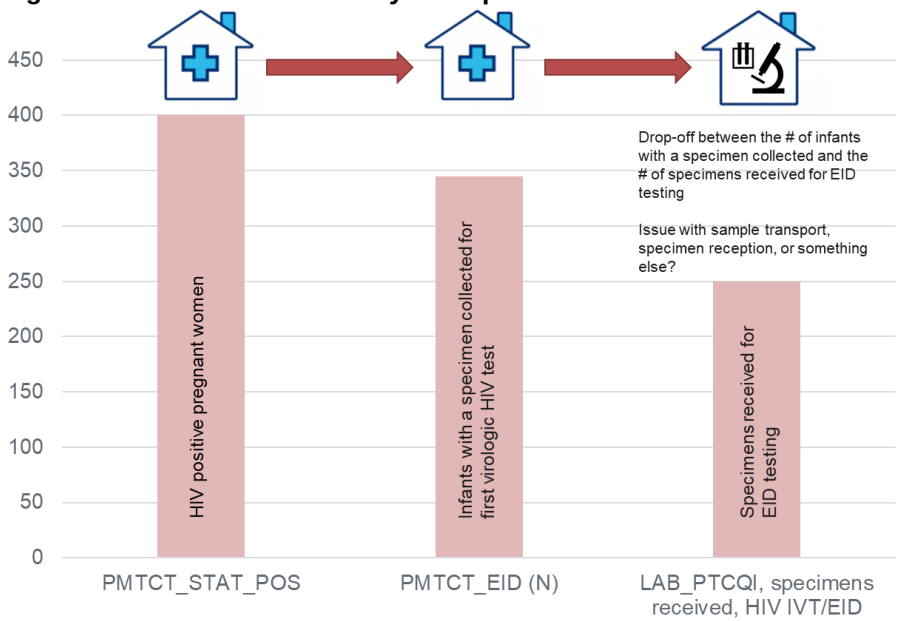
POCT site:
A. The site performs testing near or at the place of interaction with the patient/client.
B. The site performs testing in an environment which does not have a formal laboratory infrastructure.
C. Testing at the POCT site is performed by healthcare workers who may not be laboratorians.
D. Conducting POCT in one or more of the following areas:
    a. HIV rapid test
    b. Infant Virologic Testing / Early Infant Diagnosis (IVT/EID)
    c. HIV viral load
    d. TB diagnostics: Xpert or AFB
    e. CD4 testing

<table>
<tr><td></td><td>Notes: Sites conducting HIV rapid testing are considered POCT unless the testing is conducted in a laboratory (see definition of laboratory) by laboratorians. A laboratory-based testing site and POCT site may both be present at a facility. If a point-of-care assay (such as an HIV rapid test or Pima CD4) is performed at a laboratory-based testing site, CQI and PT data should be reported in the laboratory portion of the indicator (LAB_PTCQI (Laboratory)). LAB_PTCQI reporting only applies to facility-based testing. Data on CQI engagement, PT participation, or the number of specimens received for HIV rapid testing (or other POCT) that is conducted outside of a designated health facility (e.g., at a community-level service delivery point) should not be reported for LAB_PTCQI.
CQI Participation:
A POCT site is counted as participating in CQI if they are engaged in activities within the defined test category that are supported by a locally, nationally, regionally or internationally recognized CQI or certification preparedness program.
Examples of POCT CQI programs:
A. Rapid Testing Continuous Quality Improvement (RT-CQI)
B. Other established programs that utilize WHO/CDC Stepwise Process for Improving the Quality of HIV rapid testing (SPI-RT) or the WHO/CDC Stepwise process for Improving the Quality of HIV-Related Point-of-Care-Testing (SPI-POCT) Checklists to audit the POCT sites.
C. Locally-recognized basic quality management system programs
D. Locally-recognized laboratory mentorship programs
External Audit or Certification:
Refers to a documented assessment conducted by a qualified external auditor. These audits include those for national POCT site certification or for a stepwise quality improvement approaches such as the WHO/CDC Stepwise Process for Improving the Quality of HIV rapid testing (SPI-RT) or the WHO/CDC Stepwise process for Improving the Quality of HIV-Related Point-of-Care-Testing (SPI-POCT) Checklists. Internal assessments and audits, including those conducted as part of a training program curriculum; do not count towards this indicator.
PT Participation:
Defined as enrollment/participation in a local, national, regional, and/or international external quality assurance or proficiency testing program within the reporting period.
Passing PT:
A POCT site is counted as passing PT if the last scheduled and completed PT panel was received within the reporting period and scored as acceptable, successful, or satisfactory by the PT provider (see ‘Passing PT’ under laboratory testing for more information). For HIV rapid testing, if multiple testers at a POCT site participate in the same round of PT, >90% of testers must receive a passing PT score of 100% for the POCT site to be reported as passing PT. If the HIV rapid testing PT program provides one PT panel for the site (as opposed to one PT panel for each tester), the POCT site must have a PT score of 100% to be reported as passing PT.
Specimen received for testing:
A specimen is received for testing if its arrival at the POCT site was recorded in a register/log book and/or LIS within the reporting timeframe. A specimen received for testing may or may not have been tested/analyzed.</td></tr>
<tr><td>How to review for data quality:</td><td>The total numerator is automatically summed across the CQI and PT data elements for each laboratory-based testing category. This sum should equal the total number of laboratory-based testing and/or POCT sites for in each testing category at the facility and should be the same between the CQI and PT sections.</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A. Data is reported only once annually at Q4.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>CQI at laboratory-based testing sites by test category: HIV serology/diagnostic testing,</td><td>1. How many sites perform this test but do not participate in CQI?
2. How many sites perform this test and participate in CQI, but have not been externally audited or accredited?</td></tr>
</table>
</td></tr>
</table>

	HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4) [Required]	3. How many sites perform this test, participate in CQI, have been externally audited, but do not meet full accreditation standards? 4. How many sites perform this test, participate in CQI, have been externally audited & are fully Accredited?
	CQI at point-of-care-based testing sites by test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4) [Required]	1. How many POCT sites perform this test but do not participate in CQI? 2. How many POCT sites perform this test and participate in CQI, but have not been externally audited or certified? 3. How many POCT sites perform this test, participate in CQI, and have been externally audited & achieved a score of 0-1 (≤ 59%)? 4. How many POCT sites perform this test, participate in CQI, have been externally audited & achieved a score of 2-3 (60%-89%)? 5. How many POCT sites perform this test, participate in CQI, have been externally audited & achieved a score of 4-certified (≥ 90%)?
	PT at laboratory-based testing sites by test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4) [Required]	1. How many sites performed this test but do not participate in PT? 2. How many sites perform this test and participate in PT, but did not pass last round? 3. How many sites perform this test, participate in PT and passed last round?
	PT at point-of-care-based testing sites by test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4) [Required]	1. How many POCT sites performed this test but do not participate in PT? 2. How many POCT sites perform this test and participate in PT, but did not pass last round? 3. How many POCT sites perform this test, participate in PT and passed last round?
	Testing Volume (By laboratory vs. point-of-care testing and test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4) [Required]	Number of specimens received for testing at all PEPFAR-supported laboratory-based testing sites within a testing category
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	• For both CQI and PT disaggregate groups, testing category disaggregations are only applicable if specific test category is performed by the laboratory. • The most recent PT panel with a score must be satisfactory/acceptable/successful to be counted as a passing score.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used.	
Guiding narrative questions:	1. In the narrative, please define which clinical laboratory tests were included in the “other” category.	

	2. In the narrative, please define how the specimen volume was counted (i.e., specimen log, LIS, etc.).
Data Visualization & Use Examples:	**Monitoring Engagement in CQI Example:**  Year over year increases in the proportions of testing sites reaching higher levels of engagement in CQI **Monitoring Engagement in PT Example:** 

Interfacing of the Clinic and Laboratory Example:



SC_STOCK

Description:	Percentage of stock status observations from storage sites where commodities are stocked according to plan, by level in supply system	
Numerator:	Number of stock status observations per tracer commodity that are between the designed minimum and maximum quantities/months of stock from storage sites at a given level (Central, Regional, etc.) of the system	Checking this data frequently can help to avoid stock-outs through active supply chain management
Denominator:	Total number of stock status observations per tracer commodity from storage sites at a given level (Central, Regional, etc.) of the system	Total observations available are the denominator
Indicator changes (MER 2.0 v2.2 to v2.3):	None	
Reporting level:	Facility (Medical Stores including Central Medical Stores, Regional Medical Stores, and District sites which supply commodities to lower health facility)	
Reporting frequency:	Semi-Annually	
How to use:	This indicator checks to see if the supply chain system is functioning as it was designed and if storage sites at all levels are able to maintain the designed quantity of stock/months of stock to treat patients and distribute to lower level facilities which treat patients. Checking this frequently can help to avoid stock-outs through active supply chain management. A view of each level of the system (Central and Intermediate sites), using this metric can also help to locate bottlenecks within the system, which could prevent patients from receiving needed commodities; cause needless stock-outs, or unnecessary expiries.	
How to collect:	The country's supply chain standard operating procedures should outline the min and max levels for each level of the system. These levels were defined by the needed throughput (the amount of pharmaceuticals intended to flow through the system in a given period), the space available and the frequency of distribution. Observations of storage site and level-specific quantity of stock should be available through one or several of the following: The Procurement Planning and Monitoring Report for HIV and FP commodities (for condoms), a warehouse monitoring system, regular program monitoring reports, an existing logistics management information system, stock status reports/stock keeping records/regular physical counts, order forms from the central/regional/district/other levels, or regular supervision visits. For the required central level and at least one intermediate level, there may be numerous observations (through physical counts performed or spot checks) of stock status for the products of interest annually, or there may be monthly counts, either way, the stock status will be monitored closely and updated with each transaction. These observations should be analyzed in this fashion: • Document observations for each product of interest. • Sort observations for each product into "quantities between maximum and minimum quantities/months of stock" and quantities above or below maximum and minimum. • Number of observations where quantities are between maximum and minimum are the numerator. • Total observations available are the denominator. Example 1: if the Central Medical Store (CMS) has monthly stock observations for RTKs, and nine of which are within max and min levels but the remaining three represent a stock-out then for the CMS the resulting measurement would be 9/12 or 75%	

<table>
<tr><td></td><td>Example 2: If there are ten regions in a country and the regional medical stores report to the CMS quarterly, then ideally there should be 40 observations. Of these observations 25 are stocked according to plan for ARVs. In this scenario, the resulting measurement for ARVs at the regional level is 25/40 or 62.5%.</td></tr>
<tr><td>How to review for data quality:</td><td>Cross-reference data with shipments arriving, as shipments arrive the quantity of stock or the months of stock should increase. Ensure the data comes from the warehouse management system. Consult with supply chain stakeholders to ensure that data is consistent.</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A</td></tr>
<tr><td>Disaggregations:</td><td>
Numerator Disaggregations:
<table>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>System Level
[Required]</td><td>• System Level: Central Medical Stores (CMS), Regional Medical Stores, District sites which supply commodities to lower Health Facility</td></tr>
<tr><td>Commodity
[Required]</td><td>• Condoms
• ARV drugs
• Rapid test kits
• OI drugs
• Other</td></tr>
</table>
Denominator Disaggregations:
<table>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
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<tr><td>Commodity
[Required]</td><td>• Condoms
• ARV drugs
• Rapid test kits
• OI drugs
• Other</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>PEPFAR Warehouses in DATIM: Warehouses in the PEPFAR master facility list should be entered at each system level (this does not have to be re-entered on the entry screen; however, please ensure that the site has been allocated to one of the system levels)</td></tr>
<tr><td>PEPFAR-support definition:</td><td>Nonstandard definition of DSD and TA-SDI:

PEPFAR Support: PEPFAR direct support to sites within the fiscal year is to ensure continuous access to commodities for HIV/AIDS patient diagnosis, care, and treatment. Reasons why access to commodities may be interrupted include poor infrastructure, inconsistent transportation or distribution practices, lack of equipment, poor ordering procedures, personnel and technical skills issues, or stock-outs due to any one of the above from the distribution site. PEPFAR support for supply chain sites should provide consistent access to commodities needed for care and treatment.

Direct Service Delivery (DSD)
Supply chain sites can be counted as directly supported by PEPFAR when the following conditions apply:
1. PEPFAR pays for recurrent maintenance, operations, personnel such as those who are seconded or regular provision of HIV and AIDS commodities.
AND
2. There is at least annual technical support to monitor the support to the system.

Both conditions must be met in order to count the site as directly supported (DSD) by PEPFAR.</td></tr>
</table>

	Technical Assistance for Service Delivery Improvement Support (TA-SDI) Only: Supply chain sites can be counted as directly supported through technical assistance-only when the site receives recurrent (at least quarterly) technical support.
Guiding narrative questions:	1. Please provide background information to explain observations which were not stocked according to plan. a. Indicate if these instances were due to: understock, overstock, or stock-out and if these challenges lead to rationing of the product from that site or any known waste or expiries. b. Provide some root cause for the instances when a site was not stocked according to plan. i. Was the problem in-country transportation? ii. Were sites overstocked in preparation for a testing campaign, Test and Start or Multi-Month Scripting? iii. Was there a late international procurement? If so, how late (in days if possible) and which procurement services agent was responsible for the late procurement? Likewise, were there ordering or reporting challenges?

HOST COUNTRY INDICATORS

DIAGNOSED_NAT

Description:	Percentage of people living with HIV who know their HIV status
Numerator:	Number who know their HIV status
Denominator:	Number of people living with HIV (PLHIV Estimate)
Indicator changes (MER 2.0 v2.2 to v2.3):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	Diagnosed is the first 90 of the global targets. To ensure people living with HIV receive the care and treatment required to live healthy, productive lives, and to reduce the chance of transmitting HIV, it is critical that they know their status. In many countries, targeting testing and counselling at locations and populations with the highest HIV burden will be the most efficient way to reach people living with HIV and ensure they are aware of their status. This indicator captures the efficacy and coverage of HIV testing interventions. This indicator is harmonized with GARPR indicator 1.1: http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf

How to collect:	There are multiple methods to estimate the number of people living with HIV who know their status.
	• Case-based surveillance: In countries with well-functioning HIV reporting systems, the number of people diagnosed can be estimated from national case-based data. The number of deaths among PLHIV must be subtracted from the cumulative number diagnosed to calculate the number of people living with HIV who know their status.
	• Survey-based reporting:
	  ○ Certain population-based surveys include questions about known HV status. Although this information may be subject to under-reporting bias, when combined with survey-related HIV testing it can provide an estimate of known status among survey respondents.
	  ○ Many population-based surveys include questions on HIV testing history. These questions can provide a range for the proportion of PLHIV with known status. The percentage of people living with HIV in the survey who have been tested in the past 12 months and received the results provides the upper range of known status (there will be a small proportion equal to the annual incidence rate – less than 2% in most cases – of people who might have converted in the 12 months after being tested). The percentage of people living with HIV in the survey who have ever been tested and received the results provides the lower range of known status.
	  ○ When using survey-based methods, note that:
	  ▪ Household surveys are often restricted to respondents of reproductive age (15– 49), and so may not be representative of people living with HIV <15 years and >49 years.
	  ▪ Because household surveys are typically only done every five years, data from non-recent surveys may not reflect current levels of testing coverage.

Disaggregations:

Numerator Disaggregations:

Disaggregate Groups	Disaggregates
Age/Sex [Required]	• <15 F/M, 15+ F/M
Sex-Only [Conditional, if age/sex reporting is not possible]	• Female • Male

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	PLHIV Estimates	Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [PLHIV estimates submitted in the PEPFAR Implementation and Planning Attributes].
Data entered by:	This data should be entered in DATIM by the USG country team.	
Targets:	Not required.	
Guiding narrative questions:	1. Describe how the number of individuals diagnosed was calculated or estimated.	

TX_CURR_NAT

Description:	Percentage of people living with HIV receiving antiretroviral therapy
Numerator:	Number of PLHIV on ART at the end of the reporting period
Denominator:	Number of people living with HIV (PLHIV Estimate)
Indicator changes (MER 2.0 v2.2 to v2.3):	• Fine age/sex disaggregations added.
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	ART coverage is the second 90 of the global target, and an important step in ending the AIDS epidemic. Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among those living with HIV, and onward HIV transmission. Studies have also shown that early initiation, regardless of an individual's CD4 cell count, can enhance treatment benefits and save lives, and WHO currently recommends treatment for all. The percentage of adults and children receiving antiretroviral therapy among all adults and children living with HIV provides a benchmark for monitoring global targets over time and comparing progress across countries. It is one of the 10 global indicators in WHO's 2015 Consolidated strategic information guidelines for HIV in the health sector. This indicator is harmonized with GARPR indicator 1.2: http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf
How to collect:	This indicator measures the progress towards providing antiretroviral therapy to all people living with HIV. The data source for this indicator is ART program monitoring tools, such as ART patient registers, pharmacy dispensing records, and summary reporting forms. The number of adults and children receiving treatment can be obtained through data from facility- based antiretroviral therapy registers or drug supply management systems. Data should be collected continuously and aggregated on a monthly or quarterly basis to obtain subnational and national totals. The most recent full year of data should be used for annual reporting. Data should be collected from health facility recording and reporting forms, program data, health information system. This indicator can be generated by counting the number of adults and children receiving antiretroviral therapy at the end of the reporting period. This value should equal the number of adults and children who have ever started antiretroviral therapy minus those not currently on treatment prior to the end of the reporting period. This will exclude those who died, stopped treatment or were lost to follow-up during the year. Some people pick up several months of antiretroviral medicines (ARVs) at one visit, which could cover the last months of the reporting period. Efforts should be made to include these people in the numerator as receiving antiretrovirals even if they do not attend the clinic in the last month of the reporting period. When disaggregating the numerator by age, people receiving antiretroviral therapy should be reported in the relevant age category based on their age at the end of the reporting year. HIV- positive pregnant women who are on antiretroviral therapy should be included in the numerator. People receiving antiretroviral therapy in the private and public sectors should be included where data are available.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates

	Age/Sex (Fine) [Required, if possible]	• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M
	Age/Sex (Coarse) [Conditional, if finer is not possible]	• <15 F/M, 15+ F/M
	Sex-Only [Conditional, if both fine age/sex and coarse age/sex are not possible]	• Female • Male
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	PLHIV Estimates	Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [PLHIV estimates submitted in the PEPFAR Implementation and Planning Attributes].
Data entered by:	This data should be entered in DATIM by the USG country team.	
Targets:	Host countries often set targets by OU and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). Targets should align with the 95-95-95 UNAIDS HIV response initiative. If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.	
Guiding narrative questions:	1. Describe the data systems and methods of aggregation used at the national and subnational levels to report treatment data. 2. Outline any work that the host country government has done to ensure that the reported figures are accurate (i.e., data quality assessments, results adjustment, etc.). 3. Discuss progress towards aligning host-country age/sex disaggregations to standard five-year age and sex bands? 4. For targets, please describe the host country target setting process.	

