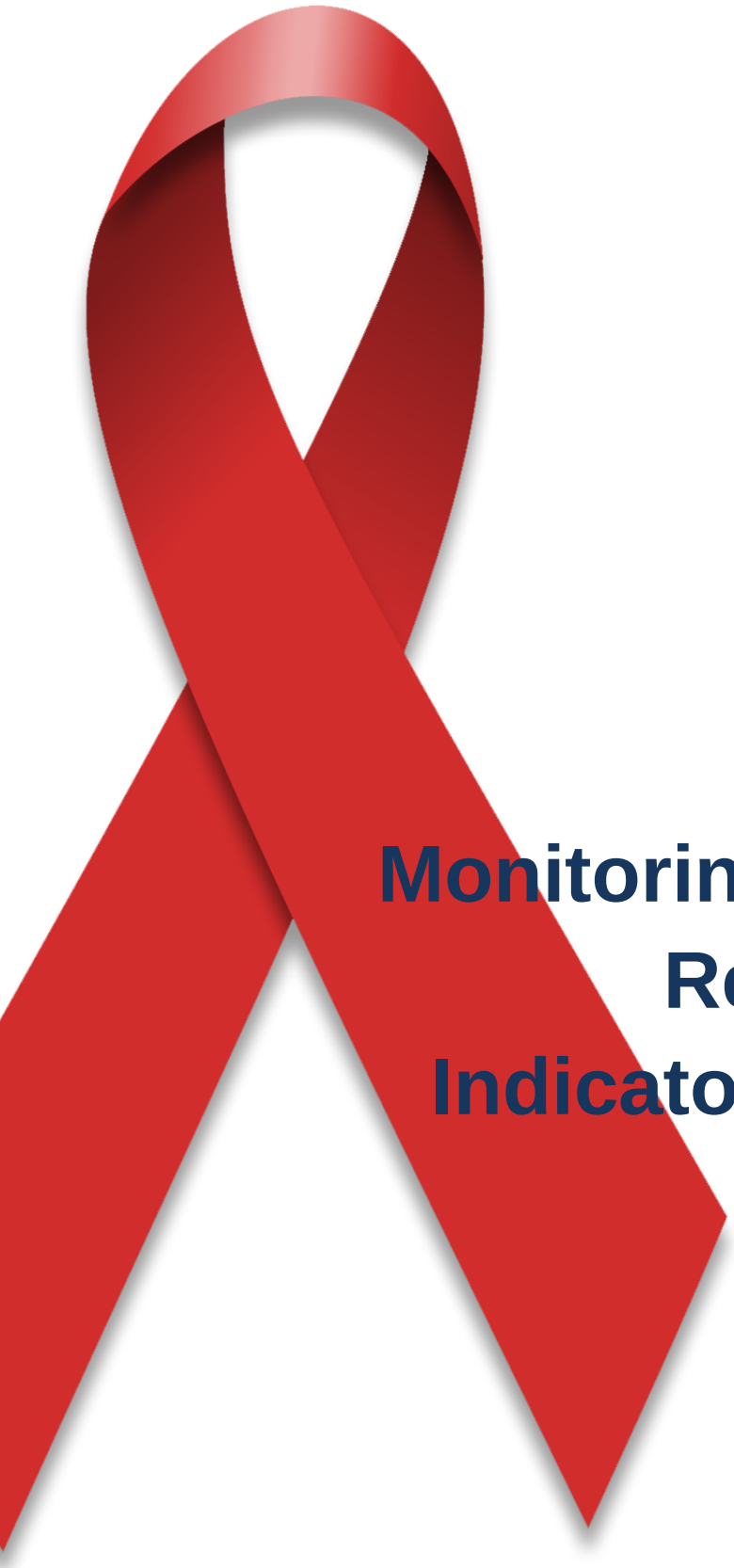

PEPFAR

Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide

Updated Release

January 2018
Version 2.2

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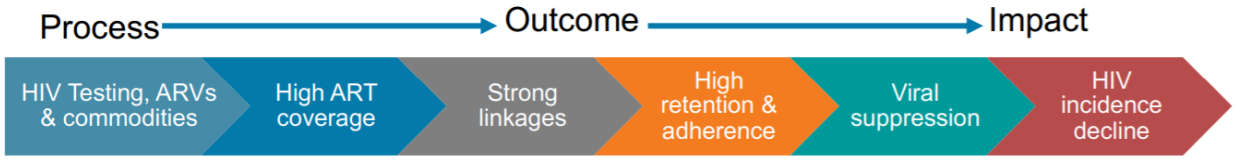
CONTENTS

ABBREVIATIONS

CQI	continuous quality improvement
DATIM	Data for Accountability, Transparency, and Impact
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
EID	early infant diagnosis
EMR	electronic medical record
FSW	female sex worker
GBV	gender-based violence
HEI	HIV-exposed infant
HIVST	HIV self-testing
HRH	human resources for health
HTS	HIV testing services
IP	implementing partner
KP	key populations
MER	monitoring, evaluation, and reporting indicators
MOH	Ministry of Health
MSM	men who have sex with men
OVC	orphans and vulnerable children
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
PT	proficiency testing
PVLS	patient viral load suppression
PWID	people who inject drugs
SID	sustainability index
SIMS	site improvement through monitoring systems
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

INTRODUCTION

PEPFAR's focus on optimizing impact is a driving force behind global efforts to reach HIV 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.



Given the global HIV progress over the past decade, planning, monitoring and resource allocation needs to 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 national and regional above-service delivery area support down to support provided for direct services at the site-level is paramount to PEPFAR's monitoring and reporting approach.

The objectives of the MER guidance document are to streamline and prioritize indicators for PEPFAR programs. As the PEPFAR MER Indicators were being updated the following was taken into consideration:

- Reduction of indicators to focus program monitoring on what matters most for epidemic control;
- Standardization of age, sex and key population disaggregations across the prevention and clinical cascades to monitor which populations are being reached with high quality evidence-based services, and to identify which populations are not being reached;
- Alignment of indicators with multilaterals and partner governments to avoid duplication of data collection where possible, and to focus on improved data and programmatic quality;
- Input from community stakeholders, technical experts, implementing partners, and PEPFAR field staff;
- Alignment with other PEPFAR data streams such as site improvement through monitoring systems (SIMS), financial monitoring, and the sustainability index (SID).

KEY CHANGES: MER 2.0 (V.1) TO MER 2.0 (V.2)

New Indicators:

HTS_SELF**:** HTS_SELF is a new indicator introduced for reporting beginning in Q1 of FY18. This indicator assesses the distribution of HIV self-test kits disaggregated by directly assisted versus unassisted self-testing. While age/sex disaggregates are requested for this indicator, it's important to remember that this indicator is assessing the distribution of self-test kits so the disaggregated data should be focused on the individual the self-test kit was distributed to and not necessarily the end use of the test kit. For more information and examples, please refer to the indicator reference sheet for HTS_SELF.

PMTCT_HEI_POS**:** PMTCT_HEI_POS is a new indicator for reporting beginning in Q1 of FY18. This indicator is being introduced in response to challenges with the former PMTCT_EID_POS indicator disaggregation in the collection of test results among those tests that were performed within the same quarter. Previously, a significant proportion of results were reported as "unknown" each quarter since results reporting was based on the date of DBS collection, but turnaround times from DBS collection to result return to site are often ≥4 weeks. DBS collected within 4 weeks of the end of the quarter generally did not have a result reported.

PMTCT_HEI_POS addresses these monitoring challenges by collecting only the positive results that returned during the reporting period. PMTCT_HEI_POS indicator was introduced to describe both early testing coverage and linkage of HIV+ infants to ART and to ensure collection of the number of infants identified as HIV+ in the first year of life that would be accurate and meaningful to program monitoring and planning. PMTCT_EID will continue to collect the virologic tests performed.

New Disaggregations:

AGE DISAGGREGATIONS**:** Data from the Population-Based HIV Impact Assessments (PHIA) provided valuable insight into the progress many PEPFAR countries have made towards achieving the 95-95-95 goals in all ages and sexes. Significant disparities in incidence and viral suppression among adults within the PEPFAR 25-49-year-old reporting age band lead 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. **Reporting on the new PEPFAR age bands will commence in FY18 Q2**.

New age bands: <1, 1-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, and 50+

Previous age bands: <1, 1-9, 10-14, 15-19, 20-24, 25-49, and 50+

Reporting on the new MER 2.0 (v2.2) will be introduced in FY 18. Country teams that are unable to meet the requirements for reporting the new age bands in FY 18 can continue reporting on the previous aggregated 25-49 year old age band through FY 18. However, **reporting on the new finer disaggregations to align with targets set is COP 18 is required beginning in FY 19**. Country teams should discuss barriers to reporting on the new disaggregations during COP 18 to determine what systems and resources can be realigned in FY 18 to ensure seamless reporting on the new age in Q1 of FY 19.

HTS_TST: Two new facility-based testing modalities have been introduced for FY18 reporting: emergency department and STI clinic. Please refer to the indicator reference sheet for HTS_TST for additional details on the new facility-based testing modalities.

LAB_PTCQI: A new disaggregate was introduced beginning in FY18 for the number of specimens received for testing at all PEPFAR-supported laboratories and point-of-care testing (POCT) sites within a testing category for the following categories: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, and CD4. LAB_PTCQI is an annual indicator so PEPFAR teams will begin reporting on this change at FY18 Q4.

Modifications to Existing Indicators

OVC_SERV: Requirements for OVC_SERV have changed significantly in FY 2018. The indicator calculation has been updated and OVC_SERV will return to being a snapshot indicator again for FY 18 reporting. Results should not be summed across reporting periods.

The numerator for OVC_SERV will be auto-calculated using the program participation status disaggregation for (1) active beneficiaries and (2) graduated beneficiaries. Beneficiaries that transferred or exited without graduation should no longer be reported in the numerator. However, these data will still be collected as OVC_SERV disaggregates.

Transferred will be further disaggregated into “transferred to a PEPFAR-supported partner” or “transferred to a non-PEPFAR-supported partner.”

These changes will be reflected in the data entry screens in DATIM beginning in FY 18 Q2.

Modifications to Existing Disaggregations

VMMC_CIRC: The VMMC follow-up status disaggregate has been updated to capture instances where post-VMMC follow-up did not take place within 14 days of the procedure or within the reporting period.

PREP_NEW: The KP type disaggregation for this indicator was updated to include ‘Other KP Type’ in addition to the MSM, TG, and FSW options that were already available.

OVC_SERV: The Age/Sex/Service Area disaggregate [DREAMS Conditional Disaggregate] was updated to include the age bands for children under 10 (<1, 1-9).

TB_PREV: Corresponding to the sharper focus of the End TB Strategy and the emphasis on TB prevention, we now report TB_PREV which identifies the proportion of patients that complete or are maintained on continuous preventive therapy. The disaggregation for “Type of TB preventive therapy” has been updated for FY18 reporting to include ART start (i.e., newly enrolled on ART vs. previously enrolled on ART). TB preventive therapy regimen disaggregates include IPT or an alternative TB preventive therapy regimen by newly or previously enrolled on ART.

TX_TB: TX_TB allows us to document the number of patients who are screened for TB and the proportion of those who are eventually started on TB therapy. This indicator also captures the number of ART patients who had a specimen sent for bacteriologic diagnosis (and type) of active TB disease. The denominator disaggregation for 'Screen Result' has been updated for FY18 reporting to include ART start to help understand if patients that screen for TB (i.e., either screen positive or screen negative) are either newly enrolled or previously enrolled on ART.

GEND_GBV: Age/sex disaggregations were added to the post-exposure prophylaxis (PEP) disaggregation. This change will help us to better understand which individuals are receiving PEP among those that have experienced sexual violence. GEND_GBV is an annual indicator so PEPFAR teams will begin reporting on this change at FY18 Q4.

Deleted Indicators

INVS_COMD: Indicator has been removed due to duplication with quarterly data submitted by principal supply chain mechanisms.

OVC ESSENTIAL SURVEY INDICATORS: The OVC MER Essential Survey Indicators are currently under review. Countries that have not yet started data collection should hold on conducting surveys until the review is complete. Countries that are in the process of data collection, or have already conducted at least one round, should continue as planned. Questions about the OVC MER essential survey indicators and related requirements can be directed to SGAC_SI@state.gov.

Deleted Disaggregations

HTS_TST: Home-based testing was removed as a community-based testing modality. Country teams that targeted for programming for FY18 within the home-based testing modality should assess the approaches outlined before implementation of these activities begins. Country teams were discouraged from planning home-based testing activities for COP 17 (FY18 implementation) as previous program data from this modality yielded sub-optimal results. Door-to-door and family testing activities targeted under this indicator should be reevaluated and shifted to alternative testing modalities that will lead to higher yield and greater programmatic progress towards the identification of positives.

PMTCT_EID: Infants' diagnoses through virologic test results (positive, negative, unknown) are no longer reported within this indicator beginning in FY18 Q1. PEPFAR is introducing the PMTCT_HEI_POS indicator which will now be used for reporting on those infants diagnosed HIV positive and their linkage to treatment. PMTCT_EID will still be collected to monitor the number of EID tests conducted.

HRH_CURR: Changes were made to the above-service delivery area reporting for this indicator. The 'Cadre Category & Support Type' disaggregation was updated to remove the 'Staff Receiving ONLY Non-Monetary Support (FTE)' option. Results should be reported at the above-service delivery area by cadre category and the following support types: 'Salaried Staff (FTE)' or 'Staff Receiving Stipends (FTE).' Requirements for HRH_CURR reporting at the facility and community-levels remain unchanged. This change goes into effect with FY17 Q4 reporting.

Indicator Clarifications

KEY POPULATIONS**:** Language changes for key populations categories were made to align with WHO guidance. 'Transgender' was changed to 'Transgender People.' 'People in prison and other enclosed setting' was changed to 'People in prison and other closed settings.'

In addition, KP guidance has been modified 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., FSW who injects drugs, MSM), 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 PrEP_NEW, HTS_TST, and TX_NEW. To better determine the KPs of interest for each indicator the key population classification document found in Appendix 1.

PMTCT_STAT*:* Clarifying language was added to the indicator definition. Data collected for this indicator should be testing data associated with **the first ANC visit** (ANC1) of the pregnancy. This reduces the risk of double counting pregnant women who could be tested multiple times during pregnancy.

TB_PREV*:* Language updated to note that this is a snapshot indicator like TX_CURR. Results should not be summed across reporting periods.

TX_TB*:* Language updated to note that this is a snapshot indicator like TX_CURR. Results should not be summed across reporting periods.

TX_PVLS: Clarifying language added to specify that only patients who have been on ART for at least 3 months should be counted under this indicator. This will ensure that all viral load test outcomes reported will be for patients who have been on ART long enough for it to be efficacious in reducing viral load. Shift in categorization of follow-up VL test done after an initial VL test result of VL>1,000. Follow-up viral loads done after an initial VL test result of VL>1,000 should be counted under routine and not targeted tests since all patients who receive an initial VL test result of VL>1000 should routinely receive a follow-up VL test after completing some enhanced adherence counseling. Guiding narrative questions were modified.

PEPFAR SUPPORT TO COMMUNITIES AND SITES

Completing the third year of quarterly site-level monitoring by all PEPFAR implementing agencies and implementing partners have 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 include all sites receiving 1 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.

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 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 site-specific activities have transitioned to government or other support, PEPFAR continues 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: PMTCT_STAT, PMTCT_ART, HTS_TST, TX_CURR, TX_NEW, and TX_RET. 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 moving the national program in their respective country to 90% ART coverage for PLHIV. Therefore, it is extremely important to have an understanding of the services being provided to PLHIV in the entire country.

Results for all centrally supported SNUs and sites should be reported for all 23 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) via the MOH data alignment process. Standard process countries that did not participate in the MOH data alignment process in FY 17 will be required to do so in FY 18.

DISAGGREGATED MONITORING

There are 3 categories of MER indicator disaggregations for the MER 2.0, which can be seen in the indicator reference sheets and the 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: Indicator disaggregates that are conditions include those for which some additional condition must be fulfilled. In MER 2.0 there are no full indicators that are conditional, but only additional disaggregations that are conditional based on additional funding or programming. There are two main types of conditional indicator disaggregations:

a. Disaggregations for those programs that have received additional funds for special programming such as DREAMS
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 national and subnational data), for which the partner has strong methodological sources (e.g., KP catchment area-denominator), or when it is both relevant and safe to enter the data at the site and/or community level (e.g., KP disaggregations for PrEP_NEW, HTS_TST, and TX_NEW).

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) national and sub-national level results narratives. Specific requirements are defined for each type of narrative. In addition, guiding narrative questions have been

introduced to provide additional technical detail and continuity within the narrative submitted across PEPFAR countries.

Guiding Narrative Questions

New for FY18, PEPFAR has included "guiding narrative questions" for each indicator. These questions or prompts can be found on the subsequent indicator reference sheets and were developed to ensure that there is continuity in the technical information reported in the narratives that 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 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) Level 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 indicator, and should describe current quarterly achievements as well as overall achievements against the fiscal year targets, and provide additional information related to specific data quality concerns or programmatic issues that may impact the assessment of partner performance. If appropriate, reference specific site-level issues that were encountered during the reporting period that may prevent achievement of the IM target. If additional information is useful for the interpretation of the results on an indicator-specific basis, please add this to the narrative. Please also indicate whether on-the-ground data quality assessments were conducted during the FY and the impact the assessment had on the results and program.

IM level narratives must also address any result discrepancies that cannot be reconciled after completing the Data Completeness and Logic Checks. Finally, the IM narratives should specifically 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 Level Narratives

Technical area level narratives summarize the de-duplicated partner achievements against summary FY 2017 targets. Technical area level narratives are required for each indicator, and should provide an overall assessment of the performance against FY 2017 targets. These narratives should also provide additional information related to specific data quality concerns or programmatic issues that may impact the assessment of overall performance. If additional information is useful for the interpretation of the results on an indicator-specific basis, please add this to the narrative.

Additionally, the technical area level narratives should specifically 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. Further focus the narratives by describing the following achievements in light of expected

trajectories for the technical area, information related to specific data quality concerns or programmatic issues that may impact the interpretation of results, data quality assessment (DQA) completion in the last 12 months, address any result discrepancies that cannot be reconciled (at the interagency level) after completing the Data Completeness and Logic Checks. Narratives should also 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?

National and Subnational Level 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 please explain
    - Note the actual reporting time frame for entered data
- Source narrative
    - What is the source of these data?
    - When were these data collected/calculated?

HOST COUNTRY NATIONAL PROGRAM

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 hous 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.

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 National and Subnational Results

At Q4 of the USG fiscal year, results from the host national 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 as part of service delivery areas. 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 2016 to June 2017). Results should be consistently reported on the same time period to be able to monitor trends over time.

Host Country National and Subnational Targets

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 targets of the national program setting process, 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. Targets for the host country national and subnational indicators should be reported into DATIM during COP.

Host Country indicators by reporting level, targets, and results

Indicator	Results	Targets	National	Sub-National
KP_MAT	✓		✓	✓
PMTCT_ART	✓	✓	✓	✓
PMTCT_STAT	✓	✓	✓	✓
TX_CURR	✓	✓	✓	✓
DIAGNOSED	✓		✓	✓
VL_SUPPRESSION	✓	✓	✓	✓
VMMC_CIRC	✓	✓	✓	✓
VMMC_TOTALCIRC	✓	✓	✓	✓

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 CEEs highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. The SIMS 2.0 Linkage Reference Table in Appendix 2 provides a listing of all SIMS 2.0 CEEs that have been directly linked to a given MER indicator; linkage data may be used for data triangulation activities to inform and contextualize MER results.

DREAMS SPECIFIC GUIDANCE

In addition to required MER reporting, it is essential that all DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) and DREAMS-like countries ensure that all implementing Partners in DREAMS SNUs report their results for and use data from all DREAMS-related indicators and their required disaggregations. 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 3 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.

- DREAMS countries: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe
- DREAMS-like countries: Botswana, Cote d' Ivoire, Haiti, Namibia, and Rwanda

MER 2.0 INFOGRAPHIC

PEPFAR MER 2.0 Indicators

Prevention

1. PrEP_NEW
2. VMMC_CIRC
3. KP_PREV
4. PP_PREV
5. OVC_SERV
6. TB_PREV
7. GEND_GBV
8. KP_MAT
9. FPINT_SITE

Knowing HIV Status

10. HTS_TST
11. HTS_SELF
12. PMTCT_STAT
13. PMTCT_EID
14. PMTCT_HEI_POS
15. PMTCT_FO
16. TB_STAT
17. OVC_HIVSTAT

On ART

18. TX_NEW
19. TX_CURR
20. PMTCT_ART
21. TB_ART
22. TX_TB

Viral Suppression

23. TX_RET
24. TX_PVLS

Health Systems

25. SC_STOCK
26. HRH_PRE
27. HRH_CURR
28. HRH_STAFF
29. LAB_PTCQI
30. EMR_SITE

Indicator Reporting Frequency by Program Area

#	Program Area Group	Indicator Code	Indicator Name	Reporting Frequency
1	Knowing Your HIV Status	HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results, disaggregated by HIV result	Quarterly
2	Knowing Your HIV Status	HTS_SELF	Number of individual HIV self-test kits distributed	Quarterly
3	On ART	PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	Quarterly
4	Knowing Your HIV Status	PMTCT_EID	Percentage of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth	Quarterly
5	Knowing Your HIV Status	PMTCT_HEI_POS	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	Quarterly
6	Knowing Your HIV Status	PMTCT_STAT	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC), disaggregated by HIV result	Quarterly
7	Prevention	PrEP_NEW	Number of individuals who have received (oral) antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection.	Quarterly
8	On ART	TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	Quarterly
9	On ART	TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Quarterly
10	Prevention	VMMC_CIRC	Number of males circumcised as part of the voluntary medical male circumcision for HIV prevention program	Quarterly
11	Prevention	KP_PREV	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	Semi-Annual
12	Knowing Your HIV Status	OVC_HIVSTAT	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including status not reported), disaggregated by status type	Semi-Annual
13	Prevention	OVC_SERV	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	Semi-Annual
14	Prevention	PP_PREV	Number of the priority populations reached with standardized HIV prevention intervention(s) that are evidence-based.	Semi-Annual
15	Health Systems	SC_STOCK	Percentage of storage sites where commodities are stocked according to plan, by level in supply system	Semi-Annual
16	On ART	TB_ART	Percentage of HIV-positive new and relapsed TB cases on ART during TB treatment	Semi-Annual
17	Prevention	TB_PREV	Proportion of ART patients who completed a standard course of TB preventive therapy within the reporting period	Semi-Annual
18	Knowing Your HIV Status	TB_STAT	Percentage of new and relapse TB cases with documented HIV status, disaggregated by HIV result	Semi-Annual
19	On ART	TX_TB	The proportion of ART patients who were screened who are receiving TB treatment	Semi-Annual

#	Program Area Group	Indicator Code	Indicator Name	Reporting Frequency
20	Health Systems	EMR_SITE	Number of PEPFAR-supported facility-based service delivery points supported by your organization that have an electronic medical record system	Annual
21	Prevention	FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	Annual
22	Prevention	GEND_GBV	Number of people receiving post-gender based violence (GBV) clinical care based on the minimum package NOTE: The indicator DOES NOT measure delivery of GBV prevention activities.	Annual
23	Health Systems	HRH_CURR	Number of health worker full-time equivalents who are working on any HIV-related activities i.e., prevention, treatment and other HIV support and are receiving any type of support from PEPFAR at facility and sites, community sites, and at the above-service delivery area level	Annual
24	Health Systems	HRH_PRE	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
25	Health Systems	HRH_STAFF	Number of health worker full-time equivalents who are working on any HIV-related activities i.e., prevention, treatment and other HIV support at PEPFAR-supported facility sites	Annual
26	Prevention	KP_MAT	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months within the reporting period	Annual
27	Health Systems	LAB_PTCQI	Number of laboratories and blood centers/banks: A. Engaged in Continuous Quality Improvement (CQI) activities B. Audited and achieved accreditation C. Performing an HIV-related test and participating in and passing Proficiency Testing (PT)	Annual
28	Knowing Your HIV Status	PMTCT_FO	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	Annual
29	Viral Suppression	TX_PVLS	Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)	Annual
30	Viral Suppression	TX_RET	Percentage of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy (Note: reporting 24 and 36 months is recommended, but optional)	Annual

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 their specific indicators requirements. Please use this layout as a guide to understand how to read the reference sheets.

<table>
<tr><td colspan="5">Indicator Code</td></tr>
<tr><td>Description:</td><td colspan="4">Long name of the indicator</td></tr>
<tr><td>Numerator:</td><td colspan="2">Long name of the numerator</td><td colspan="2">Additional information about numerator definition</td></tr>
<tr><td>Denominator:</td><td colspan="2">Long name of the denominator</td><td colspan="2">Additional information about denominator definition</td></tr>
<tr><td>Changes in indicator:</td><td colspan="4">Highlights any differences in the indicator from MER 1.0 to 2.0 and between MER 2.0 (versions 2.1 and 2.2)</td></tr>
<tr><td>How to use:</td><td colspan="4">Defines how the data is used to monitor PEPFAR program activities</td></tr>
<tr><td>How to collect:</td><td colspan="4">Defines how the data is collected (highlighting data source, issues with double counting, and important components of data collection that ensure data quality)</td></tr>
<tr><td>Reporting level:</td><td colspan="4">Defines the level at which the indicator is reported: facility, community, and/or above-service delivery area</td></tr>
<tr><td>How often to report:</td><td colspan="4">Defines the period at which the indicator is reported: Quarterly, Semi-Annually, or Annually</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Outlines specific data quality considerations for the indicator</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Defines how annual totals are calculated for the indicator at the end of the fiscal year.</td></tr>
<tr><td rowspan="5">Data elements (components of indicator):</td><td rowspan="2">Numerator: Long name of the numerator</td><td>Disaggregate Groups</td><td colspan="2">Disaggregates</td></tr>
<tr><td>Name of Disaggregate Group(s)</td><td colspan="2">Disaggregations</td></tr>
<tr><td rowspan="2">Denominator: Long name of the denominator:</td><td>Disaggregate Groups</td><td colspan="2">Disaggregates</td></tr>
<tr><td>Name of Disaggregate Group(s)</td><td colspan="2">Disaggregations</td></tr>
<tr><td colspan="4">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="4">Describes and defines the disaggregates relevant to the indicator in greater detail.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="4">Lists the indicator-specific definition for DSD vs. TA support that differ from the standard definitions outlined in the introduction section of the guidance.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="4">Lists the indicator-specific questions that implementing partners and USG country teams should address in the implementing mechanism and technical area summary narratives.</td></tr>
</table>

Prevention & Support Indicators

PrEP_NEW

Description:	Number of individuals who have been newly enrolled on (oral) 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	
Changes in indicator:	• PrEP_NEW is now reported across PEPFAR programs. It is no longer a DREAMS-specific indicator (MER 1.0 to MER 2.0). • A denominator for PrEP_NEW will no longer be collected (MER 1.0 to MER 2.0). • KP disaggregations were added (MER 1.0 to MER 2.0). • Age disaggregations updated (MER 2.0 v2.1 to v2.2). • KP disaggregation updated to include 'Other KP Type' (MER 2.0 v2.1 to v2.2).	
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 1 to support the identification of key populations at service delivery.	

<table>
<tr><td></td><td colspan="3">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.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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="3">Sum results across quarters.</td></tr>
<tr><td rowspan="4">Data elements (components of indicator):</td><td rowspan="3">Numerator: Number of individuals who have received (oral) antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>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</td></tr>
<tr><td>Key Population Type:
[Optional]</td><td>MSM: Men who have sex with men
TG: Transgender people
FSW: Female sex workers
Other KP Type: Other key population type</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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="3">Standard definition of DSD and TA used.

<u>Provision of key staff or commodities for PrEP services include</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="3">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:
• Screening tool?
• All clients considered at risk and eligible?
• Client request?</td></tr>
</table>

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 as part of the voluntary medical male circumcision (VMMC) for HIV prevention program	The numerator can be generated by counting the number of males circumcised.	
Denominator:	N/A		
Changes in indicator:	• Age disaggregations updated (MER 2.0 v2.1 to v2.2). • Follow-up status disaggregation updated to capture instances where VMMC follow-up did not take place within 14 days or within the reporting period (MER 2.0 v2.1 to v2.2).		
How to use:	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.		
Reporting level:	Facility		
How often to report:	Quarterly		
How to review for data quality:	Numerator ≥ subtotal of each of the disaggregation.		
How to calculate annual total:	Sum results across quarters.		
Data elements (components of indicator):	**Numerator**: Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program	**Disaggregate Groups**	**Disaggregates**
		Age [Required]	0-60 days, 2 months - 9 years, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+
		HIV Status and Outcome [Required]	• Number of HIV-positive clients (tested HIV positive at VMMC site) • Number of HIV-negative clients (tested HIV negative at VMMC site) • Number of clients with indeterminate HIV status or not tested for HIV at site (regardless of previous documentation)
		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. May include device removal; • Device-based VMMC: Did not follow-up within 14 days of device placement or did not follow-up within the reporting period
	Disaggregate Descriptions & Definitions		
	For HIV Status and Outcome: As VMMC_CIRC is a status indicator and not testing indicator, **ALL** men tested through the VMMC program should also be counted in the general HTS indicator "HTS_TST" **under the VMMC service delivery modality**.		
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?		

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: [Optional, recommended if available]	Total estimated number of key populations in the catchment area	The denominator is the estimated number of key populations in a defined catchment area. Programs need to define their geographic catchment area from which key population beneficiaries receive HIV prevention services. Country teams should encourage methodological harmonization across their KP partners when estimating KP population size within a catchment area.
Changes in indicator:	• KP type disaggregations changed, three testing service disaggregations were added, and HIV testing or referral of an individual to HIV testing services (HTS) is required to be offered to those who do not know their status or are self-identified as HIV negative (MER 1.0 to 2.0). • The denominator is now optional, but recommended for those with good size estimation metrics (MER 1.0 to 2.0).	
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 (if no denominator) and may help understand the relative saturation (coverage) of PEPFAR-supported KP prevention programs when reliable population size estimates are included as the denominator. 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).	

	<table><tr><th>Prevention Interventions for Key Populations</th></tr><tr><td>• Offer or refer to HTS* (Required)</td></tr><tr><td>• Targeted information, education, and communication (IEC)</td></tr><tr><td>• Outreach/Empowerment</td></tr><tr><td>• Condoms</td></tr><tr><td>• Lubricant</td></tr><tr><td>• Offer or refer to STI screening, prevention, and treatment</td></tr><tr><td>• Link or refer to ART</td></tr><tr><td>• Offer or refer to prevention, diagnosis, treatment of TB</td></tr><tr><td>• Offer or refer to screening and vaccination for viral hepatitis</td></tr><tr><td>• Offer or refer to Reproductive Health (Family Planning; PMTCT), if applicable</td></tr><tr><td>• Refer to medication-assisted therapy (MAT), if applicable</td></tr><tr><td>• Offer or refer to needle syringe program (NSP), if applicable</td></tr><tr><td>*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.</td></tr></table>
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).
Reporting level:	Facility & Community
How often to report:	Semi-Annual
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

<table>
<tr><td></td><td colspan="3">

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.
<u>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.</u>

• Denominator ≥ Numerator: The total estimated number of key populations should be greater or equal to the number of key populations provided with individual and/or small group level preventive interventions.
</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">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 rowspan="5">Data elements (components of indicator):</td><td rowspan="3">Numerator: Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>KP Type
[Required]</td><td>• 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</td></tr>
<tr><td>Testing Services
[Required]</td><td>• KP known positive;
• KP was newly tested and/or referred for testing;
• KP declined testing and/or referral</td></tr>
<tr><td rowspan="2">Denominator: Total estimated number of key populations in the catchment area. [Optional, recommended if available]</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>KP Type</td><td>• 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</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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</td></tr>
</table>

	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. Provision of key staff or commodities for KP receiving HIV prevention services include: 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. Ongoing support for HIV prevention among KP improvement includes: 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? 5. If the denominator was reported, what methodology was used to estimating the number of key populations in a defined catchment area?

PP_PREV

Description:	Number of the 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 the 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: [Optional, recommended if available]	Total estimated number of priority populations in the catchment area	The denominator is the estimated number of individuals in the priority populations. Programs need to define their geographic catchment area from which priority population clients receive HIV prevention services. Country teams should encourage methodological harmonization across their priority partners when estimating population size within a catchment area.
Changes in indicator:	• The denominator is now optional, but recommended for those with good estimation metrics (MER 1.0 to 2.0). • Updated the minimum required standardized HIV prevention interventions and included the requirement that HIV testing or referral to HIV testing service must be offered to those who are not known as diagnosed HIV positive (MER 1.0 to 2.0). • Age/sex disaggregations updated (MER 2.0 v2.1 to v2.2). • Clarifying language added for Key Populations disaggregation the notes that KP should be counted in only one KP group to avoid double-counting. More information is provided below (MER 2.0 v2.1 to v2.2).	
How to use:	The indicator represents PEPFAR-supported programming only and helps to determine PEPFAR's reach to priority populations (if no denominator). It may also help inform coverage of PEPFAR-supported programming for priority populations when reliable population size estimates are included as the denominator. **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 • Clients of sex workers • Military and other uniformed services • Mobile populations (e.g., migrant workers, truck drivers) • Non-injecting drug users **Size estimation**: The IP/country team will estimate the size of each of the priority populations in the geographic areas where the IP will implement the program. These areas are chosen based upon epidemiological data with attention to avoiding duplication	

of activities with those funded by donors (estimating the catchment area should be explained in the narratives).

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. 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.
Reporting level:	Facility & Community
How often to report:	Semi-Annual
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 for PP_PREV: Denominator is greater than or equal to the Numerator: The total number of people from priority populations must be greater than or equal to the total number of individuals from priority populations who completed a standardized HIV prevention program.

<table>
<tr><td></td><td colspan="3">Numerator is greater than or equal to the subtotal of the age/sex disaggregation: The number of individuals from priority populations who completed a standardized HIV prevention program should be greater or equal to the sum of the disaggregation by age/sex.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">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 rowspan="5">Data elements (components of indicator):</td><td rowspan="2">Numerator: Number of the priority populations reached with standardized HIV prevention intervention(s) that are evidence-based.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>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</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>Denominator: Total number of people in each priority populations [Optional, recommended if available]</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Country teams should encourage methodological harmonization across their priority population partners when estimating priority population size within a catchment area</td><td>N/A</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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). <u>Note:</u> 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 PP-friendly sites, programs should also respect the</td></tr>
</table>

	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. d. If there is "layering" (or combination) of PP_PREV interventions (i.e., various PP_PREV interventions delivered to benefit one person), please indicate the priority groups that are receiving layered interventions and if the layered interventions relate to DREAMS. 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.).

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 disaggregations: 1. Active beneficiaries 2. Graduated beneficiaries
Denominator:	N/A	
Changes in indicator:	• Clarifying language added to this indicator reference sheet. Only OVCs that **actually received services in the past three months** should be counted in this indicator. OVCs that have registered for the program, but have not yet received any services should not be counted in the results (MER 2.0 v2.1 to v2.2). • The disaggregation for program participation status has been clarified to capture types of beneficiaries: (1) active beneficiaries and (2) graduated beneficiaries, (MER 2.0 v2.2 Revised Release). • Beneficiaries that transferred or exited without graduation should no longer be reported in the numerator (MER 2.0 v2.2 Revised Release). However, these data will still be collected as disaggregates. • All indicator changes will be reflected in the data entry screens in DATIM beginning in FY 18 Q2 (MER 2.0 v2.2 Revised Release). • The transferred disaggregation was split into two separate disaggregations: transferred out to a PEPFAR-supported partner and transferred out to non-PEPFAR supported partner (MER 2.0 v2.2 Revised Release). • Indicator calculation is updated. Indicator returns to being a snapshot indicator again for FY 18 reporting. Results should not be summed across reporting periods (MER 2.0 v 2.2 Revised Release).	
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 infected with HIV. 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 adults and children. The goal of OVC programs is to build stability and resiliency in children and families-exposed, living with or affected by HIV/AIDS through rigorous case management and provision and access to health and socio-economic interventions. This indicator, by disaggregating "active" and "graduated" in the numerator and collecting additional disaggregates for "transferred out to a PEPFAR-supported partner", "transferred out to a non-PEPFAR supported partner", and "exited without graduation" measures how successful the OVC program is in building children and their families' resiliency.	
How to collect:	The data sources are the PEPFAR OVC program registers and program data generated by implementing partners. Implementing partners' registers need to record names of children and caregivers who meet the criteria for "active beneficiary" or "graduated" to generate the numerator total included in this indicator. In addition, implementing partners should record whether children or caregivers "transferred out to a PEPFAR-supported partner", "transferred out to a non-PEPFAR supported partner", and "exited without graduation."	

<table>
<tr><td></td><td colspan="3">All agencies receiving HKID funding are required to report on this indicator.

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 and tracks progress on the number of OVC graduating from PEPFAR OVC programs and tracks “exited without graduation” (such as loss-to-follow up, aging out without transition plan, moved, or died). Transferred to existing host-country programs, where the host-country program provides a sustainable response to OVC needs. Transferred to existing PEPFAR-supported programs to track movement of children and caregivers between PEPFAR-supported partners. Graduation will vary based on local criteria for achieving stability in the household.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility & Community</td></tr>
<tr><td>How often to report:</td><td colspan="3">Semi-Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">Reviewing PEPFAR OVC implementing partners’ results to ensure that there is no double counting and changes by Program Completion Status do not show high deviations from program targets and/or SNU prioritization (scale up, sustained, centrally supported, sustained commodities.

To ensure completeness, check that OVC_SERV total numerator (autocalculated based on participation status disaggregates) equals OVC_SERV results by age/sex disaggregates:

• OVC_SERV total numerator should equal OVC_SERV <1 + 1-9 + 10-14F + 10-14M + 15-17F + 15-17M + 18-24F + 18-24 M + 25+F + 25+M
• OVC_SERV total numerator should equal OVC_SERV<18 + OVC_SERV 18+
• OVC_SERV<18 = OVC_SERV <1 + 1-9 + 10-14F + 10-14M + 15-17F + 15-17M
• OVC_SERV 18+ = OVC_SERV 18-24F + 18-24 M + 25+F + 25+M</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">To calculate data for annual results for OVC_SERV:
Sum Active (children and caregivers received services in the past three months) + Graduated (OVCs that graduated from the OVC program in the past 12 months).

This indicator should be reported as a snapshot (i.e., report data as of the last day of the reporting period) in DATIM.</td></tr>
<tr><td rowspan="3">Data elements (components of indicator):</td><td rowspan="3">Numerator: Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Program Participation Status [Required]</td><td>• Active (Received at least one service in the past 3 months)
• Graduated (At Q2: Report children and parents/caregivers that graduated from the OVC program in the past 6 months. At Q4: Report children and parents/caregivers that graduated from the OVC program in the past 12 months.)</td></tr>
<tr><td>Age/Sex (For Active and Graduated) [Required]</td><td><1, 1-9, 10-14 M, 10-14 F, 15-17 M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F</td></tr>
</table>

		Exited or Transferred [Required] *Disaggregate should be reported for exited or transferred, even if no numerator (active + graduated) values are reported.*	• Transferred out to a **PEPFAR-supported partner** (At Q2: Report children and parents/caregivers that transferred out to a PEPFAR-supported partner in the past 6 months. At Q4: Report children and parents/caregivers that transferred out to a PEPFAR supported partner in the past 12 months.) • Transferred out to a **non-PEPFAR supported partner** (At Q2: Report children and parents/caregivers that transferred out to a non-PEPFAR-supported partner in the past 6 months. At Q4: Report children and parents/caregivers that transferred out to a non-PEPFAR supported partner in the past 12 months.) • **Exited without graduation** (At Q2: Report children and parents/caregivers that exited in the past 6 months. At Q4: Report children and parents/aregivers that exited in the past 12 months.)
		Age/Sex/OVC Service Area [DREAMS Conditional]	• Education Support: <1, 1-9, 10-14 M, 10-14 F, 15-17 M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F • Parenting/Caregiver Support: <1, 1-9, 10-14 M, 10-14 F, 15-17 M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F • Social Protection: <1, 1-9, 10-14 M, 10-14 F, 15-17 M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F • Economic Strengthening: <1, 1-9, 10-14 M, 10-14 F, 15-17 M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F • Other Service Areas: <1, 1-9, 10-14 M, 10-14 F, 15-17 M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F
	Disaggregate Descriptions & Definitions		

	Program Participation Status Definitions: • **"Active beneficiary"** **is an individual, a child, or parent/caregiver who has received at least one PEPFAR OVC program service in the last three months. New beneficiaries registered during the reporting period can be counted as active only if they have received at least one service in the last three months.** Assessment, enrollment, case plan development, and case plan monitoring are not considered services. Please refer to the forthcoming OVC Reporting FAQ clarification on what activities constitute a service for more information. • **"Graduation"** is defined as: 1. Graduation is defined as happens when children and parent/caregivers enrolled in PEPFAR OVC programs are deemed stable and no longer in urgent need of externally supported services. Criteria for achieving stability in the household vary and should be defined at the OU-level to be consistent across IPs. Or 2. Aging out: This only includes children who have reached the age of 18 and who have a transition plan for successful exiting from the PEPFAR OVC Program. This does not apply to children > 18 years old enrolled in secondary education. **Exited or Transferred Disaggregate Definitions:** • **"Transferred out to a non-PEPFAR-supported partner"** happens when children and families have transitioned to other forms of support programs other than PEPFAR funded OVC programs. These could include country-led programs or other donor funded programs. • **"Transferred out to a PEPFAR-supported partner"** happens when children and families have transitioned from the support of one PEPFAR partner to another PEPFAR-partner. • **"Exited without graduation"** This includes children and caregivers who are lost-to-follow up, re-located, or died and children who aged-out without a graduation plan from PEPFAR OVC program.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for OVC beneficiaries receiving care and support services in the community include: 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.) or procurement of critical commodities essential for ongoing service delivery. Partial salary support may include stipends or incentives for volunteers, or paying for transportation of those staff to the point of service delivery. For care and support services, ongoing support for OVC service delivery for improvement includes: 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. What is the total achievement of OVC_SERV for <18 years and total numerator? Please explain partners with highest/lowest performance. 2. Please explain results by participation status disaggregate: a. What criteria do beneficiaries need to achieve in order to graduate? Is that standard across partners in your OU?

	b. 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)? c. How many beneficiaries were transitioned? To whom (e.g., other NGOs, government support, etc.). Where were beneficiaries transferred? Please provide disaggregates for beneficiaries transferred to specific sources of support. d. Of those who are reported to be active, what percentage is newly enrolled? Any re-enrollments of those LTFU? If yes, how many? Are any partners especially good at finding and re-enrolling those LTFU?