VL_SUPPRESSION_NAT

Description:	Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period
Numerator:	Number of people living with HIV and on ART [in the reporting period] who have a suppressed viral load (<1000 copies/mL)
Denominator:	Number of people living with HIV (PLHIV Estimate)
Indicator changes (MER 2.0 v2.2 to v2.3):	• Fine age/sex disaggregations added.
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	Viral suppression is the third and last 90 of the global target, and the ultimate goal of the HIV treatment cascade. Patients on ART who achieve and maintain viral suppression minimize their risk of disease progression and HIV transmission. Viral suppression is a critical quality of service quality; unsuppressed viral load can be indicative of suboptimal treatment adherence and can lead to the development and spread of drug resistance. This indicator is harmonized with GARPR indicator 1.4 http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf
How to collect:	The numerator can be generated by counting the number of adults and children receiving antiretroviral therapy who have a suppressed viral load at the end of the reporting period. Count the patient if, during the reporting months, viral load has been recorded and is <1000 copies/mL. For countries with other thresholds (e.g., undetectable <50 copies/ml or <400 copies/ml), preliminary evidence from several studies suggests the proportion of those with 50 copies/ml or above and less than 1000 copies/ml is small, so no adjustment is required. The testing threshold value should be reported in the narrative for countries with thresholds other than <1000 copies/ml. Viral-load testing should be routine rather than targeted (e.g., when treatment failure is suspected). If multiple viral-load tests are done annually for a person, only the last routine test result should be reported. Results from targeted viral loads should not be reported. If viral-load testing coverage is less than 75% of those receiving antiretroviral therapy in the reporting year, results should be interpreted with caution. Tools for measuring viral load may vary across countries. Routine viral-load suppression tests from clinical and program data should be reported where available. In countries where such data are not available, results from HIV population-based surveys or drug-resistance surveys based on a random sample of people on antiretroviral therapy may be reported. Countries should report the source of the numerator and denominator data, and data from both sources should be reported if available, although clinical and program data are preferred. If results from a survey are used, that should be included when reporting. Where clinical and program data are available from routine monitoring systems, results will be recorded in patient files or in a laboratory system. Data should be de-duplicated where patients receive multiple viral-load tests in a year. If an HIV population-based or drug-resistance survey is used in place of routine program monitoring data, measurement of viral load should be done for the entire population of HIV-positive individuals where ARV is detected in specimens. Self-reported treatment status has been shown to be of limited quality. Therefore, viral-load estimates among those who report receiving antiretroviral therapy should not be used.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates

<table>
<tr><td></td><td>Age/Sex (Fine)
[Required, if possible]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M</td></tr>
<tr><td></td><td>Age/Sex (Coarse)
[Conditional, if finer is not possible]</td><td>• <15 F/M, 15+ F/M</td></tr>
<tr><td></td><td>Sex-Only
[Conditional, if both fine age/sex and coarse age/sex are not possible]</td><td>• Female
• Male</td></tr>
<tr><td></td><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>PLHIV Estimates</td><td>Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [PLHIV estimates submitted in the PEPFAR Implementation and Planning Attributes].</td></tr>
<tr><td>Data entered by:</td><td colspan="2">This data should be entered in DATIM by the USG country team.</td></tr>
<tr><td>Targets:</td><td colspan="2">Host countries often set targets by OU and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). Targets should align with the 95-95-95 UNAIDS HIV response initiative. If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. Describe the data systems and methods of aggregation used at the national and subnational levels to report treatment data.
2. Outline any work that the host country government has done to ensure that the reported figures are accurate (i.e., data quality assessments, results adjustment, etc.).
3. Discuss progress towards aligning host-country age/sex disaggregations to standard five-year age and sex bands?
4. For targets, please describe the host country target setting process.</td></tr>
</table>

PMTCT_STAT_NAT

Description:	Percentage of pregnant women with known HIV status
Numerator:	Number of pregnant women attending antenatal clinics (ANC) and/or had a facility-based delivery and were tested for HIV during pregnancy, or already knew they were HIV positive
Denominator:	Number of pregnant women who attended ANC or had a facility-based delivery in the past 12 months
Indicator changes (MER 2.0 v2.2 to v2.3):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	The risk of mother-to-child transmission (MTCT) can be significantly reduced by providing ARVs to the mother during pregnancy, delivery and (if applicable) breastfeeding. This indicator provides information on coverage of the first step in the prevention of mother-to-child transmission (PMTCT) cascade. High coverage enables early initiation of care and treatment for HIV-positive mothers. The total number of identified HIV-positive women provides the facility-specific number of pregnant women with HIV to start a facility-based PMTCT cascade. This indicator is harmonized with GARPR indicators 2.6 (http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf)
How to collect:	For the numerator and denominator: The data source is ANC, PMTCT and L&D program monitoring tools, such as patient registers and summary reporting forms. Numerator: Count all women who were enrolled in ANC during the 12-month reporting period whose HIV status is known positive, or who received an HIV test result (positive or negative) during ANC. Reconcile with all women in the L&D register who whose date of delivery was in the 12 months reporting period and whose HIV status at L&D was known positive, or who received an HIV test result (positive or negative) at ANC or L&D to avoid double counting. The numerator is a composite of the following two data components: 1. The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period 2. The number of women attending ANC, L&D who were tested for HIV and received results The numerator can be summed from categories a-d below: a. Number of pregnant women with unknown HIV status attending ANC who received an HIV test and result during the current pregnancy b. Pregnant women with known HIV infection attending ANC for a new pregnancy c. Number of pregnant women with unknown HIV status attending L&D who received an HIV test and result during their current pregnancy d. Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested for the first time in the current pregnancy and received results. A “status” is defined as a confirmed test result from a test during this pregnancy (either positive or negative) or already known HIV infection at antenatal clinic entry. An indeterminate test result should not be counted or reported as a part of this indicator. For the denominator: Count all women who were enrolled in ANC during the 12-month reporting period OR delivered at the facility (recorded in the L&D register), reconciling the latter with the former using the ANC No. to avoid double counting. As per global guidance (see GARPR link above), it is expected that the national program can reconcile information collected from ANC with L&D records. However, in MER 2.0 the PEPFAR indicator for PMTCT_ART has been simplified to collect information only at antenatal care (ANC) sites to better align with 2016 WHO Consolidated ARV guidelines,

<table>
<tr><td></td><td>reduce burden on data collection, and improve data quality. Therefore, in reporting this indicator PEPFAR operating units should 1) utilize the national system whether it is able avoid double counting or not and are not expected to collect or report this information through a separate system 2) if it this is not possible to report individuals from both ANC and L&D, please include an explanation in the narrative whether the data is from ANC, L&D and/or both.