<table>
<tr><th colspan="3">TB_PREV</th></tr>
<tr><td>Description:</td><td colspan="2">The number of ART patients who completed a standard course of TB preventive therapy within the semiannual reporting period</td></tr>
<tr><td>Numerator:</td><td>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))</td><td>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.</td></tr>
<tr><td>Denominator:</td><td>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)</td><td>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.</td></tr>
<tr><td>Changes in indicator:</td><td colspan="2">• Type of therapy by ART start disaggregation updated to indicate whether ART patients started IPT or an alternative TB preventive therapy regimen and whether they started ART in the same reporting period as TB preventive therapy or if they were on ART previously. Updated disaggregation titled, “Type of TB Preventative Therapy (TPT) by ART Start” (MER 2.0 v2.1 to v 2.2).</td></tr>
<tr><td>How to use:</td><td colspan="2">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 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. New 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 follow only 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.</td></tr>
<tr><td>How to collect:</td><td colspan="2">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. <u>Importantly, programs should ensure that patients on continuous therapy are counted only once, and not repeated in future calculations</u>.

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

<table>
<tr><td></td><td colspan="3">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 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 in the period 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 in the period 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>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Semi-Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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 colspan="3">Snapshot indicator. Use the result reported at Q4.</td></tr>
<tr><td rowspan="4">Data elements (components of indicator):</td><td rowspan="2">Numerator: Number of ART patients who completed a course of TB preventive therapy during the reporting period</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Type of TB Preventative Therapy (TPT) by ART Start: [Required]</td><td>• IPT by newly enrolled on ART
• IPT by previously enrolled on ART
• Alternative TPT regimen by newly enrolled on ART
• Alternative TPT regiment by previously enrolled on ART</td></tr>
<tr><td></td><td>Age/Sex: [Required]</td><td><15 F, >15 F, <15 M, >15 M</td></tr>
<tr><td rowspan="3">Denominator: Number of ART patients who are expected to complete a course of TB preventive therapy during the reporting period</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Type of TB Preventative Therapy (TPT) by ART Start: [Required]</td><td>• IPT by newly enrolled on ART
• IPT by previously enrolled on ART
• Alternative TPT regimen by newly enrolled on ART
• Alternative TPT regiment by previously enrolled on ART</td></tr>
<tr><td>Age/Sex: [Required]</td><td><15 F, >15 F, <15 M, >15 M</td></tr>
</table>

	Disaggregate Descriptions & Definitions
	Type of TB Preventative 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 • 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 include: 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, 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 isoniazid regimen?

KP_MAT

Description:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months within the reporting period	
Numerator:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months	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	
Changes in indicator:	No changes in this indicator.	
How to use:	When proper and sufficient dosage is administered, medication-assisted therapy (MAT) is highly effective in reducing opioid use, reducing injecting behaviors that put opioid-dependent people at risk for HIV and improving 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, such as HIV testing services, provision and/or referral and linkages to ARV treatment programs, PMTCT for female PWID and a range of other prevention and harm reduction services. Partners providing MAT referrals only should not use this indicator, unless it also meets the KP_MAT_TA requirement below. Please see key population indicator "KP_PREV" to see if services provided meet reporting criteria for that indicator.	
How to collect:	This indicator provides information on the total number of individuals who have been on treatment for at least 6 months since initiation of medication-assisted treatment (e.g., methadone, buprenorphine, or buprenorphine/naloxone to treat drug dependency) at any point in time **within the reporting period**. Therefore, 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 treatment even if they drop-out, die, or are otherwise lost to follow-up, as long as they completed the minimum of 6 months treatment. Do not count individuals who initiate treatment too late in the reporting period to be able to reach a minimum of 6 months.	
Reporting level:	Facility	
How often to report:	Annual	
How to review for data quality:	This indicator makes use of program data as part of an on-going cohort, like that used to monitor ART retention. 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:	Use annual result reported at Q4.	

Data elements (components of indicator):	**Numerator**: Number of people who inject drugs (PWID) on	**Disaggregate Groups**	**Disaggregates**
		Sex [Required]	Male; Female

	medication-assisted therapy (MAT) for at least 6 months		
	Disaggregate Descriptions & Definitions		
	N/A		
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used: Provision of key staff or commodities for PWID on MAT includes: 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. Ongoing support for MAT services for PWID service delivery improvement includes: 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?		

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	Additional information about numerator definition
Denominator:	N/A	
Changes in indicator:	• Age/sex disaggregations updated (MER 2.0 v2.1 to v2.2). • Age/sex disaggregations added to the post-exposure prophylaxis (PEP) sub-disaggregate of the sexual violence disaggregate (MER 2.0 v2.1 to v2.2).	
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	

<table>
<tr><td></td><td colspan="3">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:
• 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>Reporting level:</td><td colspan="3">Facility & Community</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annually</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Use annual result reported at Q4.</td></tr>
<tr><td rowspan="5">Data elements (components of indicator):</td><td rowspan="4">Numerator: Number of people receiving post-GBV clinical care based on the minimum package</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Violence Service Type [Required]</td><td>• Sexual Violence
• Physical and/or Emotional Violence</td></tr>
<tr><td>Violence Service Type by Age and Sex [Required]</td><td>• Sexual Violence by: Unknown Age M, Unknown Age F, <10 M, <10 F, 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
• Physical and/or Emotional Violence by: Unknown Age M, Unknown Age F, <10 M, <10 F, 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</td></tr>
<tr><td>Number of People Receiving Post-Exposure Prophylaxis (PEP) Services by Age and Sex (Disaggregate of the Sexual Violence Service Type) [Required]</td><td>• Received PEP by: Unknown Age M, Unknown Age F, <10 M, <10 F, 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</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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:</td></tr>
</table>

	• 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. Services should 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.

	Ongoing support for GEND GBV service delivery improvement includes: 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.

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	See definition below for a PEPFAR-supported service delivery point. 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.
Changes in indicator:	• This indicator has changed from an absolute count of the number of sites to have integrated family planning services to the number of service delivery areas within a site (MER 1.0 to 2.0).	
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
Voluntary FP counseling should follow the standards and best practices outlined in the "Additional References" section below.

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.). 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. Care and Treatment (including Pediatric and Adolescent Care and Treatment Services) – this includes services where ART is initiated and monitored. 2. 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.) 3. 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 4. 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. 5. 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) **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.

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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.
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>Reporting level:</td><td colspan="3">Facility by Service Delivery Area</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">Data should be reviewed regularly for the purposes of program management including monitoring progress towards achieving targets, and identifying and correcting any data quality issues. Follow PEPFAR Guidance for data quality review as circulated in Q4 reporting guidance.

Potential data quality issues for FPINT_SITE: Indicator counts individual Service Deliver Points at Sites: This indicator counts the number of service delivery points (SDP) NOT the number of sites that integrate FP services. See above for SDP definition.

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 colspan="3">Use annual result reported at Q4.</td></tr>
<tr><td rowspan="3">Data elements (components of indicator):</td><td>Numerator: Number of service delivery points supported by PEPFAR that are providing fully integrated voluntary family planning services</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><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>
<tr><td colspan="3">Disaggregate Descriptions & Definitions
N/A</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="3">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.</td></tr>
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	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?

Knowing Your HIV Status Indicators

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	
Changes in indicator:	• Age/sex disaggregates updated (MER 2.0 v2.1 to v2.2). • HTS community testing modality for home-based testing has been removed (MER 2.0 v2.1 to v2.2). • Two new HTS facility testing modalities added: STI clinic and emergency department (MER 2.0 v2.1 to v2.2). • Clarifying language added for Key Populations disaggregation the notes that KP should be counted in only one KP group to avoid double-counting. More information is provided below (MER 2.0 v2.1 to v2.2).	
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.	
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 as part of the HTS_TST indicator.** • **PMTCT_STAT** • **TB_STAT** • **VMMC_CIRC** • **PP_PREV** • **KP_PREV** • **OVC_HIVSTAT**	

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.

Note: **Serologic testing of pediatric patients should be counted under HTS_TST. However, HIV virologic testing of HIV-exposed infants should be counted under PMTCT_EID and PMTCT_HEI_POS**.
For children <1, only if serologic tests are used for diagnostic purposes should they be reported under HTS_TST. Serologic tests for screening infants should be excluded (including tests to look for HIV exposure at age 9 months or another time point). 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_TST indicator. However, 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_TST <1 indicator to report negative diagnostic results for such cases.

Note: **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 verification testing should not be recorded as HTS_TST or HTS_TST_POS, these data should nevertheless be tracked and rates of discordancy monitored.

Key Populations:
Provision of information (tested, tested positive, tested negative) on key Populations (FSW, MSM, Transgender people, PWID, and people in prisons and other closed settings) who were tested and received their results should be reported here. Importantly, reporting on this disaggregate is optional.

Key population disaggregation* see Appendix 1 to support the 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 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 identifies in order to avoid double-counting.

Note: Both KP-specific and clinical partners have the option to complete these disaggs, but only if it is safe to maintain these files and report. Age and sex data on KPs tested and receiving their results will not be reported—these disaggregates are separate and distinct from disaggregates for male/female. Please refer to the KP_PREV and PP_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.

Please also 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 M&E 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 this indicator, 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.
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

<table>
<tr><td></td><td colspan="3">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 partners de-duplicate at the reporting level.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility & Community</td></tr>
<tr><td>How often to report:</td><td colspan="3">Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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.

Numerator ≥ subtotal of each disaggregate group: The total number of individuals receiving HTS (numerator) should be equal to the sum of each individual disaggregation group (age/sex/test result/service delivery modality). If the sum of each individual disaggregation group (age/sex/test result/service delivery modality) is greater than the total number of individuals receiving HTS (numerator), then there were more individuals entered for the disaggregations than for the overall number of individuals receiving HTS. This should be corrected. If the sum of each individual disaggregation group (age/sex/test result/service delivery modality) is less than the total number of individuals receiving HTS, then some data are missing for the disaggregations. This should also be corrected.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Sum results across quarters.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>Numerator: Number of individuals who received HIV Testing Services (HTS) and received their test results</td><td>Disaggregate Groups
Age/Sex/Result/HTS Modality (Community-Level HTS Reporting) [Required]</td><td>Disaggregates
• Index (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;
• Mobile (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;
• VCT (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;
• Other Community Testing Platform: <1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15_19 F,</td></tr>
</table>

			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
		Age/Sex/Result/HTS Modality (Facility-Level HTS Reporting) [Required]	• Index (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; • STI (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; • Inpatient (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; • Emergency (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; • VCT (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; • 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 (Positive/Negative): <1, 1-9, 10-14 M, 15-19 M, 20-24 M, 25-29 M, 30-34 M, 35-39 M, 40-49 M, 50+ M;

		• PMTCT [ANC Only] (Positive/Negative): <1, 1-9, 10-14 F, 15-19 F, 20-24 F, 25-29 F, 30-34 F, 35-39 F, 40-49 F, 50+ F; • Pediatric (Positive/Negative): <5 • Malnutrition (Positive/Negative): <5 • Other PITC (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
	Key Population by Result [Optional]	• People who inject drugs (PWID): Negative, Positive • Men who have sex with men (MSM): Negative, Positive • Transgender people (TG): Negative, Positive • Female sex workers (FSW): Negative, Positive • People in prison and other closed settings: Negative, Positive

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 partner, STI), as well as, the location/place of testing (e.g., inpatient ward, VCT drop-in center). Therefore, please use a hierarchical approach to determine the appropriate modality, by prioritizing the reason for testing followed by the location/place of testing.

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:** Index testing, also referred to as partner testing/partner notification services, is an approach whereby the exposed contacts (i.e., spouse, sexual partners, biological children and needle-sharing partners) of an HIV-positive person, known as the index case, are elicited and offered HIV testing services. The Index modality is used to define testing of contacts who have been exposed to HIV through an index case. These contacts include: sexual partners, needle-sharing partners, and biological children of female index cases. Testing of persons who have not had exposure through an index case, such as neighbors or

family members not born to the index, should not be reported under the Index modality. Instead, these individuals should be counted under "other community platforms". While testing the contacts of an index case may occur in mobile, VCT or other community testing venue, this testing should be reported under the index modality, which takes precedence over the other service delivery modalities. That is, if an individual could be reported under both index testing and another modality, that individual should only be reported once under index testing.

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. Instead that should be reported under facility based VMMC modality.
c. **VCT:** 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:** Index testing, also referred to as partner testing/partner notification services, is an approach whereby exposed contacts (i.e., spouse, sexual partners, biological children, and needle-sharing partners) of an HIV-positive person, known as the index case, are elicited and offered HIV testing services. The Index modality is used to define testing of contacts who have been exposed to HIV through an index case. These contacts include: sexual partners, needle-sharing partners, and biological children of female index cases. Testing of persons who have not had exposure through an index case (i.e., non-exposed contacts), such as neighbors or family members not born to an index case, should not be reported under the Index modality. If these non-exposed contacts come to a facility for an HIV test, their results should be reported under the "VCT" modality. Index testing in a facility-based setting (testing the exposed contacts of an index case) can occur in a variety of service delivery points within a facility (e.g., TB, VCT, inpatient, etc.). However, all index-based testing should be reported using the Index modality, which takes precedence over all the other service delivery modalities That is, if an individual could be reported under both index testing and another modality, that individual should only be reported once under index testing
b. **Provider Initiated Counseling and Testing (PITC**):
    i. **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.
    ii. **Pediatrics:** Includes Provider Initiated Counseling and Testing offered to children under 14 years of age at any service delivery modality within the health facility (e.g., under 5/EPI clinic (immunization or well child services), pediatric inpatient wards, etc.). This 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.

iii. **Inpatient:** Includes Provider Initiated Testing & Counseling (PITC) occurring among those patients admitted in the inpatient and surgery wards.

iv. **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.

v. **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.

vi. **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.

vii. **PMTCT (ANC Only):** Pregnant women newly tested at antenatal care clinic (ANC) ANC setting (**who would also be reported under PMTCT_STAT**) should be reported under HTS_TST in the facility-based modality of PMTCT (ANC only). HIV testing for pregnant women as part of the PMTCT program at antenatal care clinics (ANC) to align with PMTCT_STAT. 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. If a woman is newly tested at a different service delivery point other than ANC (e.g., labor and delivery, family planning clinics, etc.), results should be reported under the appropriate facility-based HTS modality (inpatient, PITC-other, etc.) and not under the PMTCT (ANC Only) disaggregate and not under PMTCT_STAT. Please note in the HTS narrative which modality you are using to report new tests at L&D and any postnatal care (e.g., in-patient, PITC-other).

viii. **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. Use this modality for VCT walk-ins, client-initiated HIV testing, and clients who have been previously mobilized to get an HIV test. 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 definition of DSD and TA-SDI used. For HTS services, direct service delivery includes: 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. For HTS services, ongoing support for service delivery improvement includes: clinical mentoring/supportive supervision, HTS training, HTS guidance development, infrastructure/renovation of facilities (fixed, mobile, and outreach sites), site level QI/QA, 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.

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	
Changes in indicator:	• This is a new indicator for MER 2.0 (version 2.2) and OUs are required to report on it during FY18 if they support the procurement and/or distribution of HIV self-test kits.	
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 NOT 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. **For example**, 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.

<table>
<tr><td></td><td colspan="3">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.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility & Community</td></tr>
<tr><td>How often to report:</td><td colspan="3">Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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. Further, data should be reviewed to ensure the numerator does not include the number of HIV self-tests performed 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 colspan="3">Sum results across quarters.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>Numerator: Number of individual HIV self-test kits distributed</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td></td><td>Type of self-testing [Required]</td><td>Directly-assisted; Unassisted</td></tr>
<tr><td></td><td></td><td>Number of Test Kits Distributed to a Person by Age/Sex [Required for Directly Assisted; Optional for Unassisted]</td><td>• Directly-assisted self-testing by: 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;
• Unassisted self-testing by: 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</td></tr>
<tr><td></td><td></td><td>Disaggregate: 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</td></tr>
</table>

			• People in prison and other closed settings: Directly-assisted, Unassisted
		Disaggregate: Test kit distributed for use by [For Unassisted Only; Reporting Optional if data are available]	Unassisted self-testing by: Self, Sex Partner, Other
	Disaggregate Descriptions & Definitions		
	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)		
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for the distribution of HIVST kits includes: 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 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. Please describe process/methods and challenges for tracking distribution of test kits. 2. Please describe process/methods and challenges for tracking use of self-test kits. 3. Please describe process/methods and challenges for tracking linkage of individuals for repeat testing to confirm a reactive self-test result.		

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 ***(These women should also be counted in the general HTS indicator "HTS_TST")***
Denominator:	Number of new ANC clients in reporting period	N/A
Changes in indicator:	• Collected at only antenatal care (ANC) sites to better align with upcoming 2016 WHO Consolidated ARV guidelines, reduce burden on data collection, and improve data quality. No longer collected at L&D. This change is to improve data quality by aligning with the PMTCT_STAT denominator number of new ANC clients in the reporting period (MER 1.0 to 2.0). • Newly tested negative was added as a disaggregate to improve calculated yield (MER 1.0 to 2.0). • Language clarified that the collection of this indicator is at the first ANC visit (ANC1) of the pregnancy reduces the risk of double counting pregnant women who could be tested multiple times during pregnancy (MER 2.0 v2.1 to v2.2). • Age disaggregates updated (MER 2.0 v2.1 to v2.2).	
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:	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). 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". Finally, "known negative" (i.e., women who tested HIV negative prior to current pregnancy) is not reported in DATIM however it may be appropriate to report "known negative" women as part of the numerator if: 1) 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) and 2) ANC registers and reporting systems only capture 1st month or 1st ANC visit. ***(As this is a status indicator and not a testing indicator - These women should also be counted in the general HTS indicator "HTS_TST" PMTCT (ANC Only) service delivery modality).***	

<table>
<tr><td></td><td colspan="3">Women who are newly tested at a different service delivery point (e.g., labor and delivery (L&D), postnatal clinics, family planning clinics, etc.) should be reported under the appropriate facility-based HTS modality (inpatient, PITC-other, etc.). If there have been changes in the MER modality under which L&D and postnatal client testing has been reported over time, which would affect interpretation of data trends, please note this in both USG and IM-level narratives under both HTS and PMTCT_STAT.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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, but is not captured in the PMTCT_STAT indicator. Country teams should collect this data at the country level if it is pertinent to their country's epidemic, especially in high HIV burden settings and where there are concerns of ongoing transmission during the pregnancy and postpartum period.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">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 rowspan="5">Data elements (components of indicator):</td><td rowspan="3">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 ANC)</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age
[Required]</td><td>Unknown age, <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+</td></tr>
<tr><td>Status and Age
[Required]</td><td>• Known Positives: Unknown age, <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+
• Newly Tested Positives: Unknown age, <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+
• New Negatives: Unknown age, <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+</td></tr>
<tr><td rowspan="2">Denominator: Number of new ANC clients in reporting period</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age
[Required]</td><td>Unknown age, <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, 50+</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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 retesting 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.</td></tr>
</table>

	• ***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. These women should also be counted in the HTS_TST indicator. • ***New Negatives:*** Retesting of HIV-negative women at subsequent ANC visits, L&D, postnatal clinic or family planning clinic should not be counted in this indicator. Retesting for verification of positive status prior to initiating ART to reduce misdiagnosis should not be counted in this indicator.
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, 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.
Guiding narrative questions:	1. Provide context for poor performance in PMTCT_STAT coverage (Numerator/Denominator = STAT coverage) by geographic area 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. 3. PMTCT_STAT is limited to women tested at ANC1 for the current pregnancy. If additional data is available, provide total # women tested and positive in ANC2 and beyond, including through labor and delivery and the breastfeeding period (e.g., postpartum, MCH settings). This could include women who initially tested negative at ANC1 or who did not attend ANC. This data may already be reported through MER HTS modalities, but is not available for review as a specific disaggregate. This will provide context on quality of care for women and HIV-exposed infants (HEI), and a better estimate for total HEI.

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. This percentage is a proxy measure, since the infants in the numerator could include infants whose mothers were not included in the PMTCT_STAT denominator. 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	
Numerator:	Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period	Calculated indicator in DATIM, sum of: Infants who had a first virologic HIV test (sample collected) between birth and 2 months of age; Infants who had a first virologic HIV test (sample collected) between 2 and 12 months of age
Denominator:	**PMTCT_STAT_POS (see PMTCT_STAT);** Denominator is no longer collected as part of indicator, but rather is calculated as PMTCT_STAT_POS.	Calculated indicator in DATIM, sum of: 1) Newly Tested Positive, 2) Known Positive at entry **(see PMTCT_STAT, Disaggregate Group Positivity Status for more details)**
Changes in indicator:	• Clarification that reported test is based on infant's age when the sample was collected for virologic testing, not based on when sample was sent or result returned (MER 1.0 to MER 2.0). • Clarification that 1) PMTCT_STAT_POS is the denominator for this proxy indicator (MER 1.0 to MER 2.0). • Infants' diagnoses through virologic test results (positive, negative, unknown) are no longer reported within this indicator. Refer to new PMTCT_HEI_POS indicator for guidance on how to report on infants diagnosed HIV positive as well as confirmation of their ART initiation (MER 2.0 v2.1 to v2.2).	
How to use:	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 infants whose samples were collected for the first 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 would be measured in PMTCT_FO. The positive results of HIV infant virologic testing are collected in a new, separate indicator in effect for FY18, called PMTCT_HEI_POS. Please see the reference sheet for PMTCT_HEI_POS for more information, as the definitions for the new indicator are distinct from PMTCT_EID.	
How to collect:	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. Only samples collected for a first virologic HIV test should be included in this indicator. 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.
Reporting level:	Facility
How often to report:	Quarterly
How to review for data quality:	Infant testing coverage (PMTCT_EID / PMTCT_STAT_POS) is a proxy calculation, relying on PMTCT_STAT_POS as a proxy denominator for the total number of HIV exposed infants (HEI). Reviewing infants with a first virologic test (N) against PMTCT_STAT_POS results (D) 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 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 denominator from the same reporting time period. Example Limitations • PMTCT_STAT_POS could underestimate the number of HEI because it includes only women who are HIV-positive at ANC1 for the current pregnancy. It does not include women who attend ANC1 and are HIV+ but are not diagnosed; or any woman who seroconverts after ANC1, during delivery, or breastfeeding.

<table>
<tr><td></td><td colspan="3">
PMTCT_STAT_POS could overestimate the number of HEI that should be tested, because not all pregnancies may come to term.
See the new 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 colspan="3">Sum results across quarters.</td></tr>
<tr><td rowspan="3">Data elements (components of indicator):</td><td rowspan="2">Numerator: Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period</td><td>Disaggregate Groups</td><td>Disaggregates</td></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><td colspan="3">Disaggregate Descriptions & Definitions
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 colspan="3">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 including infant prophylaxis, 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.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="3">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.</td></tr>
</table>

PMTCT_HEI_POS

Description:	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.	
Numerator:	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	Calculated indicator in DATIM, sum of: HIV-infected infants whose diagnostic sample was collected between birth and 2 months of age; HIV-infected infants whose diagnostic sample was collected between 2 and 12 months of age.
Denominator:	N/A	
Changes in indicator:	• This is a new indicator for MER 2.0 v2.2. • Infants' first virologic test results (positive, negative, and unknown) are no longer being reported under PMTCT_EID. The total number of positive infants identified through virologic testing will be collected through the new PMTCT_HEI_POS indicator, however, the definition for positive infants in the new indicator is different from the definition for the PMTCT_EID positive infant disaggregate in MER 2.0 (MER 2.0 v2.1 to v2.2).	
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. 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 MER 2.2 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 an 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. **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.
Reporting level:	Facility
How often to report:	Quarterly
How to review for data quality:	**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

<table>
<tr><td></td><td colspan="3">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 colspan="3">Sum results across quarters.</td></tr>
<tr><td rowspan="4">Data elements (components of indicator):</td><td rowspan="3">Numerator: Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.</td><td>Disaggregate Groups</td><td>Disaggregates</td></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><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="4">Infant age at virologic sample collection, for positive infants Description: For the numerator to be calculated, implementing partners are required to report:
• HIV-infected infants identified in a quarter, disaggregated by <u>the age at time of sample</u> collection: 0-2 months of age, or between 2-12 months of age. These values will auto-sum to the numerator.
Positive, confirmed initiated ART by age at virologic sample collection description:
• 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:
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</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="3">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for PMTCT include</u>: 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.

<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.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="3">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.</td></tr>
</table>

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.	
Changes in indicator:	• Now includes an option for "known HIV+ at service entry" (MER 1.0 to MER 2.0). • Finer age disaggregates no longer required (MER 1.0 to MER 2.0). • Disaggregates have been added to denominator (MER 1.0 to MER 2.0).		
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 (<15 M, 15+ M, <15 F, 15+ F)) 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". ***(As this is a status indicator and not a testing indicator - These patients <u>should also</u> be counted in the general HTS indicator "HTS_TST" TB service delivery modality).***		
Reporting level:	Facility		
How often to report:	Semi-Annual		
How to review for data quality:	Only one disaggregation type is used for age and gender (coarse 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.		
Data elements (components of indicator):	**Numerator**: Number of new and relapse TB cases with documented HIV test results, during the reporting period.	**Disaggregate Groups** Age/Sex/Result [Required]	**Disaggregates** • Known Positives: Unknown age, <15 F, >15 F, <15 M, >15 M • Newly Tested Positives: Unknown age, <15 F, >15 F, <15 M, >15 M • New Negatives: Unknown age, <15 F, >15 F, <15 M, >15 M

<table>
<tr><td rowspan="4"></td><td rowspan="2">Denominator:
Total number of new and relapsed TB cases, during the reporting period.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex</td><td>Unknown age, <15 F, >15 F, <15 M, >15 M</td></tr>
<tr><td colspan="2">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="2">N/A</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="3">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for TB cases receiving HIV-related services include</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.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="3">1. Please describe how the denominator was determined.
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)?</td></tr>
</table>

OVC_HIVSTAT

Description:	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including report of no status).	
Numerator:	Number of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner, disaggregated by status type.	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)	Denominator is not collected again, as part of this indicator but is collected under the indicator OVC_SERV.
Changes in indicator:	• This indicator formerly called OVC_ACC (MER 1.0) and OVC_KNOWNSTAT (in the original MER 2.0 target setting documentation guidance) was changed to OVC_HIVSTAT to reflect that HIV status is self-reported to the implementing partner by the OVC or OVC caregiver (MER 1.0 to MER 2.0).	
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, and to facilitate access and retention in ART treatment for those who are HIV positive. When the implementing partner knows the HIV status, the program can contribute to ensuring that the children are linked to appropriate care and treatment services, all essential elements of quality case management. OVC programs can 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 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. Only OVC with no HIV status or children reported to be negative and recently experiencing sexual violence and/or other risk factors in the reporting period should be assessed for HIV risk. For older children who the IP thinks may be sexually active, they should be assessed every reporting period. • 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, encourage family disclosure and linkage to care and treatment as needed. • This indicator captures if implementing partners are tracking the self-reported HIV status of the orphans and vulnerable children 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 were tested	

<table>
<tr><td></td><td colspan="3">

This indicator also captures if implementing partners are tracking if the orphans and vulnerable children they serve who report to be HIV positive are successfully linked to and retained in treatment and care.
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.
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.

</td></tr>
<tr><td>How to collect:</td><td colspan="3">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.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility & Community</td></tr>
<tr><td>How often to report:</td><td colspan="3">Semi-Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">The OVC_HIVSTAT total numerator should ideally equal OVC_SERV<18 results. In some cases, there may be missing data for the following reasons: 1) IP was not able to collect this 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), 3) data entry error and/or 4) Peace Corps is currently not reporting on this indicator so OVC served <18 under PC would be missing.
Review any site with the following reporting issues: 1) numerator greater than 100% of OVC_SERV <age 18, 2) very low coverage of OVC_HIVSTAT, 3) sum of "Currently on ART" and "Not currently on ART" do no equal the "Reported HIV positive to IP" results and 5) sum of "Test not indicated" and "Other reasons" do not equal "Reported No Status to IP".</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Use result reported at Q4.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>Numerator: Number of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner, disaggregated by status type.</td><td>Disaggregate Groups
Status Type [Required]</td><td>Disaggregates
• Reported HIV positive to implementing partner
○ Currently receiving ART
○ Not currently receiving ART
• Reported HIV negative to implementing partner
• No HIV status reported to the implementing partner
○ Test not indicated based on HIV risk assessment
○ Other reasons</td></tr>
<tr><td></td><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td></td><td colspan="3">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</td></tr>
</table>

reporting period (regardless of where the test occurred). All entries for "reported HIV positive to IP" should be further disaggregated as "**currently receiving ART**" or "**not currently receiving ART**." 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 as "Reported HIV positive to IP" in the previous reporting period, should continue to be reported as positive during the current reporting period and their enrollment in ART 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 2) the child is tested and reported as HIV negative, or 3) the child is reported as "No Status" and under one of its disaggregates ("Test not indicated" or "Other reasons").
- "**No HIV status reported to the IP**" includes beneficiaries who fall into one of the below described categories:
  - "**Test not indicated**" – 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. (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 indicated)
  - "**Other reasons**" – includes all beneficiaries (OVC_SERV <age 18) not entered in above categories. Potential scenarios included in other reasons include:
    i. Caregiver refuses to disclose whether the child has been tested and his/her current HIV status in the reporting period
    ii. Caregiver refuses to let the IP conduct a risk assessment on the child in the reporting period.
    iii. 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.
    iv. The IP is still in the process of convincing the caregiver to get the child assessed, tested and/or disclosure of status. Since this is a new indicator and takes time, IPs may not be positioned to report within the reporting period and would be captured under – Undisclosed to IP - Other Reasons. The IP should monitor these children and provide services to encourage referral completion and disclosure in the next reporting period.
- Children entered as "No HIV status reported to the IP" with the disaggregate "Other reasons" in the previous reporting period should receive follow-up services to encourage referral completion/disclosure of status to the IP. Children reported as "No HIV Status to the IP" with the disaggregate "Test not indicated" with no changes in their risk situation for 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:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for OVC beneficiaries receiving care and support services in the community include: 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.) or procurement of critical commodities essential for ongoing service delivery. Partial salary support may include stipends or incentives for volunteers, or paying for transportation of those staff to the point of service delivery. For care and support services, ongoing support for OVC service delivery for improvement includes: 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. For OVC_HIVSTAT, if less than 100% of caregivers have reported their child's status, please explain the percentage that have not reported to the IP their child's status and the plan to get closer to 100% coverage. Are there certain partners that are struggling and how the Mission is responding? 2. For children reported as not currently on ART, what are efforts are being undertaken in response? Are there certain partners with low ART coverage, why? 3. Please explain the breakdown of those reported under No Status. What percentage were: 1) risk assessed and reported as test not indicated and 2) test indicated, 3) caregivers unwilling to disclose status; 4) incomplete referrals for testing; 5) Other reasons (please specify).

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.
Changes in indicator:	N/A	
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.	

<table>
<tr><td></td><td colspan="3">
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.
<table>
<tr><td></td><td colspan="12">FY2017 (Report results for the entire 12-month reporting period for these indicators at the Q4 reporting cycle)</td></tr>
<tr><td>Reporting Month (FY 2017)</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr>
<tr><td></td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td><td>↓</td></tr>
<tr><td>Birth Month (FY 2015)</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td></tr>
</table>

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).
</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Use annual result reported at Q4.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>Numerator: Number of HIV-exposed infants with a</td><td>Disaggregate Groups
Outcome Type [Required]</td><td>Disaggregates
• HIV-infected;
• HIV-uninfected;
• HIV-final status unknown;</td></tr>
</table>

<table>
<tr><td></td><td>documented outcome by 18 months of age disaggregated by outcome type.</td><td></td><td>• Died without status known</td></tr>
<tr><td></td><td rowspan="2">Denominator:
Number of HIV-exposed infants who were born 24 months prior to the reporting period and registered in the birth cohort.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>N/A</td><td>N/A</td></tr>
<tr><td></td><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td></td><td colspan="3">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.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="3">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,</td></tr>
</table>

	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

On ART Indicators

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	
Changes in indicator:	• TB disaggregate added to the indicator (MER 1.0 to MER 2.0). • Key population disaggregate added to the indicator (MER 1.0 to MER 2.0). • Age/sex disaggregates updated (MER 2.0 v2.1 to v2.2). • Clarifying language added for Key Populations disaggregation the notes that KP should be counted in only one KP group to avoid double-counting. More information is provided below (MER 2.0 v2.1 to v2.2).	
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.** TB/ HIV disaggregation: At initiation of ART, number of patients with a confirmed diagnosis of TB (new and relapsed) and/or on TB treatment collected from TB/HIV registers; Pregnant/BF disaggregation: Women who initiate ART while breastfeeding should be counted under this indicator but not in PMTCT_ART. Women who initiate during pregnancy and are reported under PMTCT_ART should also be reported here. Key population disaggregation* see Appendix 1 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	

<table>
<tr><td></td><td colspan="3">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.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">• Confirm that TX_CURR ≥ TX_NEW
• Only one age disaggregation type is used for age/sex: 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.
• 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.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Sum across all reporting periods</td></tr>
<tr><td rowspan="6">Data elements (components of indicator):</td><td rowspan="5">Numerator: Number of adults and children newly enrolled on antiretroviral therapy (ART)</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td><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</td></tr>
<tr><td>TB/HIV Status
[Required}</td><td>Number new on treatment with confirmed diagnosis of TB (new and relapsed) and/or TB treated</td></tr>
<tr><td>Pregnancy and breastfeeding status at ART initiation
[Required]</td><td>• Pregnant at initiation of ART;
• 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="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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="3">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for PLHIV receiving ART include:</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.</td></tr>
</table>

	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. If TX_NEW does NOT equal HTS_TST_POS, explain why. 2. If TX_NEW result is markedly different from targets, explain why.

TX_CURR

Description:	Number of adults and children currently receiving antiretroviral therapy (ART)	
Numerator:	Number of adults and children currently receiving antiretroviral therapy (ART)	The current on ART count should equal the number of adults and children with HIV infection who ever started ART **MINUS** those patients who are not currently on treatment at the end of the reporting period.
Denominator:	N/A	
Changes in indicator:	• Age/sex disaggregates updated (MER 2.0 v2.1 to v2.2).	
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.
	
	The current on ART count should equal the number of adults and children with HIV infection who ever started ART minus those patients who are not currently on treatment at the end of the reporting period.
	• Patients on ART who initiated or transferred-in during the reporting period should be counted.
	• Patients who have received enough ARVs to last to the end of the reporting period should be counted including those patients that pick up several months of antiretroviral drugs at one visit
	• 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 (LTFU). LTFU is defined as a patient who has not received ARVs in the last 90 days (three months) following their last missed appointment or missed drug pick-up. (Note: As models of service delivery change to reflect longer visit intervals for stable patients, it is important to emphasize the definition of LTFU applies to both missed visits or missed drug pick-up, but does not apply who have not received ARVs in the last 90 days (three months) following their last attended appointment or attended drug pick-up. As that interval between scheduled visits for stable patients maybe longer than 3 months.)
	
	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	

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

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.

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.</td></tr>
<tr><td>Reporting level:</td><td>Facility</td></tr>
<tr><td>How often to report:</td><td>Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td>• Confirm that TX_CURR ≥ TX_NEW
• Only one age disaggregation type is used for age/sex: 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.
• Numerator ≥ subtotal of age/sex disaggregation: The total number of adults and children newly enrolled on ART should be greater or equal to the sum of the age/sex disaggregations
• 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>Snapshot indicator. Use the result reported at Q4.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>
<table>
<tr><td>Numerator: Number of adults and children currently receiving antiretroviral therapy (ART)</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Age/Sex
[Required]</td><td><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, 40-49 M, 40-49 F, 50+ M, 50+ F</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">Age/Sex: Age is defined as the age of the patient at the date of reporting, not the age at the date of initiation on ART.</td></tr>
</table>
</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 PLHIV receiving ART include</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</td></tr>
</table>

	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. If the change in TX_CURR from the previous reporting period (TX_NET_NEW) is substantially different from TX_NEW, explain why (i.e., if you can, estimate or comment on the numbers of patients who died, transferred or were lost to follow-up). 2. Please describe the reasoning for any net losses in treatment from the previous quarter.

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):** Denominator is no longer collected as part of indicator, but rather is calculated as PMTCT_STAT_POS.	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**)
Changes in indicator:	• Collect only ART disaggregates and collected only at antenatal care (ANC) sites to better align with 2016 Consolidated WHO ARV guidelines, reduce burden on data collection, and improve data quality (MER 1.0 to MER 2.0). • Denominator is no longer collected as part of indicator, but rather is calculated as PMTCT_STAT_POS (MER 1.0 to MER 2.0).	
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". Women who initiate ART while breastfeeding should not be counted under this indicator, and should instead be reported as part of the TX_NEW indicator (see TX_NEW; disaggregate group pregnancy/breastfeeding status). 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.	
Reporting level:	Facility	
How often to report:	Quarterly	
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	

<table>
<tr><td></td><td colspan="3">documented at another facility leading to the appearance of greater than >100% coverage at one site and 0% coverage at another.

Compare the number of HIV-positive pregnant women newly initiating ART (PMTCT_ART disaggregate) and the number individuals newly initiated on ART (TX_NEW disaggregate) who are pregnant (disaggregation of the new on treatment indicator). It is expected that women are new ART initiations are reported in both indicators; however the data source is often different (ANC/PMTCT register for PMTCT_ART and ART register for TX_NEW) and to discrepancies can provide better understanding of data quality.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">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 rowspan="4">Data elements (components of indicator):</td><td rowspan="2">Numerator: Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Maternal Regimen Type [Required]</td><td>• New on ART
• Already on ART at the beginning of current pregnancy</td></tr>
<tr><td>Denominator: PMTCT_STAT_POS</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>See PMTCT_STAT.</td><td>See PMTCT_STAT.</td></tr>
<tr><td></td><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td></td><td colspan="3">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. (These should also be counted in “TX_NEW” see TX_NEW, Disaggregate group breastfeeding/pregnancy status): 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: Maybe 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="3">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.</td></tr>
</table>

Guiding narrative questions:	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.

TB_ART

Description:	The number 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.
Changes in indicator:	▪ HIV treatment disaggregate revised to be already on ART/new on ART (MER 1.0 to MER 2.0). ▪ TB_ART denominator entry removed from DATIM. TB_ART denominator is TB_STAT_POS. (MER 2.0 v2.1 to v2.2).	
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.	
Reporting level:	Facility	
How often to report:	Semi-Annual	
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 across both reporting periods.	