Pregnant women’s HIV status should be counted only once per pregnancy. This may be difficult if national guidelines recommend testing a pregnant woman more than once during a pregnancy or if a woman seroconverts during her pregnancy and has multiple tests.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Disaggregated by Status [Required]</td><td>• Known positives
• New positives
• New negatives</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>None</td><td>None</td></tr>
</table>
</td></tr>
<tr><td>Data entered by:</td><td>This data should be entered in DATIM by the USG country team.</td></tr>
<tr><td>Targets:</td><td>Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.</td></tr>
<tr><td>Guiding narrative questions:</td><td>1. Narratives should include information on how national and subnational totals have been derived for both results and targets.
2. Provide context for poor performance in PMTCT_STAT coverage (Numerator/Denominator = STAT coverage) by geographic area. Include any planned activities/remedial actions.</td></tr>
</table>

PMTCT_ART_NAT

Description:	Percentage of HIV-positive pregnant women who received antiretroviral medicine (ARV) during pregnancy to reduce the risk of mother-to-child transmission
Numerator:	Number of HIV-positive pregnant women who delivered and received ARV to reduce the risk of mother-to- child transmission during pregnancy and delivery.
Denominator:	Estimated number of HIV-positive pregnant women
Indicator changes (MER 2.0 v2.2 to v2.3):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	The risk of mother-to-child transmission can be significantly reduced by providing ARVs for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretroviral medicines to the mother or child if breastfeeding, and the use of safe delivery practices and safer infant feeding. The data will be used to track progress towards global and national goals of eliminating mother-to-child transmission; to inform policy and strategic planning; for advocacy; and for leveraging resources for accelerated scale-up. It will help measure trends in coverage of antiretroviral prophylaxis and treatment, and when disaggregated by regimen type, will also assess progress in implementing more effective antiretroviral therapy regimens. As the indicator usually measures ARVs dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases. This indicator is harmonized with GARPR indicator 2.3: (http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf)
How to collect:	For the numerator: the source of this information is national program records aggregated from program monitoring tools, such as patient registers and summary reporting forms. The numerator can be generated by counting the number of HIV-positive pregnant women who received antiretrovirals to reduce MTCT in the reporting period, by regimen. For the denominator: Two methods can be used to estimate the denominator: an estimation model, such as Spectrum, using the output, number of pregnant women needing PMTCT; or, if Spectrum estimates are not available, by multiplying the number of women giving birth in the past 12 months (which can be obtained from estimates of the central statistics office, United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in ANC and appropriate adjustments related to coverage of ANC surveys).
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Maternal Regimen Type [Required]	• New on ART • Already on ART

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
None	None

Data entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.

Guiding narrative questions:	1. Narratives should include information on how national and subnational totals have been derived for both results and targets. 2. Provide context for low PMTCT_ART coverage (PMTCT_ART_NAT / PMTCT_STAT_POS_NAT = ART coverage) by geographic area or partner/implementing mechanism, including any planned activities/remedial actions.

VMMC_CIRC_NAT

Description:	Number of males circumcised during the reporting period according to national standards
Numerator:	Number of males circumcised during the reporting period according to national standards
Denominator:	N/A
Indicator changes (MER 2.0 v2.2 to v2.3):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	There is compelling evidence that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions in which heterosexual activity plays a significant role in HIV transmission. This indicator is harmonized with GARPR indicator 3.17 (http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf) Males should be provided with circumcision as part of the VMMC for HIV prevention program and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia, or other WHO normative guidance (in the case of device-based VMMC), and per national standards by funded programs/sites in the reporting period meet the definition for the numerator. Males who are provided with circumcision using a medical device by funded programs/sites in the reporting period also meet the definition for the numerator as long as the device used is recognized or pre- qualified by WHO.
How to collect:	This indicator measures the progress in scaling up male circumcision services and should be calculated by counting male clients documented as having received VMMC within the reporting period from VMMC Registries or clients' medical records maintained by programs at Priority SNU level. Data should be collected from health facility recording and reporting forms, program data, health information system, or data maintained at Priority SNU level.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Age (Fine) [Required, if possible]	• <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+
Age (Coarse) [Conditional, if finer is not possible]	• <15, 15-29, 30+

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
N/A	N/A

Data entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.

Guiding narrative questions:	1. Narratives should include information on how national and subnational totals have been derived for both results and targets. 2. What barriers are there to further scaling up VMMC services in the country?

VMMC_TOTALCIRC_NAT

Description:	Percentage of men ever circumcised
Numerator:	Total number of men ever circumcised
Denominator:	Total population of men in the corresponding age category
Indicator changes (MER 2.0 v2.2 to v2.3):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	There is compelling evidence that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions in which heterosexual activity plays a significant role in HIV transmission. This indicator is harmonized with GARPR indicator 3.16: (http://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf)
How to collect:	Estimates derived from population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Surveys or other representative surveys); this indicator will help to determine male circumcision prevalence. The total number of men circumcised should include all men circumcised regardless if circumcised at birth, as part of the VMMC program or at any other time during their lifetime. The denominator for this indicator is the number of male populations estimates, disaggregated by age (<15, 15-29, 30+). This information is collected under the population estimates indicator in the IMPATTS (Implementation and Planning Attributes). A guide to indicators for male circumcision programs in the formal health care system. Geneva, World Health Organization/UNAIDS, 2009. http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Age	• <15, 15-29, 30+

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
Male Population Estimates, Disaggregated by Age	See guidance for inputting population estimates into DATIM. Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [Population estimates submitted in the PEPFAR Implementation and Planning Attributes].

Data entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.

Guiding narrative questions:	1. Narratives should include information on how national and subnational totals have been derived for both results and targets.

HRH_STAFF_NAT

Description:	Number of health workers who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) based out of PEPFAR-supported facility sites.
Numerator:	Number of health workers who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) based out of PEPFAR-supported facility sites.
Denominator:	N/A
Indicator changes (MER 2.0 v2.2 to v2.3):	Indicator has moved from being a standard MER indicator to host country reporting. Indicator should be reported by USG.
Reporting level:	Report at all PEPFAR-supported site: This indicator is the number of occupied positions working on HIV based out of PEPFAR facility sites.
Reporting frequency:	Annually
How to use:	This indicator is the total number of staff working on HIV based out of PEPFAR facility sites. This includes staff engaged in community work, but who are supported and based out of a PEPFAR supported facility. This includes but is not limited to Community Health Workers (CHWs) engaged in outreach, ARV delivery, or working as Linkage Officers, Peer Navigators, or Adherence Group coordinators. This is NOT a cumulative total, but a one-time count undertaken during the final quarter. Only filled staff positions at respective facility should be counted. For this indicator, a “PEPFAR supported site” should include any facility site in the PEPFAR geographic organizational hierarchy list in DATIM, which also reported any site-level programmatic target or result during the same reporting period. Omit facilities which were previously supported by PEPFAR but were not assigned any targets nor reported any results for any program area during the same reporting period. Include all health care workers irrespective of whether any or all are receiving PEPFAR support (this is captured in HRH_CURR). We do NOT need any workers reported at the community level for this indicator; workers supported by the government or other organizations, but not based out of a PEPFAR supported facility should not be reported. HIV/AIDS has placed significant demands on the already constrained health workforce in many low-income countries. The rapid scale-up of ART is placing additional demands on the health workforce. In the majority of PEPFAR countries, there are overall shortages of HRH, particularly in rural and remote areas, leading to insufficient numbers of health workers according to internationally recommended levels (2.3 doctors, nurses, midwives/1,000 population). Many countries experience HRH shortages and/or imbalances by population densities (e.g., HRH shortages in rural areas) that are not related to population health needs, including HIV epidemiology. Addressing density, distribution, and overall utilization of HRH is important in increasing access to HIV services. This indicator allows PEPFAR to analyze the availability of staff to provide HIV services at PEPFAR supported facilities. Data should be reviewed against site target achievement and investment. The first year of data collection will serve as an Integral benchmark for continued analysis. Teams can also look at this indicator in conjunction with HRH_CURR that captures number of PEPFAR supported workers at PEPFAR-supported sites. This will allow PEPFAR to conduct analysis to determine if the number of PEPFAR-supported staff is appropriate vis-à-vis the number of other staff at the facility providing HIV services. There is no universal benchmark against which to measure these data and no ideal PEPFAR to non-PEPFAR ratio. However, over time we would hope to see a decrease in the number of PEPFAR-supported staff. As this happens countries should carefully monitor any changes total number of staff working in HIV service delivery at sites and quality of services.

How to collect:

A "PEPFAR supported site" for the purpose of this indicator includes any facility site in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period.

Report all HRH at those sites who are working in HIV-related activities, regardless of whether they are supported by PEPFAR or not.

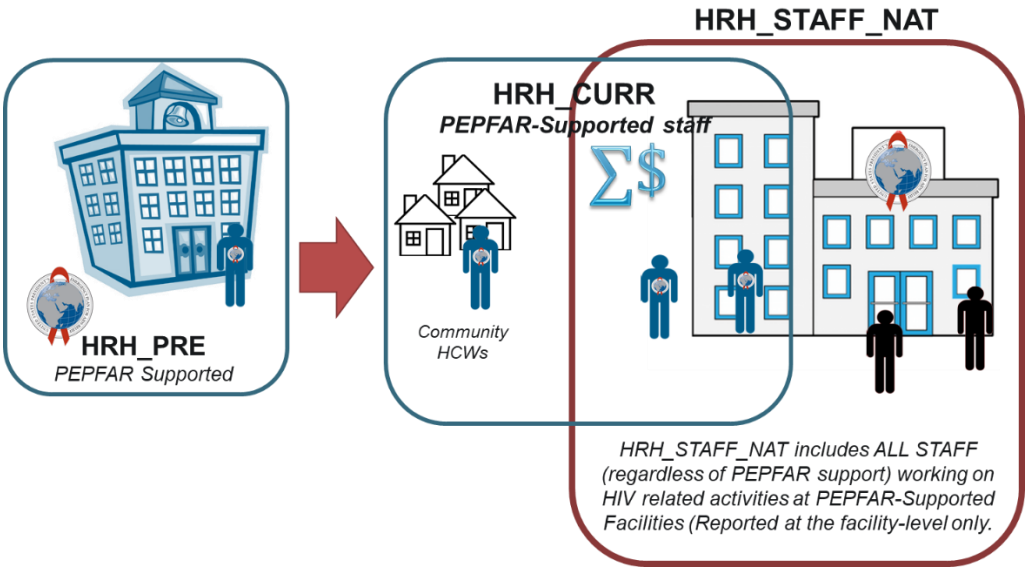
PEPFAR team should collect and report on this data during the last quarter of the year. Ideally this data would come from a MoH HRIS/HRID system, or a payroll system from a Ministry of Finance.