Data elements (components of indicator):

Numerator: Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period

Disaggregate Groups	Disaggregates
ART Status [Required]	• New on ART • Already on ART
Age/Sex [Required]	<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

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:	Provision of key staff or commodities for TB cases receiving HIV-related services include: ongoing provision of critical re-occurring costs or commodities (such as ARVs) or funding of salaries or provision of Health Care Workers for TB/HIV clinic services. Where TB and

	HIV services are not integrated, this can include support for system/personnel critical to patient referral, transfer or tracking that ensures patient linkage between the TB and HIV programs/facilities that is required to accomplish the delivery of the service. 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: Clinical mentoring and supportive supervision of staff at ART sites, Quality Improvement services support, patient tracking/referral system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management.
Guiding narrative questions:	1. 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.

TX_TB

Description:	The proportion of ART patients screened for TB in the semiannual reporting period who are receiving TB treatment.		
Numerator:	The 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:	The 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.	
Changes in indicator:	• Denominator disaggregate for TB screen results has been updated to include Start of ART by TB screen result (MER 2.0 v2.1 to v2.2).		
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.		
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. 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.		
Reporting level:	Facility		
How often to report:	Semi-Annual		
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:	Snapshot indicator. Use the result reported at Q4.		
Data elements (components of indicator):	**Numerator**: Number of ART patients who were started on TB treatment during the semiannual reporting period.	**Disaggregate Groups** ART Status (Current/New on ART) [Required]	**Disaggregates** • The number of patients starting TB treatment who newly started ART during the reporting period • The number of patients starting TB treatment who were already on ART prior to

			the start of the reporting period
		Age/Sex [Required]	<15 F, 15+ F, <15 M, 15+ M
	Denominator: The number of ART patients who were screened for TB at least once during the semiannual reporting period.	**Disaggregate Groups**	**Disaggregates**
		Start of ART by Screen Result [Required]	• New on ART/Screen Positive; • New on ART/Screen Negative; • Previously on ART/Screen Positive; • Previously on ART/Screen Negative
		Specimen Sent [Required]	Number of ART patients who had a specimen sent for bacteriologic diagnosis of active TB disease.
		Diagnostic Test (Disaggregation of Specimen Sent) [Required]	• GeneXpert MTB/RIF assay (with or without other testing) • Smear microscopy only • Additional test other than GeneXpert
		Age/Sex [Required]	<15 F, 15+ F, <15 M, 15+ M
	Disaggregate Descriptions & Definitions		
	Start of ART by Screen Result: • 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. • 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. • 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. • 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.		
PEPFAR-support definition:	For DSD for HIV-related services, the provision of key staff and/or commodities can include ongoing provision of critical re-occurring costs or commodities (such as laboratory supplies, GeneXpert cartridges etc.) and/or delivery of TB symptom screening and bacteriological testing to the counted individuals, such as through funding of salaries or provision of Health Care Workers for TB 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. For DSD and TA for TB/HIV-related services, TB and HIV clinical care facilities and community-based services will be counted as supported by TA/QI when PEPFAR provides established presence and/or routinized, frequent (at least quarterly) support for the services by PEPFAR at the point of service delivery, clinical mentoring and supportive supervision of staff providing TB/HIV services, Quality Improvement services,		

	routine support of M&E, TB screening and bacteriologic testing, commodities consumption forecasting and supply management, or specimen transport and result return.
Guiding narrative questions:	1. If the denominator does not roughly equal TX_CURR, please describe the main reasons. 2. If there are issues with reporting the disaggregations, please describe. 3. Are the patients in the numerator all receiving care from PEPFAR-supported sites? Are they receiving TB and HIV care from the same site?

Viral Suppression Indicators

TX_RET		
Description:	Percentage of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy (Note: reporting 24 and 36 months is recommended, but optional)	
Numerator:	Number of adults and children who are still on treatment at 12 months after initiating ART	The numerator is defined as the number of adults and children who are still on treatment twelve months after initiating ART.
Denominator:	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died and those who have stopped ART. Does not include transfer outs.	The denominator is defined as the number of all adults and children who were initiated on treatment in the 12-month period before the reporting period. The denominator includes those "New" on ART as well as those who "Transferred In" if they have a cohort-start date within the reporting period of interest. However, transfers-out should be taken out of both the denominator as well as the numerator. It is assumed that if a patient transfers out from an ART facility, that patient will be a "transfer in" at a new ART facility.
Changes in indicator:	• 24 and 36 months were added as optional time periods to monitor changes to retention of these patients as models of service delivery change for stable patients on ART (the definition of stable varies across contexts, but often excludes patients on ART for less than 12 months) (MER 1.0 to MER 2.0). • As models of service delivery change to reflect longer visit intervals for stable patients, it is important to emphasize the definition of LTFU applies to both missed visits or missed drug pick-up, but does not apply who have not received ARVs in the last 90 days (three months) following their last attended appointment or attended drug pick-up. As that interval between scheduled visits for stable patients maybe longer than 3 months. • Age disaggregations updated (MER 2.0 v2.1 to v2.2).	
How to use:	This indicator measures the proportion of individuals who have been retained on antiretroviral therapy (ART). ART is viewed by the scientific community and PEPFAR not only as essential for decreasing morbidity and mortality, but also as a highly effective approach to prevent HIV transmission. High retention is one important measure of program success, specifically in reducing morbidity and mortality, and is a proxy for overall quality of the ART program. Monitoring the program level retention is a critical quality of service indicator at the site, national and PEPFAR program levels as it can highlight barriers to health seeking behaviors and/or gaps in access to and provision of health services.	
How to collect:	Information should come from electronic systems (EMR) if possible. Where electronic systems do not exist ART registers/databases and cohort/group analysis forms can be used to count patients that have been retained after 12, 24 or 36 months on ART. This indicator **should NOT be estimated**. This indicator should be calculated directly from information gathered in standard cohort ART registers or electronic patient level databases.	

While reporting on 24 and 36 month retention is optional for PEPFAR reporting, it is strongly recommended so that programs can have a better understanding of longer term outcomes for patients on ART.

Sites are required to disaggregate retention by pregnancy and breastfeeding and specific age/sex disaggregates (see data element below). In order to collect this information ART registers, cohort/group analysis forms, and EMRs must document age, sex, pregnancy status, and breastfeeding status on the date of ART initiation.

Of note, for reporting purposes a three-month grace period should be observed following drug pick-up, before concluding a patient is actually LTFU. However, while practical, if follow-up of patients is delayed until LTFU is official, the majority of clients who do not present by three months of last missed appointment/drug pick-up are very unlikely to return thereafter. Therefore, for patient management, the facility should make every effort to contact a patient as soon as s/he misses an appointment and/ or drug pick-up (by phone, via community health worker) rather than waiting for the prescribed 90 days. This is particularly important when patients are routinely seen every three to six months (a patient may not have been seen for up to nine months if the facility adheres to the waiting period before attempting contact). LTFU is an ambiguous outcome that may often include patients who have self-transferred (silent transfer, without proper documentation or referral from their original primary care facility) or have died for which there is no documentation. Every effort should be made to document the more concreate outcomes for those not on ART (i.e., died, stopped ART, transfer out) to make the information more useful.

The numerator is defined as the number of adults and children who are still on treatment twelve months after initiating ART.

For example, if the PEPFAR reporting period is 1 October 2016 to 30 September 2017, countries will calculate this numerator by using all patients who started ART any time during the 12-month period from 1 October 2015 to 30 September 2016. The 12-month outcomes are defined as 1) on ART and 2) not on ART because patient died, stopped ART or was lost to follow-up (LTFU), (including silent transfers).

On ART is defined as those patients who had received enough ARVs to last to the end of the reporting period. See example below for more details.

- LTFU is defined as a patient who has not received ARVs in the last 90 days (three months) following their last missed appointment or missed drug pick-up.
- Died: Patients that are documented death during the previous 12 months period.
- Stopped ART: Patient intentionally stops ART, usually, but not always in discussion with the clinical team.
- Known Transfers: Patients who have transferred in with a known treatment initiation date that falls within the reporting period should be counted. Conversely, patients who transferred out of the facility should not be counted in the numerator (or denominator, see below)

Note: this indicator does not collect adherence information, but only retention, therefore the numerator does not require patients to have been on ART continuously for the 12-month period. Patients may be included in the numerator (and denominator) if they have missed an appointment or drug pick-up or temporarily stopped treatment

	during the 12 months since initiating treatment, as long as they are recorded as still being on treatment at month 12. For example. A patient who started ART in September 2016 would be considered "on ART at 12 months" (in September 2017) if: • The patient visited the facility and received ARVs in September 2017; **OR** • The patient had enough ARVs to last through the end of September 2017 (month 12) based on the last drug pick-up (e.g., patient received 60 days of drug on August 15th, or patient received 90 days of drug on July 1st, etc.). However, the patient would NOT be considered "on ART at 12 months" if: • The patient did NOT have enough ARVs to last through the end of September 2017 (e.g., patient received 30 days of drug on August 1st); **OR** • The patient had died, transferred out, stopped ART, or was lost to follow-up at the end of September 2017. The denominator is defined as the number of all adults and children who were initiated on treatment in the 12-month period before the reporting period. The denominator includes those "New" on ART as well as those who "Transferred In" if they have a cohort-start date within the reporting period of interest. However, transfers-out should be taken out of both the denominator as well as the numerator. It is assumed that if a patient transfers out from an ART facility, that patient will be a "transfer in" at a new ART facility. For example, for the reporting period October 1, 2016 to September 30, 2017, this will include all patients who started ART during the 12-month period from October 1, 2015 to September 30, 2016. This includes all patients, both those on ART as well as those who have died, stopped ART or were lost to follow-up (LTFU). Only sites that have been operational for at least 24 months prior to the end of the reporting period should report. PEPFAR country teams may use the USG FY reporting period as the timeframe for the 12-month cohort. Teams may also wish to 'lag' by 1-3 months the cohort-months comprising the annual cohort, in order to allow sufficient time for reporting from data sources (i.e., implementing partners and/or national systems).		
Reporting level:	Facility		
How often to report:	Annually		
How to review for data quality:	• TX_RET Denominator ≥ TX_RET Numerator • Denominator ≥ subtotal of each disaggregation: The total number of adults and children who initiated ART in the past 12 months should be greater or equal to the sum of the disaggregations by (1) Pregnancy/breastfeeding status and (2) age/sex • Numerator ≥ subtotal of each disaggregation: The total number of adults and children still on treatment at 12 months should be greater or equal to the sum of the disaggregations by (1) Pregnancy/ breastfeeding status and (2) age/sex • Number of PEPFAR supported sites that report TX_RET vs number of sites that report TX_CURR by region to determine completeness of reporting		
How to calculate annual total:	Use result reported at Q4/APR. Numerator should be divided by denominator to determine % retained; % retained for pregnant and breastfeed women; as well as children <15 % retained should be calculated separately and used to assess these programs.		
	Numerator:	**Disaggregate Groups**	**Disaggregates**
		Longer term retention	• 24-month retention

<table>
<tr><td rowspan="6">Data elements (components of indicator):</td><td rowspan="3">Number of adults and children in the cohort, who are still on treatment at 12 months after initiating ART.</td><td>[Optional]</td><td>• 36-month retention</td></tr>
<tr><td>Pregnant/Breastfeeding [Required]</td><td>• Pregnant
• Breastfeeding</td></tr>
<tr><td>Age/Sex [Required]</td><td><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</td></tr>
<tr><td rowspan="3">Denominator: Total number of adults and children who initiated ART in the in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up during the subsequent 12 months.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Longer term retention [Optional]</td><td>• 24-month retention
• 36-month retention</td></tr>
<tr><td>Pregnant/Breastfeeding [Required]</td><td>• Pregnant
• Breastfeeding</td></tr>
<tr><td></td><td>Age/Sex [Required]</td><td><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</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="4">Longer term retention: Although optional, it is recommended for sites to include their longer-term ART retention numbers (including retention at 24 and 36 months).

Pregnant/Breastfeeding: Pregnancy and Breastfeeding status is defined as the status at the date of initiation on ART, not the status at the date of reporting.

Age/sex: Age is defined as the age 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="3">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for PLHIV receiving ART include</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="3">1. If TX_RET is below 85%, describe the main reasons for non-retention or difficulties in capturing retention.
2. If there are geographic, age or sex differences in TX_RET, describe the most likely reasons</td></tr>
</table>

	3. Describe the definition of LTFU utilized by the team to determine if a patient has been retained on treatment. What systems, registers, or tools were used to calculate this indicator?

TX_PVLS

Description:	Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)	
Numerator:	Number of adult and pediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and /or supporting laboratory results within the past 12 months	If there is more than one VL test during the last 12 months, report the most recent test. Only patients who have been on ART for at least 3 months should be counted.
Denominator:	Number of adult and pediatric ART patients with a viral load result documented in the patient medical record and/or laboratory records in the past 12 months.	Only patients who have been on ART for at least 3 months should be counted.
Changes in indicator:	• The indicator now requires the suppressed viral load result to be documented in the clinic patient record and only use the laboratory system for results if it can be linked back to the individual patient file (MER 1.0 to MER 2.0). • Age disaggregations updated (MER 2.0 v2.1 to v2.2). • The indicator now requires that patients be on ART for at least 3 months to be reported on under TX_PVLS (MER 2.0 v2.2 Revised Release). • Shift in categorization of follow-up VL test done after an initial VL test result of VL>1,000. Follow-up viral loads done after an initial VL test result of VL>1,000 should be counted under routine and not targeted since all patients who receive an initial VL test result of VL>1,000 should be routinely receive a follow-up VL test after some enhanced adherence counseling (MER 2.0 v2.2 Revised Release).	
How to use:	This indicator monitors the proportion of documented viral load tests from adult and pediatric ART patients who have been on ART for at least 3 months with a suppressed result (<1,000 copies/ml), allowing ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression. Comparison of the denominator for this indicator with the result for TX_CURR can be used to estimate viral load testing coverage supported by PEPFAR.	
How to collect:	This indicator should be collected from the clinical source to assure unduplicated patient counting and receipt of results to inform patient care. Information should come from electronic systems (EMR) if possible. Where electronic systems do not exist patient registers can be used to count patients and VL collected/sent VL test (denominator) or VL results (numerator). If the standard registers or reports do not contain all the required information, individual patient files should be reviewed. To determine if a lab test was collected/sent additional supporting information for this indicator can be obtained from standard laboratory information systems (including electronic systems or paper-based registries or logbooks), but the viral load test submission and result must be able to be linked to specific patient. VL results should be reported for patients who have been on ART for at least 3 months. 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 three months.	

<table>
<tr><td></td><td colspan="3">NOTE: IF the patient file does not include this information (collected/sent VL test or VL results) but the information was reported from the laboratory information system; then it is strongly recommended that IP ensure that this information is transcribed to the patient file for improved quality care and treatment services.

This indicator should be reported for all PEPFAR supported treatment sites (reported TX_CURR and TX_NEW) with VL monitoring to promote site level use and reporting of patient viral suppression information. If a PEPFAR supported treatment site has not conducted any viral load testing, a 0 should be entered for both the denominator, as well as the numerator. Where more than one result is available for the reporting period, the most recent result should be reported. If viral load sample has been sent for testing, but no result has been recorded, this should not be included in the numerator or denominator of this indicator. Programs should describe the method(s) of data collection in their APR narratives, along with describing methodology for de-duplication of results.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annually</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">• Denominator ≥ Numerator: The number of viral load tests performed from adults and children on ART must be greater than or equal to the number of viral load tests from adult and pediatric ART patients with a viral load <1,000 copies/ml.
• Numerator ≥ subtotal of each disaggregation: The total number of viral load tests from adult and pediatric ART patients with a viral load <1,000 copies/ml should be greater than or equal to the sum of all of the disaggregation by age/sex, pregnancy/breastfeeding status, and test indication.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Use result reported at Q4/APR.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>Numerator: Number of adult and pediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and /or supporting laboratory results within the past 12 months</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td></td><td>Indication [Required]</td><td>• Routine;
• Targeted;
• Not Documented</td></tr>
<tr><td></td><td></td><td>Pregnant/Breastfeeding Indication [Required]</td><td>• Pregnant Routine;
• Pregnant Targeted;
• Pregnant Not Documented;
• Breastfeeding Routine;
• Breastfeeding Targeted;
• Breastfeeding Not Documented</td></tr>
<tr><td></td><td></td><td>Age/Sex/Indication [Required]</td><td>• Routine: <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;
• Targeted: <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;
• Not Documented: <1, 1-9, 10-14 M, 10-14 F, 15-19 M,</td></tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>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</td></tr>
<tr><td></td><td rowspan="4">Denominator: Number of adult and pediatric ART patients with a viral load result documented in the patient medical record and /or laboratory records in the past 12 months.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Indication [Required]</td><td>• Routine;
• Targeted;
• Not Documented</td></tr>
<tr><td>Pregnant/Breastfeeding Indication [Required]</td><td>• Pregnant Routine;
• Pregnant Targeted;
• Pregnant Not Documented;
• Breastfeeding Routine;
• Breastfeeding Targeted;
• Breastfeeding Not Documented</td></tr>
<tr><td>Age/Sex/Indication [Required]</td><td>• Routine: <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;
• Targeted: <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;
• Not Documented: <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</td></tr>
<tr><td></td><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td></td><td colspan="3">Indication Disaggregate Definitions:
• Routine: Refers to viral load tests obtained at standard intervals following ART initiation to monitor virologic response to ART (Timing is dependent on the National guidelines, but should be recommended to occur at least annually). This includes follow-up viral loads done after an initial VL test result of VL>1000 since follow-up tests should routinely done on patients with an initial VL>1000.
• Targeted: refers to viral load tests obtained 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.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="3">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for PLHIV receiving ART include</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</td></tr>
</table>

	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. Please describe the overall proportion of patients who received a VL (i.e., describe the overall coverage of VL testing in the country, with any differences by region or age). 2. If there were lower-than-expected numbers of targeted or routine VL testing, explain. 3. Describe any association of ART regimen type with TX_PVLS. 4. Describe the data sources used to report on this indicator (e.g. EMR, LIS, DHIS2 etc.) and efforts made to ensure individual, not tests are being reported. 5. Clarify how the program is able to ensure that only patients who have been on ART for at least 3 months are being reported. 6. Briefly describe the VL testing algorithm used in country.

Health Systems Indicators

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.
Changes in indicator:	• Semi-Annual reporting is **required** for this indicator (MER 1.0 to MER 2.0).	
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.	

<table>
<tr><td></td><td colspan="3">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%

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>Reporting level:</td><td colspan="3">Facility (Medical Stores including Central Medical Stores, Regional Medical Stores, and District sites which supply commodities to lower health facility)</td></tr>
<tr><td>How often to report:</td><td colspan="3">Semi-Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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 colspan="3">N/A</td></tr>
<tr><td rowspan="5">Data elements (components of indicator):</td><td rowspan="3">Numerator: Sum the observations of stock status for tracer commodities that are between maximum and minimum quantities/months of stock from storage sites within a given level of the system during the reporting period</td><td>Disaggregate Groups</td><td>Disaggregates</td></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>
<tr><td rowspan="3">Denominator: Total number of observations of stock status for tracer commodities at the same level of the system during the same reporting period.</td><td>Disaggregate Groups</td><td>Disaggregates</td></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>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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 colspan="3">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.</td></tr>
</table>

	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) 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. **Technical Assistance-only Support (TA-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?

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
Denominator:	N/A	
Changes in indicator:	No change.	
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 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.
Reporting level:	Above-service Delivery Area
How often to report:	Annually
How to review for data quality:	N/A

<table>
<tr><td>How to calculate annual total:</td><td colspan="3">N/A</td></tr>
<tr><td rowspan="3">Data elements (components of indicator):</td><td rowspan="2">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</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>By Cadre:
[Required]</td><td>• Doctors
• Nurses
• Midwives
• Social Service Workers
• Laboratory Professionals
• Other</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">N/A</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="3">As an 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)</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="3">None.</td></tr>
</table>

HRH_STAFF

Description:	Number of health worker full-time equivalents who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) at PEPFAR-supported facility sites	
Numerator:	Number of health worker full-time equivalents who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) at PEPFAR-supported facility sites	This indicator is the number of full-time equivalent positions (FTE) working on HIV ("HIV FTE") at PEPFAR facility sites.
Denominator:	N/A	
Changes in indicator:	No changes in this indicator.	
How to use:	This indicator is the number of full-time equivalent positions (FTE) working on HIV ("HIV FTE") at PEPFAR facility sites. Calculate part-time positions working exclusively on HIV, or full-time positions working on several areas including HIV and other illnesses, as fractions, based on hours worked relative to full-time equivalency hours. Full time equivalency hours should be the standard listed in the cadre's scheme of service and/or Ministry of Health guidelines. 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 community sites. 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.) 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.	

<table>
<tr><td></td><td colspan="3">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.</td></tr>
<tr><td>How to collect:</td><td colspan="3">PEPFAR team or Implementing Partners (IP) should collect and report on this data during the last quarter of the year. Designate one IP per site to collect HRH_STAFF. If more than one IP is working at the same PEPFAR supported facility, teams should determine which IP will collect data for HRH_STAFF. Country teams need to collect data from all PEPFAR-supported sites irrespective of PEPFAR's financial support of health workers at a site (as captured by HRH_CURR.)

Number of health workers reported should be expressed as full-time equivalency (FTE) positions, including part-time health workers or health workers who work part-time on HIV, expressed as fractions of FTE corresponding to estimated hours worked on HIV per week out of total hours per week prescribed as full-time for that cadre in the national scheme of service, or other Ministry of Health guidelines.

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.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">Numerator auto-calculates based on the sum of the cadre group type disaggregation.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Use results reported at Q4.</td></tr>
<tr><td rowspan="3">Data elements (components of indicator):</td><td rowspan="2">Numerator: Number of health worker full-time equivalents who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) at PEPFAR-supported facility sites</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>By Cadre Group Type: [Required]</td><td>• Clinical
• Clinical Support
• Management
• Social Service
• Lay
• Other</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">Cadre Group Type Definitions:
Note: In the indicator narrative, please specify which cadres you included in each cadre group.
• 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, testing and counseling providers. They should have completed a diploma or certificate program according to</td></tr>
</table>

	a standardized or accredited curriculum and support or substitute for university-trained professionals.) • **Clinical Support** workers are those who support clinical services at the site but do not directly provide services to clients: (Pharmacists, medical technologists, laboratorians, lab and pharmacy technicians) • **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** – workers who do not fit into any of the categories above.
PEPFAR-support definition:	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.
Guiding narrative questions:	1. Please provide description of how FTE was calculated. 2. For all categories of workers, including other, please provide description of specific cadres in the narrative when reporting.

HRH_CURR

Description:	Number of health worker full-time equivalents who are working on any HIV-related activities i.e., prevention, treatment and other HIV support and are receiving any type of support from PEPFAR	
Numerator:	Number of health worker full-time equivalents who are working on any HIV-related activities i.e., prevention, treatment and other HIV support and are receiving any type of support from PEPFAR	This indicator is reported at the facility, community, and above-service delivery areas.
Denominator:	N/A	
Changes in indicator:	• HRH_CURR was previously reported at the facility site and community site levels by type of cadre and type of support. Above service delivery area workers are now included in this indicator (MER 1.0 to MER 2.0). • Added new types of staffing support (Salaried staff, Staff receiving Stipends, Staff receiving non-monetary support) (MER 1.0 to MER 2.0).	
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. 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 person-time that PEPFAR-supported health workers 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 or FTEs 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 EA reporting, to identify PEPFAR support of HRH. Hours worked on HIV may be estimated using staff work-week scheduling calendars and HIV clinic/lab opening hours, and speaking with facility in-charges. For community sites, hours worked on HIV can be estimated using average beneficiary consultation times, and average number of consultations. 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	

<table>
<tr><td></td><td colspan="3">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.

We recommend that PEPFAR implementing partners following these steps:
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, lab technician).
4) 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).
5) Assign those types of support to the health workers identified on your site lists.
Create a matrix of supported health workers by cadre and support type:
6) Further split the health workers into sub-groups based on the most appropriate mutually exclusive type of PEPFAR support. (*Assign FTE to the “highest” category - Non-monetary support should be reported if you provide only non-monetary support, with no salary or stipend
7) Calculate the FTE: Hours per week that this mechanism supports for HIV-related services at this site / Hours in a full-time work week
Repeat this separately for the three types of support:
8) Take the average FTE for each cadre
9) Add up the total FTE within each broader cadre category (clinical, clinical support, management, lay, social service, other)
10) Enter this amount in DATIM in the corresponding box for cadre category – support type.

Above-service delivery area 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.</td></tr>
<tr><td>Reporting level:</td><td colspan="3">Facility, Community, and Above-Service Delivery Area.</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">Appendix 6 outlines an example HRH_CURR calculation that helps to articulate the reporting structure of this indicator.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Fill out disaggregated data entry form first, annual total will auto-calculate from 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.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>Numerator: Number of health worker full-time equivalents who are working on any HIV-related activities i.e., prevention, treatment and</td><td>Disaggregate Groups
By Cadre Category (Facility & Community-Level) by type of support provided by PEPFAR to the staff
[Required]</td><td>Disaggregates
• Clinical: Salaried Staff (FTE); Staff Receiving Stipends (FTE); Staff Receiving ONLY Non-Monetary Support (FTE);
• Clinical Support: Salaried Staff (FTE); Staff Receiving Stipends (FTE); Staff</td></tr>
</table>

	other HIV support and are receiving any type of support from PEPFAR at facility sites, community sites, and at the above-service delivery area level.		Receiving ONLY Non-Monetary Support (FTE); • Management: Salaried Staff (FTE); Staff Receiving Stipends (FTE); Staff Receiving ONLY Non-Monetary Support (FTE); • Social Service: Salaried Staff (FTE); Staff Receiving Stipends (FTE); Staff Receiving ONLY Non-Monetary Support (FTE); • Lay: Salaried Staff (FTE); Staff Receiving Stipends (FTE); Staff Receiving ONLY Non-Monetary Support (FTE); • Other: Salaried Staff (FTE); Staff Receiving Stipends (FTE); Staff Receiving ONLY Non-Monetary Support (FTE)
		By Cadre Category (Above-Service Delivery Area) by type of support provided by PEPFAR to the staff [Required]	• Management (Central Level): Salaried Staff (FTE); Staff Receiving Stipends (FTE); • Management (Subnational Unit Level): Salaried Staff (FTE); Staff Receiving Stipends (FTE); • Epidemiologist/Surveillance: Management (Central Level): Salaried Staff (FTE); Staff Receiving Stipends (FTE); • Faculty/Tutors: Management (Central Level): Salaried Staff (FTE); Staff Receiving Stipends (FTE); • Other: Management (Central Level): Salaried Staff (FTE); Staff Receiving Stipends (FTE)
	Disaggregate Descriptions & Definitions		
	Cadre Category (Facility & Community Level) Descriptions: • 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, 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. • Clinical Support workers are those who support clinical services at the site but do not directly provide services to clients: Pharmacists, medical technologists, laboratorians, lab and pharmacy technicians • 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: workers who do not fit into any of the categories above.

Cadre Category (Above Service Delivery Area) Descriptions:

- 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)
- Faculty (Tutors and Trainers) are those staff working at pre-service institutions and training centers/departments.
- Epi/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.

Type of Support Provided by PEPFAR to the Staff: For each cadre category supported by PEPFAR at the site level, further disaggregate the HIV FTE by the type of support provided by PEPFAR. The total HIV FTE should equal the sum of the HIV FTE by three types of support. Do not disaggregate the above-service delivery area cadre category FTE by type of support.

- Salary – Total number of HIV FTE positions for which PEPFAR is providing any level of financial support toward their regular salary. Include all HIV FTE (all person-time spent on HIV) if any amount of salary support is provided, even if they also receive support from sources other than PEPFAR. This represents the total FTE that are "touched" by PEPFAR salary support. 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 – Total number of HIV FTE positions for which PEPFAR does not provide salary support but does provide monetary payments in connection with the provision of HIV services. Stipend payments are not necessarily disbursed in regularly scheduled intervals, and are not necessarily commensurate with, nor benchmarked toward, a government salary scale or international salary standard. These include one-time reimbursements for expenses connected to travel or training (per diems); and supplementary payments, for example, for overtime

	worked due to HIV case burden. Payment could be made at regular intervals depending on agreement. • Non-monetary only – Total number of HIV FTE positions for which PEPFAR provides only non-monetary support. Report if PEPFAR provides 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, meals, 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. Please provide description of how FTE was calculated. 2. For all categories of workers, including other, please provide description of specific cadres in the narrative. 3. Please include description of what type types of non-monetary support are captured. 4. Please confirm that workers listed as under non-monetary receiving only non-monetary support (not in addition to salary or stipend)?

EMR_SITE

Description:	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	
Numerator:	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	Answer recorded separately for each service delivery area.
Denominator:	Denominator is not collected as part of this indicator. However, it should be the total number of PEPFAR supported active service delivery areas (those sites that reported either targets or results for indicators related to that service delivery area at each site).	
Changes in indicator:	None	
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:	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. **For example**, if services are integrated, for example EID as part of the Treatment services, then as long as EID is captured in the treatment services EMR or a separate EMR for EID is available within these services, then this would be counted as an EID EMR as well. **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. < WHO: Global Observatory for eHealth > EMR can include real-time point-of-care data entry as well as retrospective data entry. An electronic medical record (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. **Individual service delivery area/point EMR versus Integrated Health EMR:**	

<table>
<tr><td></td><td>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 focusses its work (presented in the disaggregation below). 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 included in this indicator if the EMR is on site (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.

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>Reporting level:</td><td>Facility-level by service delivery area</td></tr>
<tr><td>How often to report:</td><td>Annually</td></tr>
<tr><td>How to review for data quality:</td><td>If a site does not report ART (PEPFAR-supported ART site), then it should not be included as having an ART EMR. Number of service delivery area with an EMR should not exceed the number of service delivery areas reporting results/targets.</td></tr>
<tr><td>How to calculate annual total:</td><td>Use annual result reported at Q4.</td></tr>
<tr><td>Data elements (components of indicator):</td><td>
<table>
<tr><td>Numerator: Number of PEPFAR-supported facilities that have an electronic medical record system</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Service Delivery Area [Required]</td><td>• HIV Testing Services;
• Care & Treatment (includes Pediatric and Adolescent Care and Treatment Services;
• Antenatal and/or Maternity Services;
• Early Infant Diagnosis and/or Under Five Clinic (not Pediatric ART Services);
• TB/HIV Services</td></tr>
<tr><td colspan="3">Disaggregate Descriptions & Definitions</td></tr>
<tr><td colspan="3">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>
</table>
</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</td></tr>
</table>

	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?** A "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?** A 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.

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	
Changes in indicator:	• LAB_PTCQI will now capture the volume of specimens received for testing at laboratory-based testing sites in each testing category (MER 2.0 v2.1 to v2.2).	
How to use:	The intent of this indicator is to monitor the level of engagement in CQI and PT activities at PEPFAR-supported laboratory-based testing and/or POCT sites by testing category as well as the number of specimens received for testing at those sites. CQI and PT programs are critical to ensure efficient and quality assured laboratory testing. By monitoring the level of engagement in CQI and PT, this indicator will encourage sites to participate in CQI and PT for the first time and/or enhance their level of engagement in CQI and PT.	
How to collect:	**Which facilities are counted?** Collect data for the LAB_PTCQI, both laboratory and POCT, indicator at facilities with PEPFAR-supported laboratories. 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: g. Blood bank screening and/or cross-matching b. Hematology c. Clinical chemistry d. Serology e. Microbiology f. Malaria infection diagnostics g. STI diagnostics h. 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. 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. **Passing PT:** A laboratory-based testing site is counted as passing PT if the last scored PT panel is acceptable, successful, or satisfactory as scored by the PT provider. Be aware that scoring systems between PT providers and with test categories may differ. **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 Notes: 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)). **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

<table>
<tr><td></td><td colspan="3">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
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.
Passing PT:
A POCT site is counted as passing PT if the last scored PT panel is acceptable, successful, or satisfactory as scored by the PT provider. If multiple testers participate in the same round of PT for the same test category for a single POCT site, >80% of testers must receive a passing PT score for the POCT site to be reported as passing PT. Scoring systems between PT providers and with test categories may differ.
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>Reporting level:</td><td colspan="3">Facility</td></tr>
<tr><td>How often to report:</td><td colspan="3">Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">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 colspan="3">N/A</td></tr>
<tr><td rowspan="2">Data elements (components of indicator):</td><td rowspan="2">Numerator:
Number of PEPFAR-supported laboratories and/or POCT engaged in CQI and PT activities for each test category:
HIV Serology/ Diagnostic Testing
HIV IVT/EID
HIV Viral Load
TB Xpert
TB AFB
TB Culture
CD4</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>CQI 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]</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?
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?</td></tr>
<tr><td></td><td>CQI at point-of-care-based testing sites by test category: HIV serology/diagnostic testing,</td><td>1. How many POCT sites perform this test but do not participate in CQI?</td></tr>
</table>

		HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4) [Required]	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
	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.).

Host-Country National & Subnational Indicators

DIAGNOSED_NAT/SUBNAT

Description:	The percentage of adults and children living with HIV who know their status (have been diagnosed)	
Numerator:	Among people living with HIV, the number who know their HIV status	Disaggregation: Disaggregated data is required. If data is available use the Age/ex disaggregates, if not available use the Sex disaggregate. Do not enter both. • Sex: Male, Female • Coarse Age/Sex Disaggregation: Female<15, Male <15, Female 15+, Male 15+
Denominator:	Estimated number of adults and children living with HIV (PLHIV Estimate)	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].
How to collect:	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 1.5 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). Numerator: 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.
Reporting level:	National-Level
How often to report:	Annually
Subnational reporting:	This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical areas; so that the total of the sub-National number should equal the total number of National number.
Entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Not required.
Guiding narrative questions:	1. Narratives should include information on how the number of individuals diagnosed was calculated or estimated. 2. Narratives should also discuss how national PLHIV estimates were derived.

VL_SUPPRESSION_NAT/SUBAT

Description:	Percentage of people living with HIV on ART with a suppressed viral load	
Numerator:	Number of people living with HIV and on ART [in the reporting period] who have a suppressed viral load (<1000 copies/mL)	Disaggregation: Disaggregated data is required. If data is available use the Age/Sex disaggregate, if not available use the Sex disaggregate. Do not enter both. • Sex: Male, Female • Coarse Age/Sex Disaggregation: Female<15, Male <15, Female 15+, Male 15+
Denominator:	TX_CURR_NAT	Denominator is not collected as part of indicator, but rather is calculated as TX_CURR_NAT Numerator.
How to collect:	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 4.6 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf) Numerator: The numerator can be generated by counting the number of adults and children receiving antiretroviral therapy 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 episodic; for example, 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 episodic 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.
Reporting level:	National-Level
How often to report:	Annually
Subnational reporting:	This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical areas; so that the total of the sub-National number should equal the total number of National number.
Entered by:	This data should be entered in DATIM by the USG country team.
Targets:	Host country teams often set targets by OU level. Targets should be aligned with the 90-90-90 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. Narratives should include information on how the number of HIV+ individuals diagnosed was calculated or estimated.

TX_CURR_NAT/SUBNAT

Description:	Percentage of adults and children receiving antiretroviral therapy	
Numerator:	Number of adults and children on ART at the end of the reporting period	Disaggregation: Disaggregated data is required. If data is available use the Age/ex disaggregates, if not available use the Sex disaggregate. Do not enter both. • Sex: Male, Female • Coarse Age/Sex Disaggregation: Female<15, Male <15, Female 15+, Male 15+
Denominator:	Estimated number of adults and children living with HIV (PLHIV Estimate)	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].
How to collect:	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 4.1 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). 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.
Reporting level:	National and Subnational-Levels
How often to report:	Annually
Subnational reporting:	To adequately plan the ART program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical areas; so that the total of the sub-National number should equal the total number of National number.
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). Targets should align with the 90-90-90 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. Narratives should include information on how national and subnational totals have been derived for both results and targets. 2. Narratives should describe data systems used to aggregate treatment results at the national and subnational levels and any work that country teams have conducted to endure reporting results are accurate.

KP_MAT_NAT/SUBNAT

Description:	Percentage of people who inject drugs (PWID) on medication assisted therapy	
Numerator:	Number of people who inject drugs (PWID) on medication assisted therapy	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
Denominator:	Estimated number PWID	Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [PWID KP estimates submitted in the PEPFAR Implementation and Planning Attributes].
How to collect:	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. Data should be collected continuously at the organization level as part of service delivery and aggregated in time for national reporting cycles.	
Reporting level:	National and Subnational-Levels	
How often to report:	Annual	
Subnational reporting:	To adequately plan the key populations medication-assisted therapy (MAT) program, these numbers are needed from both the national and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; district, province etc.). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical area; so that the total of the sub-national number should equal the total number of national number.	
Entered by:	This data should be entered in DATIM by the USG country team.	
Targets:	Not required.	
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.	

PMTCT_STAT_NAT/SUBNAT

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	Disaggregation: Disaggregated data is required. This indicator should be disaggregated by: HIV status/test results: • Known HIV infection at antenatal clinic entry (Known Positive) • Tested HIV positive at ANC during current pregnancy (Newly tested positive) • Tested HIV negative at ANC during current pregnancy (Newly tested negative)
Denominator:	Number of pregnant women who attended ANC or had a facility-based delivery in the past 12 months	N/A
How to collect:	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 3.4 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). 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 indicator 3.4, 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, 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.
Reporting level:	National and Subnational-Levels
How often to report:	Annual
Subnational reporting:	To adequately plan the PMTCT program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc.). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical area; so that the total of the subnational number should equal the total number of National number.
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). Targets should be aligned with the START free, STAY free, AIDS-free super-FAST TRACK 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. 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.

PMTCT_ART_NAT/SUBNAT

Description:	Number and 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.	Disaggregation: Disaggregated data is required. The numerator should be disaggregated by the three categories below for HIV- positive pregnant women for the prevention of mother-to-child transmission: 1. Newly initiated on antiretroviral therapy during the current pregnancy (New on ART, includes Maternal triple ARV prophylaxis) 2. Already on antiretroviral therapy before the current pregnancy (Already on ART) 3. Other: All other options including • Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines) • Single dose nevirapine (with or without tail) only • Any other regimen not listed above
Denominator:	Estimated number of HIV-positive pregnant women	The number of HIV positive pregnant women who delivered within the past 12 months is also referred to as the number of pregnant women living with HIV needing antiretrovirals for preventing mother-to-child transmission
How to collect:	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 3.1 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). 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. Disaggregation of regimen definitions:	

Categories	Further Clarification	Common Examples
The first two options include women receiving lifelong antiretroviral therapy (including Option B+) 1) newly initiated on treatment during the current pregnancy (new on ART) 2) already on treatment before the pregnancy (Already on ART)	A three-drug regimen intended to provide antiretroviral therapy for life 1) Number of HIV-positive pregnant women identified in the reporting period newly initiated on antiretroviral therapy for life 2) Number of HIV-positive pregnant women identified in the reporting period who were already on antiretroviral therapy at their first antenatal clinic visit. If a woman is initiating antiretroviral therapy for life during labor, she would be counted in category 1. -If the number of women on antiretroviral therapy is not available by the timing of when they started antiretroviral therapy the number can be included in the cell titled total number of pregnant women on lifelong antiretroviral therapy. -If a woman is initiating a 3-drug regimen provided for MTCT prophylaxis started during pregnancy or as late as during labor or delivery with the intention of stopping at the end of the breastfeeding period (or stopping at delivery if not breastfeeding) (previously known as Option B), she would be counted in category 1.	Standard national treatment regimen, for example: • TDF+3TC+EFV • AZT+3TC+NVP
Other	All other suboptimal regimens are counted here including: 1) Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery) 2) Single-dose nevirapine (sd- NVP) to the mother during pregnancy or delivery 3) Any other regimen that is not ART and/or one of the two options listed above	• AZT at any point before labor + intrapartum NVP • AZT at any point before labor + intrapartum NVP +7-day post-partum tail of AZT/3TC • sd-NVP for mother only at onset of labor • sd-NVP + 7-day AZT/3TC tail ONLY • sd-NVP for mother at onset of labor and sd-NVP for baby ONLY

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).