Total number of health workers should be reported.

Report HRH who are actively working on services or programs related to HIV at the time of data collection, not including staff who have resigned, absconded, are dismissed, are pending hiring, or are on extended leave (e.g., for graduate studies). Unfilled positions or vacancies should not be included.

If possible, avoid collecting data across a period which spans across a major budgetary change or a health worker graduation and placement period.

The graphic below outlines the relationship between the HRH MER and host country indicators:



Disaggregations:

Numerator Disaggregations:

Disaggregate Groups	Disaggregates
By Cadre Category Type: [Required]	• Clinical • Pharmacy • Laboratory • Management • Social service • Lay • Other HCWs

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
N/A	N/A

Data entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Not required.
Guiding narrative questions:	1. For all categories of workers, including other, please provide description of specific cadres in the narrative when reporting.

KP_MAT_NAT

Description:	Percentage of people who inject drugs (PWID) on medication assisted therapy
Numerator:	Number of people who inject drugs (PWID) on medication assisted therapy
Denominator:	Estimated number PWID
Indicator changes (MER 2.0 v2.2 to v2.3):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	Medication assisted therapy programs should be an access point for PWID and the program should refer and link to ARV treatment programs, PMTCT for female PWID and a range of other prevention services. It is important to know how many people are reached in order to monitor how well programs are reaching PWIDs with medication-assisted treatment. This information can be used to plan and make decisions on how well the PWID audience is being reached with medication-assisted treatment. If a small percentage of the intended audience is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarters staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
How to collect:	The numerator is generated by counting the total number of individuals who have been on treatment for at least 6 months since initiation of medication-assisted treatment (e.g., using methadone or buprenorphine to treat drug dependency) at any point in time within the reporting period. The numerator should equal the number of adults who initiated and remain on medication-assisted treatment for at least 6 months prior to the end of the reporting period. Data should be collected continuously at the organization level as part of service delivery and aggregated in time for national reporting cycles.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Sex [Required]	• Female • Male

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
Estimated number PWID	See guidance for inputting population estimates into DATIM. Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [Population estimates submitted in the PEPFAR Implementation and Planning Attributes].

Data entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting period in addition to, at a minimum, the PEPFAR planned targets.

Guiding narrative questions:	1. Narratives should include information on how national and subnational totals have been derived for results. 2. Narratives should discuss the national policy environment and future plans for MAT at the national level.

APPENDICES

APPENDIX A: KEY POPULATIONS CLASSIFICATION DOCUMENT

Key Population Classification (core)	**6/14/2016**
This assessment was developed to be used in both community and facility health care settings for the purpose of helping providers identify the types of services needed by the client. The complete form should be offered to all clients, regardless of providers' assumptions about whether the client is a key population member or not. Note- all script in normal text should be read out loud to the client, italicized text is instruction to the provider. **Health Care Provider script to Client:** "I will be asking you about some sexual and drug using risk behaviors. Your responses will help me/us provide you with better care. Your answers to these questions will be kept in your confidential clinic record. Answering these questions is voluntary and you can refuse to answer any question and still receive the service you've come here for today."	
1. Do you consider yourself: male, female, transgender or other? □ MALE □ FEMALE □ TRANSGENDER (male to) FEMALE □ TRANSGENDER (female to) MALE □ _____OTHER □ REFUSE TO ANSWER	*If TRANSGENDER (male to) FEMALE: client was born a boy, but identifies as a woman* *If TRANSGENDER (female to) MALE: client was born a girl, but identifies as a man*
2. What was your sex at birth: male or female?	□ MALE □ FEMALE □ _____OTHER □ REFUSE TO ANSWER
3. Do you have sex with: men, women or both?	□ MEN ONLY □ WOMEN ONLY □ BOTH MEN AND WOMEN □ REFUSE TO ANSWER
4. Is selling sex your main source of income?	□ YES □ NO □ REFUSE TO ANSWER
5. In the last 6 months, have you injected illicit or illegal drugs?	□ YES □ NO □ REFUSE TO ANSWER

Key Population Classification	
If client answers Male to Q1 and answers Men Only or Men and Women to Q3, then classify as MSM	□
If client answers Transgender MTF or FTM to Q1, or if client identifies as a gender different from their birth sex, then classify as TG	□
If client answers Yes to Q4, then categorize as SW	□
If client answers Yes to Q5, then classify as PWID	□
If client is currently incarcerated, then classify as Person in Prison	□
Final Classification: (*mark *ALL* that apply*) □MSM □TG □SW □PWID □Person in Prison □NONE *Some clients may belong to more than one category due to overlapping vulnerabilities and behavior	

Key Populations Team, HIV Prevention Branch, CDC-Atlanta (Version 3.1)

APPENDIX B: IMPLEMENTATION AND PLANNING ATTRIBUTES (IMPATT)

Attributes	Numerator and Denominator (Disaggregations)	Reporting Level			
		Country	*PSNU*	*Community Site/SNU*	*Facility*
Planning Attributes					
POPULATION ESTIMATE	The total midyear population estimate *Disaggregation*: • Fine Age/Sex • Coarse Age/Sex	**X**	**X**		
HIV PREVALENCE ESTIMATE	The prevalence of HIV in the adult population *Disaggregation*: • Coarse Age/Sex • Sex	**X**	**X**		
PLHIV ESTIMATE	The number of adults and children living with HIV *Disaggregation*: • Fine Age/Sex • Coarse Age/Sex	**X**	**X**		
KP ESTIMATE	Number of people engaging in defined behaviors (men who have sex with men, sex workers, people who inject drugs), or belonging to defined groups (transgender people, inmates/detainees), associated with increased risk of HIV infection *Disaggregation*: By defined key population: Sex workers, PWID, MSM, Transgender people, Persons in prisons or other closed settings	**X**	**X**		
Implementation Attributes					
Prioritization Type	Prioritization is assigned annually during COP **PSNU Options:** Attained, Scale-Up: Saturation, Scale-Up: Aggressive, Sustained, Sustained: Commodities, Centrally Supported, Not PEPFAR Supported* **Community/Facility Options:** Scale-Up, Sustained, Centrally Supported, Not PEPFAR Supported		**X**	**X**	**X**
SIMS Volume	Each OU has developed a unique algorithm for identifying “high volume” SIMS facilities and communities. Field available for each community and facility to indicate if the site is high volume (yes/no).			**X**	**X**

APPENDIX C: DREAMS SNU REPORTING REQUIREMENTS

Indicator	Required Disaggregations for DREAMS	Who should report?
AGYW_PREV	**LAYERING/TIME in DREAMS by AGE/SEX** Age/sex: Females 10-14, 15-19, 20-24, 25-29 Layering: # AGYW completed at least one DREAMS service; completed full primary package; completed full primary package and additional secondary service Time in DREAMS: 0-6 months, 7-12 months, 12-24 months, 25+ months	USG inputs into DATIM based on data from all DREAMS implementing partners
GEND_GBV	**VIOLENCE SERVICE TYPE by AGE/SEX** Sexual Violence Females: 10-14, 15-19, 20-24 Physical and/or emotional violence Females: 10-14, 15-19, 20-24	All partners delivering post violence care services
HTS_TST	**SERVICE DELIVERY MODALITY/AGE/SEX/RESULT** Service Delivery Modalities Index testing, Home-based testing, Mobile testing, VCT testing, Other community testing platforms, Inpatient, PMTCT (ANC1 only), PMTCT (Post ANC1) TB, VMMC, other PITC, VCT, Index testing ***For each service delivery modality listed above, disaggregate by Age/Sex/Result below:*** Males/ Females Positive: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+ Negative: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+	All partners delivering HTS
KP_PREV	**KEY POPULATION TYPE** Key population type: Female Sex Worker (FSW)	All partners delivering KP prevention
OVC_SERV	**AGE/SEX** Females: 10-14, 15-17, 18+	All partners delivering OVC services
PMTCT_STAT	**POSITIVITY STATUS/AGE** Females Known Positive at Entry: 10-14, 15-19, 20-24 Newly Tested Positive: 10-14, 15-19, 20-24 Known Negatives: 10-14, 15-19, 20-24	All partners delivering PMTCT services
PP_PREV	**AGE/SEX** Females: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+	All partners delivering prevention services
PrEP_NEW	**AGE/SEX** Females: 15-19, 20-24, 25-29	All partners delivering PrEP
PrEP_CURR	**AGE/SEX** Females: 15-19, 20-24, 25-29	All partners delivering PrEP
TX_NEW	**AGE/SEX** Males: 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+	All partners providing treatment services
TX_CURR	**AGE/SEX** Males: 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+	All partners providing treatment services
TX_PVLS	**AGE/SEX** Males: 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+	All partners providing treatment services
VMMC_CIRC	**AGE** Males: 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+	All partners delivering male circumcision services

APPENDIX D: ILLUSTRATIVE ELIGIBLE SERVICES FOR ACTIVE OVC BENEFICIARIES (CHILDREN AND CAREGIVERS)

Overview: The table describes illustrative services for active OVC beneficiaries, both children and caregivers, organized by domain (HEALTHY, SAFE, SCHOOLED, STABLE) and beneficiary segment eligible for the service. The "all children" column indicates that any child or adolescent may be counted if they receive the service and meet the other requirements for active status (i.e., a current case plan and at least quarterly monitoring). The "caregiver and child" column indicates the activity completed by the caregiver may be counted toward both the child and caregiver as it provides direct benefit to the child. Services with a mark in both one of the child columns and the caregiver columns indicate the activity may be provided to and directly benefit a child and/or a caregiver; if a caregiver receives such a service, it may only be counted towards the caregiver and not both the caregiver and the child (in contrast to activities checked in the "caregiver and child column". This list while comprehensive is not exhaustive. For services that are not captured in the list, local USG funding agency approval must be received in order to count these services towards active OVC status.

Beneficiary received directly from project, was facilitated to obtain (e.g., transport subsidy, accompaniment), or has a completed referral, for at least one of the following services in each of the preceding two quarters:	All children	Infants and young children	Adolescents	Caregivers	Caregiver and child[1]
HEALTHY					
1. Individual health insurance coverage or health access card	✓				
2. Family health insurance coverage or health access card					✓
3. Insecticide Treated Mosquito net (ITN)	✓				
4. Age-appropriate HIV treatment literacy (for CLHIV)	✓				
5. Age-appropriate counseling and HIV disclosure support[2]	✓			✓	
6. HIV adherence support	✓			✓	
7. Completed a referral for or was facilitated to obtain HIV-related testing (HTS, EID, TB, CD4 VL)	✓			✓	
8. Completed a referral for or was facilitated to obtain HIV (or related opportunistic infection) treatment and care	✓			✓	
9. Completed a referral for or was facilitated to obtain STI treatment	✓			✓	
10. Completed a referral for or was facilitated to obtain routine healthcare	✓				
11. Completed a referral for or was facilitated to obtain emergency health care	✓			✓	
12. Structured PLHA support group	✓			✓	
13. Completed a referral for or was facilitated to obtain Early Infant Diagnosis (EID)		✓			
14. Supplementary or therapeutic foods based on moderate or severe acute malnutrition status (per assessment, e.g., MUAC)		✓			
15. Completed a referral for or was facilitated to obtain immunization appropriate to age-based national protocol		✓			
16. Regularly[3] tracked developmental milestones in HIV affected, HEU and infected infants and young children		✓			
17. Completed referrals for developmental support for HEU and HIV infected children		✓			
18. Completed a referral for or was facilitated to obtain age-appropriate HIV prevention support, including PrEP, condoms and/or VMMC			✓	✓	
19. Completed a referral for or was facilitated to obtain age-appropriate women's health counseling and/or products, including condoms			✓	✓	

[1] Activity completed by the caregiver may be counted toward both the child and caregiver as it provides direct benefit to the child.
[2] Activity may be provided to and directly benefit a child and/or a caregiver. If a caregiver receives such a service, it may only be counted towards the caregiver and not both the caregiver and the child (in contrast to activities checked in the "caregiver and child column"
[3] Regular participation should be defined based on the specific intervention and the level of participation required to derive the full intended benefit. Because some interventions can take more than a year to complete, the intervention does not have to be fully completed in the quarter to be counted.

Beneficiary received directly from project, was facilitated to obtain (e.g., transport subsidy, accompaniment), or has a completed referral, for at least one of the following services in each of the preceding two quarters:	All children	Infants and young children	Adolescents	Caregivers	Caregiver and child[1]
20. Completed a referral for or was facilitated to obtain substance abuse support by a trained provider			✓	✓	
21. Completed a referral for or was facilitated to obtain perinatal care including PMTCT				✓	
22. Household hygiene counseling and WASH messaging					✓
SAFE					
23. Safety plan	✓				
24. Structured family group conferencing to prevent occurrence/ reoccurrence of child abuse, exploitation or neglect	✓				
25. Structured psycho-social support related to family conflict mitigation and family relationships					✓
26. Post-violence trauma-informed counseling from a trained provider	✓			✓	
27. Completed a referral for or was facilitated to obtain post-violence medical care	✓			✓	
28. Session with child protection officer, police, or other local child protection authority	✓				
29. Project-filed report of suspected abuse to child protection office, police or other local authority	✓				
30. Emergency shelter/care facility or kinship care placement and monitoring for children	✓				
31. Emergency shelter/care facility					✓
32. Legal assistance related to maltreatment, GBV, trafficking, exploitation	✓			✓	
33. Structured safe spaces intervention			✓		
34. Evidenced-based intervention on preventing HIV and violence, and in reducing and avoiding sexual risk			✓		
35. Caregiver participated in a structured, HIV-sensitive, evidence-based early childhood intervention with a trained provider					✓
36. Caregiver participated in an evidence-based parenting intervention to prevent and reduce violence and/or sexual risk of their children					✓
SCHOOLED					
37. Received regular assistance/ support with homework (e.g., homework club participation)	✓				
38. Received school uniform, books, or other materials	✓				
39. Received bursary, tuition, school fees or fee exemption	✓				
40. Received assistance for re-enrollment (i.e., for drop-outs or teen mothers)	✓				
STABLE					
41. Legal & other administrative fees related to guardianship, civil registration, or inheritance					✓
42. Succession plan					✓
43. Cash transfer or another social grant					✓
44. Short-term emergency cash support					✓
45. Evidenced-based food security intervention					✓
46. Caregiver or adolescent regularly participated in a market-linked economic strengthening activity such as: a. financial literacy training b. business skills training c. entrepreneurship training and support d. agribusiness training			✓		✓

Beneficiary received directly from project, was facilitated to obtain (e.g., transport subsidy, accompaniment), or has a completed referral, for at least one of the following services in each of the preceding two quarters:	All children	Infants and young children	Adolescents	Caregivers	Caregiver and child[1]
e. women's economic empowerment f. savings groups g. linkages to formal financial institutions (banks, credit unions, MFIS, etc.) h. numeracy training i. soft skills training (job readiness, borrower training, career planning, etc.) j. small business support (business planning, market linkages, etc.)					
47. Safe shelter-related repair or construction					✓

APPENDIX E: GLOBAL OVC GRADUATION BENCHMARKS MATRIX

GLOBAL ORPHANS AND VULNERABLE CHILDREN
GRADUATION BENCHMARKS MATRIX
Updated 7-06-2018

This document provides information on the minimum global benchmarks for OVC graduation. Benchmarks are organized by domain (healthy, stable, safe, and schooled) and key objective.

"Graduation" occurs when a child and caregiver enrolled in a PEPFAR OVC program are deemed to have become more stable and no longer in need of OVC project-provided services. For caregivers and children 17 or under[4] to be counted as graduated, all child and all caregiver beneficiaries in a household must meet ALL applicable (age and HIV status specific) graduation benchmarks established by PEPFAR for improving stability. Additional guidance and tools to facilitate implementation of these global minimum benchmarks is forthcoming.

1. DOMAIN - HEALTHY

1.1. KEY OBJECTIVE - INCREASE DIAGNOSIS OF HIV INFECTION

1.1.1. BENCHMARK: All children, adolescents, and caregivers in the household have known HIV status or a test is not required based on risk assessment

DATA SOURCES AND DEFINITIONS:

- Caregivers self-reported HIV positive or negative test results for children (0-9 years)/adolescents (10-17 years)
- For children without HIV status reported by caregivers, case manager has completed a PEPFAR approved HIV risk assessment for children/adolescent showing HIV test not indicated
- Caregivers self-reported HIV test results for HIV-Exposed Infants (HEI) at 18 months of age or at least one week after cessation of breastfeeding, whichever comes later
- Caregivers self-reported HIV positive or negative test results
- For caregivers without HIV status reported, the case manager has completed the PEPFAR HIV risk assessment showing HIV test not indicated

1.2. KEY OBJECTIVE - INCREASE HIV TREATMENT ADHERENCE, RETENTION AND VIRAL SUPPRESSION

1.2.1. (a) BENCHMARK: All HIV+ children, adolescents and caregivers in the household with a viral load result documented in the medical record and/or laboratory information systems (LIS) have been virally suppressed for the last 12 months.[5]

OR If viral load testing or viral load testing results are unavailable at clinic treating HIV+ beneficiaries, then:

1.2.1. (b) BENCHMARK: All HIV+ children, adolescents, and caregivers in the household have adhered to treatment for 12 months after initiation of antiretroviral therapy[6]

DATA SOURCES AND DEFINITIONS:

- ART clinicians confirmed that HIV+ caregivers/children/adolescents are virally suppressed or if viral load testing is unavailable, regularly attending appointments and picking up medications over the past 12 months; or
- HIV+ caregivers and caregivers of HIV children/adolescents self-report that they are regularly attending appointments and picking up medications over the past 12 months
- HIV+ caregivers and HIV+ adolescents 12 years and older self-reported that they have regularly taken medication without missing doses for the past 12 months.
- Caregivers for HIV+ children and adolescents younger than 12 years self-reported that children have regularly taken medication without missing doses for the past 12 months

1.3. KEY OBJECTIVE - REDUCE RISK OF HIV INFECTION

1.3.1. BENCHMARK: All adolescents 10-17 years of age in the household have key knowledge about preventing HIV infection

[4] OVC may be aged 20 or under if they are completing secondary education

[5] Beneficiaries whose earliest viral load test result was <12 months ago are ineligible to meet this benchmark.

[6] Beneficiaries who initiated ART <12 months ago, and those with a break in adherence during the 12-month period, are ineligible to meet this benchmark.

DATA SOURCES AND DEFINITIONS:

- Adolescents aged 10-17 can describe at least two HIV infection risks in their local community, can provide at least one example of how they can protect themselves against HIV risk, and can correctly describe the location of at least one place where HIV prevention support is available.

1.4. KEY OBJECTIVE - IMPROVE DEVELOPMENT FOR CHILDREN < 5 YEARS – PARTICULARLY HIV EXPOSED AND INFECTED INFANTS/YOUNG CHILDREN

1.4.1. BENCHMARK: No children < 5 years in the household are undernourished

DATA SOURCES AND DEFINITIONS:

- Case manager or health worker confirmed that children < 5 years had a mid-upper arm circumference measuring over 12.5cm and showed no sign of bipedal edema (e.g., pressure applied on top of both feet for three seconds and did not leave a pit or indentation in the foot)
- Clinician previously treating a child for malnutrition confirmed that child has a z score of > -2

2. DOMAIN – STABLE

2.1. KEY OBJECTIVE - INCREASE CAREGIVER'S ABILITY TO MEET IMPORTANT FAMILY NEEDS

2.1.1. BENCHMARK: Caregivers are able to access money (without selling productive assets) to pay for school fees and medical costs for children 0-17

DATA SOURCES AND DEFINITIONS:

- Caregivers self-report that school fees for children and adolescents incurred over the past two terms were covered by caregivers using non-PEPFAR resources *(e.g., Caregivers did not use PEPFAR-provided cash transfers or block grants or scholarships to pay school fees)*. Caregivers described where payment for the last two school terms for school-age children came from (e.g., household financial resources, government provided cash transfer, etc.), and the money to pay the expenses does not come from the selling of a productive household asset.
- Caregivers self-report that costs associated with medicines or transport to medical appointments for children, adolescents, and caregivers incurred over the past six months were covered by caregivers using non-PEPFAR resources *(e.g., Caregivers did not use cash transfers provided by PEPFAR to pay medical costs).* Caregivers described where payment for medical costs over the past six months came from *(e.g., household financial resources),* but the money to pay the expenses comes from a productive source and not from distress selling of household assets.

3. DOMAIN – SAFE

3.1. KEY OBJECTIVE - REDUCE RISK OF PHYSICAL, EMOTIONAL AND PSYCHOLOGICAL INJURY DUE TO EXPOSURE TO VIOLENCE

3.1.1. BENCHMARK: No children, adolescents, and caregivers in the household report experiences of violence (including physical violence, emotional violence, sexual violence, gender-based violence, and neglect) in the last six months

DATA SOURCES AND DEFINITIONS:

- Children over 12 years, adolescents, and caregivers self-reported no experiences of abuse, neglect, or exploitation in the last six months
- Caregivers reported no experience of abuse, neglect or exploitation in the last six months for children under age 12 years in their care

3.1.2. BENCHMARK: All children and adolescents in the household are under the care of a stable adult caregiver

DATA SOURCES AND DEFINITIONS:

- Caregivers identified by child/adolescents as their primary caregivers confirmed that they are adults (at least 18 years old), and have cared for and lived in the same home as the child/adolescent for at least the last 12 months

4. DOMAIN – SCHOOLED

4.1. KEY OBJECTIVE - INCREASE SCHOOL ATTENDANCE AND PROMOTION

4.1.1. BENCHMARK: All school-age children and adolescents in the household regularly attended school and progressed during the last year

DATA SOURCES AND DEFINITIONS:

- School administrators confirmed that school-age children/adolescents are enrolled in school and have not missed more than 80% of school days per month during the last six months when school was in session
- School administrators confirmed that school-age children/adolescents progressed from one grade to the next grade or graduated in the last school year

APPENDIX F: QUESTIONS AND ANSWERS TO POSSIBLE OVC_SERV REPORTING SCENARIOS

Q1. *How should we count a beneficiary <18 (or 18-20 if enrolled in secondary school) that has completed all services for which they are eligible and are needed, but has not met the graduation benchmarks?*
A1. If a beneficiary <18 has completed all services for which they are eligible but is not meeting graduation benchmarks (e.g., not virally suppressed, is at continuing risk of violence, etc.), the beneficiary should be counted as "active" if they continue to be monitored by the project on at least a quarterly basis to identify any service needs and have an updated case plan. NOTE: We anticipate this to be relevant for only a small number of beneficiaries, if any.

Q2. *How should we count a beneficiary <18 who has completed all services for which they are eligible and has met all the graduation benchmarks, but whose caregiver is still participating in a project provided intervention and has not met all benchmarks (and therefore no household members can graduate)?*
A2. If a child beneficiary has completed all eligible needed services and met the graduation benchmarks but has a caregiver who is still actively participating in a project provided intervention with direct benefit to the child (see Figure 1 caregiver and child column of services), the beneficiary should be counted as "active". If the caregiver has met the criteria to be counted as active (i.e., they received at least one eligible service in each of the preceding two quarters) but not met applicable graduation benchmarks, then the caregiver should be counted as active.
NOTE: While there should be a family-centered approach to OVC services that is inclusive of caregivers, it is not necessary that caregivers receive services to count a child as active.

Q3. *How should OVC beneficiaries who are under age 18 but who are the caregivers of child(ren) also enrolled in programming be treated for OVC_SERV reporting purposes?*
A3. OVC beneficiaries under age 18 who are also caregivers of OVC beneficiaries under age 18 may be counted as active by meeting the criteria for OVC under 18 (including having an updated case plan, at least quarterly monitoring, and receipt of an eligible service from Appendix F).

Q4. *When should a beneficiary <18 be counted as exited without graduation (e.g., moved, lost to follow up)?*
A4. If a beneficiary <18 has not received a service for which they are eligible in the preceding two quarters and they have not been transferred or graduated, and their caregiver has not received HES, parenting, or food security services, then the beneficiary should be counted as exited without graduation. This includes beneficiaries who move away, die, refuse services, or are otherwise unlocatable. An inactive beneficiary may become active again if they meet the criteria in a subsequent reporting period.

Q5. *A 12-year-old beneficiary received one service in the second quarter of the fiscal year, but no services in the first quarter of the fiscal year. She did have an updated case plan and received quarterly monitoring in both quarters but had enrolled in the prior fiscal year. Can she be counted as active?*
A5. No, she must receive at least one service in each of the preceding two quarters, plus have an updated case plan and a minimum of quarterly monitoring, to be counted as active (or, her caregiver must have received a service in each of the preceding two quarters that qualified in Appendix G to be counted at the level of the child). This is to assure timely receipt of needed services.

Q6. *A 19-year-old female continues to attend secondary school based on receipt of OVC project support. She is not a caregiver to any children receiving OVC project support. Should she be counted as active if she has an updated case plan and receives quarterly monitoring to ensure school attendance and progression?*
A6. Yes, OVC beneficiaries receiving project support in both of the previous two quarters to attend secondary school and meeting the criteria for an updated case plan and quarterly monitoring may be counted as active between ages 18-20.

Q7. *Can a beneficiary receive the same service in each of the preceding two quarters and be counted as active?*
A7. Yes, if the beneficiary continues to receive a service that spans more than two quarters and is based on assessment of current needs, they may be counted as active. For example, a project may pay school fees for a child in quarter one that cover school attendance for both quarters one and two. In this case the child would be counted as active. If school fees are paid for a full year and the child is still in school, this child should be counted as served.

Q8. *If a partner has received a transfer of OVC beneficiaries from another PEPFAR OVC partner, how should those beneficiaries be counted to avoid double-counting of an individual?*

A8. The partner that is transferring the OVC beneficiaries should report them under the disaggregate "Transferred out to a PEPFAR-supported partner." The receiving PEPFAR IP should ensure that the beneficiaries receive services in a timely manner to meet the criteria to count them as "active." Because the transfer disaggregate is not included in the OVC_SERV total numerator, there is no need to account for duplication.

Q9. *Our organization is providing a service that is not included in Appendix F, can we still count the beneficiary as active?*
A9. If a beneficiary is receiving an intervention not included in the illustrative services, local USG agency staff must approve an additional or alternative intervention to ensure it meets standards to be counted towards active status.

Q10. *Do home visits that provide psychosocial support, beyond care plan development and monitoring, count as a service?*
A10. Home visits that provide care plan development and monitoring without a specific service do not count as a service. However, evidenced-based interventions including structured interventions that take place in the home count as an intervention.

Q11. *What about short-term services (such as post-GBV care) which may both start and conclude in a quarter? Would an individual receiving these services then be counted as both active and graduated (i.e., double-counted)?*
A11. To be counted as graduated or active an individual must meet the appropriate requirements which are mutually exclusive. If a beneficiary <18 and all other child and caregiver beneficiaries in their household have met the benchmarks to graduate by the end of the reporting period, then the beneficiary should be counted as graduated for the reporting period, not as active.

Q12. *Can the same beneficiary be counted twice under OVC_SERV (active) if they are supported by both an OVC project and a DREAMS project?*
A12. No, the same beneficiary may be counted only once under OVC_SERV. Each implementing partner may count the beneficiary under OVC_SERV but should use the deduplication mechanism to ensure that the individual is only counted once. However, the same beneficiary may be counted under both OVC_SERV and AGYW_PREV. Please note that this means that it is not possible to discern the overlap between OVC_SERV and AGYW_PREV and to identify the number of individual beneficiaries who are receiving only DREAMS services, DREAMS plus OVC programming including case management and monitoring, or those receiving only traditional OVC programming including case management and monitoring. DREAMS beneficiaries enrolled ONLY in DREAMS are not expected to be classified as graduated, nor be counted for transferred or exited without graduation.

Q13. *Can we count AGYW enrolled in DREAMS aged 18-24 who are not also enrolled in OVC programming?*
A13. No, DREAMS only participants aged 18-24 should not be counted under OVC_SERV and instead should be counted under AGYW_PREV, PP_PREV, an/or other MER indicators relevant to the services that they have received.

Q14. *If an OVC beneficiary being served by a Peace Corps program completes their program, should they be counted as graduated?*
A14. No, if a beneficiary does not meet the graduation benchmarks they should not be counted as graduated. If a beneficiary received at least one service in each of the preceding two quarters from a Peace Corps partner, they should be counted as active.

Q15. Can we count an uncle living in the household who provides childcare on occasion and was connected with HIV testing through the program?
A15. No, avoid counting other adults/+18 years household members who are not primary caregivers (i.e., fulfilling the role of parent or guardian) of the enrolled children. While they may indirectly benefit from program support such as home visiting/counseling, family linkage to social grants, etc. or access a one-off service such as HTS, that does not meet the standard of increasing the primary caregiver's access to critical services and support. These other adults would not need to meet graduation benchmarks for the household.

APPENDIX G: DEATH REGISTRATION COVERAGE BY COUNTRY

Country	National death registration coverage rate, based on country	Source of National death registration coverage rate	National death registration with COD coverage rate (From either from MCCD or VA)	Source of National death registration with COD coverage rate	National death registration coverage rates, based on official UNSD Data	Year(s) for Official UNSD Data	Latest year that death registration data was submitted to UNSD from 2018 Population and Vital Statistics Report
Angola	-	-	-	-	-	-	-
Botswana	76.3%	http://www.statsbots.org.bw/sites/default/files/publications/Vital%20Statistics%20%202015.pdf	-	-	75%	2014	2014
Burundi	-	-	-	-	-	-	-
Cameroon	-	-	-	-	-	-	-
Cote d'Ivoire	-	-	-	-	-	-	-
DRC	-	-	-	-	-	-	-
Eswatini	55%	Unofficial	40%		less than 75%	2010-2015	-
Ethiopia	-	-	-	-	-	-	-
Ghana	19% (2013)	http://www.statsghana.gov.gh/docfiles/publications/CRVS%20Assessment%20Report%20Final_%2018.04.17.pdf	Limited	http://www.statsghana.gov.gh/docfiles/publications/CRVS%20Assessment%20Report%20Final_%2018.04.17.pdf	25%	2014	2013
Kenya	41%	Report: Mortality Trends in Kenya 2012-2016: Cause of death, trends, and data quality (March 2018)	33.1% (with MCCD)	Report: Mortality Trends in Kenya 2012-2016: Cause of death, trends, and data quality (March 2018)	45.6%	2014	2016
Lesotho	-	-	-	-	less than 75%	2010-2015	2012
Malawi	<10%	Unofficial	<10%	Unofficial	less than 50%	2008	-
Mozambique	-	-	-	-	-	-	-
Namibia	88.5%	http://pubdocs.worldbank.org/en/184451466711154296/1617304-Namibia-ID4D-Web.pdf	-	-	70%	2008	
Nigeria	12.5%	Unofficial	-	-	-	-	-
Rwanda	30% (2014/2015)	NISR (2015), referenced in 2016 report: https://www.unicef.org/rwanda/RWA_resources_crvscafinal.pdf	"practically no reliable CoD recorded"	https://www.unicef.org/rwanda/RWA_resources_crvscafinal.pdf	less than 75%	2010-2015	2012
South Africa	96% (2011-2016)	http://www.statssa.gov.za/publications/P03093/P030932016.pdf	92% (2015)	http://www.who.int/gho/mortality_burden_disease/registered_deaths/en/	75-89%	2008	2014
Tanzania	~16% (2017)	Unofficial	8% (VS)	2018 article: http://www.vitalstrategies.org/vital-stories/tanzania-cause-92-deaths-unknown-solution-better-data/	less than 75%	2010-2015	-
Uganda	<1% (2014)	https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Uganda-Investment-Case.pdf	-	-	-	-	-
Zambia	20% (2016)	Country Presentation made in 2018, by DNRPC (Department of National Registration, Passport and Citizenship)	20%	All registered deaths require a COD, rate assumed	-	-	-
Zimbabwe	-	-			-	-	-

APPENDIX H: PROPOSED HIV-SPECIFIC SHORT CAUSE OF DEATH LIST

Proposed HIV-specific short Cause of Death list, with ICD-10 codes mapped accordingly for reference

1. **HIV disease resulting in TB**
    a. B20.0 HIV disease resulting in mycobacterial infection – HIV disease resulting in tuberculosis
2. **HIV disease resulting in cancer**
    a. B21.0 HIV disease resulting in Kaposi's sarcoma
    b. B21.1 HIV disease resulting in Burkitt's lymphoma
    c. B21.2 HIV disease resulting in other types of non-Hodgkin lymphoma
    d. B21.3 HIV disease resulting in other malignant neoplasms of lymphoid, haematopoietic and related tissue
    e. B21.7 HIV disease resulting in multiple malignant neoplasms
    f. B21.8 HIV disease resulting in other malignant neoplasms
    g. B21.9 HIV disease resulting in unspecified malignant neoplasms
3. **HIV disease resulting in other infectious and parasitic diseases (*if PEPFAR wants, they can narrow this list and push some of these to #4 below)**
    a. B20.1 HIV disease resulting in other bacterial infections
    b. B20.2 HIV disease resulting in cytomegaloviral disease
    c. B20.3 HIV disease resulting in other viral infections
    d. B20.4 HIV disease resulting in candidiasis
    e. B20.5 HIV disease resulting in other mycoses
    f. B20.6 HIV disease resulting in Pneumocystis jirovecii pneumonia – HIV disease resulting in Pneumocystis carinii pneumonia
    g. B20.7 HIV disease resulting in multiple infections
    h. B20.8 HIV disease resulting in other infectious and parasitic diseases
    i. B20.9 HIV disease resulting in unspecified infectious or parasitic disease – HIV disease resulting in infection NOS
4. **Other HIV disease, resulting in other diseases or conditions leading to death**
    a. B22 HIV disease resulting in other specified diseases (including: encephalopathy, lymphoid interstitial pneumonitis, wasting syndrome, and others)
    b. B23 HIV disease resulting in other conditions (including: acute HIV infection syndrome, (persistent) generalized lymphadenopathy, haematological and immunological abnormalities, and others)
    c. B24 Unspecified HIV disease
5. **Other natural causes**
    a. Any patient who died from natural causes (including certain cancers and infections, etc.) that were not directly related to HIV disease
6. **Non-natural causes**
    a. Any patient who died from non-natural causes (e.g., trauma, accident, suicide, war, etc.)
7. **Unknown cause**
    a. Patients in whom cause of death was truly not known

PEPFAR

U.S. President's Emergency Plan for AIDS Relief