Reporting level:	National and Subnational-Levels

How often to report:	Annual
Subnational reporting:	To adequately plan the PMTCT program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc.). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical area; so that the total of the subnational number should equal the total number of National number.
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). Targets should be aligned with the START free, STAY free, AIDS-free super-FAST TRACK 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. 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/SUBNAT

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	Disaggregation: Disaggregated data is required. Enter data disaggregated by age. • Age (<15, 15-29, 30+)
Denominator:	N/A	
How to collect:	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 1.23 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_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. 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.	
Reporting level:	National and Subnational-Levels	
How often to report:	Annual	
Subnational reporting:	To adequately plan the VMMC program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc.). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical areas; so that the total of the sub-National number should equal the total number of National number.	
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/SUBNAT

Description:	Total number of men ever circumcised	
Numerator:	Total number of men ever circumcised	Disaggregation: Disaggregated data is optional. If data is available enter by age. • Age (<15, 15-29, 30+)
Denominator:	Total population of men in the corresponding age category	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].
How to collect:	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 1.22 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). 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 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.	
Reporting level:	National and Subnational-Levels	
How often to report:	Annual	
Subnational reporting:	To adequately plan the VMMC program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU). This data should be entered for all subnational units, regardless of PEPFAR funding supporting these geographical areas, if there are no achievements, enter 0; so that the total of the subnational number should equal the total number of National number.	
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	

	with the PEPFAR planned targets (at the least) should constitute the host country targets.
Guiding narrative questions:	1. Narratives should include information on how national and subnational totals have been derived for both results and targets.

Appendices

Appendix 1: Key Population 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 2: MER and SIMS Mapping

MER Indicators and Corresponding SIMS Core Essential Elements (CEEs)	# Linkages
PrEP_NEW	**2**
C_04.04 [262] Monitoring Outreach for Key Populations [KP]	
C_04.07 [264] Service Referral System [KP]	
VMMC_CIRC	**6**
F_01.13 [013] Data Reporting Consistency – VMMC_CIRC [ALL FACILITIES]	
F_05.01 [069] VMMC Registers-Paper [VMMC]	
F_05.02 [070] VMMC Register-Electronic [VMMC]	
F_05.03 [071] Adverse Event (AE) Prevention and Management [VMMC]	
F_05.04 [072] Voluntarism and Informed Consent [VMMC]	
F_05.05 [073] VMMC Clinical Follow-Up [VMMC]	
KP_PREV	**17**
A_04.01 [430] National Guidelines for Key Populations (National level) [GUIDE]	
C_01.12 [212] Facilitation of Small Group Sessions for HIV Prevention [AP]	
C_01.13 [213] Small Group Sessions for HIV Prevention [AP]	
C_04.01 [226] Condom Availability [KP]	
C_04.02 [249] Lubricant Availability [KP]	
C_04.03 [261] STI Screening and Management Among Key Populations [KP]	
C_04.04 [262] Monitoring Outreach for Key Populations [KP]	
C_04.05 [263] Peer Outreach Management [KP]	
C_04.06 [250] Family Planning/HIV Integration Service Delivery in Community Settings [KP]	
C_04.07 [264] Service Referral System [KP]	
C_04.08 [265] Data Reporting Consistency – KP_PREV [KP]	
F_03.01 [049] Lubricant Availability at Point of Service [KP]	
F_03.02 [050] STI Screening and Management for Key Populations [KP]	
F_03.03 [051] Service Referral System [KP]	
F_03.19 [105] Systems for Family Planning (FP)/HIV Integration [C&T KP]	
F_03.20 [106] Family Planning (FP)/HIV Integration Service Delivery [C&T KP]	
F_03.21 [032] Partner HIV Testing [C&T KP]	
PP_PREV	**6**
C_01.12 [212] Facilitation of Small Group Sessions for HIV Prevention [AP]	
C_01.13 [213] Small Group Sessions for HIV Prevention [AP]	
C_01.26 [226] Condom Availability (at the Service Delivery Point) [AP-HTC]	
C_05.02 [255] Preventing HIV in Girls [OPP]	
C_05.03 [254] Girls Secondary Education Transition [OPP]	
C_05.06 [226] Condom Availability [OPP]	
TB_PREV	**3**

F_02.17 [037] Isoniazid Preventive Therapy (IPT) [C&T GEN POP]	
F_03.17 [037] Isoniazid Preventive Therapy (IPT) [C&T KP]	
F_04.14 [037] Isoniazid Preventive Therapy (IPT) [PMTCT-ANC]	
KP_MAT	**9**
A_04.01 [430] National Guidelines for Key Populations (National level) [GUIDE]	
C_04.07 [264] Service Referral System [KP]	
F_09.01 [084] Intake Treatment Plan Development [MAT]	
F_09.02 [085] TB screening and Management in MAT Facilities [MAT]	
F_09.03 [086] Psychosocial Support for MAT Clients [MAT]	
F_09.04 [087] Induction-[MAT]	
F_09.05 [088] Stabilization [MAT]	
F_09.06 [089] Dose Reduction and Termination [MAT]	
F_09.08 [091] Supply Chain Reliability (methadone and buprenorphine) [MAT]	
GEND_GBV	**4**
C_01.17 [217] Standard Guidance for Gender-Based Violence Response in Community Setting [AP]	
C_01.18 [218] Gender-Based Violence Referrals in Community Setting [AP]	
F_06.01 [074] Capacity to Provide Post-Violence Care Services [GBV]	
F_06.02 [075] Availability of Post-Violence Care Services [GBV]	
OVC_SERV	**13**
A_05.01 [440] Management and Planning – strategic planning (Social Services) (National level) [SOC OVC]	
A_05.05 [444] Management and Planning – operational planning (Social Services) (Sub-national level) [SOC OVC]	
C_03.01 [252] Case Management Services [OVC]	
C_03.02 [255] Preventing HIV in Girls [OVC]	
C_03.03 [257] Linkages to HIV Testing [OVC]	
C_03.04 [258] Child Protection Services [OVC]	
C_03.05 [253] Education Services [OVC]	
C_03.06 [254] Girls Secondary Education Transition [OVC]	
C_03.07 [256] Economic Strengthening and Social Protection Services [OVC]	
C_03.08 [259] Early Childhood Development Services [OVC]	
C_03.09 [246] Community Pediatric Nutrition Screening & Referral to Clinical Services [OVC]	
C_03.10 [250] Family Planning/HIV Integration Service Delivery in Community Settings [OVC]	
C_05.02 [255] Preventing HIV in Girls [OPP]	
FPINT_SITE	**6**
F_02.20 [040] Systems for Family Planning (FP)/HIV Integration [C&T GEN POP]	
F_02.21 [041] Family Planning (FP)/HIV Integration Service Delivery [C&T GEN POP]	
F_03.19 [105] Systems for Family Planning (FP)/HIV Integration [C&T KP]	
F_03.20 [106] Family Planning (FP)/HIV Integration Service Delivery [C&T KP]	
F_04.17 [040] Systems for Family Planning (FP)/HIV Integration [PMTCT]	
F_04.18 [041] Family Planning (FP)/HIV Integration Service Delivery [PMTCT]	

HTS_TST	39
A_01.04 [404] Quality Assurance of HIV Testing Services (National level) [LAB]	
A_01.09 [409] Quality Assurance of HIV Testing Services (Sub-national level) [LAB]	
A_10.07 [496] Data Use for RTK Distribution Decision making (National level) [SC RTK NATL]	
A_10.08 [497] Supervision/Monitoring for RTK Supply Chain (National level) [SC RTK NATL]	
A_10.09 [498] Data Use for RTK Distribution Decision making (Sub-national level) [SC RTK SNU]	
A_10.10 [499] Supervision/Monitoring for RTK Supply Chain (Sub-national level) [SC RTK SNU]	
C_01.13 [213] Small Group Sessions for HIV Prevention [AP]	
C_01.20 [220] HIV Proficiency Testing at the Organization Assessment Point [AP-HTC]	
C_01.21 [221] Supply Chain Reliability (Rapid Test Kits) at the Organization Assessment Point [AP-HTC]	
C_01.23 [223] HIV Testing Quality Assurance at the Organization Assessment Point [AP-HTC]	
C_01.25 [225] Confidentiality of HIV Testing Services at the Organization Assessment Point [AP-HTC]	
C_01.33 [233] Compliance with National Testing Algorithm and Strategy [AP HTC]	
C_01.34 [234] HIV Testing Quality Assurance at the Service Delivery Point [AP HTC]	
C_01.36 [236] Confidentiality of HIV Testing Services at the Service Delivery Point [AP HTC]	
C_02.02 [243] Partner HIV Testing [PLHIV]	
C_03.03 [257] Linkages to HIV Testing [OVC]	
F_01.11 [011] Data Reporting Consistency – HTC_TST [ALL FACILITIES]	
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]	
F_01.20 [020] Supply Chain Reliability-Rapid Test Kits [ALL FACILITIES-COMM]	
F_02.12 [032] Partner HIV Testing [C&T GEN POP]	
F_02.13 [033] Routine HIV testing of Children of Adult Patients [C&T GEN POP]	
F_02.22 [042] Routine HIV Testing for Children [C&T PEDS]	
F_03.21 [032] Partner HIV Testing [C&T KP]	
F_03.22 [033] Routine HIV testing of Children of Adult Patients [C&T KP]	
F_04.01 [052] ANC Register-Paper [PMTCT-ANC]	
F_04.02 [053] ANC Register-Electronic [PMTCT-ANC]	
F_04.11 [032] Partner HIV Testing [PMTCT-ANC]	
F_04.21 [058] PITC for Maternity Patients [PMTCT-L&D]	
F_04.32 [033] Routine HIV testing of Children of Adult Patients [PMTCT-ANC]	
F_07.01 [076] Compliance with National Testing Algorithm and Strategy [HTC]	
F_07.02 [077] Quality Assurance of HIV Testing Services [HTC]	
F_07.04 [079] Facility Level HIV Proficiency Testing [HTC]	
F_08.01 [080] Routine PITC for Adult TB Patients [TB]	
F_08.03 [082] Routine PITC for Pediatric TB Patients [TB]	
F_09.07 [090] HIV Testing [MAT]	
F_10.03 [094] Test SOPs [LAB]	
F_10.04 [095] Quality Testing Monitoring [LAB]	
F_10.05 [096] Results and Information Management [LAB]	
F_10.06 [097] Testing Interruptions [LAB]	

PMTCT_STAT	7
F_01.12 [012] Data Reporting Consistency – PMTCT_STAT [ALL FACILITIES]	
F_04.01 [052] ANC Register-Paper [PMTCT-ANC]	
F_04.02 [053] ANC Register-Electronic [PMTCT-ANC]	
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities	
F_04.07 [024] ART Register-Paper [PMTCT-ANC]	
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]	
F_04.21 [058] PITC for Maternity Patients [PMTCT-L&D]	
PMTCT_EID	**14**
A_01.03 [403] Specimen Referrals (National level) [LAB]	
A_01.08 [408] Specimen Referrals (Sub-national level) [LAB]	
F_04.01 [052] ANC Register-Paper [PMTCT-ANC]	
F_04.02 [053] ANC Register-Electronic [PMTCT-ANC]	
F_04.19 [057] Patient Tracking -HIV+ Breastfeeding Women [PMTCT]	
F_04.25 [062] Early Infant Diagnosis [HEI]	
F_04.27 [064] Tracking HIV-Exposed Infants [HEI]	
F_04.29 [066] HIV Exposed Infant/Early Infant Diagnosis Registers-Paper [HEI]	
F_04.30 [067] HIV Exposed Infant/Early Infant Diagnosis Register-Electronic [HEI]	
F_04.31 [068] Supply Chain Reliability (Early Infant Diagnosis) [HEI]	
F_10.03 [094] Test SOPs [LAB]	
F_10.04 [095] Quality Testing Monitoring [LAB]	
F_10.05 [096] Results and Information Management [LAB]	
F_10.06 [097] Testing Interruptions [LAB]	
TB_STAT	**2**
F_08.01 [080] Routine PITC for Adult TB Patients [TB]	
F_08.03 [082] Routine PITC for Pediatric TB Patients [TB]	
OVC_HIVSTAT	**2**
C_03.01 [252] Case Management Services [OVC]	
C_03.03 [257] Linkages to HIV Testing [OVC]	
PMTCT_FO	**15**
A_01.03 [403] Specimen Referrals (National level) [LAB]	
A_01.08 [408] Specimen Referrals (Sub-national level) [LAB]	
F_04.01 [052] ANC Register-Paper [PMTCT-ANC]	
F_04.02 [053] ANC Register-Electronic [PMTCT-ANC]	
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities	
F_04.19 [057] Patient Tracking -HIV+ Breastfeeding Women [PMTCT]	
F_04.25 [062] Early Infant Diagnosis [HEI]	
F_04.27 [064] Tracking HIV-Exposed Infants [HEI]	
F_04.29 [066] HIV Exposed Infant/Early Infant Diagnosis Registers-Paper [HEI]	

F_04.30 [067] HIV Exposed Infant/Early Infant Diagnosis Register-Electronic [HEI]
F_04.31 [068] Supply Chain Reliability (Early Infant Diagnosis) [HEI]
F_10.03 [094] Test SOPs [LAB]
F_10.04 [095] Quality Testing Monitoring [LAB]
F_10.05 [096] Results and Information Management [LAB]
F_10.06 [097] Testing Interruptions [LAB]
TX_NEW **37**
A_10.01 [490] Supply Chain: ARVs (National level) [SC ARV NATL]
A_10.02 [491] Data Use for ARV Distribution Decision making (National level) [SC ARV NATL]
A_10.03 [492] Supervision/Monitoring for ARV Supply Chain (National Level) [SC-ARV NATL]
A_10.04 [493] Data Use for ARV Distribution Decision making (Sub-national level) [SC ARV SNU]
A_10.05 [494] Supervision/Monitoring for ARV Supply Chain (Sub-national level) [SC ARV SNU]
C_01.19 [219] HTC Referrals to HIV Care and Treatment at the Organization Assessment Point [AP-HTC]
C_01.32 [232] POCT Referral and Linkages [AP-POCT]
C_02.06 [247] Community-Based Linkage and Retention Support Services [PLHIV]
F_01.10 [010] Data Reporting Consistency – TX_NEW-C&T [ALL FACILITIES]
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]
F_01.15 [015] Medication Dispensing [ALL FACILITIES-COMM]
F_01.16 [016] Supply Chain Reliability-Adult ARVs [ALL FACILITIES-COMM]
F_01.18 [018] Supply Chain Reliability -Pediatric ARVs [ALL FACILITIES-COMM]
F_02.01 [021] Patient/Beneficiary Records [C&T GEN POP]
F_02.03 [023] Patient Tracking-Pre-ART Patients [C&T GEN POP]
F_02.04 [024] ART Register-Paper [C&T GEN POP]
F_02.05 [025] ART Register-Electronic [C&T GEN POP]
F_02.06 [026] Pre-ART Register-Paper [C&T GEN POP]
F_02.07 [027] Pre-ART Register-Electronic [C&T GEN POP]
F_02.08 [028] ART Eligibility [C&T GEN POP]
F_03.04 [021] Patient/Beneficiary Records [C&T KP]
F_03.06 [023] Patient Tracking-Pre-ART Patients [C&T KP]
F_03.07 [024] ART Register-Paper [C&T KP]
F_03.08 [025] ART Register-Electronic [C&T KP]
F_03.09 [026] Pre-ART Register-Paper [C&T KP]
F_03.10 [027] Pre-ART Register-Electronic [C&T KP]
F_03.11 [028] ART Eligibility [C&T KP]
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities
F_04.07 [024] ART Register-Paper [PMTCT-ANC]
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]
F_04.27 [064] Tracking HIV-Exposed Infants [HEI]
F_04.28 [065] Enrollment of HIV-Infected Infants Identified through Early Infant Diagnosis (EID) Services into ART Services [HEI]
F_04.29 [066] HIV Exposed Infant/Early Infant Diagnosis Registers-Paper [HEI]

F_04.30 [067] HIV Exposed Infant/Early Infant Diagnosis Register-Electronic [HEI]	
F_07.03 [078] HTC Referrals to HIV Care and Treatment [HTC]	
F_08.02 [081] ART Provision for HIV-Positive Adult TB Patients [TB]	
F_08.04 [083] ART Provision for HIV-Positive Pediatric TB Patients [TB]	
TX_CURR	**30**
A_10.01 [490] Supply Chain: ARVs (National level) [SC ARV NATL]	
A_10.02 [491] Data Use for ARV Distribution Decision making (National level) [SC ARV NATL]	
A_10.03 [492] Supervision/Monitoring for ARV Supply Chain (National Level) [SC-ARV NATL]	
A_10.04 [493] Data Use for ARV Distribution Decision making (Sub-national level) [SC ARV SNU]	
A_10.05 [494] Supervision/Monitoring for ARV Supply Chain (Sub-national level) [SC ARV SNU]	
C_02.01 [242] Adherence Support [PLHIV]	
C_02.06 [247] Community-Based Linkage and Retention Support Services [PLHIV]	
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]	
F_01.15 [015] Medication Dispensing [ALL FACILITIES-COMM]	
F_01.16 [016] Supply Chain Reliability-Adult ARVs [ALL FACILITIES-COMM]	
F_01.18 [018] Supply Chain Reliability -Pediatric ARVs [ALL FACILITIES-COMM]	
F_02.01 [021] Patient/Beneficiary Records [C&T GEN POP]	
F_02.02 [022] Patient Tracking-ART Patients [C&T GEN POP]	
F_02.04 [024] ART Register-Paper [C&T GEN POP]	
F_02.05 [025] ART Register-Electronic [C&T GEN POP]	
F_02.10 [030] Adherence Support-[C&T GEN POP]	
F_03.04 [021] Patient/Beneficiary Records [C&T KP]	
F_03.05 [022] Patient Tracking-ART Patients [C&T KP]	
F_03.07 [024] ART Register-Paper [C&T KP]	
F_03.08 [025] ART Register-Electronic [C&T KP]	
F_03.13 [030] Adherence Support [C&T KP]	
F_04.03 [054] ART in PMTCT Facilities [PMTCT-ANC]	
F_04.05 [056] Patient Tracking-HIV+ Pregnant Women [PMTCT-ANC]	
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities	
F_04.07 [024] ART Register-Paper [PMTCT-ANC]	
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]	
F_04.09 [030] Adherence Support-[PMTCT-ANC]	
F_04.19 [057] Patient Tracking -HIV+ Breastfeeding Women [PMTCT]	
F_04.29 [066] HIV Exposed Infant/Early Infant Diagnosis Registers-Paper [HEI]	
F_04.30 [067] HIV Exposed Infant/Early Infant Diagnosis Register-Electronic [HEI]	
PMTCT_ART	**15**
C_02.01 [242] Adherence Support [PLHIV]	
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]	
F_01.15 [015] Medication Dispensing [ALL FACILITIES-COMM]	

F_01.16 [016] Supply Chain Reliability-Adult ARVs [ALL FACILITIES-COMM]	
F_02.04 [024] ART Register-Paper [C&T GEN POP]	
F_02.05 [025] ART Register-Electronic [C&T GEN POP]	
F_04.01 [052] ANC Register-Paper [PMTCT-ANC]	
F_04.02 [053] ANC Register-Electronic [PMTCT-ANC]	
F_04.03 [054] ART in PMTCT Facilities [PMTCT-ANC]	
F_04.05 [056] Patient Tracking-HIV+ Pregnant Women [PMTCT-ANC]	
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities	
F_04.07 [024] ART Register-Paper [PMTCT-ANC]	
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]	
F_04.09 [030] Adherence Support-[PMTCT-ANC]	
F_04.22 [059] ARVs at Labor and Delivery [PMTCT-L&D]	
TX_TB	**10**
A_01.03 [403] Specimen Referrals (National level) [LAB]	
A_01.08 [408] Specimen Referrals (Sub-national level) [LAB]	
F_02.16 [036] TB Screening [C&T GEN POP]	
F_02.18 [038] TB Diagnostic Evaluation Cascade [C&T GEN POP]	
F_02.24 [044] Pediatric TB Screening [C&T PEDS]	
F_03.16 [036] TB Screening [C&T KP]	
F_03.18 [038] TB Diagnostic Evaluation Cascade [C&T KP]	
F_04.13 [036] TB Screening [PMTCT-ANC]	
F_04.15 [038] TB Diagnostic Evaluation Cascade [PMTCT-ANC]	
F_09.02 [085] TB screening and Management in MAT Facilities [MAT]	
TB_ART	**13**
C_01.19 [219] HTC Referrals to HIV Care and Treatment at the Organization Assessment Point [AP-HTC]	
C_01.32 [232] POCT Referral and Linkages [AP-POCT]	
C_02.01 [242] Adherence Support [PLHIV]	
C_02.06 [247] Community-Based Linkage and Retention Support Services [PLHIV]	
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]	
F_01.15 [015] Medication Dispensing [ALL FACILITIES-COMM]	
F_01.16 [016] Supply Chain Reliability-Adult ARVs [ALL FACILITIES-COMM]	
F_01.18 [018] Supply Chain Reliability -Pediatric ARVs [ALL FACILITIES-COMM]	
F_02.04 [024] ART Register-Paper [C&T GEN POP]	
F_02.05 [025] ART Register-Electronic [C&T GEN POP]	
F_02.10 [030] Adherence Support-[C&T GEN POP]	
F_08.02 [081] ART Provision for HIV-Positive Adult TB Patients [TB]	
F_08.04 [083] ART Provision for HIV-Positive Pediatric TB Patients [TB]	
TX_RET	**28**
A_10.01 [490] Supply Chain: ARVs (National level) [SC ARV NATL]	
A_10.02 [491] Data Use for ARV Distribution Decision making (National level) [SC ARV NATL]	

A_10.03 [492] Supervision/Monitoring for ARV Supply Chain (National Level) [SC-ARV NATL]	
A_10.04 [493] Data Use for ARV Distribution Decision making (Sub-national level) [SC ARV SNU]	
A_10.05 [494] Supervision/Monitoring for ARV Supply Chain (Sub-national level) [SC ARV SNU]	
C_02.01 [242] Adherence Support [PLHIV]	
C_02.06 [247] Community-Based Linkage and Retention Support Services [PLHIV]	
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]	
F_01.15 [015] Medication Dispensing [ALL FACILITIES-COMM]	
F_01.16 [016] Supply Chain Reliability-Adult ARVs [ALL FACILITIES-COMM]	
F_01.18 [018] Supply Chain Reliability -Pediatric ARVs [ALL FACILITIES-COMM]	
F_02.01 [021] Patient/Beneficiary Records [C&T GEN POP]	
F_02.02 [022] Patient Tracking-ART Patients [C&T GEN POP]	
F_02.04 [024] ART Register-Paper [C&T GEN POP]	
F_02.05 [025] ART Register-Electronic [C&T GEN POP]	
F_02.10 [030] Adherence Support-[C&T GEN POP]	
F_02.19 [039] Facility Linkage to Community Care & Support Services for Adult/Child PLHIV [C&T GEN POP]	
F_03.04 [021] Patient/Beneficiary Records [C&T KP]	
F_03.05 [022] Patient Tracking-ART Patients [C&T KP]	
F_03.07 [024] ART Register-Paper [C&T KP]	
F_03.08 [025] ART Register-Electronic [C&T KP]	
F_03.13 [030] Adherence Support [C&T KP]	
F_04.05 [056] Patient Tracking-HIV+ Pregnant Women [PMTCT-ANC]	
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities	
F_04.07 [024] ART Register-Paper [PMTCT-ANC]	
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]	
F_04.09 [030] Adherence Support-[PMTCT-ANC]	
F_04.19 [057] Patient Tracking -HIV+ Breastfeeding Women [PMTCT]	
TX_PVLS	**20**
A_01.03 [403] Specimen Referrals (National level) [LAB]	
A_01.08 [408] Specimen Referrals (Sub-national level) [LAB]	
C_02.01 [242] Adherence Support [PLHIV]	
C_02.06 [247] Community-Based Linkage and Retention Support Services [PLHIV]	
F_02.01 [021] Patient/Beneficiary Records [C&T GEN POP]	
F_02.04 [024] ART Register-Paper [C&T GEN POP]	
F_02.05 [025] ART Register-Electronic [C&T GEN POP]	
F_02.10 [030] Adherence Support-[C&T GEN POP]	
F_02.11 [031] ART Monitoring [C&T GEN POP]	
F_02.26 [046] Pediatric ART Monitoring [C&T PEDS]	
F_03.04 [021] Patient/Beneficiary Records [C&T KP]	
F_03.07 [024] ART Register-Paper [C&T KP]	

F_03.08 [025] ART Register-Electronic [C&T KP]	
F_03.13 [030] Adherence Support [C&T KP]	
F_03.14 [031] ART Monitoring [C&T KP]	
F_04.06 [021] Patient/Beneficiary Records for ART/pre-ART /PMTCT B+ Facilities	
F_04.07 [024] ART Register-Paper [PMTCT-ANC]	
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]	
F_04.09 [030] Adherence Support-[PMTCT-ANC]	
F_04.20 [031] ART Monitoring [PMTCT]	
LAB_PTCQI	**11**
A_01.01 [401] Proficiency Testing (PT)/External Quality Assurance (EQA) (National level) [LAB]	
A_01.02 [402] Laboratory/Point-of-Care Technology (POCT) Quality Improvement (QI) Program (National level) [LAB]	
A_01.03 [403] Specimen Referrals (National level) [LAB]	
A_01.04 [404] Quality Assurance of HIV Testing Services (National level) [LAB]	
A_01.05 [405] National Blood Transfusion Service Accreditation (National level) [LAB]	
A_01.06 [406] Proficiency Testing (PT)/External Quality Assurance (EQA) (Sub-national level) [LAB]	
A_01.07 [407] Laboratory/Point-of-Care Technology (POCT) Quality Improvement (QI) Program (Sub-national level) [LAB]	
A_01.08 [408] Specimen Referrals (Sub-national level) [LAB]	
A_01.09 [409] Quality Assurance of HIV Testing Services (Sub-national level) [LAB]	
F_10.04 [095] Quality Testing Monitoring [LAB]	
F_11.04 [103] Quality Assurance [POCT]	
SC_STOCK	**38**
A_10.01 [490] Supply Chain: ARVs (National level) [SC ARV NATL]	
A_10.02 [491] Data Use for ARV Distribution Decision making (National level) [SC ARV NATL]	
A_10.03 [492] Supervision/Monitoring for ARV Supply Chain (National Level) [SC-ARV NATL]	
A_10.04 [493] Data Use for ARV Distribution Decision making (Sub-national level) [SC ARV SNU]	
A_10.05 [494] Supervision/Monitoring for ARV Supply Chain (Sub-national level) [SC ARV SNU]	
A_10.06 [495] Supply Chain: Rapid Test Kits/Diagnostics (National level) [SC RTK NATL]	
A_10.07 [496] Data Use for RTK Distribution Decision making (National level) [SC RTK NATL]	
A_10.08 [497] Supervision/Monitoring for RTK Supply Chain (National level) [SC RTK NATL]	
A_10.09 [498] Data Use for RTK Distribution Decision making (Sub-national level) [SC RTK SNU]	
A_10.10 [499] Supervision/Monitoring for RTK Supply Chain (Sub-national level) [SC RTK SNU]	
A_10.11 [500] Supply Chain: Food and Nutrition (National level) [SC FN NATL]	
A_10.12 [501] Data Use for Food and Nutrition Commodity Distribution Decision making (National level) [SC FN NATL]	
A_10.13 [502] Supervision/Monitoring for Food and Nutrition Supply Chain (National level) [SC FN NATL]	
A_10.14 [503] Data Use for Food and Nutrition Commodity Distribution Decision Making (Sub-national level) [SC FN SNU]	
A_10.15 [504] Supervision/Monitoring for Food and Nutrition Supply Chain (Sub-national level) [SC FN SNU]	
A_10.16 [510] Medicines Regulatory System - Registration (National level) [MED REG]	
A_10.17 [511] Medicines Regulatory System – Quality Assurance / Quality Control (National level) [MED REG]	
A_10.18 [512] Medicines Regulatory System – Pharmacovigilance (National level) [MED REG]	
C_01.21 [221] Supply Chain Reliability (Rapid Test Kits) at the Organization Assessment Point [AP-HTC]	

C_01.26 [226] Condom Availability (at the Service Delivery Point) [AP-HTC]	
C_01.28 [228] POCT Supplies, Reagents and Equipment [AP-POCT]	
C_02.08 [226] Condom Availability [PLHIV]	
C_02.09 [249] Lubricant Availability [PLHIV]	
C_04.01 [226] Condom Availability [KP]	
C_04.02 [249] Lubricant Availability [KP]	
C_05.06 [226] Condom Availability [OPP]	
F_01.03 [003] Risk Reduction Counseling and Condom Availability [ALL FACILITIES]	
F_01.14 [014] Supply Chain Management [ALL FACILITIES-COMM]	
F_01.16 [016] Supply Chain Reliability-Adult ARVs [ALL FACILITIES-COMM]	
F_01.17 [017] Supply Chain Reliability-Cotrimoxazole [ALL FACILITIES-COMM]	
F_01.18 [018] Supply Chain Reliability -Pediatric ARVs [ALL FACILITIES-COMM]	
F_01.19 [019] Supply Chain-Pediatric Cotrimoxazole (ALL FACILITIES-COMM)	
F_01.20 [020] Supply Chain Reliability-Rapid Test Kits [ALL FACILITIES-COMM]	
F_03.01 [049] Lubricant Availability at Point of Service [KP]	
F_04.31 [068] Supply Chain Reliability (Early Infant Diagnosis) [HEI]	
F_09.08 [091] Supply Chain Reliability (methadone and buprenorphine) [MAT]	
F_10.06 [097] Testing Interruptions [LAB]	
F_11.05 [104] Supplies, Reagents and Equipment [POCT]	
HRH_PRE	**1**
A_03.04 [423] HRH Regulation (National level) [HRH]	
HRH_CURR	**2**
A_03.04 [423] HRH Regulation (National level) [HRH]	
F_01.05 [005] Support and Assessment of Staff Performance [ALL FACILITIES]	
HRH_STAFF	**1**
A_03.04 [423] HRH Regulation (National level) [HRH]	
EMR_SITE	**11**
C_01.05 [205] Beneficiary/Client Records [AP]	
C_01.08 [208] Data Quality Assurance [AP]	
F_01.09 [009] Data Quality Assurance [ALL FACILITIES]	
F_02.05 [025] ART Register-Electronic [C&T GEN POP]	
F_02.07 [027] Pre-ART Register-Electronic [C&T GEN POP]	
F_03.08 [025] ART Register-Electronic [C&T KP]	
F_03.10 [027] Pre-ART Register-Electronic [C&T KP]	
F_04.02 [053] ANC Register-Electronic [PMTCT-ANC]	
F_04.08 [025] ART Register-Electronic [PMTCT-ANC]	
F_04.24 [061] L&D Register-Electronic [PMTCT-L&D]	
F_04.30 [067] HIV Exposed Infant/Early Infant Diagnosis Register-Electronic [HEI]	

Appendix 3: DREAMS and DREAMS-Like SNU Reporting Requirements

Indicator	Required Disaggregations for DREAMS	Who Should Report?
PMTCT_STAT	***POSITIVITY STATUS/AGE:*** Females: Known at Entry Positive: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39; Newly Tested Positive: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39; Known Negatives: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39	All IPs delivering PMTCT Services
PrEP_NEW	***AGE/SEX:*** Females: 15-19, 20-24, 25-29, 30-34, 35-39	All IPs delivering PrEP
HTS_TST	***SERVICE DELIVERY MODALITY/AGE/SEX/RESULT:*** Service Delivery Modalities: Index testing, Mobile testing, VCT testing, Other community testing platforms, Inpatient, PMTCT (ANC only), TB, VMMC, other PITC, VCT, Index testing, STI, Emergency *For each service delivery modality listed above, disaggregate by Age/Sex/Result below: Females: Positive: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39 Negative: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39 Males: Positive: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39 Negative: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39	All IPs delivering HTS
KP_PREV	***KEY POPULATION TYPE:*** Key population type: Female Sex Worker (FSW)	All IPs delivering KP prevention services
PP_PREV	***AGE/SEX:*** Females: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39 Males: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39	All IPs delivering prevention services
GEND_GBV	***VIOLENCE SERVICE TYPE/AGE/SEX:*** Sexual Violence: Females: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39 Physical and/or emotional violence: Females: 10-14, 15-19, 20-24, 25-29, 30-34, 35-39	All IPs delivering post violence care services
VMMC_CIRC	***AGE:*** Males: 15-19, 20-24, 25-29, 30-34, 35-39	All IPs delivering male circumcision services
OVC_SERV	***AGE/SEX/SERVICE AREA:*** Education Support: Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Parenting/Caregiver program: Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Social Protection (including cash transfer): Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Economic Strengthening:	Only DREAMS-funded partners providing OVC services in DREAMS SNUs should report

Indicator	Required Disaggregations for DREAMS	Who Should Report?
	Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Other service areas: Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+	
TX_NEW	***AGE/SEX:*** Females: 15-19, 20-24, 25-29, 30-34, 35-39 Males: 15-19, 20-24, 25-29, 30-34, 35-39	All IPs providing treatment services
TX_CURR	***AGE/SEX:*** Females: 15-19, 20-24, 25-29, 30-34, 35-39 Males: 15-19, 20-24, 25-29, 30-34, 35-39	All IPs providing treatment services
TX_RET	***AGE/SEX:*** Females: 15-19, 20-24, 25-29, 30-34, 35-39 Males: 15-19, 20-24, 25-29, 30-34, 35-39	All IPs providing treatment services

Appendix 4: Frequency & Level of Reporting Table

Quarterly	Semi-Annual	Annual	Host-Country Indicators
•HTS_TST Ⓕ Ⓒ	•KP_PREV Ⓕ Ⓒ	•EMR_SITE Ⓢ	•DIAGNOSED_(NAT/SUBNAT)
•HTS_SELF Ⓕ Ⓒ	•OVC_HIVSTAT Ⓕ Ⓒ	•FPINT_SITE Ⓢ	•KP_MAT_(NAT/SUBNAT)
•PMTCT_ART Ⓕ	•OVC_SERV Ⓕ Ⓒ	•GEND_GBV Ⓕ Ⓒ	•PMTCT_ART_(NAT/SUBNAT)
•PMTCT_EID Ⓕ	•PP_PREV Ⓕ Ⓒ	•HRH_CURR Ⓕ Ⓒ Ⓐ	•PMTCT_STAT_(NAT/SUBNAT)
•PMTCT_HEI_POS Ⓕ	•SC_STOCK Ⓜ	•HRH_PRE Ⓐ	•TX_CURR_(NAT/SUBNAT)
•PMTCT_STAT Ⓕ	•TB_ART Ⓕ	•HRH_STAFF Ⓕ	•VL_SUPPRESSION_(NAT/SUBAT)
•PrEP_NEW Ⓕ	•TB_PREV Ⓕ	•KP_MAT Ⓕ	•VMMC_CIRC_(NAT/SUBNAT)
•TX_CURR Ⓕ	•TB_STAT Ⓕ	•LAB_PTCQI Ⓕ	•VMMC_TOTALCIRC_(NAT/SUBNAT)
•TX_NEW Ⓕ	•TX_TB Ⓕ	•PMTCT_FO Ⓕ	
•VMMC_CIRC Ⓕ		•TX_PVLS Ⓕ	
		•TX_RET Ⓕ	

Legend & Reporting Level Definitions	
(N/D)	Report both numerator and denominator values as described in the relevant Indicator Reference Sheet(s).
Ⓐ = Above-Service Delivery Area	**Report at the at the above-site-level (OU-level by IM). This corresponds to the OU (country)-level in DATIM.** Above site data in DATIM is entered at the operating unit by implementing partner level (OU IM). The data is not linked to a geographic location in DATIM, but to an Implementing partner only.
Ⓒ = Community	**Report at the community-level in DATIM.** Data reported at the community level often encompasses a larger geographic location, not a single structure. Each country team has defined its own community site area. In most cases, these overlap with districts or other geographic entities defined in the DATIM hierarchy.
Ⓕ = Facility	**Report at the facility-level in DATIM.** Data entered at the facility level is linked to an existing facility site in the PEPFAR site list. Facility-level data includes one or more structures with a fixed geographic location.
Ⓢ = Service Delivery Area	**Report at the facility-level by service delivery area. This corresponds to the facility-level in DATIM.** Service delivery areas (SDA) can be found within both facility and community site locations. Reporting at this level focuses on service delivery areas within a site, where specific services are being provided (e.g., testing, treatment, PMTCT, VMMC, etc.).
Ⓜ = Medical Store	**Report at medical stores. This corresponds to the "medical store" organizational unit group in DATIM.** Site administrators in-country enter medical stores at the facility level. The SC_STOCK indicator will be available only for medical stores assigned to the "medical store" organizational unit group. Medical stores are submitted and assigned to the "medical store" organizational unit group via the DATIM Support HelpDesk.

Indicator Frequency & Type		
Quarterly	Report 3 months of results for these indicators at each reporting cycle.	
Semi-Annual	Report 6 months of results for these indicators. Report totals as of the last day of the reporting period.	
Annual	Report results for entire 12 month reporting period for these indicators at the Q4 reporting cycle.	
Host Country Indicators	National	Aggregate host country results should be entered in DATIM in the national dataset at the OU-level. This data should reflect the overall country results, including PEPFAR and other stakeholder achievements.
	Subnational (at PEPFAR priority SNU-level)	Subnational host country results data should be entered in the subnational dataset at the PEPFAR Prioritization SNU-level in DATIM. This data should reflect overall results for the SNU, including PEPFAR and other stakeholder achievements.

Appendix 5: Implementation and Planning Attributes (IMPATTS)

Indicators to be used to analyze program coverage levels:

Indicators	Numerator and Denominator (Disaggregations)	Description
POPULATION ESTIMATE_NAT / SUBNAT	The total midyear population estimate *Disaggregation*: • Sex • Adults/Children	These figures provide the denominators for the calculation of multiple epidemiological parameters
HIV PREVALENCE ESTIMATE_NAT / SUBNAT	The prevalence of HIV in the adult population *Disaggregation*: • Sex • Adults/Children	Knowing the percentage of adults in a country who are living with HIV is fundamental for understanding the burden of HIV at the national and sub-national levels, for planning programs to serve people living with HIV, and for monitoring the impact of HIV programs. Disaggregating prevalence estimates by sex, and geographical distribution is crucial for tailoring a country's response to needs. Disaggregation is also necessary for monitoring program coverage and impact.
KP ESTIMATE_NAT / SUBNAT	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 • Men who have sex with men • People who inject drugs • Transgender people • Persons in prisons or other closed settings	Program planning for key populations can be more efficient if there are accurate estimates of the size of these populations. The figures enable national AIDS programs, ministries of health, donors and non-profit and multilateral organizations to efficiently allocate resources to adequately meet the prevention needs of key populations. Size estimates are also important for modelling the HIV epidemic.
PLHIV ESTIMATE_NAT / SUBNAT	The number of adults and children living with HIV Disaggregating people living with HIV estimates by sex, age, and geographical distribution is crucial for tailoring a country's response to needs. Disaggregation is also necessary for monitoring program coverage and impact. *Disaggregation*: • Sex • Adults/children	Knowing the number of adults and children in a country who are living with HIV is fundamental for understanding the burden of HIV at the national and sub-national levels, for planning programs to serve people living with HIV, and for monitoring the impact of HIV programs. The estimated number of people living with HIV provides the potential size of the group entering the care and treatment cascade, and it also serves as the denominator for the first two of the 95–95–95 treatment targets.

Appendix 6: HRH_CURR Example Calculation

		Receiving any PEPFAR salary support			***Received stipend; non-salary, monetary***			***Receiving ONLY non-monetary***				
Category	Cadre / specialization / role	Number of persons	***Average*** percent of full-time work week spent providing HIV treatment prevention and support	HIV FTE	Persons receiving stipend, not salary	***Average*** percent of full-time work week spent providing HIV treatment prevention and support	HIV FTE	Persons receiving only non-monetary support	***Average*** percent of full-time work week spent providing HIV treatment prevention and support	HIV FTE	Total persons receiving any PEPFAR support	Total HIV FTE
Clinical	MCH Nurse				2	25%	0.500				2	0.500
	Pediatric nurse				3	10%	0.300				3	0.300
	General nurse										0	0.000
	Infectious disease nurse	1	100%	1.000							1	1.000
	Midwife										0	0.000
	Doctor (part-time)	1	10%	0.100	2	10%	0.200				3	0.300
	Medical officer	1	25%	0.250							1	0.250
	(sum of all clinical)			1.350			1.000			0.000		
Lay	Community health worker				2	50%	1.000	8	33%	2.664	10	3.664
	Adherence counselor							4	100%	4.000	4	4.000
	Outreach worker, part-time				5	20%	1.000				5	1.000
	MSM peer navigator							3	100%	3.000	3	3.000
	(sum of all lay)			0.000			2.000			9.664		
			= to enter in DATIM							Grand Total	32	14.014


UNITED STATES PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF