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

Monitoring, Evaluation, and Reporting Indicator Reference Guide

MER 2.0 (Version 2.6.1)
September 2022

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Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral
BF	breastfeeding
CBS	case-based surveillance
COD	cause of death
COP	PEPFAR Country Operational Plan
CQI	continuous quality improvement
CRVS	civil registration and vital statistics
CXCA	cervical cancer
DATIM	Data for Accountability, Transparency, and Impact
DQA	data quality assessment
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD	direct service delivery
EID	early infant diagnosis
EMR	electronic medical record
FBO	faith-based organization
FCI	Faith and Community Initiative
FSW	female sex worker
FY	fiscal year
GAM	UNAIDS Global AIDS Monitoring
GBV	gender-based violence
HCW	health care worker
HEI	HIV-exposed infant
HIVST	HIV self-testing
HRH	human resources for health
HTS	HIV testing services
IIT	interruption in treatment
IM	implementing mechanism
IP	implementing partner
L&D	labor and delivery
LTFU	lost to follow-up
KP	key populations
KPIF	Key Populations Investment Fund
MAT	medication-assisted treatment
MER	monitoring, evaluation, and reporting indicators
MMD	multi-month dispensing
MOH	Ministry of Health
MSM	men who have sex with men

OVC	orphans and vulnerable children
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHIA	Population-Based HIV Impact Assessment
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
POART	PEPFAR Oversight and Accountability Response Team
POCT	point-of-care testing
PP	priority populations
PrEP	pre-exposure prophylaxis
PT	proficiency testing
PVLS	patient viral load suppression
PWID	people who inject drugs
SID	sustainability index
SI	strategic information
SIMS	site improvement through monitoring systems
STI	sexually transmitted infection
TA-SDI	technical assistance for service delivery improvement
TB	tuberculosis
TG	transgender people
TX	treatment
UNAIDS	Joint United Nations Programme on HIV/AIDS
USG	United States Government
VL	viral load
VLS	viral load suppression
VMMC	voluntary medical male circumcision
WHO	World Health Organization

Acknowledgments

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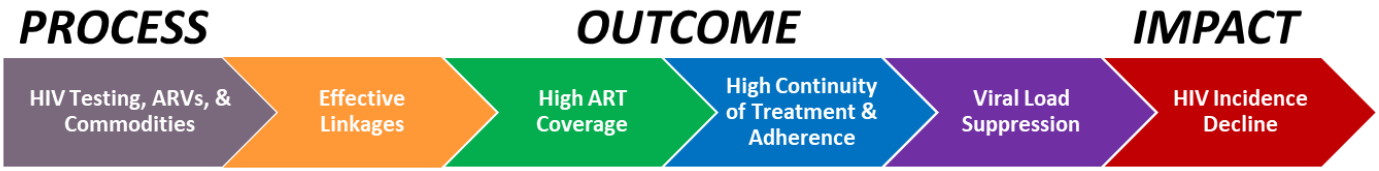
Overview

PEPFAR's focus on optimizing impact is a driving force behind global efforts to reach HIV epidemic control, defined as the point at which the total number of new HIV infections falls below the total number of deaths from all causes among HIV-infected individuals. 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.

UNAIDS data shows that many PEPFAR countries have successfully reduced HIV incidence and are at or near epidemic control. (Refer to the latest COP Guidance for information on progress towards epidemic control by country.) As countries reach and maintain epidemic control, the program monitoring approach will shift to focus on case surveillance and examining viral load suppression gaps to improve programmatic implementation for specific populations not yet at 95-95-95.

Figure 1: PEPFAR Monitoring: Getting from Process to Impact



Given the global HIV progress over the past decade, planning, monitoring, and resource allocation must occur at the subnational, community, and site levels in order to achieve the greatest impact. Collection and use of disaggregated data that characterizes the populations (e.g., age, sex, key or priority populations, etc.) served in the lowest geographic areas where HIV services are being provided is critical in understanding current program performance and planning for future performance. Overlaying that data with the partners that are supporting the implementation of HIV services can also help us to understand the fidelity with which programmatic interventions are being taken to scale within those specific populations and geographic regions.

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

PEPFAR reviews MER indicators on an annual basis to ensure:

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

Granular aggregate data has been a powerful tool to monitor and manage the progress of programs in reaching epidemic control. As countries continue to reach and maintain epidemic control, there is a need for individual level data systems to address the remaining gaps among specific populations (e.g. 15-25 year-olds, key populations). Discussions with PEPFAR staff and external stakeholders, as well as feedback submitted through the MER Refresh survey, highlight a need for information based off of electronic individual-level data systems. Individual-level data can track clients across the clinical cascade and is nimble to evolving programmatic

questions. Country programs and governments should continue to work to develop individual-level EMR, laboratory, surveillance, and other data systems that can monitor patient outcomes in conjunction with other disease areas, especially as the HIV cohort continues to age. The following indicator requests submitted through the MER Refresh survey are examples of critical information needs that could be answered using individual level data. This information will not be collected through MER this year, but countries should prepare to report on it in the future by utilizing individual level data systems:

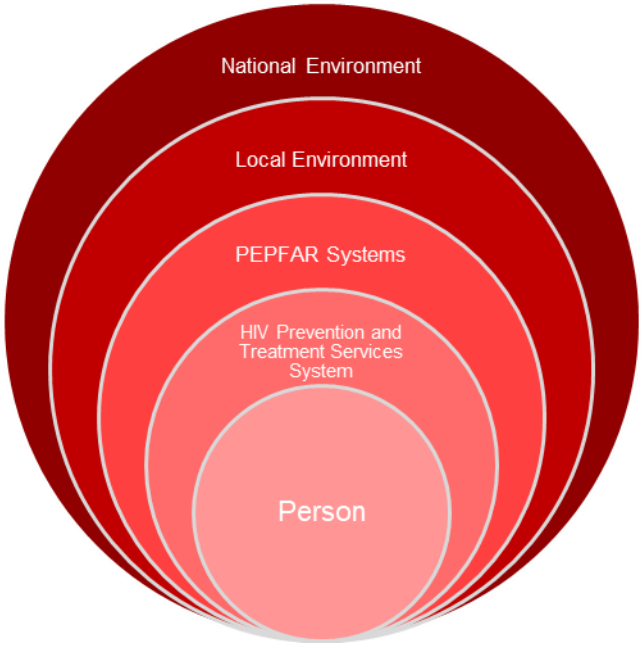
- Number of TB clients with a recent negative HIV status
- Number of clients with a reactive self-test that received a confirmatory test, as well as test result
- Number of ART clients on specific TPT regimens, including 1HP and 3HP
- ARV clients receiving multi-month dispensation by fine age
- Viral load coverage and suppression among pregnant and breastfeeding women by age

Strong surveillance systems are a critical component of a sustainable health systems infrastructure. This has been further illustrated by the COVID-19 pandemic. Health infrastructure, laboratory systems, and surveillance systems developed for HIV have been utilized in the COVID-19 response, with HIV and COVID-19 data reviewed together. Additionally, individual-level data systems will be integral in determining gaps across the clinical cascade that developed during the COVID-19 pandemic. With countries at or nearing epidemic control, it is important that COVID-19 does not deter patient outcomes and the health of people living with HIV. Therefore, drilling down to the individual and tailoring programs to specific populations will be necessary to continue to close these final gaps.

PERSON-CENTERED MONITORING

The MER strives to drive program monitoring to a more patient-centered approach. Per the 2022 WHO Consolidated Guidelines on Person-Centred Strategic Information, person-centered monitoring refers to a shift from monitoring measuring services (e.g., the number of HIV tests or people on treatment) to monitoring people at the center of their access to linked HIV and health services. In essence, this marks a shift to better support the clients accessing services by focusing more on their individual health outcomes.

Figure 2: Patient-Centered Monitoring in PEPFAR



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

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

Person-centered monitoring and care is best practice in serving both the needs of the patient and the goals of reaching epidemic control program more broadly. To reach epidemic control, all people living with HIV (PLHIV) must be identified, linked immediately to treatment, and have continuity of treatment to achieve viral suppression. If PLHIV do not have continuity of treatment, they are at risk of continued transmission and costly interventions are needed to track them.

Both the PEPFAR MER Guidance and the 2022 WHO Consolidated Guidelines on Person-Centred Strategic Information underscore the importance of tracing patients whose treatment has been interrupted. PEPFAR defines interruption in treatment (IIT) as no clinical contact for 28 days after the last scheduled appointment or expected clinical contact. This is equivalent to the WHO concept of loss to follow up (LTFU). The use of the 28-day standard for IIT and LTFU is critical to promote timely identification of patient outcomes among patients known to have missed clinical visits or drug pickups. Clients should be traced in an active, safe, and confidential way that assures sustained adherence to treatment moving forward. Health care workers should leverage best practices to reach clients experiencing IIT, while protecting confidentiality. Interruptions in antiretroviral treatment can cause viral load to rebound in as little as one to two weeks in HIV+ patients that were previously suppressed on ART therapy. The longer a patient remains off treatment, the greater the likelihood that their viral load will rebound to a point of no longer being undetectable.

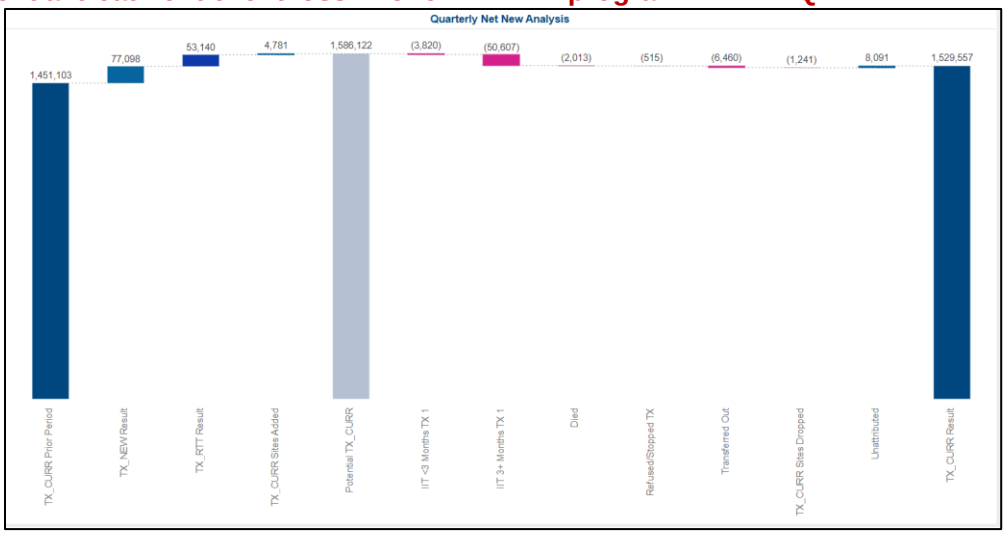
Because undetectable viral load means that patients cannot transmit HIV (U=U), it is important to get patients back on treatment not only for their own health, but for the health of others in the community. Expeditious action in defaulter tracing to bring clients back to treatment well before their viral load has the opportunity to rebound is a key example of how patient centered monitoring ensures the best outcome for both the patient and towards our shared goal of epidemic control. However, some countries are struggling to maintain gains towards epidemic

control because of the inability to provide continuity on treatment for patients. Providing services in a manner that keeps people on life-long ART is fundamentally the way HIV services should be planned for and delivered.

Figures 3a below is an illustrative example of client loss in one PEPFAR program in FY21 Q2. While the program reports a quarterly TX_NEW result of 77,098, a quarterly TX_RTT of 53,140, and a quarterly TX_CURR result of 1,529,557, there is only a reported net new on treatment of 78,454. This means that roughly 51,784 patients from the total treatment cohort did not remain on treatment due to continuity of treatment issues, data quality issues, etc. By examining TX_ML, we can see that the majority of known losses are due to clients who were on treatment for more than 3 months prior to experiencing an interruption in treatment.

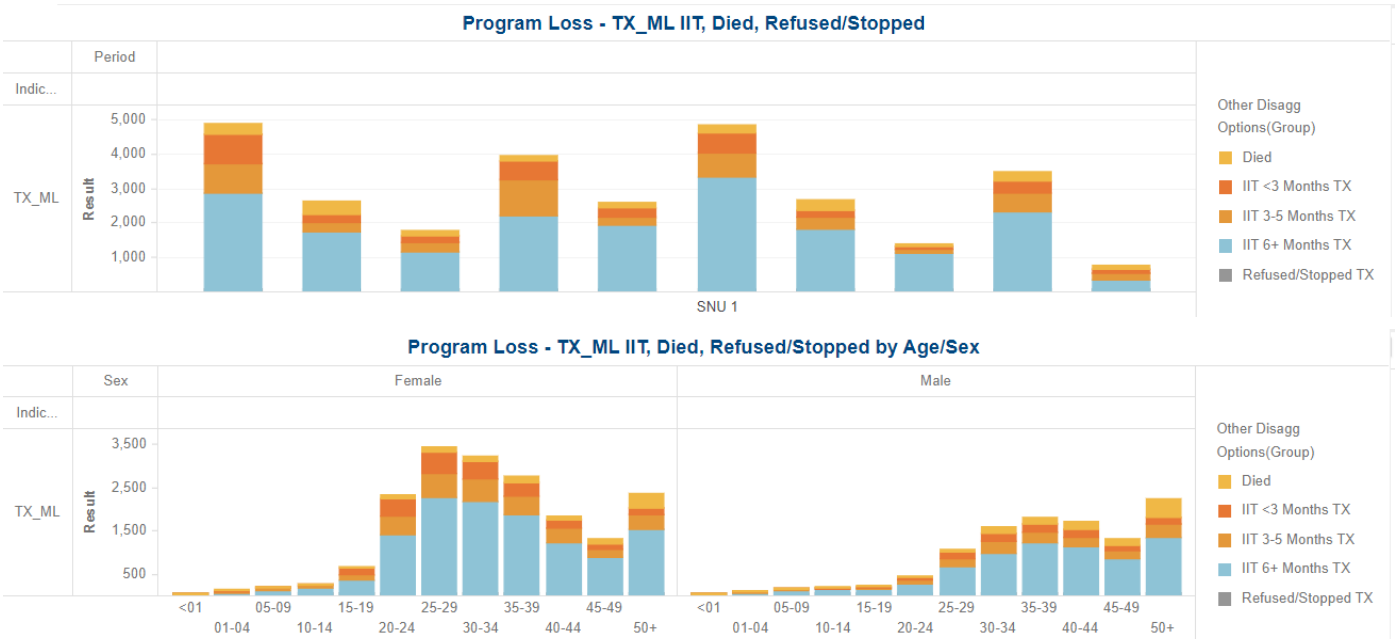
Figure 3b shows a detailed breakdown of TX_ML for the same program. The data show that the SNU on the far right is experiencing the most program loss, while most interruptions in treatment are among females in the 20-34 age range who have been on treatment for 3+ months.

Figure 3a: Potential treatment client loss in one PEPFAR program in FY21 Q2



Source: PEFPAR Panorama, Treatment Single OU Dossier, “Waterfall analysis – TX_NET_NEW”

Figure 3b: Detailed breakdown of TX_ML data



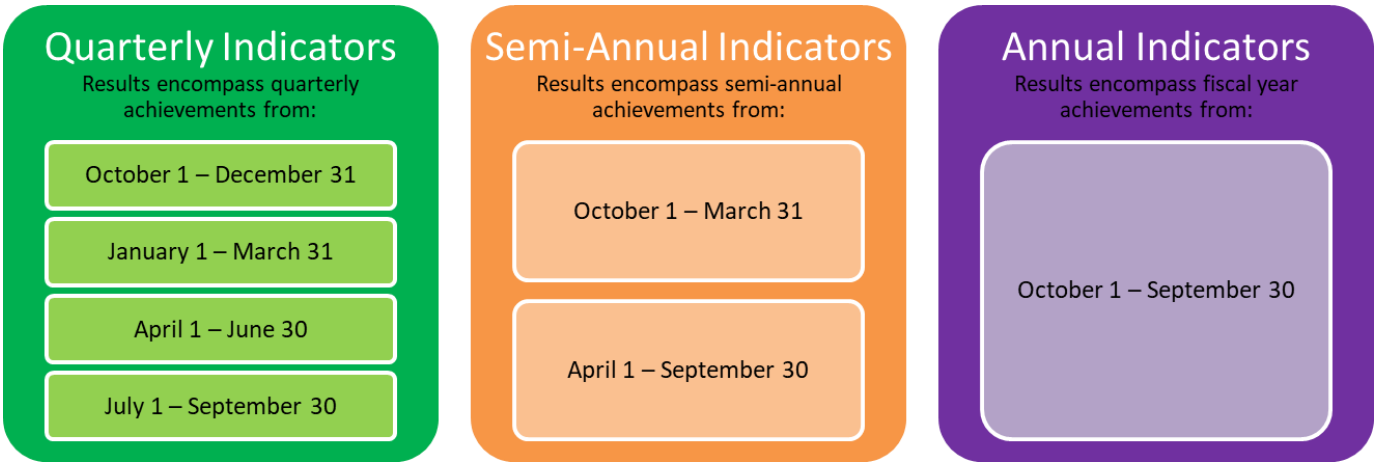
Source: PEPFAR Panorama, Treatment Single OU Dossier, “Program Loss”

MER REPORTING REQUIREMENTS

Quarterly program results document site-level achievements realized in each quarter of the U.S. government fiscal year (October 1 – September 30). MER data is due on a standard cycle approximately 45 days after each reporting period ends. Refer to the PEPFAR Data Calendar for key deadlines and data cleaning dates.

PEPFAR MER indicators vary in periodicity of reporting. Different indicators reflect different time periods for services being provided. Quarterly indicators are those indicators focused primarily on the clinical cascade: HIV case finding, diagnosis, linkage, treatment, continuity of treatment, and viral load suppression. Semi-annual indicators are those focused primarily on HIV prevention and supply chain monitoring. Annual indicators are those focused primarily on health systems and host country reporting.

Figure 4: Indicator reporting frequency and the PEPFAR fiscal year



Based on programmatic gaps in case finding, linkages, index testing scale-up, and continuity of treatment some indicators such as HTS_TST, HTS_TST_POS, HTS_RECENT, HTS_INDEX, TX_ML, TX_RTT, TX_NEW, and linkages should be monitored by PEPFAR programs more frequently (e.g., weekly) than what is required in the MER. Moving to real-time (or near real-time) monitoring of key indicators helps to ensure that rapid actions are taken to course correct areas of underperformance well before the next POART.

Please contact SGAC_SI@state.gov with any additional questions about the MER-related reporting requirements.

DISAGGREGATED MONITORING

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

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

Age: In order to advance the standardization of patient monitoring and routine health information systems, PEPFAR requires standardized reporting by five-year age bands. PEPFAR programs are required to report on the following standard age groups: <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and 50+. Starting in FY23, the age bands for all treatment and viral suppression indicators will be expanded to 50-54, 55-59, 60-64, and 65+. It is recommended that country teams review data on life expectancy and new infections and prepare to extend in-country and/or national reporting systems beyond the 50+ age band threshold as appropriate.

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

Key Populations: Reporting of key population disaggregations will be required beginning in FY 2020 for settings where it is safe to collect this data. Both clinical and key population-specific partners should complete these disaggregations, but only if it is safe to maintain these files and report. ***The first priority of data collection and reporting of program data for 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.

The key populations disaggregations for clinical indicators are as follows: people who inject drugs, men who have sex with men, transgender people, female sex workers, and people in prison and other closed settings.

Key populations disaggregations are included for the following indicators: KP_PREV, HTS_TST, HTS_RECENT, HTS_SELF, PrEP_NEW, PrEP_CT, TX_NEW, TX_CURR, TX_ML, TX_RTT, and TX_PVLS. However, it is important to note that an individual's inclusion in some key populations is subject to change over time (e.g., an individual may engage in sex work or inject drugs for specific periods in their life) and should be assessed at each clinical encounter to ensure accurate reporting of these disaggregations on indicators such as TX_CURR.

The PEPFAR key populations reporting guidance is designed to avoid double-counting and ensure that the KP data reported can be meaningfully interpreted. Despite persons potentially falling into more than one KP disaggregate (e.g., an FSW who injects drugs, MSM that is currently incarcerated), implementing partners should be instructed to **report an individual in only one KP category** with which s/he is most identified. This guidance applies to all key populations-associated indicators. Refer to the key populations classification document found in Appendix A for additional information on how to assess the needs of key populations client.

Priority Populations: PP_PREV includes a series of optional priority population types for reporting. Please note that although reporting of the priority populations disaggregation is optional – it is highly recommended.

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

DISAGGREGATION TYPES:

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

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

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

a. Disaggregations for those programs that have received initiative-specific funds for special programming such as DREAMS. There is also one full indicator, AGYW_PREV, that is conditional and based on DREAMS funding.
b. Disaggregations for which field teams have received permission or a waiver from their PEPFAR Program Manager 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 written 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., priority population disaggregations in PP_PREV).

PEPFAR SUPPORT TO COMMUNITIES AND SITES

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

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

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

DSD: Individuals will be counted as receiving direct service delivery support from PEPFAR when BOTH of the conditions below 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 solely providing financial support at the national, regional or district level, site level support will be through annual visits. However, to support the host country government with quality monitoring, it is recommended that results reported through national health information systems should be jointly monitored with the government on a quarterly basis. SIMS visits may also be conducted at these sites if quality issues are identified.

Due to the financial investments PEPFAR provides at the above-service delivery area in centrally supported sites and SNUs, it is important that results be provided to ensure that quality assurance initiatives are having the intended impact. PEPFAR programs should be focused on supporting the national program in their respective country to achieve 90% ART coverage (i.e., 95-95-95) for PLHIV; therefore, it is extremely important to understand the services provided to PLHIV across the entire country.

While patient and beneficiary-support activities have transitioned to government or other support, PEPFAR continues to provide support for overarching activities, such as quality assurance and quality improvement (QA/QI) to ensure that patients continue to receive quality services. As such, PEPFAR will continue monitoring activities in centrally supported sites annually via the following indicators: HTS_TST, TX_CURR, TX_NEW, TX_PVLS, PMTCT_STAT, and PMTCT_ART.

Results in centrally supported areas should be reported once annually at Q4 each year. Site-level data in centrally-supported areas should be reported on the Central Support (CS) tab of the DATIM data entry screen for each of the six indicators required for centrally supported reporting: HTS_TST, TX_CURR, TX_NEW, TX_PVLS, PMTCT_STAT, and PMTCT_ART. For additional information, please refer to Appendix G: Central Support.

AGE DISAGGREGATIONS:

Required reporting on the five-year age bands was introduced in Q1 of FY 2019. Reporting on these age bands will continue in FY 2023. **Methods of extrapolating or estimating age disaggregated results data are not permitted.** If you have questions, contact your PEPFAR Program Manager and SGAC_SI@state.gov. The table below describes the evolution of the standard, required age bands for PEPFAR reporting from FY 2015 through FY 2023. Note that there are some indicator-specific variations to these requirements.

As of FY 2022, 20% of PLHIV reported in TX_CURR are above the age of 50. Collection of expanded age data is needed for planning appropriate HIV services for older adults as well as integrated service needs. As the treatment cohort continues to age, the ability to monitor lifelong patient outcomes is critical. In FY 2022, the TX_CURR 50+ age band was expanded to 50-54, 55-59, 60-64, 65+. In FY 2023, these age bands will be expanded for all treatment and viral suppression indicators. There will be a 50+ age band option for circumstances where reporting on 50-54, 55-59, 60-64, 65+ is not feasible.

Table 1: Evolution of PEPFAR Finer Age Bands for Results Reporting

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<tr><th colspan="10">Evolution of PEPFAR Finer Age Bands for Results Reporting</th></tr>
<tr><th colspan="2">FY 2015 – FY 2016</th><th colspan="2">FY 2017</th><th colspan="2">FY 2018</th><th colspan="2">FY 2019 – FY 2022</th><th colspan="2">FY 2023
TX & VLS indicators only</th></tr>
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<tr><td>60-64</td><td>M / F</td></tr>
<tr><td>65+</td><td>M / F</td></tr>
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HOST COUNTRY NATIONAL PROGRAM

PEPFAR works closely with host countries, particularly with Ministries of Health, to jointly monitor the HIV response. Monitoring the host country HIV response is critical to understanding both the achievements and the gaps at the subnational level and within specific populations. Host country data are used to inform PEPFAR programs and guide how PEPFAR resources are allocated. 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.

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

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

At the host country national level, to sufficiently monitor its national response, the host country government's national set of indicators should include the minimum set of harmonized global indicators (UNAIDS Global AIDS Monitoring) 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.

PEPFAR host country national and subnational level indicators represent results obtained within the entire host country regardless of PEPFAR support. All PEPFAR countries should report host country results at Q4 each fiscal year.

Host country results are also reported at the site-level for a subset of indicators. The majority of these facility-level indicators will be reported through the PEPFAR-MOH data alignment process. In FY23, all PEPFAR operating units are expected to report through the PEPFAR-MOH data alignment on an annual basis for the following indicators: HTS_TST, TX_CURR, TX_NEW, TX_PVLS, PMTCT_STAT, PMTCT_ART, and TB_PREV.

HOST COUNTRY TARGETS

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

HOST COUNTRY RESULTS

At Q4 of the USG fiscal year, results from the host country systems should be reported up until the most recent month of collection and include 12 months of data. These may not align with the USG fiscal year end results. These data should be collected continuously at the subnational level. Data should be in line with GARPR and UNAIDS reported data, where available, although they may differ due to different reporting periods. In the narratives, please indicate what months the data include (e.g., October 2022-September 2023; or July 2022 to June 2023). Results should be consistently reported on the same time period to be able to monitor trends over time.

Table 2: Host Country indicators by reporting level, targets, and results

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

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

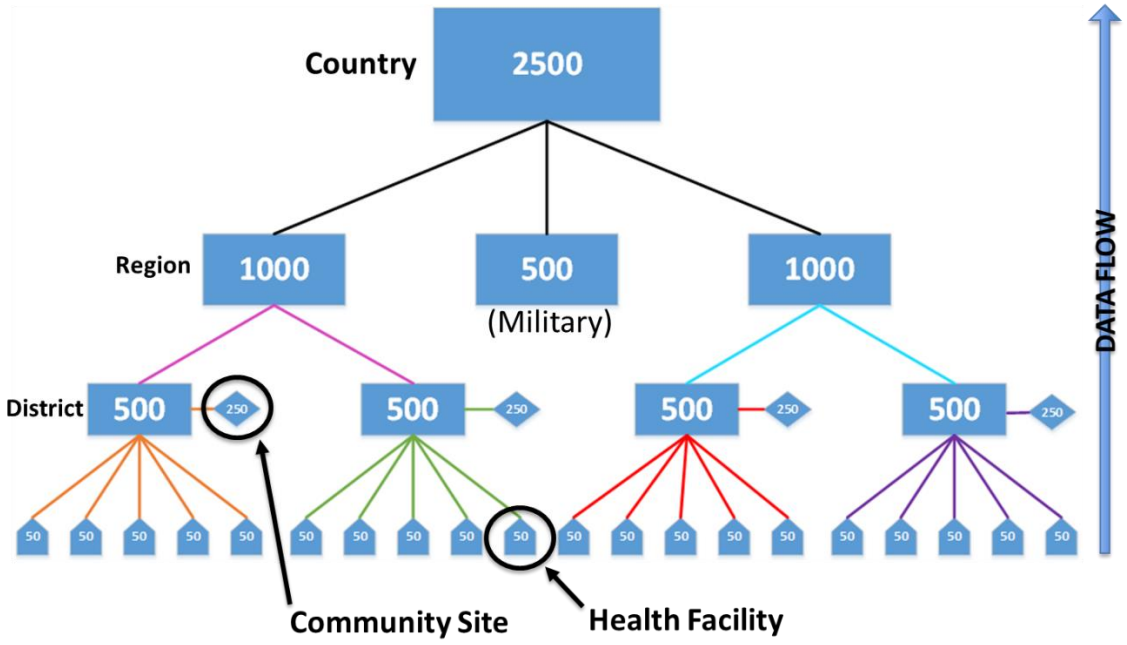
REPORTING MER RESULTS IN DATIM

MER program results are reported in DATIM (Data for Accountability, Transparency, and Impact). Data are reported into DATIM by both implementing partners (IP) and USG staff in country depending on the type of indicator. Please refer to the indicator-specific requirements in the MER for more details.

If you are an implementing partner or USG agency or HQ staff member that needs to access DATIM, visit the following link to request an account: https://register.datim.org/.

Results in DATIM are entered at the facility and community-levels in DATIM and aggregate up to the district, regional and national levels as shown in the data flow diagram below.

Figure 5. MER data flow from the site to country level



ROUTINE DATA CLEANING & COMPLETENESS CHECKS

PEPFAR programs are expected to have reviewed, cleaned, analyzed, and interpreted their program results data prior to submission of their results to headquarters. Country teams are expected to conduct routine data cleaning and completeness checks using the Data Review Tool before submitting results in DATIM. For a list of data quality checks used across PEPFAR systems, please refer to the MER Validation Guide on DATIM Support.

There are several levels for data quality checks to be initiated by the responsible person at the site, implementing partner, PEPFAR country agency and interagency, and the headquarters levels. The data quality checks and review include both completeness and logic checks. Completeness checks begin at the site level with routine review of patient level data at the source of collection such as registers, EMRs or patient charts. These patient monitoring tools should be reviewed for entry completeness at each reporting period.

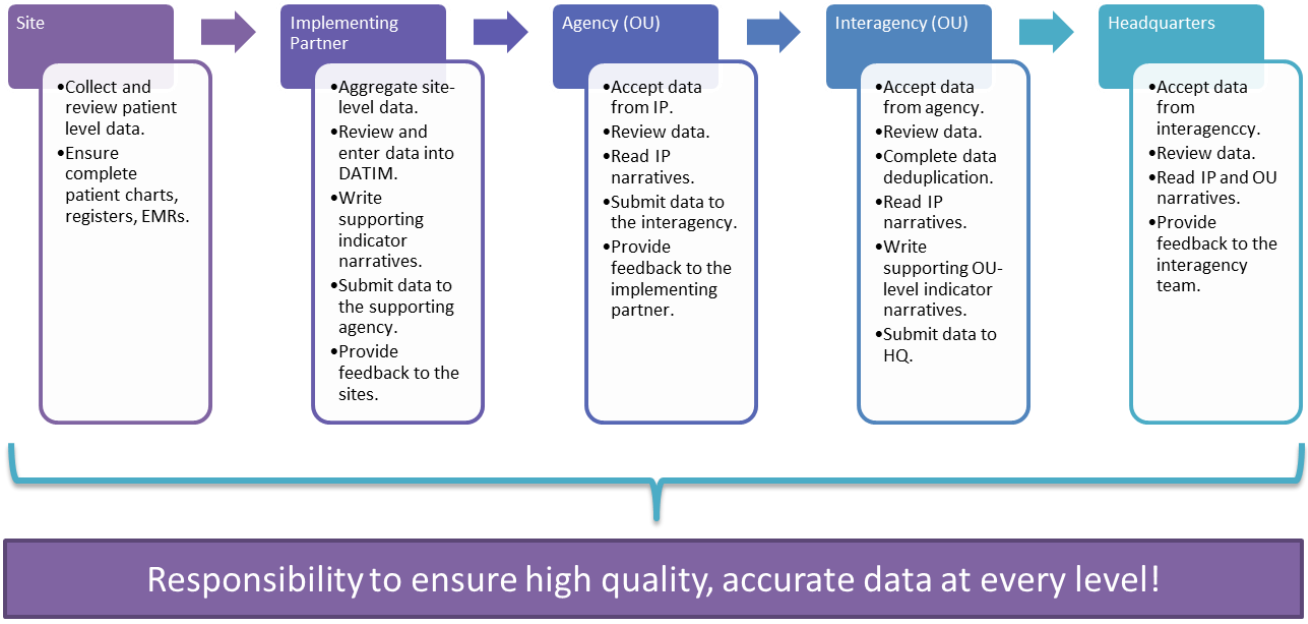
Once implementing partner staff have completed data entry for the reporting period, the IP should confirm the overall completeness of data by reviewing a set of DATIM "Favorites" that display MER indicators' "numerator" value and "denominator" values by disaggregation totals (e.g., total by age/sex, total by service delivery point/test result, total by age/sex/service type, etc.). An overview of DATIM completeness favorites and instructions on how to use them can be found below.

When USG agency staff "Accept" MER results data from IPs within DATIM, these same DATIM Favorites should be reviewed to verify data completeness; if any issues are identified, these should be flagged by the AOR/COR, Activity Manager, or SI point of contact and returned to the IP for corrections or revisions. A set of data validation and logic checks should also be carried out between indicators before data is submitted to Interagency.

DATA ENTRY AND REVIEW PROCESS OVERVIEW

The in-country review of data completeness is a shared responsibility across all stakeholders, including data entry and review by implementing partners, review by agency, and further review and de-duplication data at the Interagency level.

Figure 6. MER data entry and review process



Implementing Partner Review Process

1. Enter results data.
2. Review data for completeness and accuracy.
3. If data is complete and accurate, "Submit" data to agency via Data Approvals App.
4. If data is incomplete, but can be justified, “Submit” data to agency via Data Approvals App and explain any data completeness issues in indicator narrative.
5. If data is incomplete and not justified, return to Step 1

Once implementing partner staff have completed data entry for the reporting period, they should confirm the overall completeness of data by reviewing the DATIM favorites provided by the “MER Result & Target Review” DATIM dashboard that display MER indicators’ “Numerator” value and “Denominator” value by disaggregation totals (e.g., total by age/sex, total by service delivery point/test result, total by age/sex/service type, etc.). If there are data completeness issues, the IP should work to address these problems or acknowledge data completeness limitations within the implementing mechanism indicator performance narrative.

Agency Review Process

1. “Accept” data from implementing partner via Data Approvals App.
2. Review data for completeness and accuracy.
3. If data is complete and accurate, "Submit" data to Interagency via Data Approvals App.
4. If data is incomplete but can be justified, “Submit” data to Interagency via Data Approvals App and refer to any data completeness issues identified by partners in the OU-level indicator narrative.
5. If data is incomplete and not justified, “Return” data to IP via Data Approvals App and email IP point of contact explaining any issues identified.

Interagency Review Process

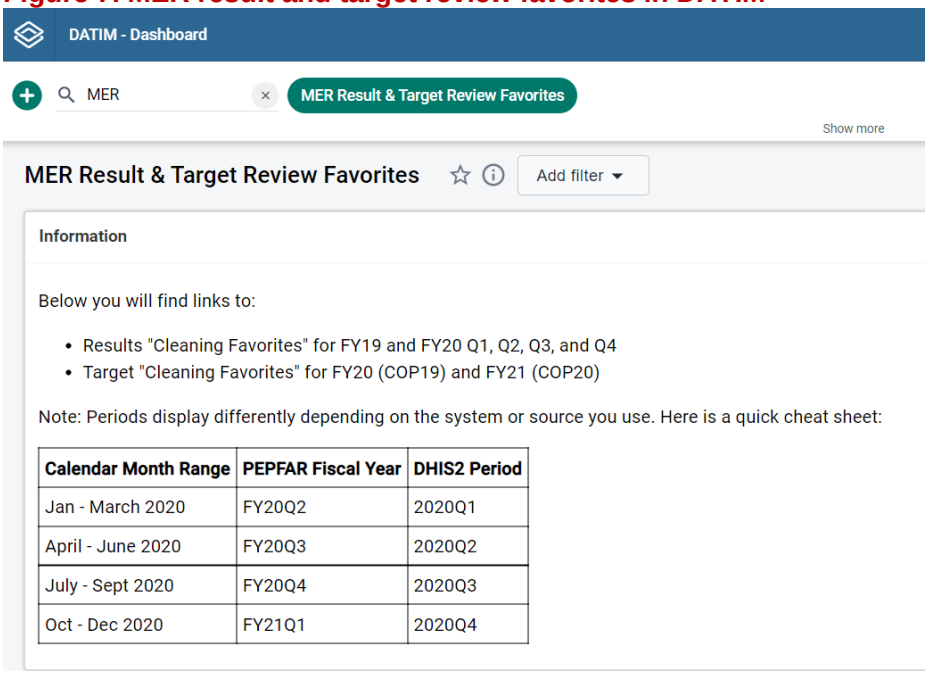
1. “Accept” data from implementing agency via Data Approvals App.
2. Review data for completeness and accuracy.
3. Conduct data de-duplication as required across all IMs via the Data De-Duplication App
4. If data is complete, "Submit" data to Global via Data Approvals App
5. If data is incomplete but can be justified, “Submit” data to Global via Data Approvals App and refer to any data completeness issues in indicator narrative
6. If data is incomplete and not justified, “Return” data to agency via Data Approvals App and email agency point of contact explaining any issues identified

USG Interagency staff should review all submitted data using the DATIM Data Completeness Favorites prior to submission to headquarters; with three levels of accountability (IP, agency, interagency), it is expected that data completeness challenges should be identified, addressed, and/or explained as part of the USG technical area indicator narratives. If any data inconsistencies are identified and have not already been documented in the narrative, data must be sent back down to the agency and then to the IP level for the inconsistency to be either reconciled or, if irreconcilable, documented in the narrative.

DATA REVIEW COMPLETENESS TOOLS

MER Data Cleaning and Completeness Review Favorites (or “Favorites”) are saved data query outputs generated from live data within DATIM as submitted by implementing partners. S/GAC has created and shared a list of standard “favorites” globally to help DATIM users validate data for completeness and consistency of entry across their program. These reports emulate the MER data entry screens and allow all DATIM users to review the totals of MER indicators. If the totals are not equal to the users’ expected result, users can look at the disaggregated data to see where a data error is present. These favorites are tagged to the “MER Result & Target Review Favorites” dashboard that is accessible to all DATIM users on the main landing page when a user logs into the system as seen in the screenshot below.

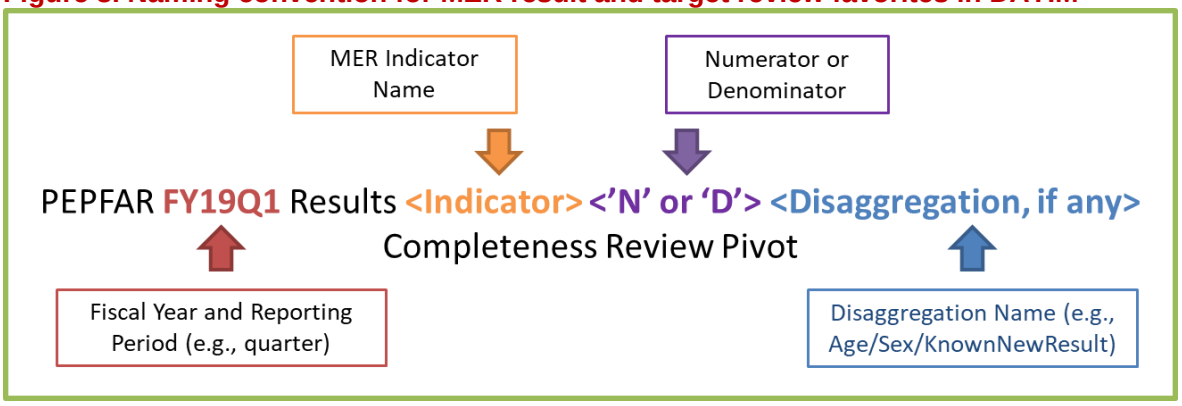
Figure 7. MER result and target review favorites in DATIM



Calendar Month Range	PEPFAR Fiscal Year	DHIS2 Period
Jan - March 2020	FY20Q2	2020Q1
April - June 2020	FY20Q3	2020Q2
July - Sept 2020	FY20Q4	2020Q3
Oct - Dec 2020	FY21Q1	2020Q4

In addition to their availability on the dashboard, the data cleaning favorites can also be found in DATIM's pivot table app. Each canned cleaning favorite uses the following naming convention:

Figure 8. Naming convention for MER result and target review favorites in DATIM



If an indicator is calculated by auto-summing other indicators and/or disaggregates, AUTO-SUM" will be present in the favorite's name (as seen underlined in the example for HTS_SELF found below). Also, for testing indicators, "Facility" or "Community" will appear after the fiscal year and reporting section of the favorite name to easily discern testing modalities.

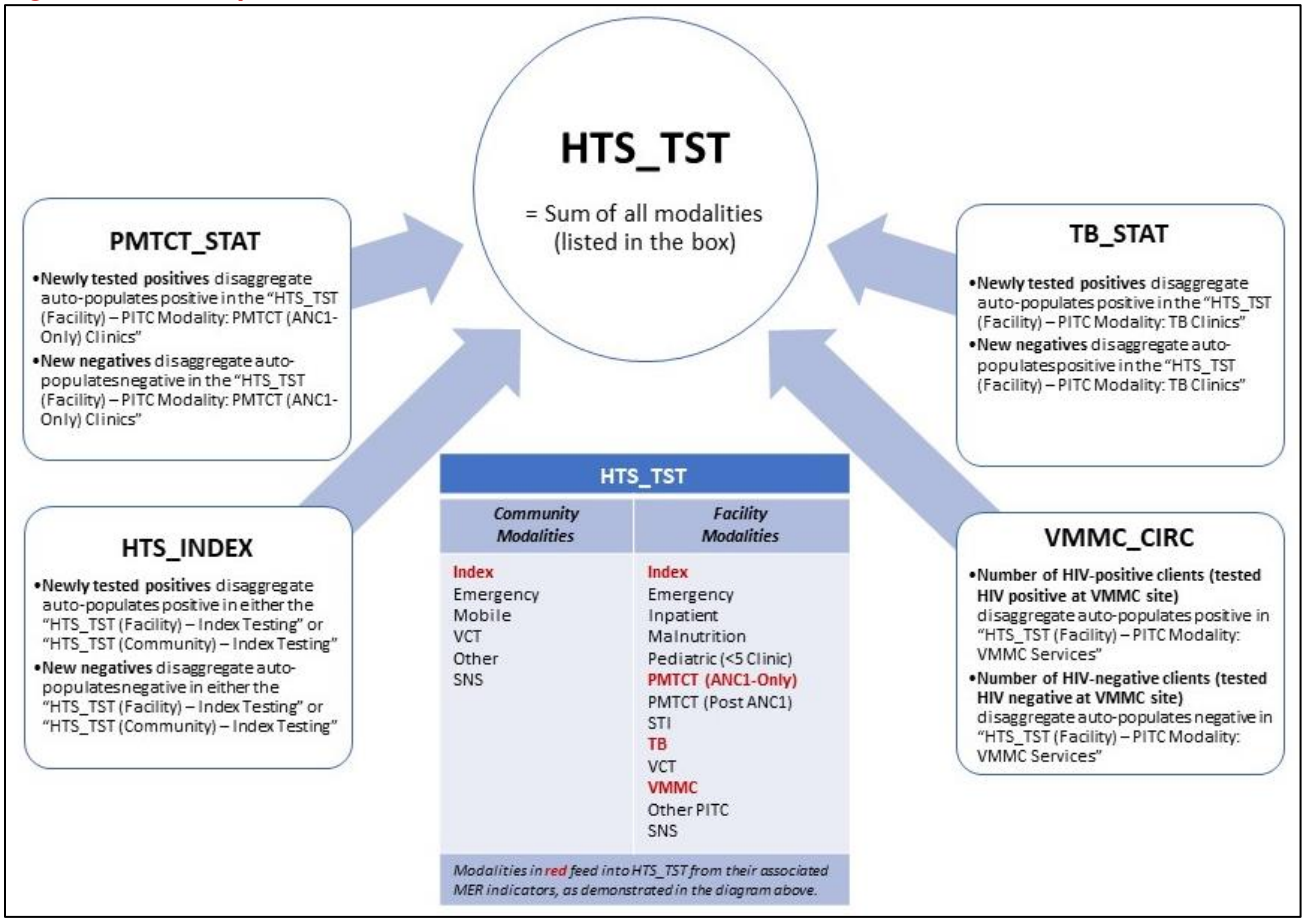
For example, the DATIM favorite to review the results for the distribution of HIV self-test kits (i.e., HTS_SELF) by age, sex, and test kit distribution method is named:

PEPFAR FY19Q1 Results HTS_SELF N AUTO-SUM Age/Sex/HIVSelfTest Directly Assisted/Unassisted Completeness Review Pivot

AUTO-POPULATION OF HTS_TST MODALITIES:

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

Figure 9: Auto-Population of HTS_TST from Associated Indicators



AUTO-SUM NUMERATORS AND DENOMINATORS:

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

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

MER INDICATOR NARRATIVES

Four types of narratives are required as part of quarterly data submissions: (1) IM level narratives, (2) technical area level narratives (3) host country results narratives, and (4) initiative-specific narratives. Specific requirements are defined for each type of narrative. In addition, guiding narrative questions were introduced for FY 2018 reporting to provide additional technical detail and continuity within the narratives submitted across PEPFAR countries.

GUIDING NARRATIVE QUESTIONS

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

Each indicator has 3-5 questions or prompts included within the indicator reference sheet that should guide **both implementing partners and USG technical area experts** in the development and framing of both the IM and technical area narratives – in addition to the narrative requirements provided in the paragraphs below.

IMPLEMENTING MECHANISM (IM) INDICATOR NARRATIVES

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

- **Respond to the guiding narrative questions defined in the indicator reference sheet, as applicable.**
- Provide additional information related to specific data quality concerns or programmatic issues that may impact the assessment of partner performance. Indicate whether data quality assessments were conducted during the reporting period and the impact the assessment had on the results and program.
- If appropriate, reference specific site-level issues that were encountered during the reporting period that may prevent achievement of the IM target.
- Provide additional information that is useful for the interpretation of the results on an indicator-specific basis.
- 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.

USG TECHNICAL AREA INDICATOR NARRATIVES

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

- **Respond to the guiding narrative questions defined in the indicator reference sheet, as applicable.**
- Provide additional information that would be useful for the interpretation of the results, including specific data quality concerns or programmatic issues that may impact the assessment of overall performance.
- Describe the nature of support the partners are providing that qualifies the results to be categorized as Direct Service Delivery (DSD) or Technical Assistance for Service Delivery Improvement (TA-SDI) in accordance with PEPFAR MER guidance.
- Describe the achievements in light of expected trajectories for the technical area.
- Provide information on data quality assessment (DQA) completion in the last 12 months.
- Address achievements by prioritization level and DSD and TA-SDI support. For example, is there an overlap between PEPFAR and the Global Fund in support for ART services?

HOST COUNTRY INDICATOR TARGETS & RESULTS NARRATIVES

National level indicator narratives provide an opportunity for teams to discuss the host country response beyond PEPFAR supported activities. For national indicators, both a justification and a source narrative are required for

each indicator. Also take note that narratives for both National (_NAT) and Subnational (_SUBNAT) should be recorded in the _NAT narrative section in DATIM.

Justification Narrative

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

Source Narrative

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

INITIATIVE-SPECIFIC NARRATIVES

Initiative-specific narratives provide an opportunity to better understand key investments and interventions as they relate to PEPFAR's special initiatives (e.g., DREAMS, Faith and Community Initiative, etc.). These narratives are collected in DATIM and country teams should respond to the initiative-specific prompts and guidance listed in the "Monitoring Special Initiatives" chapter.

CALCULATED INDICATORS

A calculated indicator is a MER indicator that is generated using values that were entered manually via DATIM. Calculated indicators facilitate analysis of MER data and reduce the chance for error introduced by manual calculations. **Three** types of calculated indicators are shown below. Please refer to Appendix B for a detailed list of calculated indicators and their corresponding calculations.

Type 1: Sum of disaggregates to Total Numerator
The "Total Numerator" value for each indicator is calculated from the sum of specific disaggregates within the indicator. This prevents discrepancies resulting from entering the total numerator and disaggregates separately.

Example:
TB_STAT Total Numerator =
TB_STAT Known Positives by age/sex
+ TB_STAT Newly Tested Positives by age/sex
+ TB_STAT New Negatives by age/sex

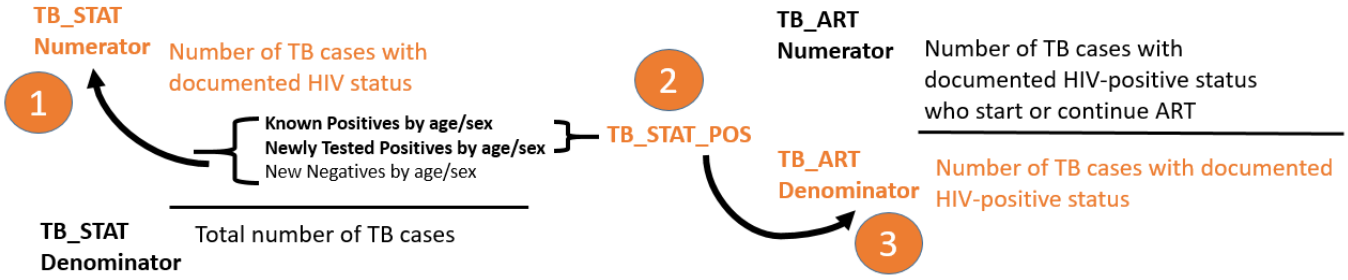
Type 2: Sum of disaggregates to new disaggregate
Often, there are specific groups of disaggregates that are reviewed on a routine basis. Rather than summing the disaggregates during each analysis, a calculated disaggregate is generated to facilitate the review. In this example, TB_STAT_POS is calculated to generate the total number of HIV-positive individuals documented as part of TB_STAT.

Example:
TB_STAT_POS =
TB_STAT Known Positives by age/sex
+ TB_STAT Newly Tested Positives by age/sex

Type 3: Copying of data to new indicator
In many cases, data that is collected as part of one indicator is useful for analysis in another indicator. Rather than require that the same data be entered in multiple places, the data can be entered once and copied to other system-generated indicators. In this example, the number of HIV-positive TB cases is collected as part of TB_STAT, and used as the denominator for TB_ART. TB_ART (D) is not entered directly – it is generated automatically using values that were originally entered under TB_STAT.

Example:
TB_ART Denominator = TB_STAT_POS =
TB_STAT Known Positives by age/sex
+ TB_STAT Newly Tested Positives by age/sex

Figure 10: Calculated indicator examples
Calculated indicators are shown in orange.



DATA QUALITY

Reliable data is the key to reaching the 95-95-95 goals. Measuring the success of PEPFAR's initiatives requires strong monitoring and evaluation (M&E) systems that can routinely produce high quality data. Efforts to ensure data quality, therefore, are not singular events occurring randomly. Rather, these processes need to become institutionalized as part of the entire data management cycle. Once achieved, data quality helps to ensure that limited resources are used effectively, progress toward established goals is accurately monitored, measured and reported, and decisions are based on strong evidence.

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

Data quality has always been a focus of global HIV monitoring and reporting efforts. Specifically, all countries conducting programming supported by PEPFAR are expected to have a data quality strategy in place. For example, data quality assessments (DQAs) should be routinely conducted and action should be taken because of these DQAs. If errors are identified in data, these should be remediated at the point of service delivery as well as in the PEPFAR and host-country reporting systems as soon as possible.

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

Understanding the treatment gaps by location and populations means conducting DQAs by age and sex to correct discrepancies by population that exist in the TX_CURR numbers. Significant shifts in age and sex coverage levels can be observed when TX_CURR numbers are reset based on DQAs.
For more information on data quality, please refer to "Data Quality Assessment of National and Partner HIV Treatment and Patient Monitoring Systems." The approved DQA protocol from this guidance can also be found in Appendix C.

STANDARDIZED HEALTH DATA EXCHANGES & SURVEILLANCE SYSTEMS

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

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

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

These surveillance systems, when comprehensive, emphasize case finding and case reporting of new diagnoses (including recent infections), identify if the newly diagnosed are linked to treatment, and provide disaggregation by age, sex, geography, and risk. This in turn can trigger a public health response to effectively intervene and make the necessary adjustments from a surveillance and programmatic perspective to prevent new cases as countries strive to achieve and sustain epidemic control. There are several paths countries can take to obtain standardized health data exchanges and surveillance systems that track individual patients with the removal of duplicates by key HIV sentinel events [first HIV positive diagnoses (by new and chronic infection), first CD4 count (after diagnosis), antiretroviral treatment (ART) initiation, first viral load test, viral suppression (follow up viral load tests), and death]. We describe two paths: (1) case-based surveillance (CBS) and (2) linkage of routine program data. Both approaches allow countries to monitor HIV cases longitudinally, providing real-time estimates of new diagnosis, treatment, and viral suppression by age, sex, and sub-national unit.

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

COMMITMENT TO DATA TRANSPARENCY

PEPFAR is committed to data transparency. Site (de-identified) and SNU-level results are posted each quarter for the public to view, download, and analyze through Panorama Spotlight.

For more in-depth analyses, partners and stakeholders external to PEPFAR may request access to data for additional PEPFAR data elements. For more specific information around data sharing in PEPFAR, please consult the PEPFAR Data Governance policy.

Key Updates and Changes: MER 2.6 to MER 2.6.1

Through the past several years of quarterly, site-level monitoring, PEPFAR programs have used data to improve implementation. Changes to the MER guidance highlight key program areas (e.g., index testing services) that should be taken to scale. Tables 3 and 4 and Figure 11 on the following pages highlight the key details for the MER indicators.

This guidance goes into effect with FY 2023 reporting with the first reporting on these indicators taking place in Q1 of FY 2023 for results that occurred from October 1 – December 31, 2022.

For changes prior to version 2.6.1, refer to the MER guidance from previous years.

INDICATOR TRAININGS:

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

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

NEW INDICATORS:

None

NEW DISAGGREGATIONS:

CXCA_TX: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

PMTCT_ART: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

TB_ART: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

TX_ML: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

TX_NEW: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

TX_PVLS: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

TX_RTT: Expanded 50+ age band to 50-54, 55-59, 60-64, 65+.

CHANGES IN REPORTING FREQUENCY:

See Table 4 for more details on indicator reporting frequency.

None

RETIRED INDICATORS

None

Table 3: Indicator Summary Table

Indicator Code	Indicator Group	Indicator Description	Reporting Frequency	Changes for FY23
AGYW_PREV	Prevention	Percentage of adolescent girls and young women (AGYW) that completed at least the DREAMS primary package of evidence-based services/interventions.	Semi-Annual	
CXCA_SCRN	Testing	Number of HIV-positive women on ART screened for cervical cancer	Semi-Annual	
CXCA_TX	Treatment	Percentage of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	Semi-Annual	X
EMR_SITE	Health Systems	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	Annual	
FPINT_SITE	Prevention	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	Annual	
GEND_GBV	Prevention	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	Semi-Annual	
HRH_PRE	Health Systems	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	Annual	
HTS_INDEX	Testing	Number of individuals who were identified and tested using Index testing services and received their results	Quarterly	
HTS_RECENT	Testing	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period	Quarterly	
HTS_SELF	Testing	Number of individual HIV self-test kits distributed	Quarterly	
HTS_TST	Testing	Number of individuals who received HIV Testing Services (HTS) and received their test results	Quarterly	
KP_MAT	Prevention	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months	Annual	
KP_PREV	Prevention	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	Semi-Annual	

LAB_PTCQI	Health Systems	Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing (POCT) sites engaged in continuous quality Improvement (CQI) and proficiency testing (PT) activities.	Annual	
OVC_HIVSTAT	Testing	Percentage of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with HIV status reported to implementing partner.	Semi-Annual	
OVC_SERV	Prevention	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	Semi-Annual	
PMTCT_ART	Treatment	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	Quarterly	X
PMTCT_EID	Testing	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	Quarterly	
PMTCT_FO	Testing	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	Annual	
PMTCT_HEI_POS	Testing	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	Quarterly	
PMTCT_STAT	Testing	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)	Quarterly	
PP_PREV	Prevention	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	Semi-Annual	
PrEP_CT	Prevention	Number of individuals, excluding those newly enrolled, that return for a follow-up visit or re-initiation visit to receive pre-exposure prophylaxis (PrEP) to prevent HIV during the reporting period	Quarterly	
PrEP_NEW	Prevention	Number of individuals who were newly enrolled on pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	Quarterly	
SC_ARVDISP	Health Systems	The number of adult and pediatric ARV bottles (units) dispensed by ARV drug category at the end of the reporting period	Semi-Annual	
SC_CURR	Health Systems	The current number of ARV drug units (bottles) at the end of the reporting period by ARV drug category	Semi-Annual	
TB_ART	Treatment	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	Annual	X
TB_PREV	Prevention	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the previous reporting period who completed therapy	Semi-Annual	
TB_STAT	Testing	Percentage of new and relapse TB cases with documented HIV status	Quarterly	

TX_CURR	Treatment	Number of adults and children currently receiving antiretroviral therapy (ART)	Quarterly	
TX_ML	Treatment	Number of ART patients (who were on ART at the beginning of the quarterly reporting period or initiated treatment during the reporting period) and then had no clinical contact since their last expected contact	Quarterly	X
TX_NEW	Treatment	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Quarterly	X
TX_PVLS	Viral Suppression	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	Quarterly	X
TX_RTT	Treatment	Number of ART patients who experienced IIT during any previous reporting period, who successfully restarted ARVs within the reporting period and remained on treatment until the end of the reporting period.	Quarterly	X
TX_TB	Treatment	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment.	Semi-Annual	
VMMC_CIRC	Prevention	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period	Quarterly	

Table 4: Frequency of Reporting Table

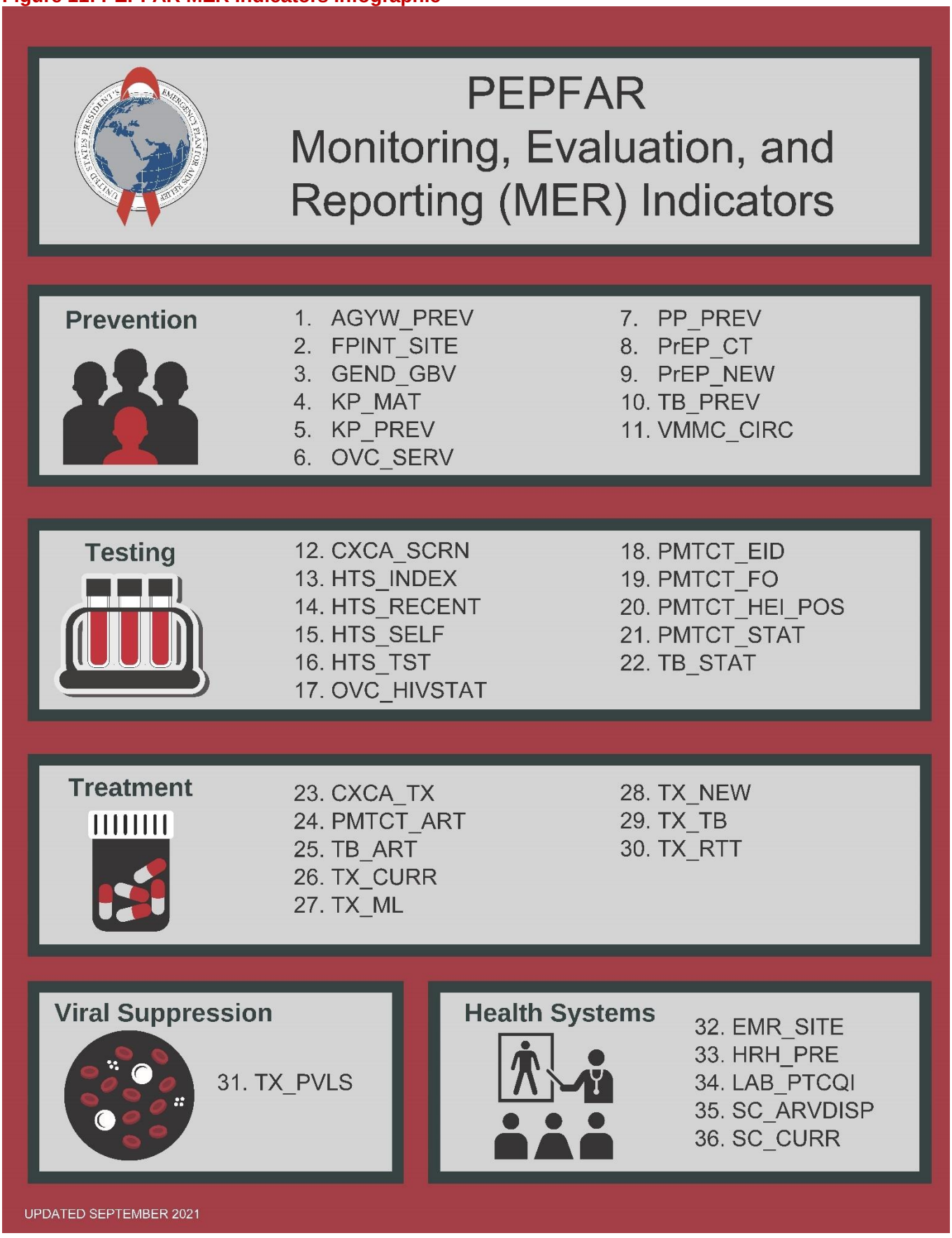
PEPFAR MER 2.6.1
Indicator Frequency Table

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

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

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

Figure 11: PEPFAR MER Indicators Infographic



How to read a PEPFAR indicator reference sheet

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

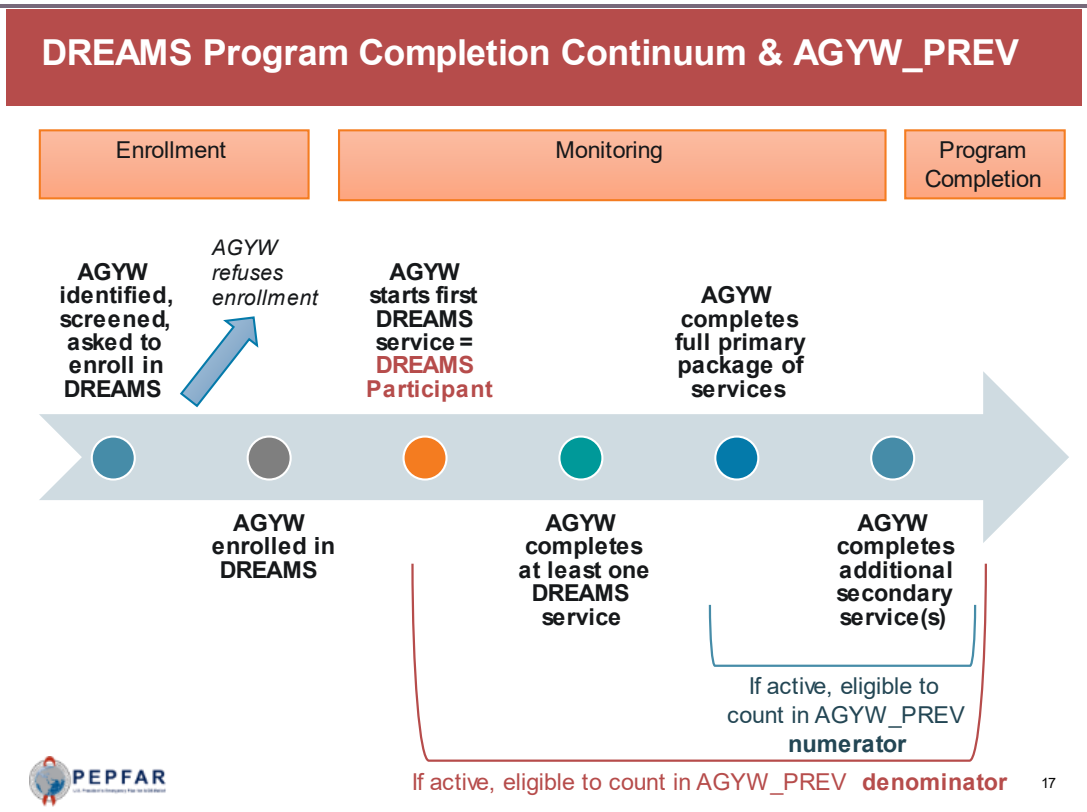
Indicator Code

Description:	*Name of the indicator*	
Numerator:	*Name of the numerator*	*Descriptive information about the numerator*
Denominator:	*Name of the denominator*	*Descriptive information about the denominator*
Indicator changes (MER 2.0 v2.6 to v2.6.1):	*Highlights any changes that have occurred between MER 2.0 (versions 2.6 and 2.6.1). For changes prior to version 2.6.1, refer to the guidance from previous years.*	
Reporting level:	*Defines the level at which the indicator is reported: facility, community, and/or above-site*	
Reporting frequency:	*Defines the period at which the indicator is reported: quarterly, semi-annually, or annually*	
How to use:	*Defines how the data is used to monitor PEPFAR program activities*	
How to collect:	*Defines how the data is collected (highlighting data source, issues with double counting/deduplication, and important components of data collection that ensure data quality)*	
How to review for data quality:	*Outlines specific data quality considerations for the indicator*	
How to calculate annual total:	*Defines how annual totals are calculated for the indicator at the end of the fiscal year*	
Disaggregations: *In each indicator reference sheet, within the disaggregations section, the disaggregate group that will be used to auto-sum to the numerator or denominator total is highlighted in **BOLD** text. Not all indicators will auto-calculate.*	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Name of Numerator Disaggregate Group(s) [Disaggregate Requirements: (e.g., Required, Optional]	• *Disaggregations*
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	Name of Denominator Disaggregate Group(s) [Disaggregate Requirements: (e.g., Required, Optional]	• *Disaggregations*
Disaggregate descriptions & definitions:	*Describes and defines the disaggregates relevant to the indicator in greater detail*	
PEPFAR-support definition:	*Lists the indicator-specific definition for DSD vs. TA-SDI support that differ from the standard definitions outlined in the introduction section of the guidance*	
Guiding narrative questions:	*Lists the indicator-specific questions that implementing partners and USG country teams should address in the implementing mechanism and technical area summary narratives*	
Data Visualization & Use Examples:	*This section is included on the reference sheet for a highlighted subset of indicators and depicts example analyses or visualizations of the indicator's data. Examples are **not exhaustive** but are intended to be illustrative and informative. PEPFAR field teams and implementing partners are encouraged to continually innovate and improve upon any data visualizations provided here.*	

PREVENTION & SUPPORT INDICATORS

AGYW_PREV

Description:	Percentage of active DREAMS participants that completed at least the DREAMS primary package of evidence-based services/interventions.	
Numerator:	Number of active DREAMS participants that have completed at least the DREAMS primary package of services/interventions as of the end of the reporting period	The numerator is the sum of the following age/sex/layering disaggregates: 1. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions but no additional services/interventions 2. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions AND at least one secondary service/intervention
Denominator:	Number of active DREAMS participants that have started or completed any DREAMS service/intervention as of the end of the reporting period	The denominator is the sum of the following age/sex/layering disaggregates: 1. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions but no additional services/interventions 2. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions AND at least one secondary service/intervention 3. Number of active DREAMS participants that have completed at least one DREAMS service/intervention but not the full primary package 4. Number of active DREAMS participants that have started a DREAMS service/intervention but have not yet completed it
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Community (Reported by USG team, not implementing partners)	
Reporting frequency:	Semi-Annually	
How to use:	This indicator reflects program data on how many AGYW are being served in DREAMS and how many active DREAMS participants have received the intended layered services/interventions to prevent HIV seroconversion. Specifically, this indicator will measure how many active DREAMS participants have completed the DREAMS primary package of services/interventions, the primary package plus any secondary services/interventions, and how many have not yet completed the primary package. **Who is Captured Under AGYW_PREV:** AGYW should only be counted under AGYW_PREV if they are an **active** DREAMS participant (see below for definition of active participant). The graphic and definitions below outline the client flow for this indicator in more detail, as aligned with the DREAMS program completion continuum:	



Enrolled: AGYW identified based on country-specific eligibility criteria/assessment for HIV risk and accepts enrollment into the DREAMS program.

While a vulnerability assessment and/or enrollment screening may be a prerequisite to receiving a DREAMS service, the enrollment or screening by itself is not considered a qualifying DREAMS service under this indicator. AGYW who are within the 10-24 age band but do not meet DREAMS criteria and have not been enrolled in DREAMS should not be counted in this indicator. They should instead be counted under other MER indicators such as OVC_SERV or PP_PREV as relevant to the definition of these indicators and the services that they receive.

DREAMS Participant: AGYW is enrolled in DREAMS and has started or completed at least one DREAMS service/intervention.

Active DREAMS Participant: AGYW is enrolled in DREAMS and has started or completed at least one DREAMS service/intervention in the past 6 months (at Q2) or 12 months (at Q4). Only active DREAMS participants are counted under AGYW_PREV.

Inactive DREAMS Participant: AGYW is enrolled in DREAMS and at one time had started or completed at least one DREAMS service/intervention but has not started or completed a service/intervention within the past 6 months (at Q2) or 12 months (at Q4). Reasons for being inactive include AGYW that are lost-to-follow-up, or AGYW who have fully completed the DREAMS program in a previous reporting period (please see DREAMS program completion definition below).

Defining the Country-Specific DREAMS Package:
Each country is responsible for designating its own primary package of services/interventions for each DREAMS AGYW age band (10-14, 15-19 and 20-24) based

on the DREAMS Guidance. All 15 DREAMS countries will be required to submit a DREAMS Layering Table detailing their primary/secondary/contextual interventions for each age band to S/GAC and their AGYW ISMEs on an annual basis.

- Primary services/interventions are defined as interventions that ALL AGYW in an age group should receive if they are enrolled in DREAMS in an OU.
- Secondary services/interventions are needs-based interventions that are part of an OU's DREAMS core package but may not be received by all AGYW in that age group (i.e., only AGYW who experience violence should receive post-violence care).
- Contextual interventions are those that are part of an OU's DREAMS core package but cannot be linked to an individual AGYW (i.e., community mobilization). Note that these interventions should be included in your layering table but are not tracked as part of the AGYW_PREV indicator as, by definition, they are not linked to individual AGYW.

Only services provided by PEPFAR count under AGYW_PREV. However, if PEPFAR implementing partners are making active referrals to a service provided by a non-PEPFAR entity, the active referral may be counted as a DREAMS service under AGYW_PREV. If this is the case, your OU-specific Layering Table should specify this (e.g., "facilitating access to government education subsidies" instead of just "education subsidies").

Counting Service and Package Completion:

Services/interventions should only be counted towards primary package completion if the AGYW has completed that particular service/intervention. Countries should define **service/intervention completion** as part of their country-specific DREAMS Layering Table. Completion definitions should be based on normative guidance and instructions from program developers where available (e.g., country may count a multi-session intervention as complete after participant has attended 80% of the sessions if that is what the instructions from the program developer indicate as completion). Do not count an intervention towards primary/secondary package completion for an individual AGYW until it has been completed per the country's service completion definition. Please note that "primary package completion" as tracked in AGYW_PREV and "DREAMS program completion" as defined in the DREAMS Guidance are not the same thing. **DREAMS program completion** requires that an individual AGYW has completed both the primary package for her age group, as well as all secondary interventions that are appropriate based on her needs.

An AGYW must have completed at least one service in the past 6 months at Q2 or the past 12 months at Q4 to be counted in any of the following disaggregates: "completed the full primary package and no additional services", "completed the primary package and at least one additional service", or "completed at least one service but not the full primary package." At Q2 and Q4 reporting, AGYW should be reported under the disaggregate that reflects the snapshot of her current layering status since beginning the DREAMS program. For example, if an AGYW completed her last service in the primary package in the last 6 months (at Q2) or 12 months (at Q4) then she may be counted in the corresponding numerator disaggregate for the current time period, even if she enrolled and began receiving services in DREAMS beginning in a previous year or reporting period. For AGYW reported in the disaggregate of "completed at least one service but not the fully primary package", any DREAMS service (from the primary or secondary package) may be counted.

An AGYW that is enrolled and has started a DREAMS service but has not yet completed it as of the end of the reporting period is still considered an active DREAMS participant (see above). She would be reported in the corresponding disaggregate. If an AGYW has already completed a DREAMS service/intervention while in DREAMS, she should be reported under one of the layering disaggregates indicating service completion. For example, if an AGYW has completed HTS but is in process of completing a multi-session prevention curriculum at Q2 (and has not yet completed the primary package), she should be counted in the "completed at least one DREAMS service but not the full primary package" disaggregate.

	Using AGYW_PREV Results to Ensure Programmatic Layering: The focus of this indicator is to track the layering of the country-specific DREAMS primary package of services/interventions, rather than tracking individual services/interventions themselves. Specific services received by AGYW will continue to be counted under PP_PREV, OVC_SERV, HTS_TST, PREP_NEW, PREP_CT, PMTCT_STAT, GEND_GBV, KP_PREV, etc. as appropriate. Furthermore, AGYW enrolled in DREAMS and receiving DREAMS services should be counted under this indicator regardless of the intervention(s) funding the services that they received. For example, if an AGYW is enrolled in DREAMS and receives HIV testing, education support, and PrEP in the reporting period, she would be counted under HTS_TST, PREP_NEW, PREP_CT, and OVC_SERV if she meets the definition of each respective indicator. She would also be counted under AGYW_PREV under the appropriate layering and time in DREAMS disaggregates to track if she has received the age-appropriate primary package of DREAMS services/interventions. Active DREAMS participants ages 10-17 years that receive eligible OVC service(s) and who are not otherwise enrolled in the OVC Comprehensive program should be counted under the OVC_SERV "DREAMS" disaggregate (see OVC_SERV reference sheet). An illustrative list of eligible services can be found in Appendix E (e.g. education support, primary prevention of HIV and violence intervention, etc.). AGYW meeting this definition should be reported under both AGYW_PREV and the OVC_SERV DREAMS disaggregate regardless of partner or funding type. AGYW_PREV was not created to measure or show the impact of DREAMS, it was created to monitor fidelity to layering and to assess DREAMS implementation on the ground. DREAMS country teams should review multiple data sources (i.e., ongoing analyses per the DREAMS Program Completion and Saturation Document) along with AGYW_PREV to evaluate overall DREAMS program performance and coverage. Results from this indicator will be used to ensure that layering of DREAMS services is happening across agencies and partners within DREAMS districts and will be used to make programmatic decisions to ensure comprehensive, patient-centered prevention programming for AGYW. AGYW_PREV results will help field teams and HQ answer several essential questions related to DREAMS programming, quality, and reach, including: 1. How many active DREAMS participants are in the DREAMS program? 2. Is layering happening as intended for all AGYW receiving DREAMS services? Are there specific services/interventions that are not reaching AGYW as intended? Are there specific SNUs where layering is stronger or weaker? Are there specific age bands where layering is stronger or weaker? 3. How does layering change over the time a girl is enrolled in DREAMS? a. **Benchmark: Have 90% of active DREAMS participants completed at least the primary package after being in DREAMS for 13+ months?** b. How long is it taking for AGYW (by age band) to complete the primary package? (e.g. we would not expect AGYW in the younger age bands to complete the primary package in <6 months) 4. Where are active DREAMS participants along the DREAMS program completion continuum? Please refer to the "Data Visualization & Use" section below for example visualizations of AGYW_PREV. Each OU's DREAMS service package and completion definitions differ, as do their program cycles for enrollment and DREAMS program completion. Therefore, direct comparisons between OUs should not be made without understanding the contextual components of their DREAMS programs.
How to collect:	**This indicator should be reported only in SNUs where approved, DREAMS-funded activities are occurring**. **All SNUs receiving DREAMS funds are expected to have AGYW_PREV results.** **This indicator will be inputted in DATIM by the USG team, not individual IPs since this indicator involves data from multiple implementing partners over time**. It is recommended that one coordinating partner track layering data within an OU; however,

<table>
<tr><td></td><td>since layering occurs between multiple implementing partners and across time and mechanisms the <u>USG team (DREAMS Coordinator or DREAMS POC(s)) is best placed to input the data for AGYW_PREV.</u>

Data collection requires reliable tracking systems that are designed to count the number of one-on-one encounters or participation in group interventions and that reduce double-counting of individuals in a reporting period. A unique identifier should be assigned to AGYW enrolled in DREAMS to track individual-level completion of DREAMS services across partners providing DREAMS services, where applicable. Data should be collected at every encounter/point of service and aggregated in time for PEPFAR reporting cycles.

Examples of successful DREAMS layering data collection include the use of unique IDs, DREAMS passports or ID cards, and DHIS2 databases. It is a best practice to have one implementing partner that is responsible for the coordination of layering data systems; this partner then works across agencies and partners to ensure that all DREAMS services/interventions available to AGYW are captured within the system. Since layering occurs across partners, agencies, and over time, this indicator will be inputted by USG personnel (e.g., DREAMS coordinator or interagency DREAMS POCs).</td></tr>
<tr><td>How to review for data quality:</td><td>Data should be reviewed regularly for the purposes of program management, to monitor progress of layering, and to identify and correct any data quality issues. Potential data quality issues for AGYW_PREV:

Numerator is less than or equal to the denominator. The total number of AGYW that have started or completed any DREAMS service in the reporting period must be larger than the number of AGYW that have completed at least the primary package as of the end of the reporting period.

If total number of AGYW changes over time, they should be accounted for in the narrative as inactive (either lost or completed DREAMS program).</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a <u>snapshot</u> indicator. Results should reflect a snapshot of each active DREAMS participant’s layering status since they initially became a DREAMS participant until the end of the Q4 reporting period.

Q4 numerator = Number of active DREAMS participants that have fully completed the DREAMS primary package of services/intervention but no additional services as of Q4 + Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions and at least one secondary service/intervention as of Q4

Q4 denominator = Number of active DREAMS participants that have started or completed any DREAMS service within the past 12 months (i.e., the sum of all 4 AGYW_PREV disaggregates).</td></tr>
<tr><td>Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Layering and Time in DREAMS by Age/Sex
[Required]</td><td>• Number of active DREAMS participants that have <u>fully completed the DREAMS primary package of services/interventions but no additional services/interventions</u> as of the past 6 months at Q2 or the past 12 months at Q4. Enrolled in DREAMS for:
○ 0-6 month(s) by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
○ 7-12 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
○ 13-24 months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
○ 25+ months by: 10-14 F, 15-19 F, 20-24 F, 25-29 F
• Number of active DREAMS participants that have <u>fully completed the primary package of services/interventions AND at least one secondary service/intervention</u> as of the past 6 months at Q2 or the past 12 months at Q4. Enrolled in DREAMS for:</td></tr>
</table>

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

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

</td></tr>
<tr><td></td><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Layering and Time in DREAMS by Age/Sex
[Required]</td><td>

Number of active DREAMS participants that have <u>fully completed the DREAMS primary package of services/interventions but no additional services/interventions</u> as of the past 6 months at Q2 or the past 12 months at Q4 [already captured in the numerator]
Number of active DREAMS participants that have <u>fully completed the primary package of services/interventions AND at least one secondary service/intervention</u> as of the past 6 months at Q2 or the past 12 months at Q4. [already captured in the numerator]
Number of active DREAMS participants that have <u>fully completed at least one DREAMS service/intervention but NOT the full primary package</u> of services/interventions as of the past 6 months at Q2 or the past 12 months at Q4. Enrolled in DREAMS for:

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

Number of active DREAMS participants that have <u>started a DREAMS service/intervention but have not yet completed it</u> in the past 6 months at Q2 or 12 months at Q4. Enrolled in DREAMS for:

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

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

Violence Prevention
Education Support
Comprehensive Economic Strengthening

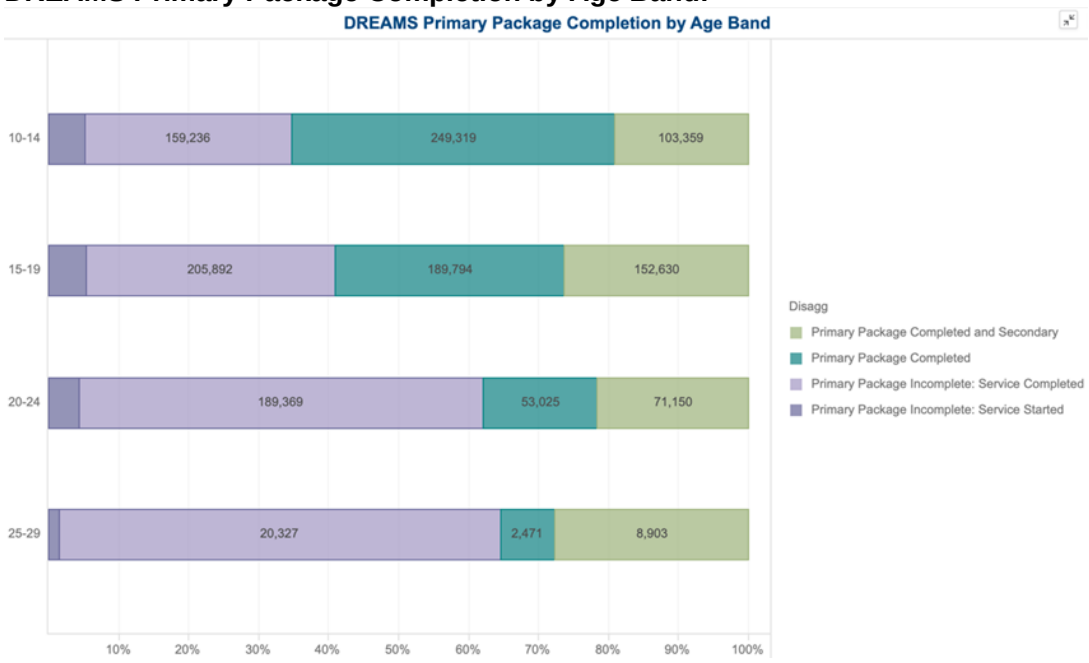
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Numerator & Denominator Disaggregates:

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

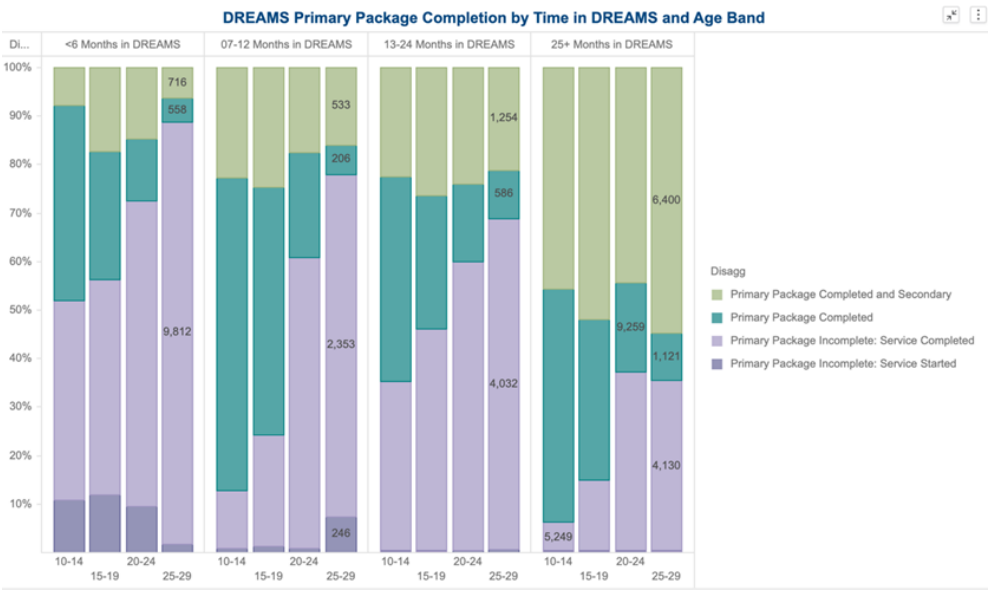
<u>Age/Sex disaggregate</u>: This should represent the current age of the AGYW at the end of the current reporting period. For example, if a girl is enrolled when she is 14 but turns 15 during the reporting period, she should be reported in the 15-19 age band and receive the corresponding primary services. She does not need to re-complete any duplicative services/interventions that are in the primary package for both the 10-14 and 15-19 age band.
While the DREAMS Layering Table focuses on the DREAMS target age groups of 10-24-year-old AGYW, the 25-29 age band is included here to account for AGYW who have aged over 24 years since initial DREAMS enrollment. DREAMS programming should not target 25-29-year-old AGYW unless explicitly approved in your COP.
<u>Layering of services/interventions disaggregate</u>: Countries should use their approved DREAMS Layering Tables to determine the makeup of the primary package of services/interventions reported in this indicator. A service should not be counted towards package completion until it is fully completed by the individual AGYW (see above).

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

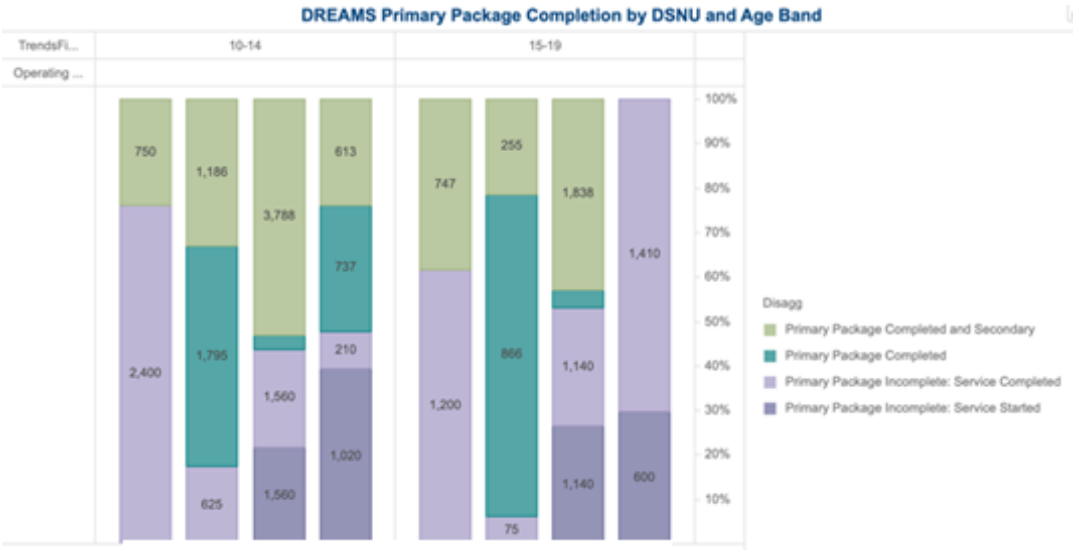
	○ Time in DREAMS disaggregate: Represents the time since each AGYW became a DREAMS participant (i.e., since the AGYW was enrolled and started or completed at least one DREAMS service/intervention). • **Service Disaggregates [required]:** Service disaggregates should only be reported for active DREAMS participants (i.e., AGYW enrolled in DREAMS that have started or completed at least one DREAMS service in the past 6 months at Q2 or past 12 months at Q4). The AGYW's first service in DREAMS could be a violence prevention intervention, education support, or comprehensive economic strengthening. ○ Violence Prevention: Report the number of AGYW enrolled in DREAMS that **completed** an evidence-based intervention focused on preventing violence within the past 6 months (at Q2) or past 12 months (at Q4). Interventions include: curriculum-based programs in schools, sports programs, or other community venues to change knowledge, skills and norms; parenting/caregiver programs that address violence prevention with parents, but also involve the AGYW. AGYW should be counted under this disaggregate only when they have completed the intervention per the OU-specific DREAMS Layering Table. ○ Education Support: Report the number of AGYW enrolled in DREAMS who have received educational support to remain in, advance, and/or rematriculate in school within the past 6 months (at Q2) or past 12 months (at Q4). Interventions include: school block grants, individual bursaries, tuition, school fees, or fee exemption, support for uniforms and scholastic materials. ○ Comprehensive Economic Strengthening: Report the number of AGYW ages 15-24 years enrolled in DREAMS that **completed** a comprehensive economic strengthening intervention within the past 6 months (at Q2) or past 12 months (at Q4). To be considered a comprehensive economic strengthening intervention, the following components must be included: 1) gender-sensitive training, 2) start-up support for entrepreneurship or linkage to employment for wage employment, 3) mentoring or coaching. All OUs should also have a market assessment to guide comprehensive economic strengthening programming and provide AGYW access to savings groups. AGYW should be counted under this disaggregate only when they have completed the intervention as defined in the OU-specific layering table.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for AGYW receiving HIV prevention services includes: ongoing procurement of critical commodities such as condoms, teaching materials, or community promotion materials; funding for salaries of personnel delivering the individual, small group, or community-level intervention; stipends or incentives for volunteers; or paying for transportation of those staff to the point of Service delivery. Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For AGYW 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:	Each OU should submit one narrative response, based on input from all agencies and implementing partners. 1. What challenges and/or data quality issues did you face in reporting on AGYW_PREV during this reporting period? What is your OU's approach to address these reporting challenges? 2. What challenges did you experience with implementing layering (i.e., service disruptions, specific subgroups that had difficulty participating, specific partners that had trouble linking to services, etc.)? If there are gaps in DREAMS layering, which services (by age group) are the most challenging for AGYW to complete? What is your OU's approach to improve these layering challenges?

	3. Describe your OU's approach to ensuring that partners are layering services and interventions for AGYW enrolled in DREAMS, including ensuring effective bi-directional referral mechanisms and linkages have been established between clinical and community-based platforms. In your response, please include answers to the following questions: a. How is your OU ensuring that AGYW visiting ANC, family planning, HTS, and STI clinical settings are assessed for DREAMS eligibility? b. What proportion of AGYW that were enrolled in this reporting period were referred from healthcare settings? 4. Please note if your OU has a large number of inactive DREAMS participants (i.e., AGYW who are enrolled in DREAMS and at one point completed or started a service, but not within 6 months at Q2 or 12 months at Q4)? What are the reasons why AGYW are not active in DREAMS, and what is being done to re-engage these AGYW into the DREAMS program?
Data Visualization & Use Examples:	**DREAMS Primary Package Completion by Age Band:** 

DREAMS Primary Package Completion by Time in DREAMS & Age Band:



DREAMS Primary Package Completion by DREAMS SNU & Age Band:



FPINT_SITE

Description:	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	
Numerator:	Number of service delivery points supported by PEPFAR that are providing fully integrated voluntary family planning services	Note: a service delivery point is NOT the same as a site. There can be numerous service delivery points within one site (such as multiple fixed locations or mobile clinics within one PEPFAR defined site).
Denominator:	Number of total service delivery points at a site supported by PEPFAR	Not collected through the data entry screens, determined by number of sites reporting service delivery area.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility by Service Delivery Point	
Reporting frequency:	Annually	
How to use:	This output indicator aims to measure progress towards integrating voluntary FP within the PEPFAR platform at the service delivery level. It captures information about whether FP integration is occurring at various HIV service delivery points within PEPFAR supported sites. Many PEPFAR sites will have numerous service delivery points within each site. For example, if one hospital receives PEPFAR support for both the HIV treatment department AND the ANC department, and both provide family planning services, 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. Judgments and personal opinions are not appropriate in a clinic setting. This indicator will be used to monitor coverage of HIV/FP integration at a global level. **Therefore, detailed information on completion of referrals, FP service uptake, types of contraceptive methods offered on site, and other critical components of integrated programs will not be captured through this indicator but should be maintained at the site or programmatic level.**	
How to collect:	**Definition: Voluntary Family Planning Service Provision** To be considered as a PEPFAR-supported service delivery point that directly provides fully integrated voluntary FP services, all 3 criteria below must be met. If a service delivery point provides fewer than 3 of the services noted below, it should not be counted under this indicator. The PEPFAR-supported HIV service delivery point must provide for all relevant clients, including partners in HIV discordant couples (as documented by standard operating procedures, guidelines, protocols, manuals and/or intake documents, etc.): 1. Assessment of voluntary FP needs through routine screening;	

2. Provision of voluntary FP counseling (including safe pregnancy counseling for those wishing to become pregnant, or those who are pregnant);
3. Provision or referral of a broad range of modern contraceptive methods, in accordance with the National FP policy guidelines, for clients who voluntarily wish to delay or prevent pregnancy. It is very much preferred for methods to be available onsite. If referrals are given, they must include detailed information (e.g., facility location, hours of operation, etc.) about where methods can be accessed.

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

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

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

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

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

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

- People living with HIV (PLHIV) and their partners should be provided with information on and be able to exercise voluntary choices about their health, including their sexual and 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.

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

FP use should always be a choice, made freely and voluntarily, independent of the person‘s HIV status.
The decision to use or not to use FP should be free of any discrimination, judgment, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
Access to and provision of health services, including antiretroviral treatment, for PLHIV should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of antiretroviral treatment and other drug interactions).
PLHIV who wish to have children should have access to safe and non-judgmental pregnancy counseling services.

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

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

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

</td></tr>
</table>
Denominator Disaggregations:
<table>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>
PEPFAR-Supported Service Delivery Point at a site
A PEPFAR-supported service delivery point uses PEPFAR funds to directly provide HIV-related services in the following areas including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART); screening and prophylaxis for opportunistic infections (OI); other health services for people living with HIV (e.g., positive health, dignity and prevention (PHDP), nutrition support, etc.), and prevention activities for priority populations (key populations and adolescent girls and young women). It can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point(s).
PEPFAR service delivery points for FP/HIV integration include the following:
1. HIV Testing services - includes counselling (pre-test information and post-test counselling); linkage to appropriate HIV services; and coordination with laboratory services to support quality assurance and the delivery of correct results. FP services can be made available with HIV testing services, especially for key populations and adolescent girls and young women as well as for HIV serodiscordant couples (even if
</td></tr>
</table>

	FP integration is targeting key or priority populations, if occurring in HTS the integration should be documented under HTS). 2. Care and Treatment (including Pediatric and Adolescent Care and Treatment Services) – this includes services where ART is initiated and monitored. 3. Antenatal and/or Maternity services - this includes FP education and healthy timing and spacing messages in the ANC setting (when a woman is pregnant and receiving PMTCT services and/or FP counseling and method provision post-partum.) 4. Priority Population Prevention services – this includes priority population programming, such as drop in centers and prevention sites focused on adolescent girls and young women (i.e., DREAMS). FP integration can also take place across the clinical cascade for priority populations, including care and treatment which would be recorded under care and treatment service delivery point. 5. Key Population Prevention services – this includes programming for Men who have sex with men, Transgender people, Sex workers, and People who inject drugs, such as drop in centers. FP integration can also take place across the clinical cascade for key populations, including care and treatment which would be recorded under care and treatment service delivery point.
PEPFAR-support definition:	The PEPFAR support categories of DSD and TA-SDI do not apply. To report results for this indicator, it is expected that PEPFAR provides support to the HIV service delivery area. Definition: For this indicator, a “PEPFAR supported site” should include any facility site in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period. Definition: For this indicator, a “PEPFAR-Supported Service Delivery Point” is a service delivery point at a PEPFAR supported site that uses PEPFAR funds to provide HIV-related services. There can be one or more service delivery points (SDPs) within a single PEPFAR supported site. Many PEPFAR supported 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 SDPs. These SDPs can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Please note, if a site has multiple locations to support **one** HIV service, only one SDP should be reported. For example, if a hospital conducts HIV testing on Floor 2 and Floor 3 and integrates family planning into testing services, only one service delivery point should be reported.
Guiding narrative questions:	1. Which service delivery points within supported facilities are providing integrated family planning services to people living with HIV or those at risk of acquiring HIV? (e.g., HIV prevention, HTS, C&T, PMTCT, KP, etc.) 2. What contraceptive services or methods are provided on site, and which contraceptive methods are provided through referral? Is there a tracking mechanism to ensure referrals are completed (e.g., that the client received the service)? 3. How do you ensure the quality of FP services offered at the site?

GEND_GBV

Description:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	
Numerator:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	This indicator DOES NOT include GBV prevention activities or non-clinical community-based GBV response.
Denominator:	N/A	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-annual	
How to use:	This indicator measures delivery of a basic package of post-GBV clinical services (including PEP and EC) as a result of any GBV i.e. not limited to GBV associated with any HIV service delivery activities. NOTE: This indicator DOES NOT include GBV Prevention activities or non-clinical community-based GBV response (e.g., shelter programs, case management). This indicator will enable PEPFAR to: • To determine the number of individuals that are suffering from GBV and reporting to clinical partners. • To assess whether post-GBV clinical services are being used. • Gain an understanding of the uptake of post-GBV clinical services offered across PEPFAR countries. • Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. • Support efforts to assess the impact of post-GBV clinical services by correlating the reach (i.e., number of people served) of these services over time with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as survey data (DHS/PHIA/VACS). • Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.	
How to collect:	Data sources are standard program monitoring tools, such as forms, log books, spreadsheets and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of service delivery (i.e., ANC, PMTCT, ART, etc.) and aggregated in time for PEPFAR reporting cycles. The indicator can be generated by counting the number of persons receiving post-GBV clinical care, disaggregated by the age group and sex of the client receiving the service, as well as the type of service (sexual violence or emotional/physical violence) and PEP provision (see below for disaggregation information). To adequately capture the provision of these services, logs and monitoring forms will need to be used wherever the services are offered. These forms will need to track both the outcome of the initial assessment and the provision of referrals or services. For PEP specifically, registries should collect both the administration of the PEP as well as its completion and the patient's adherence. **Special considerations:** As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing	

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

Total sexual violence numerator ≥ PEP age/sex disaggregates for the same reporting period.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Violence Service Type by Age/Sex [Required]</td><td>• Sexual Violence by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Physical and/or Emotional Violence by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of People Receiving Post-Exposure Prophylaxis (PEP) Services by Age/Sex (Disaggregate of the Sexual Violence Service Type) [Required]</td><td>• Received PEP by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Violence Service Type Disaggregate Definitions:
Sexual violence (post-rape care): Although guidelines for post-rape care will vary from country to country, in addition to treatment of serious or life-threatening medical issues (e.g., lacerations, broken bones) and the necessary forensic interviews and examinations, the minimum package of post-rape care services should always begin with an assessment of the client's specific needs. The following represents the Minimum Package for post-rape care services that must be in place to count under this indicator:
• Provision of Clinical Services: (all of the following must be in place, including relevant commodities, and ability to count individuals—independent of whether individuals use the specific service)
• Rapid HIV testing with referral to care and treatment as appropriate
• Post exposure prophylaxis (PEP) for HIV -- if person reached within the first 72 hours
• STI screening/testing and treatment
• Emergency contraception, if person is reached in the first 120 hours. PEPFAR funds cannot be used to procure EC. EC is legal in all PEPFAR countries except Honduras, so should be available in all countries except for Honduras
• Counseling (other than counseling for testing, PEP, STI and EC)

Physical and/or emotional violence (other Post-GBV care): GBV can take many forms and includes physical and emotional violence. The following services should be available for persons who have experienced GBV that is not sexual. If a client experiences both sexual and physical and/or emotional violence, the client should be</td></tr>
</table>

	counted under the sexual violence disaggregate-only. However, the client should receive the appropriate services as defined under both packages. 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. <u>Ongoing support for GEND_GBV service delivery improvement includes</u>: mentoring and supportive supervision, training, guidance development, site level QA/QI, regular assistance with monitoring and evaluation functions and data quality assessments, or commodity consumption forecasting and supply management.
Guiding narrative questions:	1. How are GBV cases identified in the community and/or at the facility? If cases are identified at the community, how are they referred to a facility for post-GBV clinical care? 2. Of those coming in for services who are screened and disclose sexual violence, what proportion receive PEP? What proportion of those who disclose sexual violence refuse PEP? 3. Is site level data on the type of violence disclosed collected? If so, please provide available data in the narratives on the proportion that disclose physical and/or emotional violence, and of those choose to receive services. 4. What proportion of clients experienced both sexual and physical/emotional violence? a. Note: If clients experience both sexual and physical/emotional violence, they should only be counted under sexual violence to ensure that there is no duplication.

KP_MAT

Description:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months	
Numerator:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months within the reporting period	This indicator provides information on the total number of individuals who have been on treatment for at least 6 months within the reporting period.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Annually	
How to use:	When proper and sufficient dosage is administered, medication-assisted therapy (MAT) is highly effective in reducing opioid use and the injecting behaviors that put opioid-dependent people at risk for HIV. In addition, MAT can help improve continuity of treatment for those who are on ART. Therefore, all people who are dependent on opioids should be offered and have access to this service. The implementation of MAT programs should facilitate and enhance access to HIV-specific services for PWID including HIV testing services, linkages to ARV treatment programs, PMTCT for female PWID, and a range of other prevention and harm reduction services. Implementing partners providing MAT referrals-only should not use this indicator unless it the services being provided meet the KP_MAT_TA requirement outlined in the PEPFAR-support definitions below. Please refer to the "KP_PREV" indicator to see if the services provided meet reporting criteria for that indicator as well.	
How to collect:	This indicator provides information on the total number of individuals who have been on medication-assisted therapy (e.g., methadone, buprenorphine, or buprenorphine/naloxone to treat drug dependency) for at least six months within the reporting period. Consequently, data for this indicator can be generated by counting the number of individuals who are currently receiving MAT or received at least 6 months of MAT in the reporting period in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. Count all individuals who have completed at least 6 months of MAT even if they drop-out, die, or experience interruption in treatment, as long as they completed the minimum of 6 months MAT within the reporting period. Do not count individuals who initiate treatment too late in the reporting period to be able to reach a minimum of 6 months by the time of reporting.	
How to review for data quality:	This indicator makes use of program data as part of an on-going cohort. The MAT register and/or patient-level data can be used to determine the number of people starting MAT in the defined period, as a cohort, and the number of those who are still in treatment at 6 months and who were on MAT for at least six months during the reporting period. Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues.	
How to calculate annual total:	N/A. Data is reported only once annually at Q4.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Sex	• Male • Female

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	N/A	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used: 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?	

KP_PREV

Description:	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	
Numerator:	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	The numerator can be generated by counting the number of unique individuals from an activity who are reached with prevention interventions designed for the intended key population.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	This indicator provides information on the total number of unique individuals that have received individual-level and/or small-group level intervention(s). This indicator will help determine the reach of key populations and may help understand the relative saturation (coverage) of PEPFAR-supported KP prevention programs when reliable population size estimates are available. Small-group intervention is defined as less than or equal to 25 individual attendees in one setting. HIV testing services (HTS) or referring an individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this indicator. A partner may count an individual (with unknown HIV serostatus or self-identified as HIV negative) as having received a prevention activity if they have provided, offered, or referred to HTS AND at least one additional listed prevention activities below (outside of HTS) during the reporting period. If an individual is already known to be HIV positive at the time of the outreach, s/he should receive at least one of the interventions listed in the table (outside of HTS) to qualify as being counted under this indicator. The table below lists the prevention interventions that a partner may offer in addition to HTS (or HTS referral).	

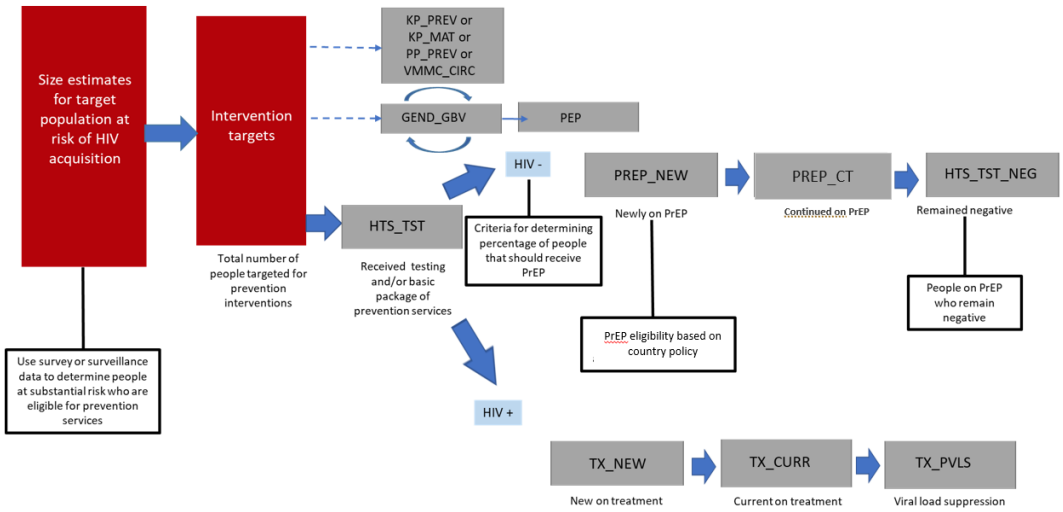
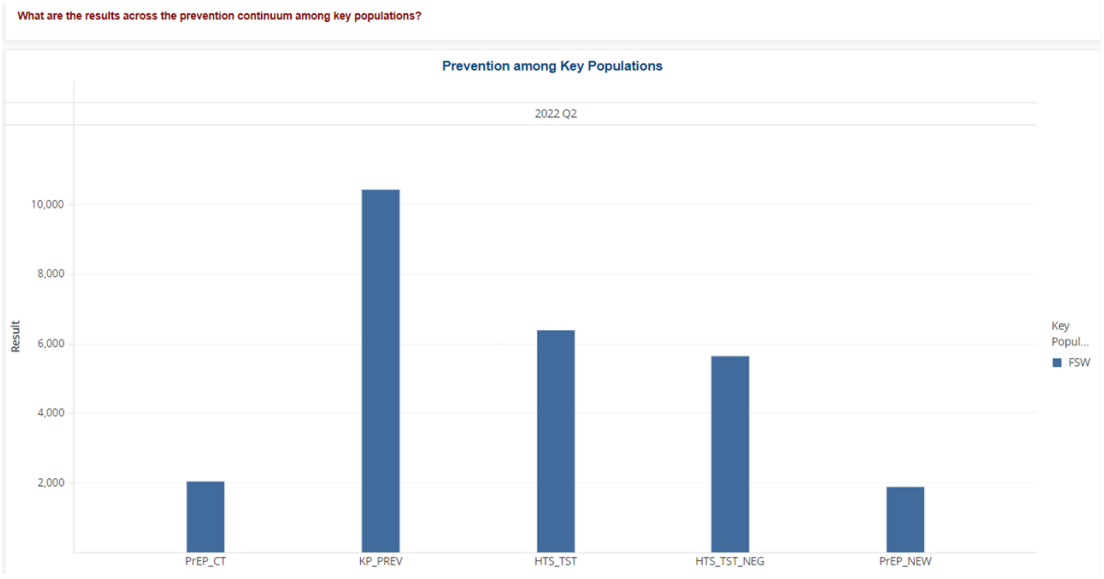
Prevention Interventions for Key Populations
• **Offer or refer to HTS* (Required)**
• Targeted information, education, and communication (IEC)
• Outreach/Empowerment
• Condoms
• Lubricant
• Offer or refer to STI screening, prevention, and treatment
• Link or refer to ART
• Offer or refer to prevention,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

<table>
<tr><td></td><td colspan="2"><table><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></td></tr>
<tr><td>How to collect:</td><td colspan="2">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, <u>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</u>. For example, if an individual had received prevention interventions under KP_PREV through PEPFAR-supported program in January 2020 and was counted as being reached in FY20 Q2 reporting cycle, and this same individual was later reached with prevention services again by PEPFAR-supported program in June 2020, that individual should NOT be reported again in the FY20 Q4 reporting period. This de-duplication is critical to accurately track the <u>ANNUAL</u> 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 FY20 but was only counted once under KP_PREV in FY20).</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues. Potential data quality issues with KP_PREV are:
Numerator
The Numerator is = to the sum of the disaggregation: The number of KP reached with individual and/or small-group level preventive interventions should be equal to the sum of KP disaggregates.
Despite persons potentially falling into more than one KP disaggregate (e.g., FSW who injects drugs), implementing partners should be instructed to report an individual in only one KP category with which s/he/they is most identified.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.</td></tr>
<tr><td>Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>KP Type
[Required]</td><td>• MSM
• TG
• Female SW
• PWID
• People in prisons and other closed settings</td></tr>
<tr><td></td><td>KP Type by Testing Services [Required]</td><td>• KP known positive by MSM, TG, FSW, PWID, people in prisons and other closed settings;</td></tr>
</table>

		• KP was newly tested and/or referred for testing by MSM, TG, FSW, PWID, people in prisons and other closed settings; • KP declined testing and/or referral by MSM, TG, FSW, PWID, people in prisons and other closed settings
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	KP Type by 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. Clients tested positive in previous reporting periods should be counted as Known Positives. • **Newly Tested and/or Referred for Testing:** Persons within each key population type for whom HIV testing is indicated because they do not know their HIV status or their last HIV-negative test was more than 3-6 months ago (or more/less frequently as indicated by National Guidelines) should either be offered an HIV test on site or given information about where and when they can access an HIV test at another nearby clinic. Every attempt should be made to ensure the client is linked with HIV testing services that are KP-competent, 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-competent 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. For each KP group reached, please describe the minimum set of services provided to that group, in addition to services that may depend on the client's individual risk or circumstances, as determined by the KP program.
Data Visualization & Use Examples:	**HIV Prevention Cascade:**  **KP Prevention Cascade:** 

OVC_SERV

Description:	Number of individuals served by PEPFAR OVC programs for children and families affected by HIV	
Numerator:	Number of individuals served by PEPFAR OVC programs for children and families affected by HIV	The numerator is the sum of the following Program Participation Status disaggregates: 1. OVC Comprehensive Active and Graduated participants (children and caregivers) 2. DREAMS participants 3. OVC Preventive participants
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added language clarifying graduation protocol for C/ALHIV • Updated guidance to reflect prevention program focus on children 10-14	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	One of PEPFAR's mandates is to care for "children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects" (PEPFAR authorization). To meet this mandate, PEPFAR's Orphans and Vulnerable Children (OVC) programming serves the dual purposes of mitigating the impact of HIV/AIDS on children and adolescents and their families, as well as preventing HIV/AIDS-related morbidity and mortality. COP21 Guidance details an approach to risk and resilience for the OVC portfolio that responds to the current stage of the HIV/AIDS pandemic and the child's needs. To implement this framework, three distinct but complementary models are required to address children's vulnerabilities and provide appropriate support services: OVC Comprehensive, OVC Preventive, and DREAMS (Figure 1). OVC_SERV is a direct (output) measure of the number of individuals receiving PEPFAR OVC program services for children and families affected by HIV/AIDS across these three models. **Figure 1: Three Distinct but Complementary OVC_SERV Program Models** **OVC Comprehensive** • *Family-based* • Children aged 0-17 with known risk factor (i.e., HIV+, SVAC) • Case management & multiple supportive interventions • Graduation benchmarks **OVC Preventive** • *Group-based* • Boys & girls aged 10 -14 in highest burden SNUs • Single evidence-based intervention **DREAMS** • *Individual* • AGYW aged 10-17 at elevated risk of HIV in DREAMS SNUs • Layered interventions (DREAMS core package) Individuals may programmatically be in multiple models based on their unique needs. For OVC_SERV categories are mutually exclusive.	

The OVC_SERV indicator can be used to:

- Determine the number of individuals (by age/sex and program status) that were served by the OVC Comprehensive Program.
- Understand the program participation status (i.e. active, graduated) or transferred/exited status of individuals in the OVC Comprehensive Program.
- Assess the ratio of caregivers to children or adolescent participants within the OVC Comprehensive Program.
- Identify the number of children aged 10-14 years that exclusively received an approved primary prevention of HIV and sexual violence intervention (i.e. primary prevention of both HIV and sexual violence) through the OVC Preventive Program.
- Gain an understanding of the number of AGYW enrolled in DREAMS that received one or more eligible OVC services as part of their DREAMS core package of services/interventions in a reporting period.
- Ensure that OVC program implementation is matching community needs.

Determining Which Model(s) to Report Under

While individuals may programmatically be served by multiple OVC models, the three program model categories are mutually exclusive for the purposes of OVC_SERV reporting. To ensure that individual children and adolescents are not double-counted under this indicator, the following hierarchy of the OVC_SERV program models must be followed when reporting on OVC_SERV (Figures 2 & 3). In some OUs and SNUs, this may require implementing partners to compare their program cohorts to determine under which OVC_SERV program model disaggregate an individual should be counted. Example scenarios are below:

- A 14-year-old girl is enrolled in the OVC Comprehensive Program, is an active DREAMS participant, and has completed an approved primary prevention of HIV and sexual violence intervention. She should be reported exclusively in the “OVC Comprehensive” disaggregate by the partner implementing the OVC Comprehensive program. The partners who serve her in the OVC Preventive or DREAMS program should not report her under OVC_SERV.
- A 10-year-old boy is enrolled in the OVC Comprehensive Program and also completes an approved primary prevention of HIV and sexual violence intervention. He should be reported exclusively under the “OVC Comprehensive” disaggregate. The partner implementing the OVC Preventive program should not report this participant under OVC_SERV because he is already being reported under OVC_SERV through the partner implementing the OVC Comprehensive program.
- A 13-year-old girl is an active DREAMS participant, completes an approved primary prevention of HIV and sexual violence intervention, and is NOT enrolled in the OVC Comprehensive Program. She should be reported exclusively under the “DREAMS” disaggregate when she completes her first OVC_SERV eligible service (see Appendix E). She should also be counted under AGYW_PREV. The partner implementing the OVC Preventive program should not report this participant in their results because she is already being reported under OVC_SERV through the partner implementing DREAMS.
- A 12-year-old boy completes an approved primary prevention of HIV and sexual violence intervention and is not enrolled in the OVC Comprehensive program. He should be reported exclusively under the “OVC Preventive” disaggregate. This is the only scenario where the partner implementing the OVC Preventive program will report an individual under OVC_SERV -- when it is the only program model an individual is participating in.
- A 19-year-old female is completing secondary education with OVC program support and is the caregiver of a child in the OVC Comprehensive program. Both she and her child should be reported as “OVC” under the “OVC Comprehensive” disaggregate. The caregiver will not be counted under the “Caregiver” disaggregate because she is already being counted under the OVC Comprehensive 18-20 disaggregate.

Figure 2: Hierarchy of OVC_SERV Program Models for Individuals <18

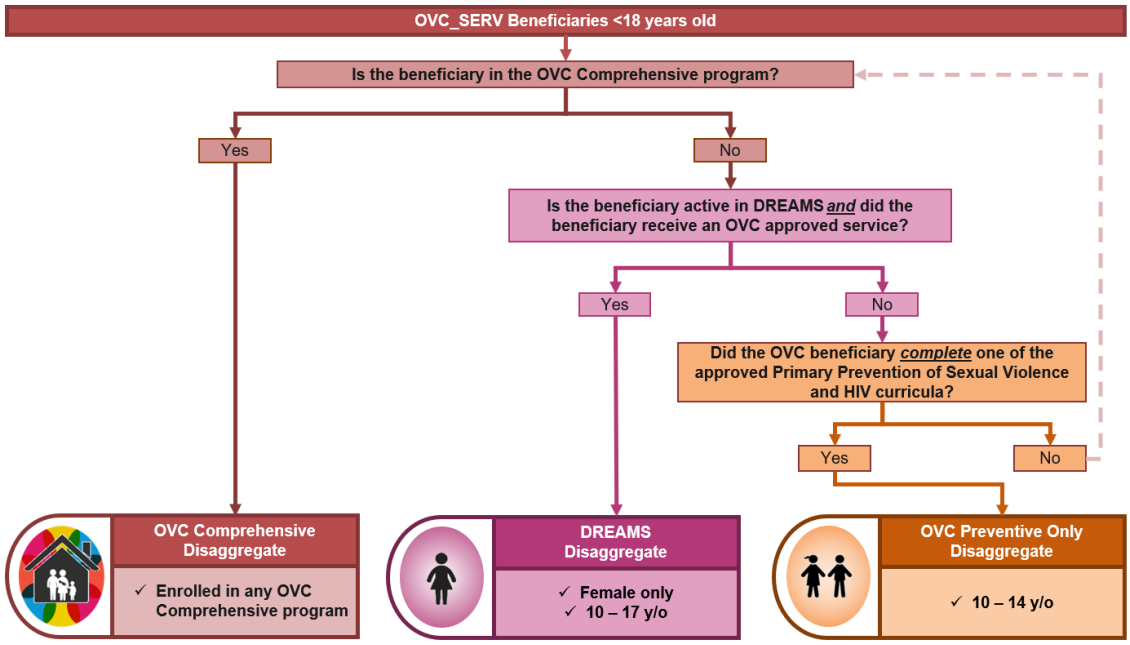
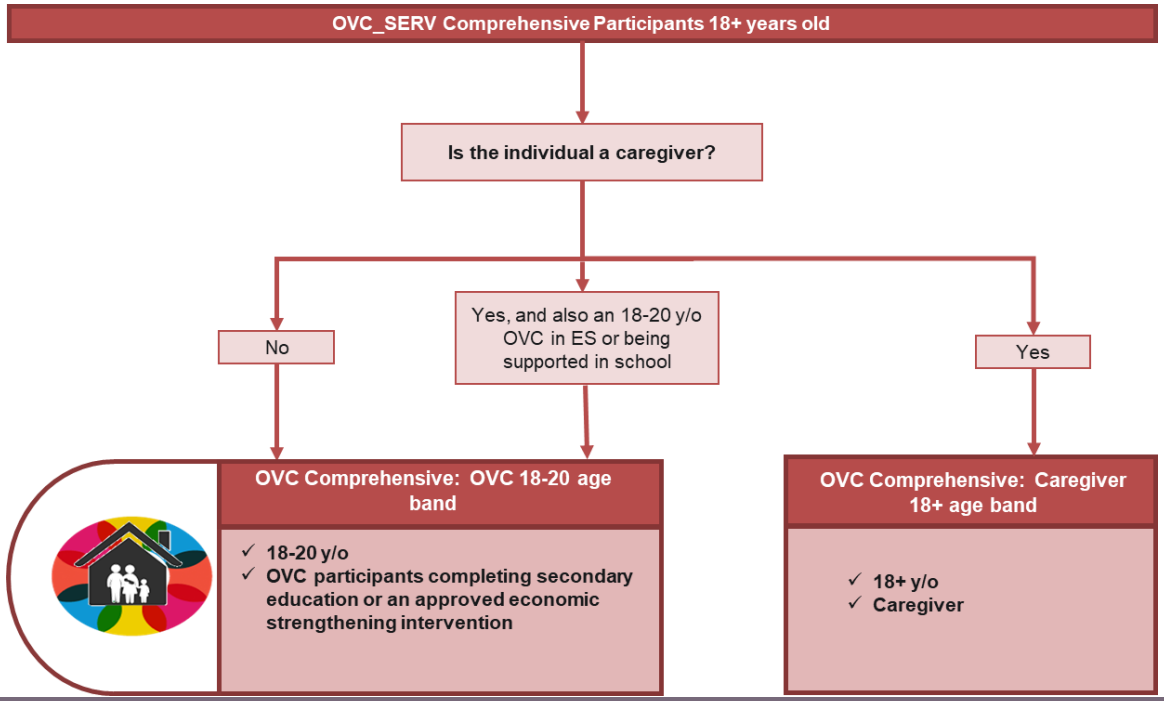


Figure 3: Hierarchy of OVC_SERV Comprehensive OVC & Caregiver Categories for Individuals 18+



How to collect:	Data sources include PEPFAR OVC program registers and other records of program data generated by implementing partners (IPs). Implementing partners' registers need to record sex and ages of children and caregivers who meet the criteria for the disaggregates included in this indicator (e.g. participation status, program model). Use of a unique ID system is recommended. All agencies and IPs serving individuals that meet the definition of OVC_SERV across program models are required to report on this indicator (e.g. OVC partners, DREAMS partners serving AGYW 10-17 with eligible OVC services). Additionally, agencies and IPs implementing approved primary prevention of HIV and sexual violence interventions (e.g. OVC Preventive) are required to report on this indicator regardless of funding source.

<table>
<tr><td></td><td colspan="2">Each individual should be counted only once under OVC_SERV in the reporting period. Please follow the hierarchy detailed in Figures 2 & 3 to ensure that each individual is reported under only one program model (i.e. OVC Comprehensive, DREAMS, or OVC Preventive). Efforts will need to be made to de-duplicate OVC_SERV data in SNUs with multiple IPs implementing the various program models. For example, if different IPs are serving OVC Comprehensive, OVC Preventive, and DREAMS program participants in one SNU, then these IPs will need to compare program records to determine under which OVC_SERV program disaggregate individual participants should be counted under following the reporting hierarchy. An IP implementing the OVC Preventive program model may end up reporting significantly fewer individuals than they are actually serving, because the Preventive model falls lowest on the hierarchy in Figure 2, and individuals may already be counted in a different program model disaggregate. When targets are set by program model, this should also be taken into consideration. The only individuals who should be reported in the Preventive model are those who are not receiving services in the Comprehensive model or in DREAMS. Correct reporting of OVC_SERV will require comparing program records with IPs implementing the other program models in the same SNU to determine how many program models an individual is participating in and where to count them. Similarly, the only individuals who should be reported in the DREAMS model are those not receiving services in the Comprehensive model. All individuals receiving services in the Comprehensive model should be counted there.

For those reported under OVC Comprehensive, IPs must record the participation status of children and caregivers (i.e. active or graduated) or if they are transferred out to a PEPFAR-supported partner, transferred out to a non-PEPFAR supported partner, or exited without graduation. The program participation status and transfer/exit disaggregate categories are mutually exclusive.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Review PEPFAR OVC implementing partners' results to ensure that there is no double counting between program models (e.g. OVC Comprehensive, DREAMS, OVC Preventive) and between program participation status and transfer/exit disaggregate categories within OVC Comprehensive.

Review IP and site results for deviations from one period to the next which may indicate rapid exit and entry of program participants or high sudden graduation rate in one, versus another period.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">This is a snapshot indicator. Individuals should only be counted once by each partner at Q4 reporting. Individuals should only be counted under one OVC program model at Q4 reporting (see Figures 2 & 3 and "how to collect" section above).

Q4 OVC_SERV = (OVC Comprehensive Active Q4 + Graduated Q4) + (DREAMS Q4) + (OVC Preventive Q4)

All disaggregates except for "active" under OVC Comprehensive are a snapshot for the entire fiscal year at the time of reporting. This includes graduated, exited, and transferred disaggregates under OVC Comprehensive; DREAMS; and OVC Preventive.
Under OVC Comprehensive, program participation status at the end of Q4 should take precedence for where to count an individual (i.e., if an individual was counted as exited without graduation at Q2 but had met the criteria to be counted as active at Q4, then they should be reported at Q4 only under the active category and not in the total reported for exited without graduation).</td></tr>
<tr><td rowspan="2">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>OVC Comprehensive [Required]</td><td>Program Participation Status
● Active
○ OVC, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M
○ Caregiver, by: 18+ F/M
● Graduated
○ OVC, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M</td></tr>
</table>

		○ **Caregiver**, by: 18+ F/M
	OVC Exited or Transferred [Required]	● Transferred out to a PEPFAR-supported partner ● Transferred out to a non-PEPFAR supported partner ● Exited without graduation
	DREAMS [Required]	● Age/Sex: Unknown age F/M, 10-14 F/M, 15-17 F/M
	OVC Preventive [Required]	● Age/Sex: Unknown age F/M, 5-9 F/M, 10-14 F/M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A

Disaggregate descriptions & definitions:

Please see Figures 2 & 3 to help determine under which disaggregate category to report individual program participants. Remember that for the purposes of OVC_SERV reporting these categories are **mutually exclusive.**

OVC COMPREHENSIVE

Active: A child or caregiver who has received at least one eligible PEPFAR OVC program service in each of the preceding two quarters. New individuals enrolled during the reporting period can be counted as active only if they have received at least one service in the preceding quarter.

- **Child program participants ("OVC")** are defined as children and adolescents aged 0-17 years. Individuals aged 18-20 years are also included as "OVC" if they are completing secondary education or an approved economic strengthening intervention.
  - OVC aged 18-20 should be counted in the OVC 18-20 age/sex disaggregate, rather than the Caregiver 18+ age/sex disaggregate, even if they are caregivers themselves (see Figure 3).
- **Caregivers** fulfill the role of parent or guardian to a child program participant. For OVC_SERV, there should be no more than two primary caregivers per household. In most cases, given the vulnerability status of the households PEPFAR serves, there is likely to be only one primary caregiver. While adults or household members who are not caregivers fulfilling the role of parent or guardian may indirectly benefit from program support or access a one-time service, they should not be counted, as that does not meet the intention of increasing primary caregivers' access to critical services and support.
- **All active OVC Comprehensive participants (both children and caregivers) must:**
  - Have a case plan that has been developed or updated in the last 12 months that monitors their progress towards the graduation benchmarks (see details on the benchmarks below).
  - Have received directly from the project, was facilitated to obtain, or has a completed referral for at least one intervention in each of the preceding two quarters (see Appendix E for illustrative eligible interventions; if a service is not included on this list, the partner must seek and receive approval from local USG funding agency and note this in the OVC_SERV narrative).
    - Intake assessment, enrollment, subsequent assessments including HIV risk assessment, case plan development, and case plan monitoring are considered critical administrative processes rather than services, but remain critical to ensuring provision of needs-based services in a timely manner.
- **In addition, child program participants ("OVC") aged 0-17 years and OVC aged 18-20 years completing secondary education or an approved economic strengthening intervention must:**
  - Be monitored at least quarterly, but as often as is necessary according to the child's safety, schooling, stability, and health status. Monitoring includes establishing contact in person, or virtually where needed, to ensure that the case plan is progressing, and documentation of this contact is recorded in the case plan.

Graduated: The point at which a household enrolled in a PEPFAR OVC Comprehensive Program is deemed to have become more resilient and is no longer in need of PEPFAR OVC project-provided services. For caregivers and child program participants to be counted as an individual

graduated in DATIM, all child and all caregiver program participants in a household must meet all applicable (age and HIV status specific) graduation benchmarks established by PEPFAR for improving resiliency in the household.

- At Q2: Report the number of children and caregivers that graduated from the OVC program in previous two quarters. At Q4: Report the number of children and caregivers that graduated from the OVC program in the past four quarters.
- For the purposes of graduation, a household is defined as all children in the household/family unit less than age 18 years who based on risk assessment are enrolled in the OVC project and their caregiver(s) (not to exceed two people fulfilling the role of parent or guardian per household/family unit).
- PEPFAR guidance for graduation from an OVC project includes the following eight benchmarks (Figure 4) which align with the illustrative services in Appendix E. Please see Appendix F for additional details, definitions, and data sources for each minimum required benchmark. Countries may include additional benchmarks based on local criteria for achieving stability, but the eight global benchmarks are a minimum requirement.
- Please note: CLHIV enrolled in the comprehensive program should follow the same graduation protocols as other enrolled children. When they and their families meet all of their applicable required graduation benchmarks (including viral suppression which is only applicable to CLHIV and HIV+ Caregivers), they should be graduated from the program and counted under the OVC_SERV Comprehensive Graduated disaggregate and removed from the Active disaggregate. Because this may cause the associated indicator OVC_HIVSTAT_POS to decrease, please explain any graduations of CLHIV in the narrative section to account for it. As with all children and families enrolled in the comprehensive program, it is critical to remind graduating C/ALHIV and their caregivers that they can re-enroll at any time that they are not meeting the benchmarks.

Figure 4: Minimum Required Graduation Benchmarks

Benchmarks	Beneficiaries					House-hold
	All ages	HIV+	10–17 years	0–4 years	School age	
1. Known HIV status (or test not required)	✓					
2. Virally suppressed		✓				
3. Knowledgeable about HIV prevention			✓			
4. Not malnourished				✓		
5. Improved financial stability						✓
6. No violence						✓
7. Not in a child-headed household						✓
8. Children in school					✓	

Exited or Transferred:

- Data reported into the Exited or Transferred disaggregate should only include individuals exiting or transferring from the OVC Comprehensive program. However, the Exited or Transferred disaggregate will not be included in the OVC Comprehensive total. The OVC Comprehensive total includes only active and graduated program participants.
- At Q2: Report the number of children and caregivers that exited or transferred from the OVC program in previous two quarters. At Q4: Report the number of children and caregivers that exited or transferred from the OVC program in the past four quarters.
- **"Transferred out to a non-PEPFAR-supported partner"** is defined as when a child or caregiver has transitioned to programs that are not PEPFAR funded. These could include country-led services or other donor-funded programs.
- **"Transferred out to a PEPFAR-supported partner"** is defined as when a child or caregiver has transitioned from the support of one PEPFAR partner to another PEPFAR partner.

- **"Exited without graduation"** is defined as when a child or caregiver has not received program services in each of the past two preceding quarters or is lost-to-follow up, re-located, died, or the child has aged-out of the program without the household meeting graduation benchmarks from the PEPFAR OVC program.

DREAMS

- **Active DREAMS participants aged 10-17**
  - To be counted under this disaggregate, an active DREAMS participant **who is not otherwise actively enrolled in the OVC Comprehensive Program** must complete a DREAMS service/intervention that is also included in the list of OVC_SERV illustrative services (Appendix E).
    - At Q2: Report those that completed an eligible OVC intervention in the previous two quarters. At Q4: Report those that completed an eligible OVC intervention in the past four quarters.
    - Examples of DREAMS services that are also an OVC_SERV eligible services include: receipt of education support, completion of an evidence-based primary prevention intervention, participation in a structured safe spaces intervention, provision of psycho-social support and/or legal assistance related to child protection or violence cases, etc. (see Appendix E for more examples).
  - These individuals are not required to have an OVC case plan or to be monitored using the OVC graduation benchmarks. Active DREAMS participants should also be counted under the AGYW_PREV indicator according to their layering status.
  - Active DREAMS participants aged 10-17 should be counted under both AGYW_PREV and the OVC_SERV DREAMS disaggregate, per each indicator's definition. Intervention completion definitions should be consistent across indicators and should be documented in each OU's DREAMS layering table (see AGYW_PREV reference sheet). Note that it is possible for some individuals to be counted under AGYW_PREV but not the OVC_SERV DREAMS disaggregate. Only DREAMS AGYW who meet the definition above should be counted under OVC_SERV, whereas all DREAMS participants are counted under AGYW_PREV according to their layering status
  - Active DREAMS participants aged 18+ who are not otherwise actively enrolled in the OVC Comprehensive Program should NOT be counted under OVC_SERV.
  - PEPFAR IPs who serve AGYW meeting the above definition, regardless of funding source, partner type, or platform, should report on this indicator (i.e. both OVC and DREAMS partners can and should report following indicator guidance).

OVC PREVENTIVE

Prevention of HIV and sexual violence are important services that fit under the core components of the OVC program. Delivery of these services may differ from the OVC Comprehensive model. Individuals counted in this disaggregate are:

- **Children aged 10-14 who have completed only a primary prevention of HIV & sexual violence intervention**
  - These individuals are not otherwise actively receiving services in the OVC Comprehensive program and are not active DREAMS participants. Therefore, they are not required to have an OVC case plan or to be monitored using the OVC graduation benchmarks.
  - At Q2: Report the number of children that have completed an approved primary prevention intervention in the past two quarters. At Q4: Report the number of children that have completed an approved primary prevention intervention in the past 4 quarters.
  - Approved primary prevention of sexual violence and HIV interventions are as follows: Families Matter Program, Parenting for Lifelong Health (also known as Sinovuyo), Coaching Boys into Men, and No Means No Worldwide. Countries are strongly encouraged to implement one of these four pre-approved curricula. All other curricula used for 10-14 primary prevention must be approved by S/GAC and the relevant

agency HQ and must include the three S/GAC evidence-informed modules on healthy and unhealthy relationships, healthy choices about sex, and understanding consent.

Figure 5: OVC_SERV Numerator Categories

Program Model	Who	What	When Reported
OVC Comprehensive	**Active Children** • Children (ages 0-17) • Youth 18-20 completing secondary school or an approved economic intervention	• Have received 1+ eligible program services • Have a current case plan (updated within last year) • Are monitored at least quarterly • Are monitored against the graduation benchmarks	• At Q2 & Q4: Meets definition in each of the past two quarters, *or* in past quarter if beneficiary was newly enrolled
	Active Caregivers • Ages 18+ • Fulfill role of parent/guardian • ≤ 2 per household	• Have received 1+ eligible program services • Are monitored against the graduation benchmarks	
	Graduated Children & Caregivers • See respective definitions above	• All children and caregivers in a household have met all applicable graduation benchmarks	• At Q2: graduated in past 2 quarters • At Q4: graduated in past 4 quarters
DREAMS	• **Active DREAMS beneficiary ages 10-17** • NOT enrolled in OVC Comprehensive Program	• Have received 1+ DREAMS services that are also an eligible OVC_SERV service • Do not need an OVC case plan or to be monitored using the graduation benchmarks	• At Q2: received eligible service in past 2 quarters • At Q4: received eligible service in past 4 quarters
OVC Preventive Only	• **Children ages 10-14** • NOT enrolled in OVC Comprehensive Program or in DREAMS	• Have completed an approved primary prevention of HIV & sexual violence intervention • Do not need an OVC case plan or to be monitored using the graduation benchmarks	• At Q2: completed intervention in past 2 quarters • At Q4: completed intervention in past 4 quarters

PEPFAR-support definition:

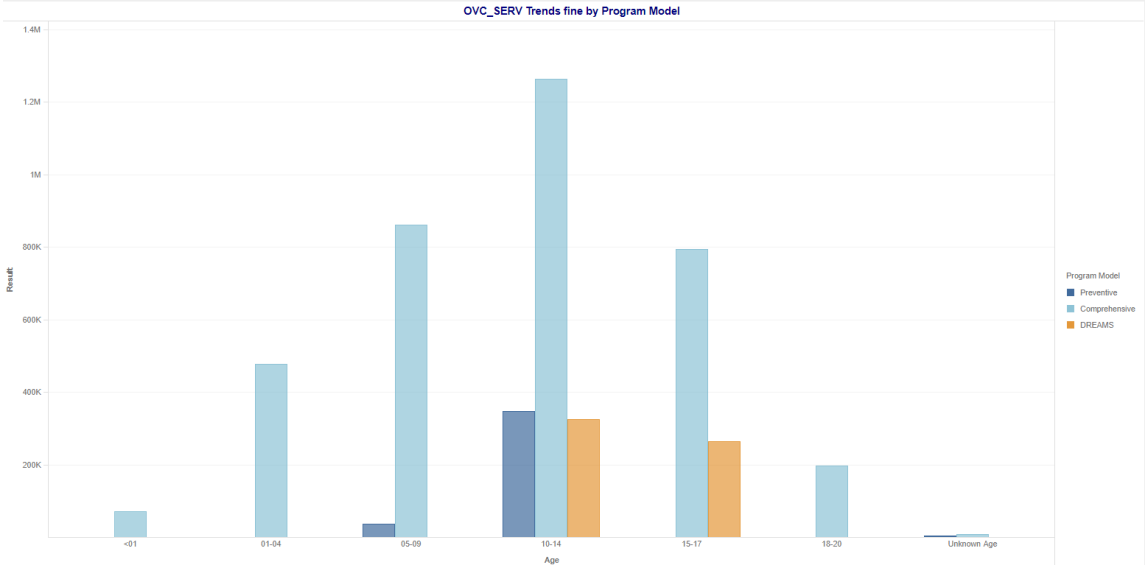
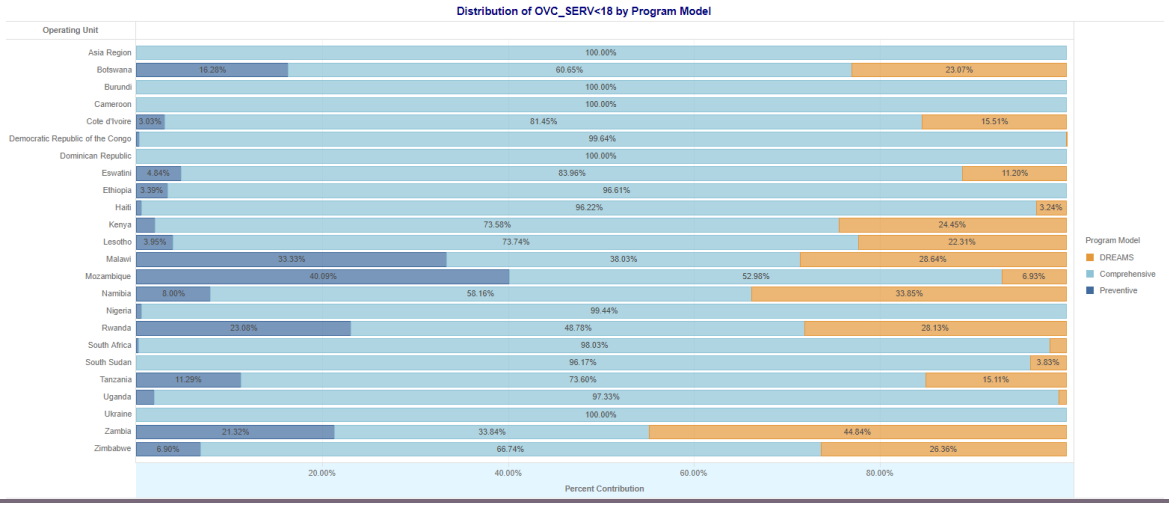
Modifications to standard definition of DSD and TA-SDI related to eligible goods and services:

Provision of key staff or eligible goods/services for OVC program participants receiving care and support services in the community includes: For participants of OVC programs, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group, or community level activity (e.g., psychosocial support, child protection services, education, etc.). Partial salary support may include stipends or incentives for volunteers/para-social workers or paying for transportation of those staff to the point of service delivery. For goods or services to be eligible, goods or services (e.g., bursaries, cash transfers, uniforms) can either be paid for out of the implementing partner's budget or be provided as a result of the IPs efforts to leverage and mobilize non-project resources. For example, an IP may help individuals fill out and file forms necessary for the receipt of government provided cash transfers, social grants, or bursaries for which they are eligible. Given the focus on long-term local ownership, IPs are encouraged to mobilize goods and services whenever possible.

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. Please explain reasons and context for highest/lowest performing partners' performance (i.e., results/target) for OVC_SERV total numerator and OVC_SERV <18, including any programmatic shifts or monitoring updates.
2. For OVC Comprehensive, please explain results by Program Participation Status:
    a. For active program participants, were there any interventions that were provided and approved by local USG funding agency that were not included in the illustrative examples (Appendix E)?
    b. For graduation, were any of the benchmarks especially challenging to achieve or monitor? If so, which ones and why?

	c. For graduation, please note how many of the total graduated results were CLHIV graduations. 3. For OVC Comprehensive, please explain results by exited/transferred: a. How many individuals exited without graduation? Please explain the reasons for exiting without graduation and try to quantify with percentages if possible. Are there certain partners with higher rates of exiting without graduation? How are you managing this with the partner(s)? b. How many individuals were transferred? To whom (e.g., other NGOs, government support, etc.) were they transferred? Where were beneficiaries transferred? Please provide disaggregates for beneficiaries transferred to specific sources of support. 4. For the OVC Preventive disaggregate, which approved primary prevention of HIV and sexual violence intervention(s) were implemented during the reporting period? Were there any implementation challenges that affected results? 5. For the DREAMS disaggregate, what were the most common interventions that DREAMS participants received? Were there any implementation challenges that affected results? 6. Please explain the steps taken by partners working in the same district to ensure that individuals were counted in the correct program model disaggregate and were not counted more than once.
Data Visualization & Use Examples:	 

PP_PREV

Description:	Number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	
Numerator:	Number of priority populations reached with standardized HIV prevention intervention(s) that are evidence-based	The numerator is the number of individuals from each priority population reached with HIV prevention interventions during the reporting period. For the purposes of reporting, the team will sum the numbers reached in each of the priority populations and report that total (details of the priority populations reached should be explained in the narratives).
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	The indicator represents PEPFAR-supported programming only and helps to determine PEPFAR's reach to priority populations. It may also help inform coverage of PEPFAR-supported programming for priority populations when reliable population size estimates are available. **Priority populations:** Priority populations should be defined by each country in the indicator narrative and must have a documented HIV prevalence or incidence greater than the general population of the country. Groups that might be counted as priority populations include: • Adolescent girls and young women (determined using the reported age/sex disaggregations) • Adolescent boys and young men (determined using the reported age/sex disaggregations) • Adult men (determined using the reported age/sex disaggregations) • Clients of sex workers • Displaced persons • Fishing Communities • Military and other uniformed services • Mobile Populations • Non-injecting drug users **Package of interventions:** Together with the IP, the country team designs a set of interventions for each of the priority populations. In a defined catchment area for the specific priority population, all prevention interventions may not be offered by one IP. However, all required intervention must be available in the catchment area for the priority population. Interventions must adhere to written protocols, include goals and activities, and be designed to promote adoption of key behaviors that support HIV prevention and service uptake among the priority population(s). The interventions should comprise multiple encounters with the same individuals or groups. **Children aged 10-14 who are receiving an approved primary prevention of HIV and sexual violence intervention should be reported under OVC_SERV OVC Preventive disaggregate and not PP_PREV. Please see the OVC_SERV reference sheet for further detail.**	

HIV testing services (HTS) or screening/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 screening or referral to HTS will not be a required element of this indicator.

Conducting risk assessments or screening to determine the need for HIV testing also meets the HTS component of PP_PREV. For example, if there is a ten-year-old girl enrolled in DREAMS, we would anticipate that she would not need to be tested for HIV if a risk assessment determines that she is not sexually active, and she does not have any additional risk factors for HIV.

The table below lists the interventions that must be offered in addition to HTS (or HTS screening/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.
• HTS screening or referral to HIV testing services; facilitated linkage to care and prevention services; and/or support services to promote use of, continuity of, and adherence to care.	• HTS screening or referral to HIV testing services; facilitated linkage to care and prevention services; and/or support services to promote use of, continuity of, 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 serostatus or self-identified as HIV negative) as having received a prevention intervention if they have provided HTS and/or HTS screening 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**

<table>
<tr><td></td><td><u>interventions during the same reporting period they will be reported as a returning beneficiary and not counted again in the reporting period.</u>

Furthermore, <u>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</u>. 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 <u>NOT</u> 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).

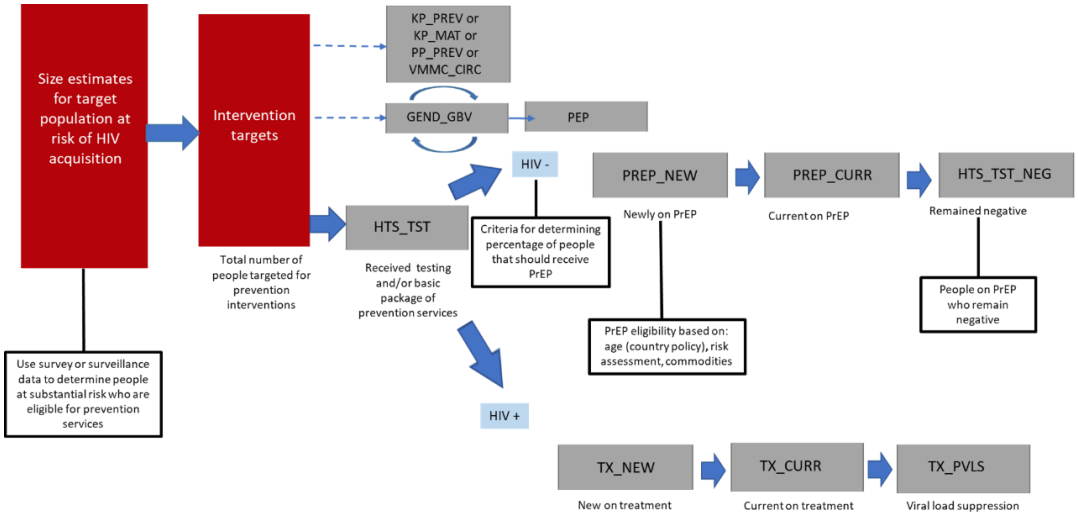
If possible, a unique identifier should be assigned to program participants or names can be collected to track individual participation in the prevention interventions/sites.

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

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

<u>Note that AGYW and adult men are NOT listed here as these population groups can be ascertained using the age/sex disaggregate group found above</u>.</td><td>• Clients of sex workers
• Displaced persons (e.g., refugees)
• Fishing communities
• Military and other uniformed services (including police, border guards, and security workers)
• Mobile Populations (e.g., migrant workers, truck drivers)
• Non-injecting drug users
• Other Priority Population Type (Describe in the narrative)</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Testing Services Disaggregates Definitions:
• Known Positive: Persons within each priority population type for whom HIV testing is not indicated because they are known to be HIV-positive. HIV-positive test results</td></tr>
</table>

	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 priority population type for whom HIV testing is indicated because they do not know their HIV status or their last HIV-negative test was more than 3-6 months ago (or more/less frequently as indicated by National Guidelines) should either be offered an HIV test on site or given information about where and when they can access an HIV test at another nearby clinic. Every attempt should be made to ensure the client is linked with HIV testing services that are PP-friendly, and where possible the completed referral should be documented (i.e., the client accessed HIV testing). Note: Persons who access testing and whose results are 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 priority populations with HIV testing as part of the package of HIV prevention services and to provide HIV testing on site or PP-friendly sites, programs should also respect the autonomy of clients to decline this service. Clients who decline testing and/or referral can still receive other prevention services, if the benefits of HIV testing were explained and testing or a referral for testing was offered. • **Test not required based on risk assessment:** Persons who, based on screening or a risk assessment, do not require a test for HIV during the reporting period. That is, it was determined through the screening or risk assessment that an HIV test was not needed.
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 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. 2. 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.

	3. If PP_PREV increased or decreased by >25% since the last reporting period, please explain the reasons (e.g., budget changes, changes to how curriculum-based interventions are tracked, activities included in PP_PREV that were previously counted elsewhere, etc.).
Data Visualization & Use Examples:	**HIV Prevention Cascade:** 

PrEP_CT

Description:	Number of individuals, excluding those newly enrolled, that return for a follow-up visit or re-initiation visit to receive pre-exposure prophylaxis (PrEP) to prevent HIV during the reporting period	
Numerator:	Number of individuals that returned for a follow-up or re-initiation visit to receive PrEP during the reporting period	N/A
Denominator:	N/A	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Updated narrative questions	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	Tenofovir-containing oral PrEP reduces the risk of HIV acquisition among numerous populations when taken consistently. WHO guidelines recommend offering oral PrEP to those at substantial risk of HIV infection. This level of elevated risk has been seen among serodiscordant couples with inconsistent condom use when the partner living with HIV is not virally suppressed or when there are partners outside of the main relationship, pregnant and breastfeeding women, people in prison or other closed settings, men who have sex with men (MSM), transgender people (TG), sex workers (SW) of all genders, and people who inject drugs (PWID), as well as adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. PEPFAR supports WHO guidelines on the use of oral PrEP as part of a package of comprehensive structural, biomedical and behavioral prevention services. Additional biomedical PrEP products are becoming available and recently WHO guidelines also recommend the vaginal PrEP ring be offered as an additional prevention choice for women at substantial risk of HIV infection as part of combination prevention approaches. In most settings, oral PrEP and new PrEP products will be integrated into existing prevention or treatment services for the target population. As PEPFAR continues to scale up PrEP service delivery, monitoring the PrEP cascade will be important to understand which populations are using this prevention intervention, as well as their length of time using it and their HIV outcome. Understanding the PrEP cascade by population will help improve implementation strategies for those in highest incidence communities initiating PrEP and the strategies for supporting continuity of PrEP.	
How to collect:	The numerator can be generated by counting the number of established PrEP users that returned for a follow-up visit during the reporting period. newly initiating PrEP during the reporting period should be counted only under PrEP_NEW. PrEP_CT counts re-initiations and follow-up visits for established PrEP clients and intends to measure continuity of PrEP use. Unlike HIV treatment, PrEP use does not have to be lifelong. Effective PrEP tracks periods of risk of HIV acquisition and may cease once an individual is no longer at risk for HIV. This indicator intends to measure continued use of PrEP at any point within the reporting period. ○ At Q1: report the number of returning PrEP users that had at least one PrEP follow-up or re-initiation visit that took place during Q1. ○ At Q2: report the number of returning PrEP users that had at least one PrEP follow-up or re-initiation visit that took place during Q2. ○ At Q3: report the number of returning PrEP users that had at least one PrEP follow-up or re-initiation visit that took place during Q3. ○ At Q4: report the number of returning PrEP users that had at least one PrEP follow-up or re-initiation visit that took place during Q4. • PrEP users should not be counted in PrEP_NEW and PrEP_CT in the same reporting period. If an individual initiates PrEP during the reporting period and returns for a follow-	

<table>
<tr><td></td><td>up visit during the same reporting period, that individual should only be counted in PrEP_NEW in that reporting period.
• If an established user has multiple follow-up visits within the same reporting period, they should only be counted once, in accordance with their most recent visit in the reporting period.
• If an individual tests positive at his or her PrEP follow-up appointment and is then initiated on PEPFAR-supported treatment in the same reporting period, that individual could be counted as PREP_CT in addition to TX_NEW and TX_CURR (given successful transfer into the ART program) within that reporting period. They would not be counted under PREP_CT in subsequent reporting periods.
• The reporting level for this indicator is the facility level only. If PrEP is being provided at community-based sites, these sites should be connected to or have a relationship to a clinical facility. The community sites providing PrEP programming should count the number of individuals currently on PrEP being served through the community service delivery point, and then those data should be reported through the facility connected to that community site.

Key Populations (KPs):
Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery.

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

NOTE: In accordance with 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 should complete these KP disaggregations, but only if safe to maintain these files and to report.</td></tr>
<tr><td>How to review for data quality:</td><td>Numerator ≥ subtotal of test result disaggregate group. Numerator ≥ subtotal of KP population type disaggregate group.</td></tr>
<tr><td>How to calculate annual total:</td><td>There should be no annual total. PrEP users who continue on PrEP across reporting periods will be counted in multiple reporting periods; therefore, to avoid double-counting, the numerator should not be summed across reporting periods.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex
[Required]</td><td>• 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Test Result
[Required]</td><td>• Positive
• Negative
• Other</td></tr>
<tr><td>Key Population Type
[Required]</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>Pregnancy/breastfeeding status
[Optional]</td><td>• Pregnant
• Breastfeeding</td></tr>
</table>
</td></tr>
</table>

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	• Age is defined as the age at the time of the visit during the reporting period. • Test result is defined as the HIV testing result received by returning PrEP users. A person on PrEP should be receiving an HIV test according to national guidelines or at least once a quarter. In the unlikely event that an HIV test is not administered, or the result is not known, this test result should be counted as "Test result: Other." • Pregnancy/breastfeeding status should be confirmed at each visit.	
PEPFAR-support definition:	Standard definition of DSD and TA used. Provision of key staff or commodities for PrEP services includes: ongoing procurement of critical commodities (excluding HTS commodities) such as "tenofovir-containing PrEP" which could be TDF alone, TDF/FTC, or TDF/3TC, or funding for salaries of personnel providing any of the prevention package components (i.e., clinicians, outreach workers, program managers). Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. Ongoing support for HIV prevention among PrEP services includes: mentoring and supportive supervision; training; organizational strengthening; QA/QI; program design like development of training curricula, PrEP guidance development, or standard operating procedures (SOPs) and follow-up to ensure quality of care; regular assistance with monitoring and evaluation functions and data quality assessments; or supply chain management	
Guiding narrative questions:	1. What support does PEPFAR provide at this site in terms of staffing, commodities and laboratory services? 2. Roughly what proportion of those returning for PrEP are estimated to continue longer than three months? 3. How are you tracking and/or finding individuals who have discontinued PrEP? 4. What reasons are individuals citing for discontinuing their use of PrEP?	

PrEP_NEW

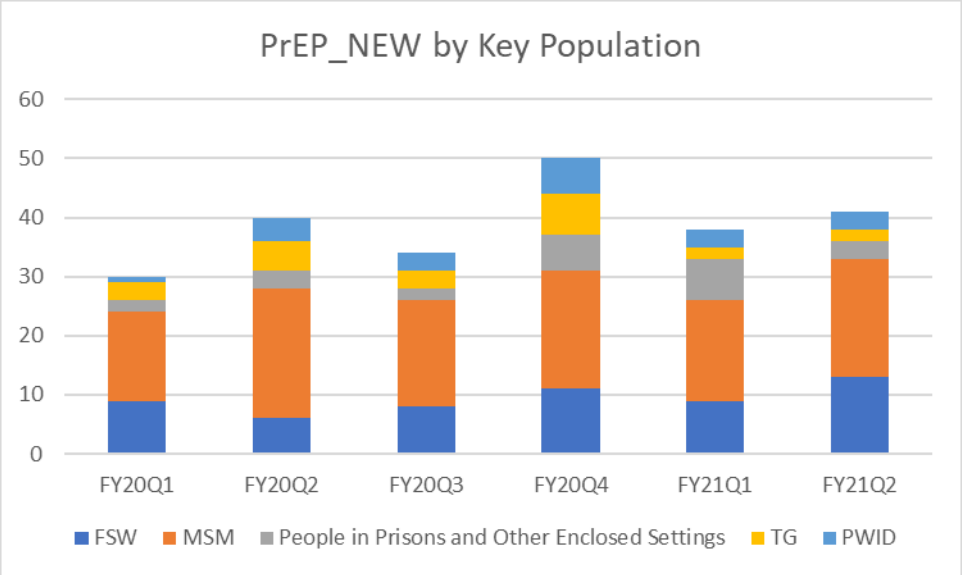
Description:	Number of individuals who were newly enrolled on pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	
Numerator:	Number of individuals who were newly enrolled on pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period	The numerator is generated by counting the number of people newly enrolled on PrEP (including WHO specified regimens "tenofovir-containing PrEP" which could be TDF alone, TDF/FTC, or TDF/3TC) during the reporting period, in accordance with the demonstration project guidance or the nationally approved protocol (or WHO/UNAIDS standards).
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Updated narrative questions	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
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 PrEP 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.	
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 users are recorded at the time they newly initiate into a program. Individuals 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. Any process to determine PrEP eligibility should include questions about a person's exposure to or risk of gender-based violence and intimate partner violence, with appropriate interventions or referrals provided as needed. **Key Populations (KPs):** Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery. The first priority of data collection and reporting of PrEP 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.	

<table>
<tr><td></td><td>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 should complete these KP disaggregations, but only if safe to maintain these files and to report.</td></tr>
<tr><td>How to review for data quality:</td><td>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>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex
[Required]</td><td>• 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Key Population Type:
[Required]</td><td>• People who inject drugs (PWID)
• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People in prison and other closed settings</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Age 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>Standard definition of DSD and TA used.

<u>Provision of key staff or commodities for PrEP services includes</u>: ongoing procurement of critical commodities such as “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>1. What strategies are used to ensure PrEP is offered as part of a comprehensive HIV prevention package?
2. Roughly what proportion of those offered PrEP at the site agrees to start PrEP?
3. Roughly how many of those offered PrEP and those starting PrEP have pregnant or breastfeeding status?</td></tr>
<tr><td>Data Visualization & Use Examples:</td><td>*see the next page for visual example*</td></tr>
</table>

Example Visual of PrEP Initiation over time by KP Group



TB_PREV

Description:	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the **previous** reporting period who completed therapy	
Numerator:	Among those who started a course of TPT in the **previous** reporting period, the number that completed a full course of therapy (for continuous IPT programs, this includes the patients who have completed the first 6 months of isoniazid preventive therapy (IPT), or any other standard course of TPT such as 3 months of weekly isoniazid and rifapentine, or 3-HP)	The numerator is generated by counting the number of PLHIV on ART from the **previous** reporting period who were documented as having received at least six months of IPT or having completed any other standard course of TPT (such as 3-HP).
Denominator:	Number of ART patients who were initiated on any course of TPT during the **previous** reporting period	The denominator is generated by counting the total number of patients on ART who were started on any course of TPT during the reporting period **prior to** the one being reported.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator measures the performance of HIV programs in scaling up TPT, with the goal of preventing progression to active TB disease among PLHIV and decreasing ongoing TB transmission in this population. As part of a cascade from TX_CURR to TB screening (captured in TX_TB), this indicator will inform programs on the pace of scale-up, and the proportion will allow for monitoring of cohorts through completion of therapy. Disaggregates on the timing of ART and age/sex breakdowns will allow programs to monitor those who are newly starting ART, an important focal population in all countries and in particular in countries that have already provided TPT for many of their PLHIV in care.	
How to collect:	The denominator can be generated by counting the total number of patients who initiated any regimen of TPT in the semiannual reporting period that is **prior to** the one being reported on. For example, if reporting is for Q1 and Q2 of a fiscal year (e.g., October 2019 to March 2020), then the denominator would include those that were started on TPT in Q3 and Q4 of the previous fiscal year (e.g., April to September 2019). If a TPT register is being used, then this would require simply framing out the dates that define the previous reporting period and counting all those who started TPT. **Importantly, programs should ensure that patients on continuous isoniazid therapy are counted only once, when they initiate therapy (denominator) and after they complete the first six months (numerator); care should be taken to ensure they are not included in future calculations**. If a patient is initiated on TPT and dies before TPT completion, this patient should be recorded in the denominator, but not in the numerator. If a patient initiates TPT at one site, completes at another, and is a documented transfer, that patient should be recorded in the denominator at the site where they initiated TPT, and they should be recorded as completed TPT (numerator) at the new site.	

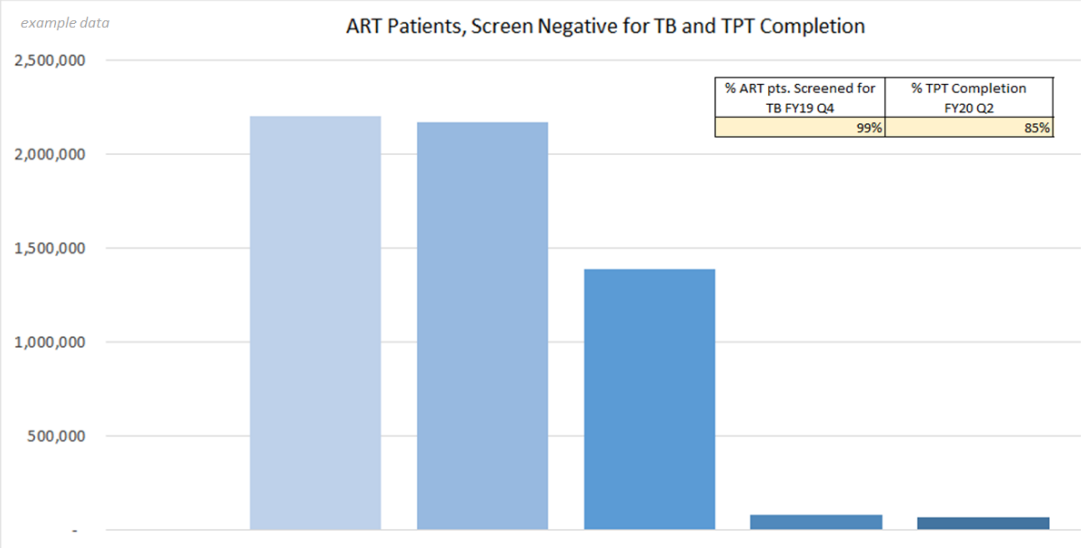
	The numerator can be generated by counting the subset of patients from the denominator who received at least six months of IPT or have completed another standard course of TPT. If a TPT register is being used, this would require framing out the dates that define the previous reporting period, identifying those that initiated TPT during the reporting period (the denominator) and then documenting the number of those patients who completed the course of TPT that they started during that reporting period. This should include the patients who completed a shorter alternative course, such as 3-HP, as well as those who are on prolonged or continuous IPT who have completed their first six months of therapy. Note: If a patient was started on IPT in the previous reporting period (e.g., Q3 or Q4 FY2019), he/she would have completed during the current reporting period (e.g., Q1 or Q2 FY2020). **For IPT:** • All patients who started any form of IPT, including prolonged or continuous IPT, at any time in the previous 6-month reporting period (i.e., at any time in the 6 months before the start of the period being reported) should be included in the denominator. Among the denominator, those that completed at least six months of isoniazid therapy would have done so in the period currently being reported (the numerator). The few patients who started and completed IPT in the previous reporting should be included and counted in the numerator and the denominator. **For 3-HP**: • Patients who are taking 3-HP may have initiated and completed therapy in the previous reporting period, or they may have initiated TPT in the previous reporting period and completed TPT in the period currently being reported. • Any patient who started 3-HP at any point in the previous reporting period would be included in the denominator. • Any patient from that denominator who completed the course would be included in the numerator; this would include those who completed 3-HP in the first 3 months of the period being reported on. **For alternative regimens:** • Patients who are taking other regimens (such as 1-HP) may also have initiated and completed therapy in the previous reporting period or they may have initiated TPT in the previous reporting period and completed TPT in the period currently being reported. Include and count patients under both scenarios (start and completion in the same reporting period AND start in the previous reporting period but completion in the one currently being reported). These data elements can be collected from the ART register or from separate TPT registers. In some countries, TB presumptive registers might contain this information as well, but the information will need to be cross referenced for ART status.
How to review for data quality:	Data Element ≥ subtotal of each of the disaggregations.
How to calculate annual total:	The TB_PREV denominator and numerator should be analyzed independently of other data and the results reported in Q2 and Q4 should be summed to calculate the total number of ART patients who initiated and completed a course of TPT. When analyzing this data in conjunction with data on TB screening for ART patients (TX_TB), it is important to align the correct reporting periods. For example, TB_PREV captures those who were initiated on TPT during the **previous** reporting period, so it should be compared to TB screening (TX_TB Denominator) and TX_CURR data from the **previous** reporting period.

<table>
<tr><td rowspan="4">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex by ART Start: [Required]</td><td>• Newly enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• Previously enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Age/Sex by ART Start: [Required]</td><td>• Newly enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M
• Previously enrolled on ART: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Age/Sex by ART Start Descriptions:
• Newly enrolled on ART: These individuals initiated TPT within 6 months of being enrolled on ART; data to be submitted by the following disaggregates: <15F/M, 15+F/M Unknown Age F/M
• Previously enrolled on ART: These individuals initiated TPT at least 6 months (or longer) after being enrolled on ART; data to be submitted by the following disaggregates: <15F/M, 15+F/M, Unknown Age F/M</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

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

Ongoing support for patients receiving routine HIV-related services includes: training of HIV service providers, clinical mentoring and supportive supervision of staff at HIV sites, infrastructure/renovation of facilities, support of HIV service data collection, reporting, data quality, QI/QA of HIV services support, ARV and TPT consumption forecasting and supply management, support of lab clinical.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. What proportion of patients who completed TPT received IPT, 3-HP, or an alternative TPT regimen (e.g., 1-HP)?
2. Roughly what proportion of patients who received TPT were treated with the 6-month isoniazid regimen?
3. Broadly describe the main reasons why TPT was not completed (e.g., adverse events, interruption in treatment, patients refused to continue, etc.).
4. Roughly what proportion of all PLHIV on treatment have already completed TB preventive therapy prior to this reporting period (and were not eligible for TPT and not include in this indicator)?
5. If TB preventive therapy was not provided to all PLHIV in care, what are the main reasons for limited scale-up?</td></tr>
<tr><td>Data Visualization & Use Examples:</td><td colspan="2">*see the next page for visual example*</td></tr>
</table>

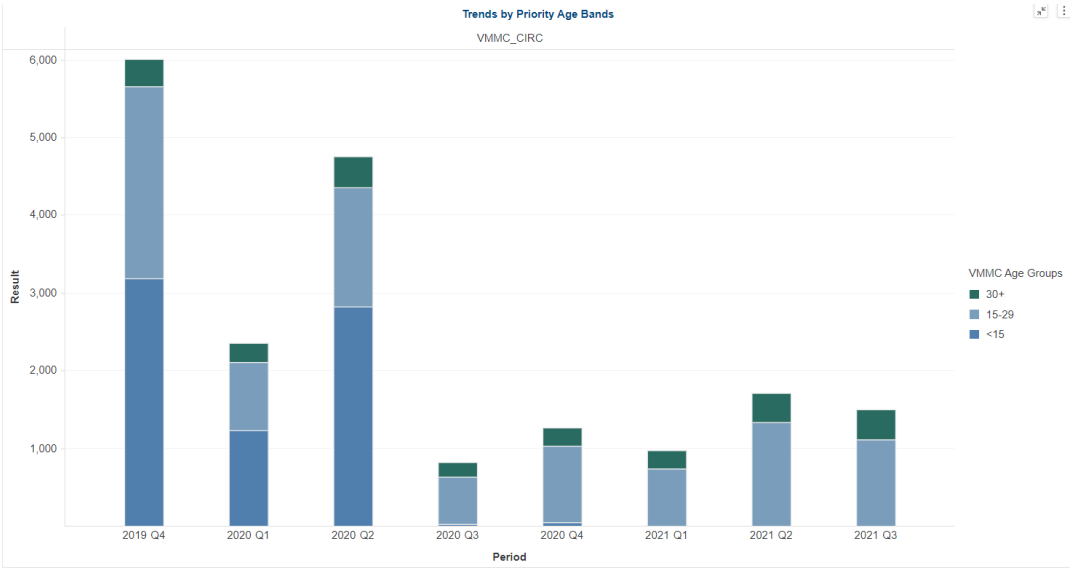
Example Visual of ART Patients Screen Negative for TB and TPT Completion



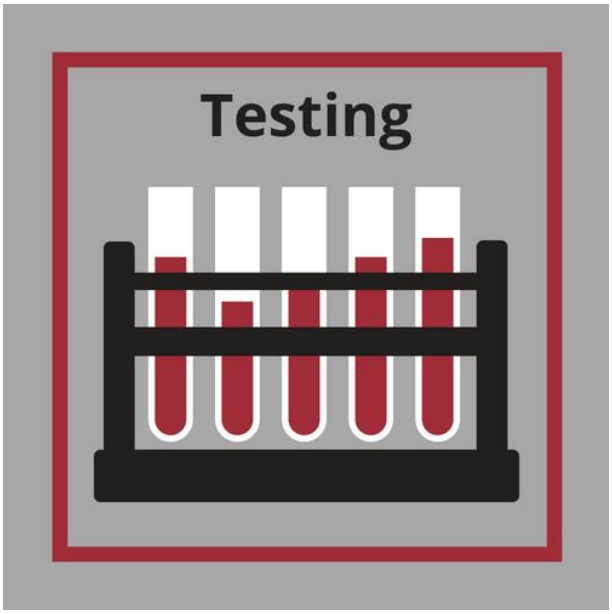
TX_CURR FY19 Q4	TX_TB Den. FY19 Q4	TX_TB Den. NEG FY19 Q4	TB_PREV Den. FY20 Q2	TB_PREV Num. FY20 Q2
2,204,371	2,171,796	1,390,121	77,480	66,088
# ART patients	# ART patients screened for TB	# ART pts. screened negative	# initiated during previous reporting period	# completed TPT

VMMC_CIRC

Description:	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period	
Numerator:	Number of males circumcised	The numerator can be generated by counting the number of males circumcised.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator tracks the number of male circumcisions conducted during the reporting period and assists in potentially determining coverage of circumcision in the population over time. The total number of males circumcised indicates a change in the supply of and/or demand for VMMC services. Additionally, disaggregations are required and are used to evaluate whether prioritized services have been successful at reaching the intended population (by age, HIV status, and circumcision technique), targets have been achieved, and whether modeling inputs should be adjusted. An additional level of disaggregation below the circumcision technique level is required for follow-up status, since post-operative clinical assessments are part of good clinical care and low follow-up rates may indicate a problem in program quality.	
How to collect:	The numerator can be generated by counting the number of males circumcised as part of the VMMC for HIV prevention program. This information can generally be found in VMMC Register, or client medical records maintained by each program/site/service provider.	
How to review for data quality:	Disaggregations for HIV status and outcome and circumcision technique should be equal to (but not exceed) the numerator. The circumcision technique by follow-up status disaggregate should be less or equal to the circumcision technique disaggregate.	
How to calculate annual total:	Sum results across quarters.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Age [Required]	• 0-60 days, 2 months-1 year, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
	HIV Status and Outcome by Age [Required] ***Underlined portions auto-populate into the VMMC HTS_TST modality.***	• Number of HIV-positive clients (tested HIV positive at VMMC site) by: <1 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age • Number of HIV-negative clients (tested HIV negative at VMMC site) by: <1 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age • Number of clients with indeterminate HIV status or not tested for HIV at site (regardless of previous documentation) by: <1 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
	Circumcision Technique [Required]	• Surgical VMMC • Device-based VMMC
	Circumcision Technique/Follow-up Status (Sub-disaggregation of the VMMC circumcision technique disaggregation)	• 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.

	[Required]	• Device-based VMMC: Did not follow-up within 14 days of device placement or did not follow-up within the reporting period
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	N/A	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for VMMC include</u>: medical instruments, supplies, or medicines needed for the VMMC procedure, or funding for salaries for HCW who deliver VMMC services. <u>Ongoing support for VMMC service delivery improvement includes</u>: 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?	
Data Visualization & Use Examples:	**VMMC Trends by Priority Age Band** 	

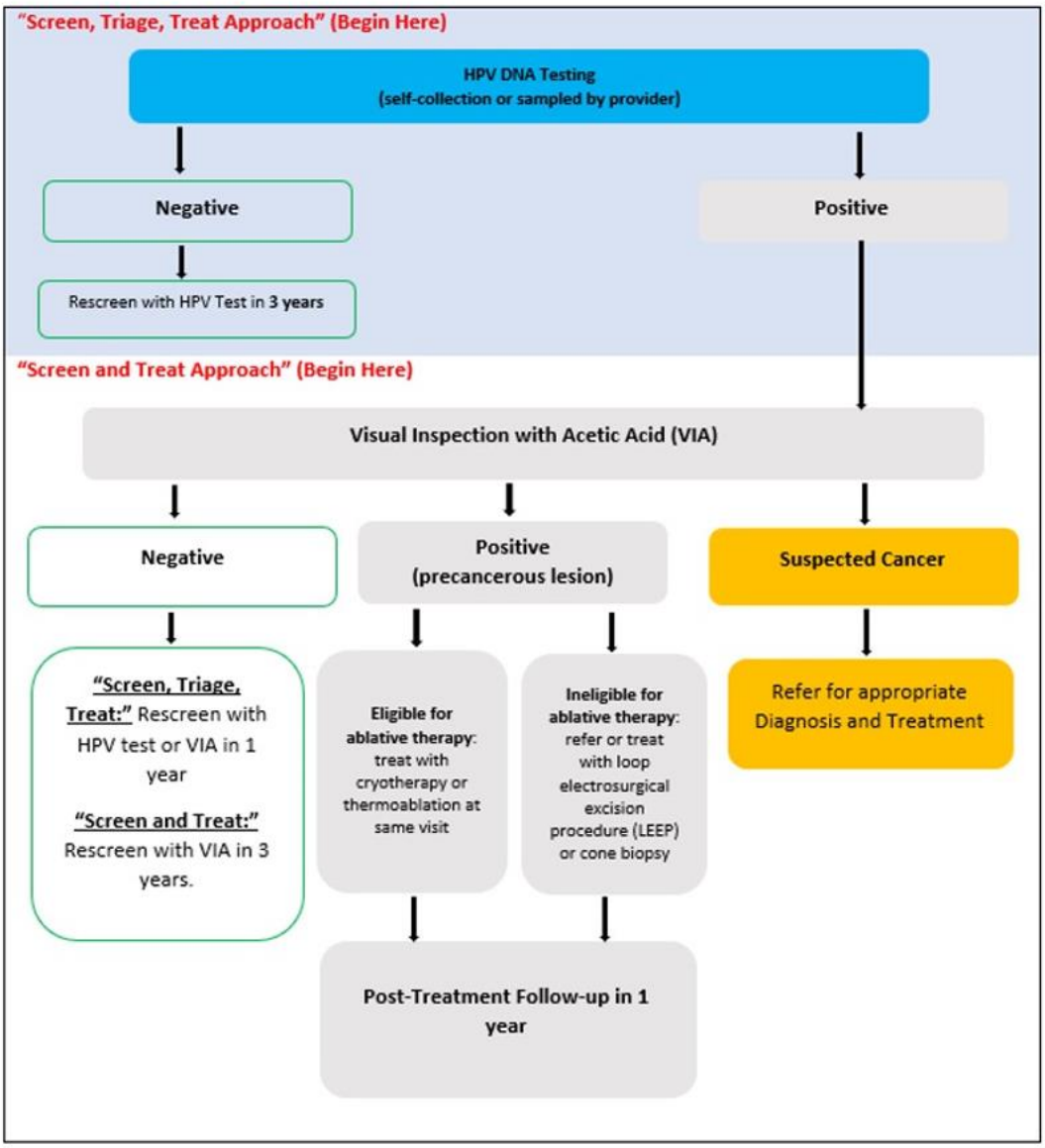
TESTING INDICATORS



CXCA_SCRN (including CXCA_SCRN_POS)

Description:	Number of HIV-positive women on ART screened for cervical cancer	
Numerator:	Number of HIV-positive women on ART screened for cervical cancer	The numerator captures the number of individual HIV-positive women on ART who received a screening test for cervical cancer.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added clarifying language on screen-triage-treat strategy and visual on PEPFAR algorithm for cervical cancer screening • Updated narrative questions	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator is vital for understanding and estimating the demand for screening services and forecasting and planning for the resources required to meet that demand and the resulting treatment needs. Disaggregation enhances sensitivity of this indicator in order to help identify the need for further outreach, as well as trigger further situational investigation at lower levels of the health system. CXCA_SCRN and CXCA_TX should be analyzed together at the district or sub-regional level that includes sites where both screening and treatment would occur, in order to monitor the percentage of positive women who receive treatment while accounting for patient referrals between facilities. For VIA, the benchmark of 5%-25% screen-positivity for women (aged 30-60) screened for the first time should be used when monitoring performance. (WHO, 2013; ACCP, 2004)	

How to collect:	The primary data sources for this indicator are registers or logbooks in use at the point of cervical cancer screening service delivery at PEPFAR supported ART sites. Client and facility level data collection tools should include the data elements required for disaggregation.
	
	Data for the numerator should be generated by counting the total number of HIV-positivewomen on ART who received a cervical cancer screening test.
	
	For the purposes of this indicator, “screened” is defined as receiving the tests necessary to determine the need for treatment of precancerous lesions – or referral for suspected invasive cervical cancer.
	• For programs using a VIA based screen-and-treat strategy, the number of women receiving aVIA result should be counted here.
	• For programs using a screen-triage-treat strategy (e.g., HPV test with VIA triage, with treatmentonly if the woman is VIA positive), the following should be counted:
	  ○ The number of women who received a negative result on the initial screening test(e.g., HPV test)
	  ○ The number of women who received BOTH a positive result on the initial screening test (e.g., HPV test) AND either a positive (or suspected cancer) or negative result on the triage test (e.g., VIA) should be counted here.
	
	Only completed screenings should be counted under this indicator – screening tests that were not completed due to cervicitis or who had a positive HPV screen with no follow up VIA should not be counted and should be reported in the narratives. Screening visits where cancer is suspected based on initial speculum examination, prior to the application of acetic acid, should be counted as “completed screenings”. This is because the **defined purpose** of the screening was **fulfilled** (i.e., to identify individuals with increased probability of having either the disease itself or a precursor of the disease).	

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


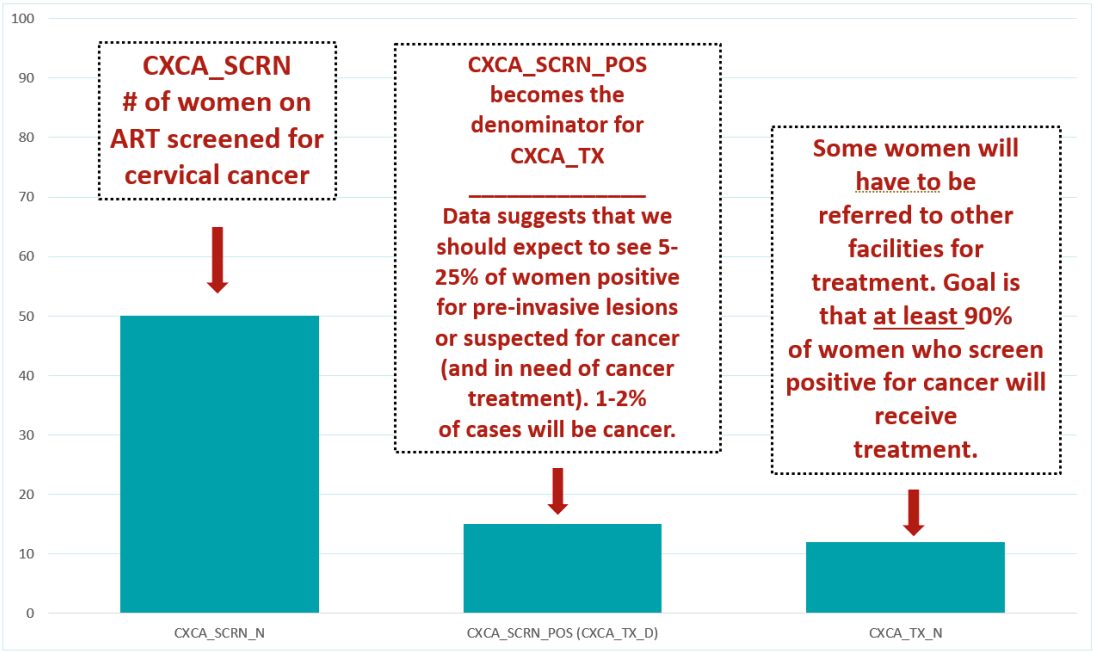
</td></tr>
<tr><td>How to review for data quality:</td><td>The numerator for this indicator should not be larger than TX_CURR among women 15+.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across reporting periods for the numerator.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Screening Visit Type and Result by Age [Required]</td><td>

1st time screened (Negative, Positive, Suspected Cancer) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
Rescreened after previous negative (Negative, Positive, Suspected Cancer) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
Post-treatment follow-up (Negative, Positive, Suspected Cancer) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age

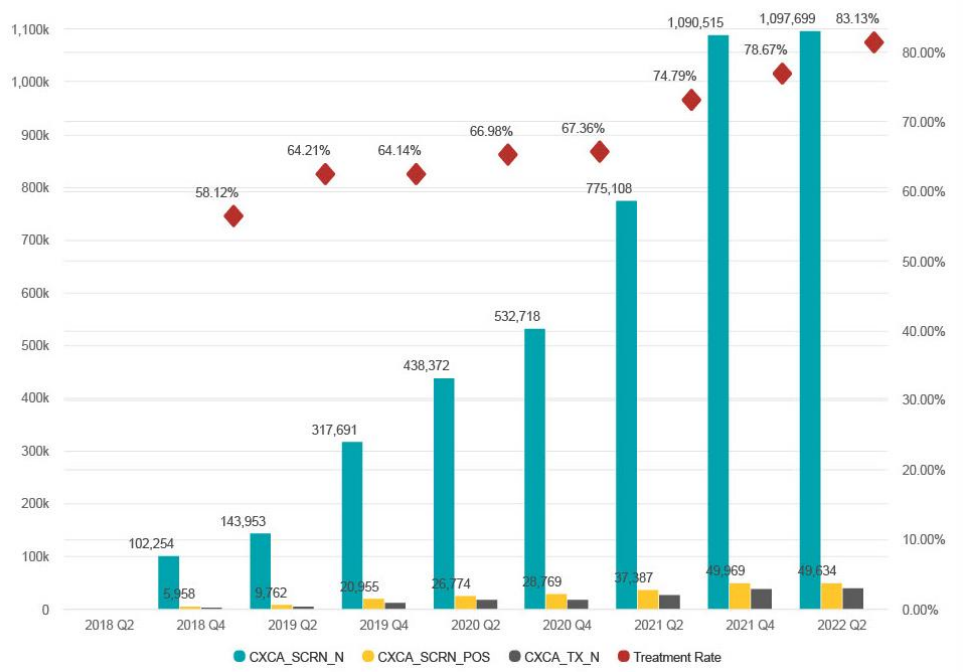
</td></tr>
</table>
</td></tr>
</table>

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A

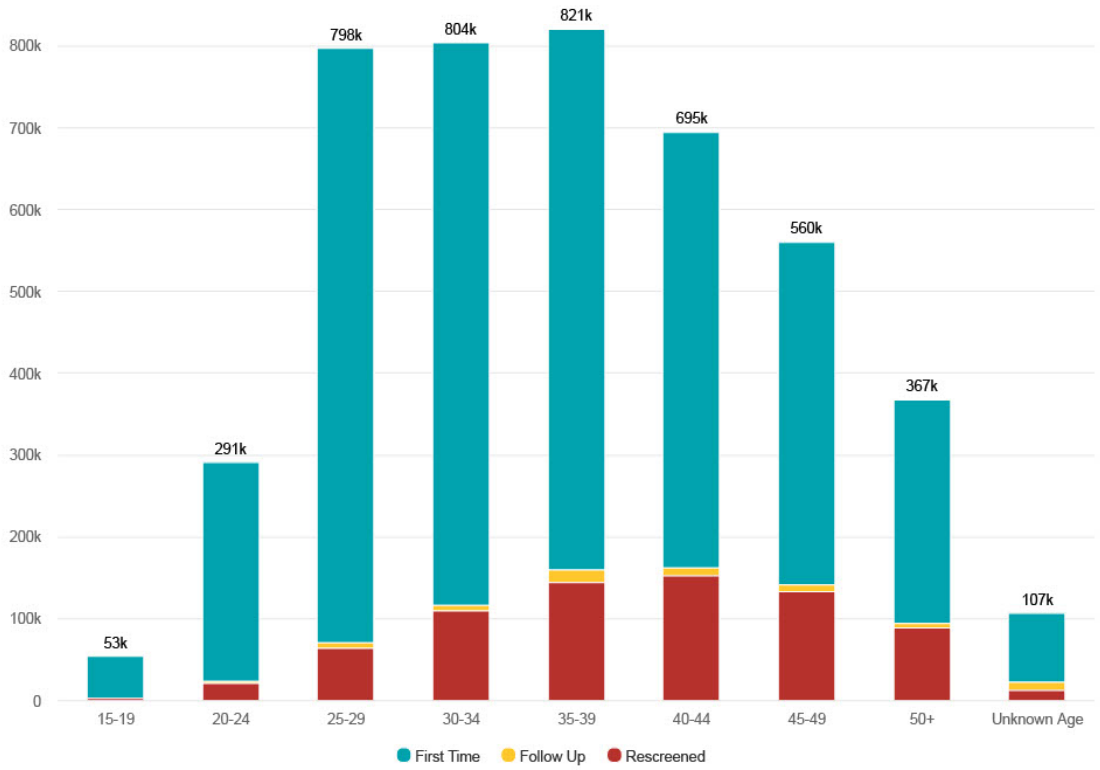
Disaggregate descriptions & definitions:	**Result:**
	• Negative
	  ○ Indicates that neither a lesion, nor any indication of invasive cervical cancer were visualized during the VIA test, including a negative VIA after a positive HPV test. Although not captured in MER reporting, custom indicators may be used to track screening outcomes by testing modality.
	• Positive (**CXCA_SCRN_POS**)
	  ○ Indicates the visualized presence of aceto-white lesion on the cervix following the application of acetic acid.
	  ○ In practice, women with a positive result are further differentiated into 'eligible for cryotherapy' and 'ineligible for cryotherapy', based on the size and location of the lesion.
	  ○ Women with fulminating masses or other indication of suspected cervical cancer are not counted under this disaggregate.
	• Suspected Cancer
	  ○ Indicates the visualized presence of a fulminating mass, or other clinical indicator suspicious for invasive cervical cancer.
	
	In practice, women with a VIA screening (or triage) test result of "positive" or "suspected cancer" are both considered **screen-positive** (or triage-positive); however, for the purposes of monitoring, screen-positive results are separated into precancerous lesions ("positive" disaggregate) and suspected cancer ("suspected cancer" disaggregate) because the care pathways for each are different. Precancerous lesions may be treated immediately with outpatient procedures, whereas suspected cancer requires further evaluation (colposcopy, biopsy, diagnosis) before treatment options can be considered. Clinical definitions can be found in WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, second edition. Geneva: World Health Organization; 2021.
	
	Screening Visit Type
	• 1st Time screening
	  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the screening-naïve HIV-positive population – only women being screened for the first time in their lifetime should be counted under this disaggregate
	• Rescreening after previous negative result
	  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received a negative result on their most recent screening test
	  ○ WHO recommends that HIV-positive women or women of unknown HIV status who receive a negative cervical cancer screening test result be rescreened every 3-5 years.
	  ○ As a program matures, countries should consider adding an additional performance indicator which measures whether women that should return for routine rescreening in a given time period are returning in that time period (e.g., number of rescreened women in a given time period, over the number of women who were expected to be rescreened in the same time period)
	• Post-treatment follow-up screening
	  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received precancerous lesion treatment due to a positive screening result on their last screening test
	  ○ Some national guidelines require post-treatment follow-up screening at intervals that differ from the PEPFAR screening algorithm – programs should use additional indicators to monitor the additional follow-up time points, and this should be noted in the narrative.	

PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. For cervical cancer screening services, direct service delivery includes: ongoing procurement of critical screening related commodities or requisite materials such as specula, acetic acid, bright white light source (bulbs/lamp, or torch/batteries), or other consumables (cotton swabs, exam gloves, gauze, etc.), or funding for salaries of screening service providers including program managers, supervisors, and/or coordinators. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For cervical cancer screening services, ongoing support for service delivery improvement includes: clinical mentoring/supportive supervision, VIA training, guidance development, infrastructure/renovation of facilities, site level QI/QA, routine support of M&E and reporting, or commodities consumption forecasting and supply management.
Guiding narrative questions:	1. Are there any barriers you face encouraging HIV-positive women on ART to get screened for cervical cancer and, if so, what would be helpful to overcome these barriers? 2. Please provide the context for how real-time (or near real-time) imaging technologies are in use at your sites. For instance, do you have the option to send images to a central location for review? If so, do they provide feedback while the client is still at your site or does the delay in processing necessitate a return visit for the client? 3. Please report any quality improvement activities that are ongoing for VIA, particularly when the positivity rates are below 5% or above 25%. 4. Please report whether your facility uses a screen and treat approach or a screen, triage, and treat approach; clinician or self-collection of HPV tests, including the number HPV tests performed; and any challenges you are experiencing with the implementation and scale up of HPV testing.
Data Visualization & Use Examples:	**HIV/Cervical Cancer Cascade:** 

Cervical Cancer Screening to Treatment Analysis:



Screening Type by Fine Age:



HTS_INDEX

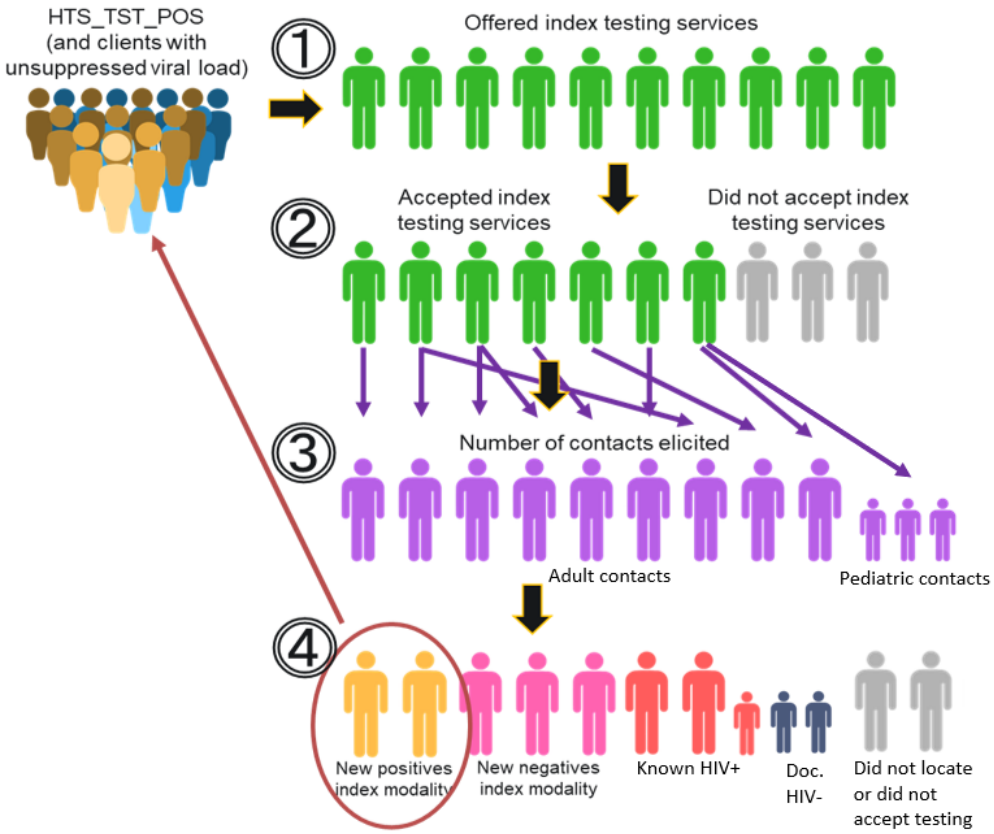
Description:	Number of individuals who were identified and tested using index testing services and received their results	
Numerator:	Number of individuals who were identified and tested using index testing services and received their results	This indicator aims to monitor the scale and fidelity of implementation of HIV index testing-related services
Denominator:	N/A	There is no official denominator. However, this indicator represents a cascade and the collected disaggregations serve as both numerators and denominators when analyzing the index testing cascade.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added clarifying language throughout the reference sheet • Streamlined narrative questions	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This is the first MER indicator to monitor PEPFAR programming of HIV index testing services (often also referred to as Partner Notification Services, partner testing, contact tracing, etc.). Index testing is an approach whereby the exposed contacts (i.e., sexual partners, biological children, biological siblings of pediatric index clients, and anyone with whom a needle was shared) of a person living with HIV (i.e., index client), are elicited and offered HIV testing services in a safe and ethical manner. In this context, index testing refers to any HIV testing of the contacts of an index client (i.e., a person known to be HIV positive). **Only the following persons count as contacts:** a. Current or past sexual partner(s) b. Biological children (<19 years of old). Biological children reported under HTS_INDEX should only include: • Biological children of an HIV-positive mother, and/or • Biological children of male index clients (fathers) when the biological mother is HIV-positive, she is deceased, or her HIV status is not known, not documented, or unable to be obtained. c. Biological parents (if the index client is a child) d. Biological siblings of pediatric index clients e. Anyone with whom a needle was shared. It is important to offer timely HIV testing to biological children of women with an unknown HIV status (i.e., do not delay the child's HIV test to first reach and test the biological mother). It is also imperative to offer HIV testing to children whose biological mothers with HIV or unknown HIV status have died. If the index client is the child, his/her biological mother should be offered HIV testing services, and if the mother is HIV-positive or deceased, the biological father should be offered HIV testing services. In addition, all biological siblings of the index child should be offered HIV testing services. In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease. Every newly diagnosed individual becomes a subsequent index client from whom to elicit contacts. Like HTS_TST and HTS_SELF, HTS_INDEX is reported at facility and community levels. Testing of persons who have not had exposure through an index client, such as neighbors or family members (e.g., children of HIV-negative mother, grandparents, etc.) not born to the index, should ***not*** be reported under HTS_INDEX. Testing of non-contacts should be reported under the modality that best reflects the service delivery point where testing	

	occurred. For example, if HIV testing were conducted in a mobile clinic, unexposed contacts would be reported under the 'Mobile' modality of HTS_TST. All index testing services must meet WHO's 5C minimum standards, including consent, counseling, confidentiality, correct test results, and connection to HIV prevention (for both HIV-positive and HIV-negative individuals), and HIV care and treatment services (often referred to as'linkage', for HIV-positive individuals). The 5 Cs are essential for all HTS, especially in the context of identifying contacts for HIV testing. Additionally, all index clients should be screened for Intimate Partner Violence (IPV) per WHO guidelines. An index client should never feel as if they are required to provide contacts in order to receive any services. Overall, all index testing services being offered at all PEPFAR-supported sites should adhere to PEPFAR's Guidance on Implementing Safe and Ethical Index Testing Services. Note: The reporting of HTS_INDEX data by an implementing partner should **not** be used toinfer whether or not a partner has conducted index testing in a manner compliant with PEPFAR's Guidance on Implementing Safe and Ethical Index Testing Services. Additionalmonitoring, such as through SIMS, adverse events monitoring, and remediation efforts, is essential in order to ensure compliance with the index testing guidance. HTS_INDEX is separated into several steps (1-4 below) that are aligned with core components of index testing implementation. These steps are part of a cascade of implementation that begins with an offer of index testing services to the index client and ends in provision of an HIV test (and results) to the contacts named by the index client. Thisfinal step 4 (and the age sex disaggregates) will **auto-populate** into the 'Index' modality in HTS_TST for either facility or community. The steps are: 1. **How many index clients were offered index testing services?** This is the number of index clients (newly diagnosed positive, previously known positives who are not on ART, or clients with unsuppressed viral load) who were offered (e.g., counseled on) index testing services (regardless of whether or not those services were accepted by the index client) in compliance with PEPFAR's Guidance on Implementing Safe and Ethical Index Testing Services. PEPFAR continues to emphasize universal offer of index testing services that are consistently provided in a safe and ethical manner. 2. **How many index clients accepted index testing services?** This is the number of index clients who accepted (e.g., agreed to through informed consent) provision of index testing services by a provider (acceptance of counseling on index testing, or acceptance of elicitation of current or past sexual partners/partner notification, etc.). *PEPFAR's guidance is centered on universal offer of safe and ethical index testing services (Step 1) and there is no expected minimum threshold of acceptance rates (Step 2).* 3. **How many contacts did the index client provide?** This is the number of contact names provided by the index client as a result of accepting index testing services, and additional contact information may be provided at a follow-up appointment if not immediately available. The index client provides the age (<15 years or ≥15 years) and sex (male or female) of the contact(s). Since the index client 'self-reports' these data, the contact's recorded age and/or sex does not need to be corrected in Step 3 if differing age/sex information is collected in Step 4. As mentioned above, contacts are only sexual partners, biological children/parents, and anyone with whom a needle was shared. 4. **How many contacts were tested for HIV and received their results?** Of those tested and received their results, how many tested positive and negative? This is the number of contacts who were tested for HIV and received a seropositive or seronegative result. The positive and negative disaggregations do not include the contact's self-reported status; only the actual provision of an HIV diagnostic test (which, by definition, excludes HIV self-tests) to the contact. However, please note that previous diagnoses (i.e.,

known positives) should also be recorded as “known positive” in Step 4. ***Individuals who are known to be living with HIV should not be retested.***

Biological children (< 19 years of age) of any index client and biological siblings of pediatric and adolescent index clients who have a documented negative test (not a self-test) can be reported as “documented negative with no other HIV exposure risk” (documented negative). HIV-exposed children reported in this category should have received a final negative HIV test at 18 months of age or 3 months after breastfeeding ended, whichever occurred later. Children who have a documented negative HIV test after the time period for EID services may also be counted.

Children with any known or suspected HIV exposure should be retested, including but not limited to: breastfeeding from a mother living with HIV, known or suspected sexual activity, contact or abuse, needle stick exposure (unsafe injection practices) or through a blood transfusion. If a child is reported to have received a negative test in the past but the documentation is missing or unavailable, the child should be retested rather than waiting to retrieve the documentation. **The documented negative disaggregate applies only to index contacts in the pediatric age bands (<15y years of age).** All index contacts ≥15 years of age who are not known positive should receive an HIV test, regardless of whether they are a child of an index case or other type of contact.



Reporting and use of this indicator should not preclude any other data collection or indicators that may be used to monitor implementation, effects, and outcomes related to HIV index testing services. That is, other data may need to be collected and used by the program to ensure efficient and effective implementation of index testing services either at the facility or community level. For example, to have a more accurate denominator for contacts tested, programs may also collect information about the number of contacts reached among the contacts elicited. Furthermore, of those contacts reached, how many agreed to test for HIV? Programs may also wish to disaggregate the numbers of contacts reached and tested by the four different approaches to index testing (e.g., client, dual,

	contract, and provider) to see which approaches are most effective. Programs could also track the number of newly diagnosed partners and children linked to HIV treatment.
How to collect:	The suggested data source is a designated HIV Index Testing Services register or logbook. This will allow easier collection of the data for each step in the index testing cascade shown above (see Steps 1-4 above). Alternatively, existing HTS registers, log books, and reporting forms already in use to capture HTS can be revised to include the steps mentioned above and the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems, and non-governmental organization records. Other important considerations for reporting on high-fidelity index testing services: • For a contact to be counted under Step 4, he/she must be tested for HIV and receive their result (seropositive or seronegative) or be a known positive. That contact could either self-report a known exposure to someone with HIV as their reason for testing, have an index testing referral letter/card/coupon given to them from their HIV-positive partner/family member (client-referral approach), or have been identified during the elicitation process and contacted by a provider. For example, if someone comes to a facility or mobile unit and requests an HIV test and reports a known exposure to someone with HIV as their reason for testing, that person should be counted under HTS_INDEX. Further, that individual's HIV diagnosis must be confirmed using a nationally validated testing algorithm. For example, an HIV-positive rapid HIV test performed at the community- or facility- level must be confirmed with a second and third (in some contexts) test, which may be performed at the same site or at a different facility. If the confirmatory test is performed at a different facility, then this may require follow-up by implementing partners to confirm the diagnosis before reporting on the Step 4. • For children <1 year old, only serologic tests used for diagnostic purposes should be reported under HTS_INDEX. Serologic tests for screening infants should be excluded (including tests to look for HIV exposure at age 9 months or another time point). For example, you may use the HTS_INDEX <1 disaggregate to report negative diagnostic results if a serologic-based test is used to confirm the absence of HIV infection in infants (<1 year old) who have not breastfed for at least 3 months prior to testing. However, since confirmed diagnosis of HIV infection in children < 18 months of age requires virologic, and ***not*** serologic, tests, the general expectation is not to see results in the <1 "known positive" or "new positive" disaggregate of the HTS_INDEX indicator. HIV virologic testing of HIV-exposed infants should be counted under PMTCT_EID and as appropriate, PMTCT_HEI_POS. • Programs that utilize the 'dual-referral' approach (i.e., the provider/counselor sits with an index client and their partner(s) to assist with disclosure and/or partner testing) may want to offer re-testing to the index client to protect his or her safety. In this case, the index client's test result should NOT be counted again under HTS_INDEX or HTS_TST. Individuals who undergo couples testing (i.e., neither partner knows their status) should be counted under HTS_TST and the appropriate service delivery modality should be indicated (e.g., ANC). • The partner elicitation process of index testing is a continuous process. Ongoing partner elicitation should strike a balance between offering individuals who are living with HIV the opportunity for assistance in notifying partners and the respect/support of the client in their decision to continue participation in index testing services. Providers/counselors should follow local SOPs to determine when PLHIV are asked again about any new partners or previous partners that may not have been disclosed by the index client previously. That is, for Step 3 on 'Contacts Elicited', contacts may not be elicited all in one session with the HTS counselor. Elicitation may even continue into the next reporting quarter. • Some of the contacts tested in Step 4, may not have been part of the elicitation process in Step 2 and Step 3. For example, contacts may choose to come forward themselves after a discussion with the index client. Regardless, any contact who is tested for HIV should be counted under Step 4.

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

Retesting for verification of HIV positive status before or at antiretroviral (ART) initiation should not be counted under HTS_INDEX. Retesting for verification is primarily conducted as a quality assurance activity to avoid misdiagnosis and to ensure those initiated on ART are indeed HIV positive. Therefore, retesting for verification should only be conducted for persons who have received an HIV diagnosis, but have not yet been initiated on ART.
Clients who present for testing as the result of receiving a social network testing coupon or referral, but who identify as being a sexual and/or needle-sharing partner with an individual known to be living with HIV should be counted under HTS_INDEX and not under the HTS_TST SNS modality.

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

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

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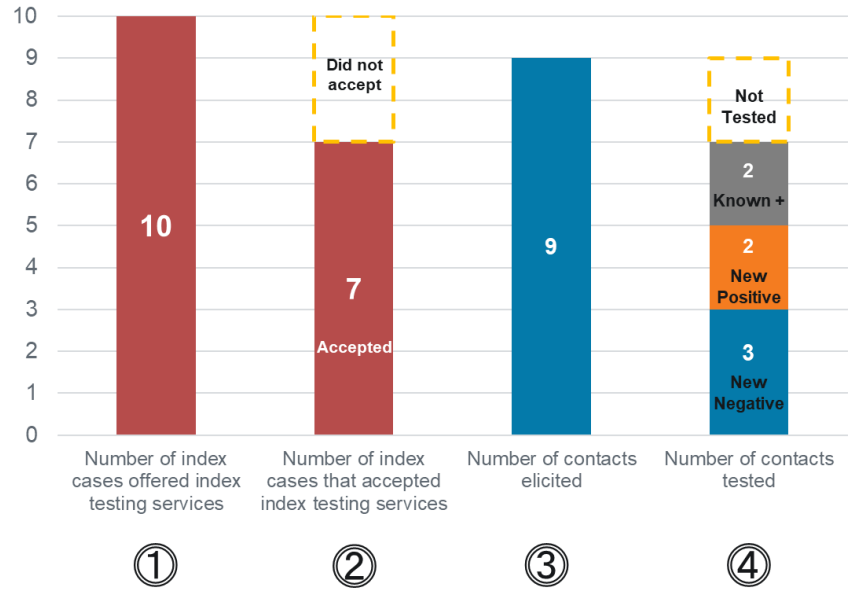
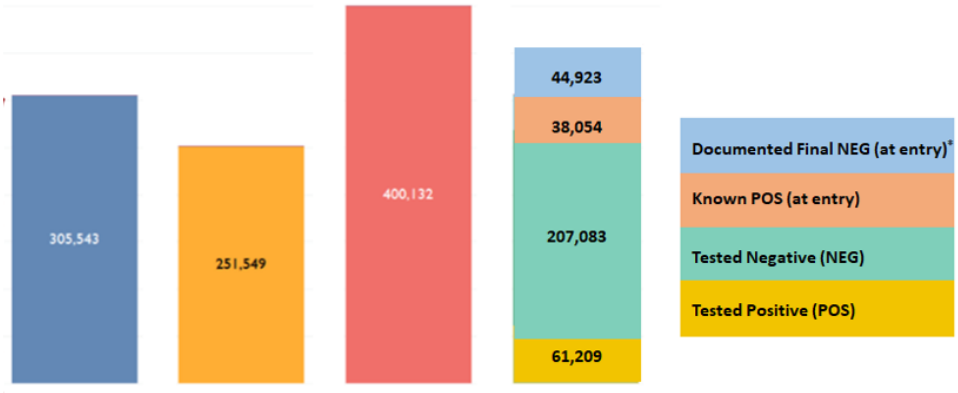
</td></tr>
</table>

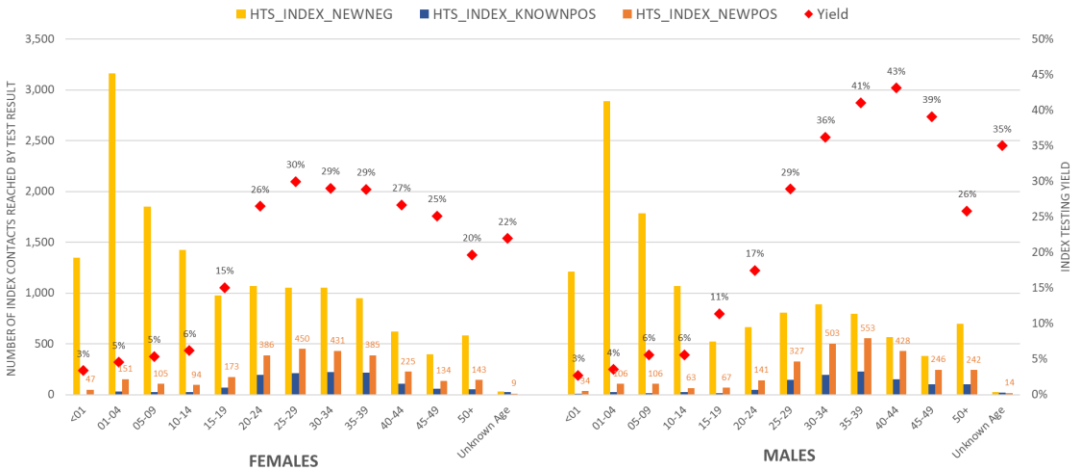
	Number of <u>contacts tested by test result</u> and age/sex [Required] ***<u>Underlined portions auto-populate into the INDEX HTS_TST modality.</u>***	• <u>New positives by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u> • <u>New negatives by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u> • Known positives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Documented negatives by: 1-4 F/M, 5-9 F/M, 10-14 F/M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	Please refer to the stepwise process outlined in the "how to use" and "how to collect" sections for more details.	
PEPFAR-support definition:	Standard definitions of DSD and TA-SDI apply. <u>For HTS services, direct service delivery includes</u>: ongoing procurement of critical HTS related commodities such as rapid HIV test kits or requisite materials (lancets, capillary tubes), samples and materials for proficiency testing, other HIV diagnostic commodities, or funding for salaries of HIV testing service providers including counselors, laboratory technicians, program managers, and/or community health workers. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>For HTS services, ongoing support for service delivery improvement includes</u>: clinical mentoring/supportive supervision, HTS training, HTS guidance development, routine support of HTS M&E and reporting, or HIV test kits consumption forecasting and supply management.	
Guiding narrative questions:	1. What are the challenges and facilitators to universally offering index testing services? Please address notable operational considerations with offering index testing to a) individuals newly diagnosed with HIV, and b) individuals previously diagnosed with HIV who are not virally suppressed.	
Data Visualization & Use Examples:	**Index Testing Cascade: Adults**  	

Index Testing Cascade: Children



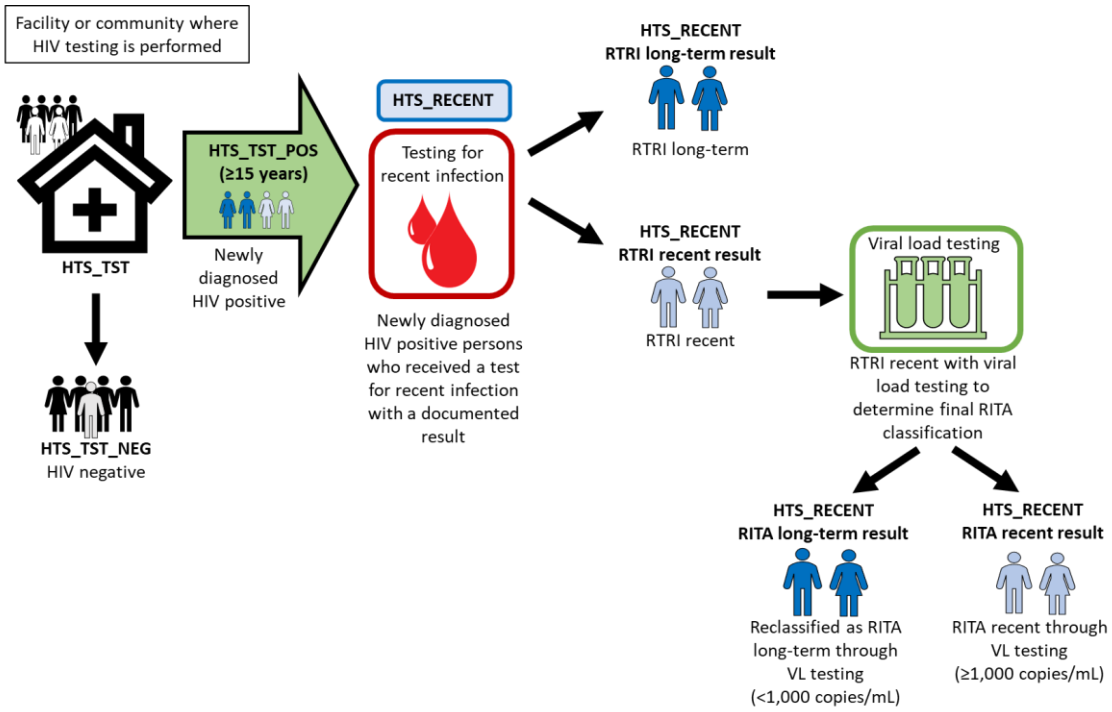
1. Number of index cases offered testing services
2. Number of index cases who accept testing services
3. Number of contacts elicited
4. Number of contacts tested

Results and Yield of Index Testing by Age and Sex:



HTS_RECENT

Description:	Number of newly diagnosed HIV-positive persons who received testing for recent infection with a documented result during the reporting period	
Numerator:	Number of newly diagnosed HIV-positive persons who received a test for recent infection with a documented result during the reporting period	HTS_RECENT should be reported alongside HTS_TST at facilities/communities where tests for recent infection have been incorporated as a supplemental test in addition to the country-approved HIV diagnostic testing algorithm
Denominator:	N/A	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added clarifying language throughout the reference sheet • Updated narrative questions	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	As countries progress toward epidemic control, surveillance of newly diagnosed persons will ensure that interventions target those at highest risk of acquiring or transmitting HIV infection. One approach is to identify recent HIV infections, defined as those acquired within approximately the last one year. Use of rapid tests for recent HIV-1 infection (RTRI) will facilitate the establishment of a surveillance system to quickly detect, monitor, and characterize recent infections among newly diagnosed HIV cases. Data from a recent infection surveillance system contributes to data-driven approaches to fine-tune a country's programmatic response through prioritized programming and resource allocation. Recommended use of this indicator is described below. For additional information on recent infection surveillance, please refer to the latest PEPFAR COP guidance on recent infection testing. Planning and implementation resources, including template protocol, SOPs, training materials, and tools available on the Tracking with Recency Assays to Control the Epidemic (TRACE) eLearning Hub. • **Surveillance:** Characterization of recent and long-term HIV infections will enable the identification of geographic areas and/or demographic groups that may benefit from intensified prevention and testing activities. Results may also be used to monitor epidemic trends over time. • **Public Health Program Response:** Monitoring the number and percentage of recent infections by facility and community can be used to identify areas with ongoing active transmission, in order to target and optimize HIV program services to interrupt disease transmission. Disaggregation by age, sex, modality, and key population type can further identify subpopulations at higher risk to inform program planning and implementation. Changes over time should be monitored to assess program impact. • **Program Implementation:** The indicator may be used to monitor the rollout of testing for recent infection. A crude estimate of testing coverage may be calculated using: HTS_RECENT by applicable age/sex bands divided by HTS_TST_POS by applicable age/sex bands. Note that this proxy coverage estimate may exceed 100% in areas where HIV testing is not directly supported by PEPFAR, however, recency testing coverage may still be monitored at sites where HTS results are available to assess program implementation and data quality. Tests for recent infection should be performed as a supplementary test for persons who are diagnosed with HIV-1 through the national HIV testing algorithm and consent to recency testing. The results of tests for recent infection should be used for surveillance purposes and should not determine clinical management of the individual or be used to prioritize tracing of contacts of newly diagnosed HIV positive individuals with recent HIV infection. Results may or may not be returned to patients depending on country context and policies, although PEPFAR ***does not*** recommend the return of the individual result to	

	the client, record, or provider. If results are returned to patients, counseling messages should be provided to explain the results and emphasize that HIV care and treatment will not differ based on recent infection status. Please see the diagram below that describes the HTS_RECENT flow in more detail. **HTS_RECENT Flow: Recent infection testing algorithm (RITA) – RTRI plus and viral load test** 
How to collect:	Data for this indicator is reported at both the facility and community levels. HTS_RECENT should be reported alongside HTS_TST at facilities and communities where tests for recent infection have been incorporated as a supplemental test to the country-approved HIV diagnostic testing algorithm. Only RTRI results from individuals should be reported. No quality control (QC) or proficiency panel results should be reported as an RTRI result. Even if the testing algorithm requires facility or community-based providers to refer specimens to a laboratory or hub facility for testing for recent infection, the indicator should be reported under the facility or community testing partner, ideally, where the client was initially diagnosed. This means that HTS_RECENT should be reported by the clinical service partner (or equivalent) supporting the facility or community where the client was initially diagnosed with HIV. Surveillance partners supporting recent infection surveillance may share aggregated findings with clinical service partners and stakeholders to promote program strengthening and tailored prevention efforts. Laboratory partners should share viral load results with clinical service partners to facilitate reporting. Electronic case-based surveillance systems that incorporate RTRI and RITA results may be used to collect and report data for this indicator. Tools specifically designed for RTRI and RITA results are another option to collect and report data. Country guidelines may vary in reference to the time point and setting at which testing for recent infection is conducted. HTS is recommended, but other service delivery points may be considered if the test for recent infection is conducted within a short period of initial HIV diagnosis. Ideally, the test for recent infection should be conducted at the same time as diagnosis.

<table>
<tr><td></td><td>If guidelines specify that viral load testing be conducted alongside the test for recent infection as part of a RITA, then these results should be recorded in addition to the RTRI results.
Because RITA results will take longer than RTRI, do not wait for RITA results to report the RTRI results. RITA results should be reported only during the same MER reporting period when the RTRI was conducted. This only applies to MER reporting; all RITA results should always be reported to national systems. Any RITA results that are missing or delayed due to prolonged turnaround time of VL testing should be outlined in the narrative and any RITA results that come in after the reporting period close can be added during the data cleaning period. Viral load testing should be incorporated at facilities/communities with ready access to viral load testing or sample referral networks but is not required at facilities/communities that do not have this infrastructure in place. When reporting on HTS_RECENT (RITA), be sure to only report viral load tests that are performed in the setting of recency surveillance and on RTRI recent samples.

Key Populations:
Information on tests for recent infection should be reported by key population (PWID, MSM, TG, FSW, and people in prison or other closed settings) where it is safe to collect this information.

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

Note: Both key population-specific and clinical partners should complete these disaggregations, but only if it is safe to maintain these files and report. Age and sex data on key populations receiving tests for recent infection will not be reported. Please refer to the KP_PREV indicator reference sheets for more information on working with key populations. The first priority of data collection and reporting of HTS_RECENT 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.</td></tr>
<tr><td>How to review for data quality:</td><td>• HTS_TST_POS (≥15 years) ≥ HTS_RECENT: The number of persons age ≥15 years who received HIV testing services and received a positive result should be greater than or equal to the number of persons who tested for recent infection. HTS_TST_POS may be less than HTS_RECENT in instances where only recency testing is PEPFAR-supported and HTS_TST_POS results are unavailable. At sites where HTS is not PEPFAR-supported, HTS_RECENT results should be compared with HTS results where available.
• HTS_RECENT (RTRI) > HTS_RECENT (RITA): The number of persons with an RTRI result should be greater than the number of persons with a RITA result through viral load testing. RITA results, if viral load testing is being done, should be reported as a subset of RTRI recent results.
• HTS_RECENT ≥ subtotal of key population disaggregates: The number of persons who tested for recent infection should be greater than or equal to the sum of the key population disaggregation group.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>Numerator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Modality and RTRI Result by Age/Sex (community-level reporting)
[Required]</td><td>• Index by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Mobile by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
</table>

		• SNS by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VCT by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Other community testing platform by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Modality and RTRI Result by Age/Sex (facility-level reporting) [Required]	• Index by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Emergency by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Inpatient by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • PMTCT [ANC1 only] by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • PMTCT [post ANC1: pregnancy/L&D/BF] by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • SNS by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • STI by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • TB by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VCT by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VMMC by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Other PITC by RTRI recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Modality and RITA Result by Age/Sex (community-level reporting) [Required if doing RITA]	• Index by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Mobile by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • SNS by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VCT by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M

		• Other community testing platform by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Modality and RITA Result through Viral Load Testing by Age/Sex (facility-level reporting) [Required if doing RITA]	• Index by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Emergency by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Inpatient by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • PMTCT [ANC1 only] by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • PMTCT [post ANC1: pregnancy/L&D/BF] by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • SNS by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • STI by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • TB by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VCT by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VMMC by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Other PITC by RITA recent or long-term result: 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	RTRI Result by Key Population Type [Required]	• RTRI recent by 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 • RTRI long-term by 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
	RITA Result through Viral Load Testing by Key Population Type [Required if doing RITA and data available]	• RITA recent by 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 • RITA long-term by people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), female sex workers (FSW), people in prison and other closed settings

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	• N/A

Disaggregate descriptions & definitions:

Modality

- Service delivery modalities can reflect a reason for testing (e.g., index, STI), as well as the location/place of testing (e.g., inpatient ward, VCT drop-in center). This should match the modalities used for HTS_TST reporting. Please refer to the HTS_TST indicator reference sheet for descriptions of the modalities.

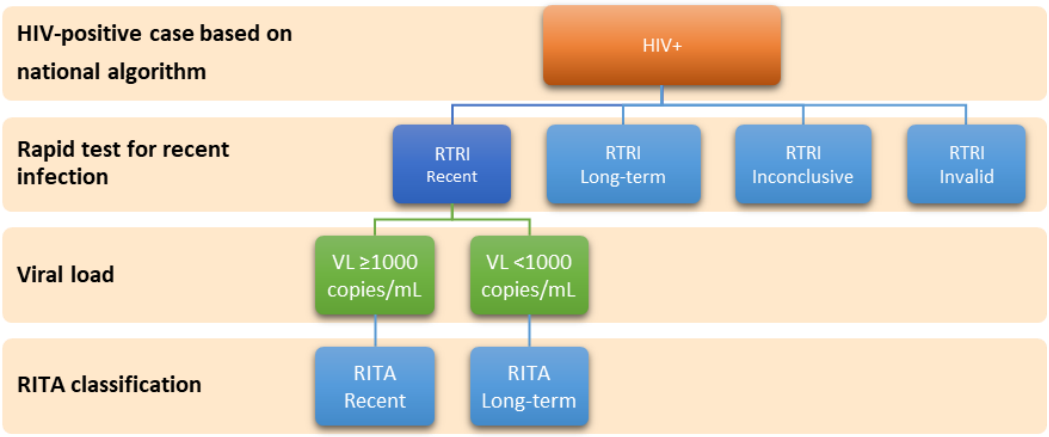
RTRI result

- RTRI refers to the rapid test for recent infection. All results from the RTRI should be reported regardless of viral load testing to determine recency uptake.
- Only RTRI results from individuals should be reported. No quality control (QC) or proficiency panel results should be reported as an RTRI result.
- A recent result on the RTRI means that the person was likely infected within the last one year. Viral load testing should be used to reduce misclassification of RTRI recent results.
- A long-term result on the RTRI means that the person was likely infected more than one year ago. This is the final result and does not require additional testing.
- The RTRI may produce two other results: invalid and inconclusive. These results should not be reported for this indicator but should be captured in the country's recent infection surveillance database for monitoring purposes. In the event of an invalid or inconclusive result, please follow the country's established procedures for dealing with these results (e.g., retesting, reporting, quality control, etc.).

RITA result

- Viral load testing, as part of a recent infection testing algorithm (RITA), is highly recommended to maximize the accurate identification of recent infections. Persons who receive viral load testing should be reported as a subset of those reported under RTRI recent.
- A RITA recent result refers to a person with an RTRI recent result and a viral load result of ≥1,000 copies/mL and therefore has a final classification of recent.
- A RITA long-term result refers to a person with an RTRI recent result but a viral load result of <1,000 copies/mL and therefore has a final classification of long term.

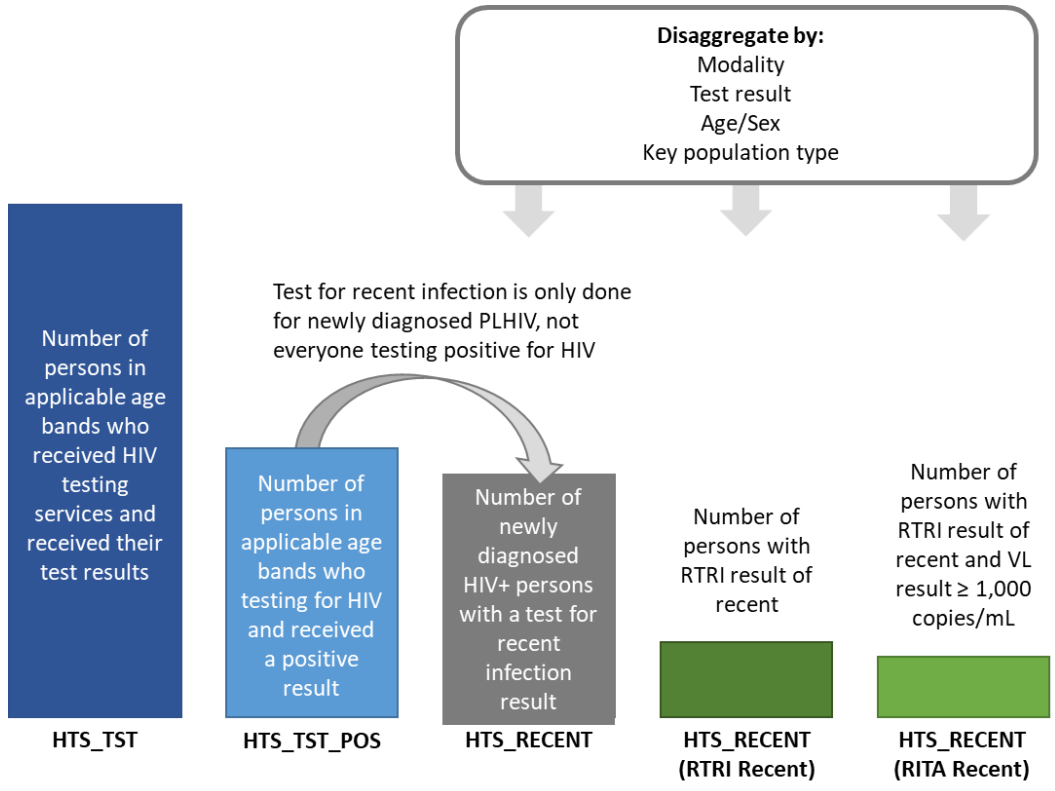
Recent infection testing algorithm (RITA)



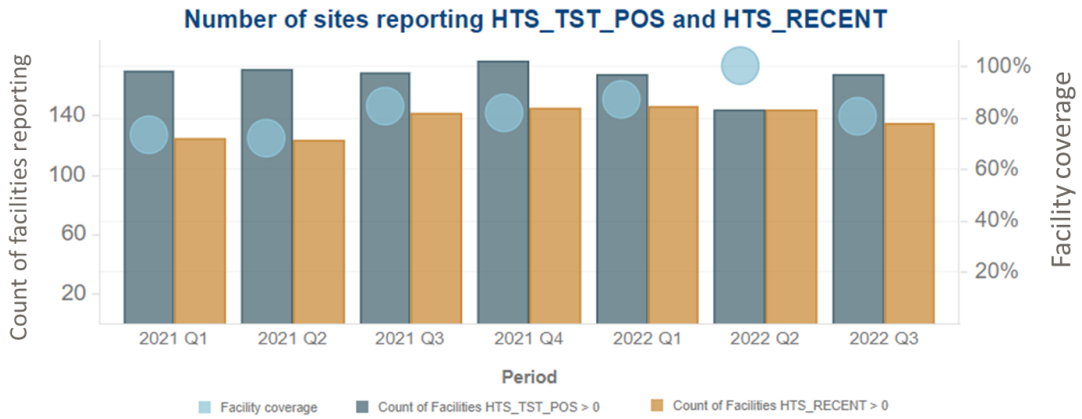
PEPFAR-support definition:

Standard definitions of DSD and TA-SDI apply.

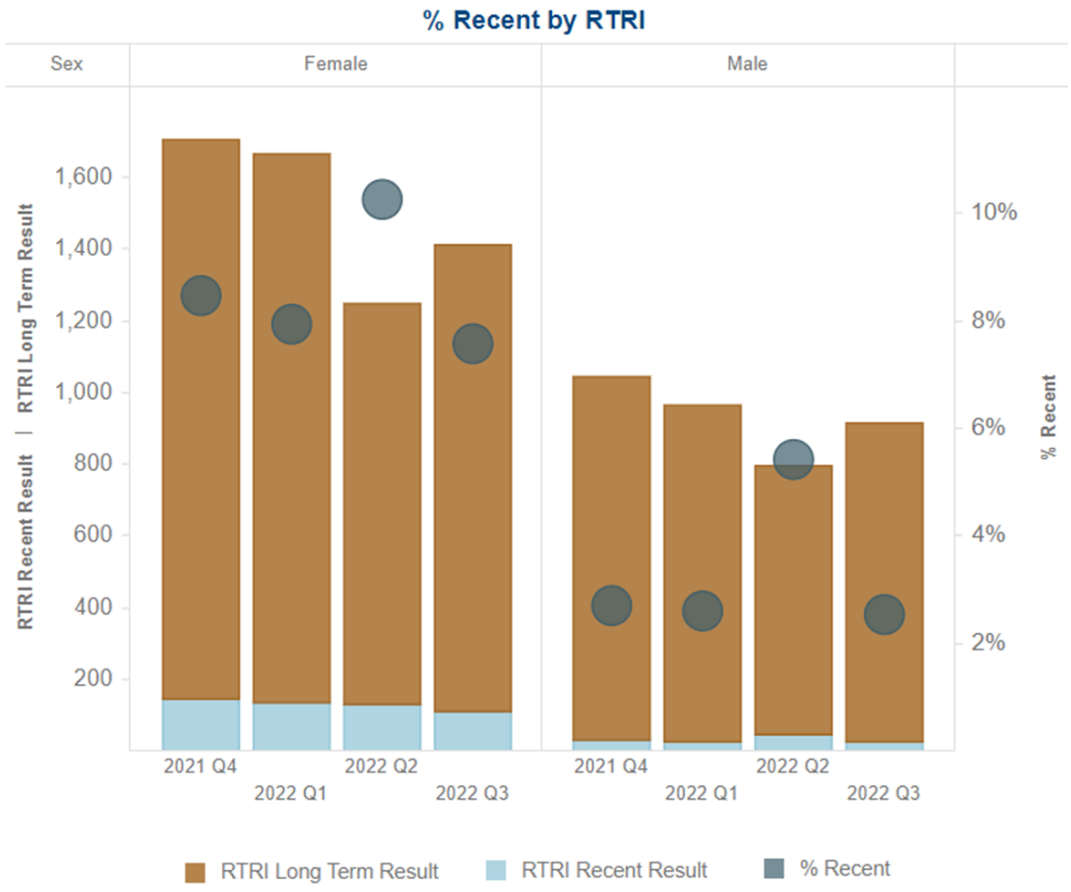
For HTS services, direct service delivery includes: ongoing procurement of critical HTS related commodities such as rapid HIV test kits or requisite materials (lancets, capillary tubes), samples

	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. <u>For HTS services, ongoing support for service delivery improvement includes</u>: clinical mentoring/supportive supervision, HTS training, HTS guidance development, routine support of HTS M&E and reporting, or HIV test kits consumption forecasting and supply management.
Guiding narrative questions:	1. As testing for recent infection is being scaled, please describe the stage/scope of implementation (SNUs, sites, populations, etc.). Please describe any interruptions to implementation in this quarter and how this might have affected HTS_RECENT results. 2. If viral load testing is being done to determine RITA classification, please explain if the total number of people who received VL testing does not equal the number reported under RTRI recent. Include the number of RITA results that are missing or unavailable. Note that due to turnaround time, viral load results may be delayed, and RTRI results should be reported regardless of whether viral load results are available. 3. If HTS_RECENT does not equal HTS_TST_POS (≥15 years) for the sites/populations doing testing for recent infection, please explain why. Note that newly diagnosed PLHIV infected with HIV-2 who are not co-infected with HIV-1 should not be tested for recent infection. 4. Please investigate and explain how recency results from MER reporting compare to in-country recency data (from country dashboards where available).
Data Visualization & Use Examples:	**HIV Recency Testing Cascade:** 

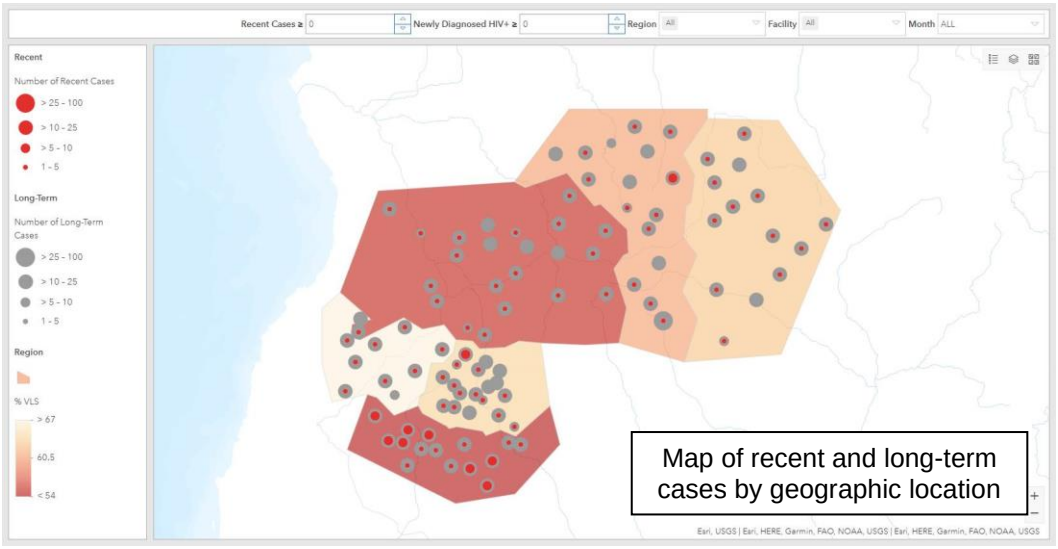
Facility HTS_RECENT Coverage:



Test for Recent Infection Results by Sex



Mapping Recent Infections:



Map of recent and long-term cases by geographic location

HTS_SELF

Description:	Number of individual HIV self-test kits distributed	
Numerator:	Number of individual HIV self-test kits distributed	This indicator aims to monitor trends in the distribution of HIV self-test kits within a country at the lowest distribution point.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Strengthened language regarding the use of HIVST within pediatric populations. • Updated narrative questions.	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This is the first MER indicator to monitor PEPFAR programming of HIV self-testing approaches and distribution HIV self-test kits. HIV self-testing (HIVST) 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. Select HIVST assays may also be used by an adult to help screen a child for HIV, and it is important that HIVST assays are only used in populations for which the specific assay has been validated and in accordance with national HTS guidelines. HIV self-testing approaches include unassisted self-testing and directly assisted self-testing (see "Disaggregate descriptions and definitions"). Self-test kits can be distributed in various ways (e.g., 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, clients of FSWs, and parents or caregivers of children ≥ 2 years of age with an unknown HIV status). 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 (e.g., men, adolescents/young adults, and key populations), or where there are barriers to HIV testing and achievement gaps for the 1st 95 (e.g., children).	
How to collect:	The suggested data source is a (newly developed) HIVST 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, logbooks, 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., for themself, for their partner(s), for their child(ren) ≥ 2 years of age, etc.). **Data for the numerator should be generated by counting the number of individual HIV self-test kits distributed, and <u>NOT</u> the number of individuals receiving an HIV self-test kit.** Number of self-test kits distributed should be captured and reported at the lowest distribution point. The lowest distribution point refers to the individual/site distributing 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 HIVST kits to give out during an outreach event. The outreach workers return from their event having distributed 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 HIVST kits distributed is 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 (e.g. self, sex partner, other) in the unassisted model. The findings can support national government and PEPFAR programs assess how effective 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. **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 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 three additional test kits along with her: one for her sex partner, one for her friend to use at a later time, and one to screen her biological child. These three test kits would be counted as unassisted. For the age/sex breakdown under unassisted, three (3) tests would go in the 15-19-year-old female age band because three tests were distributed to the female in that age band. 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 '2' in the 'other' disaggregate to account for the test she planned to distribute to her friend and the test she planned to use to screen her biological child. 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: 1. The type of self-testing (i.e., directly assisted vs. unassisted), and 2. Age/sex demographic information for test kits distributed using the directly assisted self-testing model will as these individuals should have received an in-person HIV test kit demonstration and demographic information should be collected at that time. Implementing partners should ensure that HIVST users receive materials on how they can access, at their discretion, confirmatory testing or be linked to enhanced prevention, such as PrEP. Implementing partners, and their sub-recipients, should emphasize strategies that maximize the distribution of HIVST to hard(er)-to-reach populations and minimize barriers to acceptance, such as requiring contact information or follow up activities that do not allow for anonymity. 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.

<table>
<tr><td>How to review for data quality:</td><td>Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues. For example, the number of test kits distributed should not be greater than the number of test kits a provider was allocated during the reporting period. Careful attention is required regarding the number of HIVST kits distributed through pharmacies and online platforms.

Implementing partners should review their data to ensure that HTS_SELF is not reported under HTS_TST (or HTS_TST_POS) results. Furthermore, data should be reviewed to ensure the numerator does not include the number of HIV self-tests performed or used, nor a definitive diagnosis (rapid HIV diagnostic tests should be reported under HTS_TST).

The “directly-assisted” disaggregate should be reviewed to see if additional information was collected related to: 1) test result (negative or reactive) and 2) linkage for repeat testing to confirm a reactive self-test result. While not required for this indicator, this information should be collected by implementing partners as part of routine program monitoring.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Type of self-testing [Required]</td><td>• Directly-assisted
• Unassisted</td></tr>
<tr><td>Number of Test Kits Distributed to a Person by Age/Sex
[Required for Directly Assisted; Optional for Unassisted]</td><td>• Directly-assisted by: 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Unassisted by: 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of Test Kits Distributed to Key Populations
[Optional for both Directly Assisted and Unassisted]</td><td>• People who inject drugs (PWID): Directly-assisted, Unassisted
• Men who have sex with men (MSM): Directly-assisted, Unassisted
• Transgender people (TG): Directly-assisted, Unassisted
• Female sex workers (FSW): Directly-assisted, Unassisted
• People in prison and other closed settings: Directly-assisted, Unassisted</td></tr>
<tr><td>Test kit distributed for use by [For Unassisted Only; Reporting Optional if data are available]</td><td>• Unassisted self-testing by:
○ Self
○ Sex Partner
○ Other</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Type of self-testing:
• According to WHO, “Directly assisted HIV self-testing (HIVST): refers to when individuals who are self-testing for HIV receive an in-person demonstration from a trained provider or peer before or during HIVST, with instructions on how to perform a self-test and how to interpret the self-test result. This assistance is provided in addition to the manufacturer-supplied instructions for use and other materials found inside HIVST kits” (WHO, 2016).
• According to WHO, “Unassisted HIV self-testing refers to when individuals self-test for HIV using only a self-test kit that includes manufacturer-provided instructions for use. As with all self-testing, users may be provided with links or contact details to access additional support, such as telephone hotlines or instructional videos” (WHO,</td></tr>
</table>

	2016) • In addition to reporting the total number HIV self-test kits distributed to individuals, the HTS_SELF indicator includes several disaggregates to characterize aspects of distribution. **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 (including biological children),friend, etc.)
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for the distribution of HIVST kits includes</u>: ongoing procurement of HIVST kits or funding for salaries of providers who distribute or directly assist with HIVST including counselors, laboratory technicians, program managers, and community health workers. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>For HIVST, ongoing support for service delivery improvement includes</u>: clinical mentoring/supportive supervision, HIVST training, HIVST guidance development, site level QI/QA, routine support of HIVST M&E and reporting, or HIVST kit consumption forecasting and supply management.
Guiding narrative questions:	1. Describe the process/methods and challenges for tracking distribution of test kits. 2. Describe the extent to which HIVST is being used to improve HIV case finding among children. 3. Describe the extent to which HIVST is being used within HIV prevention programs. 4. Describe the system(s) in place, as well as challenges, for collecting and reporting data on distribution of HIVST kits for prevention programming (e.g., PrEP, DREAMS, VMMC, PMTCT, OVC).

HTS_TST (including HTS_TST_POS)

Description:	Number of individuals who received HIV Testing Services (HTS) and received their test results	
Numerator:	Number of individuals who received HIV Testing Services (HTS) and received their test results	The numerator captures the number of individuals who received HIV Testing Services (HTS) and received their test results. At a minimum, this means the person was tested for HIV and received their HIV test results
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Clarified that presumptive and diagnoses should be reported for the TB modality. • Clarified guidance for testing for children <1 year of age. • Clarified guidance for index testing of biological children. • Clarified guidance around malnutrition modality. • Updated narrative questions.	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This indicator is intended to monitor trends in the uptake of HTS (regardless of the service delivery modality and population group) within a country. The disaggregation by test result provides information about the proportion of persons testing HIV seropositive and the effectiveness of HTS programs in identifying people living with HIV (PLHIV) over time. Further disaggregations are intended to monitor access to and uptake of HTS by population (age, sex, and test result), HTS setting and service delivery modality. The findings can support national governments and PEPFAR programs to determine the coverage and identify gaps in HTS services. These data may also be useful for projecting programmatic commodities and system needs such as HIV test kits and other staffing resources, although the numerator reflects the number of individuals tested, not the number of tests performed. Please reference the WHO Consolidated Guidelines on HIV Testing Services for information "relevant to the provision of HTS and…issues and elements for effective delivery of HTS that are common in a variety of settings, contexts and diverse populations".	
How to collect:	Existing HTS registers, logbooks, and reporting forms already in use to capture HTS can be revised to include the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems, and non-governmental organization records. Data for the numerator should be generated by counting the total number of individuals who received HTS and their test results. Note: Although several other MER indicators (see below) may report on the HIV status of individuals, actual testing of individuals must be reported under HTS_TST. Thus, any persons who are newly tested as part of the programs linked to the indicators listed below (i.e., PMTCT, TB, VMMC, Prevention services) must be reported under one of the HTS_TST modalities, unless otherwise indicated below. • PMTCT_STAT (data from PMTCT_STAT auto-populates to HTS_TST PMTCT ANC1-Only modality) • TB_STAT (data from TB_STAT auto-populates to HTS_TST TB modality) • VMMC_CIRC (data from VMMC_CIRC auto-populates to HTS_TST VMMC modality) • HTS_INDEX (data from HTS_INDEX auto-populates to HTS_TST Index modality) • PrEP_CT • PP_PREV • KP_PREV • OVC_HIVSTAT	

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

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

For children <1 year of age: Confirmed diagnosis of HIV infection in children < 18 months of age requires virologic, and ***not*** serologic, tests. Therefore, the general expectation is for there to be no results under the HTS_TST <1 age disaggregate. Implementing partners should report HIV virologic testing of HIV-exposed infants under PMTCT_EID and as appropriate, PMTCT_HEI_POS. Any (limited) use of serologic diagnostic assays should be reported under the appropriate HTS_TST age and sex disaggregates.

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

Key Populations (KPs):
Provision of information (tested, tested positive, tested negative) on KPs (FSW, MSM, transgender people, PWID, and people in prisons and other closed settings) who were tested and received their results should be reported under the KP disaggregates. However, the KP disaggregate is NOT an HTS_TST modality. All KP testing should be reported under the appropriate HTS modality. **For example**, a community site keeps secure and safe records of all key populations tested at that site. This community site has determined it can report on the KP disaggregate in a safe and confidential way. Of the 100 individuals who were identified as KP, and who were tested and received their results (including confirmation of diagnosis) at this site, the community site reports 100 under the appropriate modality (in this case, VCT) AND reports 100 under the KP disaggregate.

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

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

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

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

Data Systems and Tools

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

1. This indicator counts the number of individuals tested and **not** the number of tests conducted. All efforts should be made to ensure data are collected on individuals tested vs. number of tests conducted through de-duplication. Within HTS registers, collecting data on the following variables should be considered to help in these efforts:
    a. Retesting status: new tester, re-tester (i.e., tested in the last 3 months), retesting to verify an HIV-positive diagnosis before ART initiation
    b. HIV testing services - *HIV test results, date of HIV test, receipt of HIV test results, previously tested during the reporting period
    c. Demographic - Client's Unique ID, name, *sex, and *age at time of HTS services
    d. Date HIV-positive individual was linked to treatment
    e. Site - *site name and ID, district, region, province, and *service delivery modality
2. Using unique identifiers for individuals is one way to account for retesting and avoid double reporting if electronic systems are available to easily link data through these unique identifiers. Another approach is to record information about prior testing on the HTS client register.
3. For an individual to be counted under HTS_TST, their HIV diagnosis must be confirmed using a nationally validated testing algorithm. For example, an HIV-positive rapid HIV test performed at the community- or facility- level must be confirmed with a second test, which may be performed at the same site or at a different facility. If the confirmatory test is performed at a different facility, then this may entail follow-up by implementing partners to confirm the diagnosis before reporting on this indicator. The implementing partner who first identified and tested the individual should report on HTST_TST under the appropriate modality; however, that implementing partner must ensure that the diagnosis of the individual tested is confirmed. That is, only a confirmed diagnosis (positive or negative) counts under HTS_TST regardless of the modality used for reporting. Similarly, simply only confirming the diagnosis of an individual who has already been tested (as per the national testing algorithm) does not fulfill the requirements for reporting on HTS_TST regardless of the modality used.
4. Note: Retesting for verification of HIV positive status before or at antiretroviral (ART) treatment initiation is only done for persons who have already been diagnosed HIV-positive as per the national HIV testing guidelines. All clients diagnosed HIV-positive should be retested for verification before or at ART initiation with a new specimen and preferably a second operator using the same national HIV testing strategy. Retesting for verification is primarily done as a quality assurance activity to avoid misdiagnosis and to ensure those initiated on ART and treatment services are indeed HIV positive. Thus, HIV testing conducted to verify status should not be counted under HTS_TST, since

<table>
<tr><td></td><td colspan="2">their initial HIV diagnosis will have already been counted at the point of the initial receipt of the HIV diagnosis (as per the national HIV testing guidelines).
5. Patient level Deduplication: adding “has patient been tested in the last 3 months” to the HTS facility and community registers can help implementing partners de-duplicate at the reporting level.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Only one age disaggregation type is used for age/sex/test result received:
The number of individuals newly receiving ART must be disaggregated by age and sex.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum results across quarters.</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>HTS Modality and Result by Age/Sex (Community-Level HTS Reporting) [Required]

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

<u>Underlined modalities auto-populate for their respective parent indicators.</u></td><td>• <u>Index (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</u>
• Emergency (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Inpatient (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
• Malnutrition (by Positive/Negative result) by: <1 F/M, 1-4 F/M
• Pediatric <5 Clinic (by Positive/Negative result) by: <1 F/M, 1-4 F/M
• <u>PMTCT [ANC1-Only] (by Positive/Negative result) by: <1 F, 1-4 F, 5-9 F, 10-14 F, 15-19 F, 20-24 F, 25-29 F, 30-34 F, 35-39 F, 40-44 F, 45-49 F, 50+ F, Unknown Age F</u>
• PMTCT [Post ANC1: Pregnancy/L&D/BF] (by Positive/Negative result) by: <1 F, 1-4 F, 5-9 F, 10-14 F, 15-19 F, 20-24 F, 25-29 F, 30-34 F, 35-39 F, 40-44 F, 45-49 F, 50+ F, Unknown Age F
• SNS (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-</td></tr>
</table>

		34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • STI (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • TB (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • VCT (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • TB (Positive/Negative): <1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15_19 F, 20-24 M, 20-24 F, 25-29 M, 25-29 F, 30-34 M, 30-34 F, 35-39 M, 35-39 F, 40-49 M, 40-49 F, 50+ M, 50+ F; • VMMC (by Positive/Negative result) by: <1 M, 1-4 M, 5-9 M, 10-14 M, 15-19 M, 20-24 M, 25-29 M, 30-34 M, 35-39 M, 40-44 M, 45-49 M, 50+ M, Unknown Age M • Other PITC (by Positive/Negative result) by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
	Result by Key Population Type [Required]	• People who inject drugs (PWID) by Positive/Negative • Men who have sex with men (MSM) by Positive/Negative • Transgender people (TG) by Positive/Negative • Female sex workers (FSW) by Positive/Negative • People in prison and other closed settings by Positive/Negative
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	**Disaggregates: Service Delivery Modality** In addition to reporting the total number of individuals tested and receiving their test results and the total type of test results received (negative, positive), HTS_TST data should be disaggregated by service delivery modality, and then also by age/sex/test result within each service delivery modality. Service delivery modalities can reflect a reason for testing (index, SNS, STI), as well as the location/place of testing (e.g., inpatient ward, VCT drop-in center). For example, STI, Index, and SNS in this context refer to a reason a person is seeking or being offered an HIV test - e.g., the person suspects he/she may have an STI, or the person is a contact of an index client or a member of a key population (see modalities below for more details). Reporting the reason for testing (STI, index, or SNS), takes precedence over the location or setting (inpatient, VCT, drop-in center) where an individual is tested. Contacts of index clients should be reported under Index (either facility or community in accordance with where index testing services were delivered) if the index client agreed to index testing services and the contact that returned for testing is one of the contacts listed during the elicitation process. Index testing should only be used to refer direct contacts (i.e., sexual partners, needle-sharing partners, and biological children (< 19 years of age), and biological siblings of pediatric index clients) while SNS can be used to recruit direct contacts as well as other high-risk individuals who do not meet the definition of a direct contact. If the index client agrees to SNS in addition to index testing services, a system to track those referrals must be implemented to properly report those contacts under the index testing or SNS modality. Index testing should take precedence over SNS if	

the individual tested was listed as a contact during the elicitation process. A single person should only be counted once under any given modality.

Service delivery modalities are defined as:

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

A. **Index:** Importantly, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information). Index testing, also referred to as partner testing/partner notification services, is an approach whereby the exposed contacts (i.e., sexual partner(s), biological child(ren) < 19 years of age, biological siblings of pediatric index clients and anyone with whom a needle was shared) of an HIV-positive person (i.e., index client), are elicited and offeredHIV testing services. That is, in this context, index testing refers to any HIV testing of contacts of an index client (i.e., a known positive).

Only the following persons count as contacts:

f. Current or past sexual partner(s)
g. Biological children (<19 years of old). Biological children reported under HTS_INDEX should only include:
    - Biological children of an HIV-positive mother, and/or
    - Biological children of male index clients (fathers) when the biological mother is HIV-positive, she is deceased, or her HIV status is not known, not documented, or unable to be obtained.
h. Biological parents (if the index client is a child)
i. Biological siblings of pediatric index clients
j. Anyone with whom a needle was shared.

It is important to offer timely HIV testing to biological children of women with an unknown HIV status (i.e., do not delay the child's HIV test to first reach and test the biological mother). It is also imperative to offer HIV testing to children whose biological mothers with HIV or unknown HIV status have died. If the index client is the child, his/her biological mother should be tested, and if positive or deceased, the father should be tested as well. In addition, all biological siblings of the index child should be offered HIV testing services.

In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease, and every newly identified positive becomes a subsequent index client from whom to elicit contacts. While testing the contacts of an index client may occur in mobile, VCT or other community testing venue, this testing should be reported under HTS_INDEX. That is, if an individual could be reported under both HTS_INDEX and another HTS_TST modality, that individual should only be reported once under HTS_INDEX. Again, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information).

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

C. **SNS (Social Network Strategies):** Social network strategies are a set of distinct case-finding approaches that use individuals' high-risk network connections to refer individuals for HIV testing. These approaches, which include enhanced peer outreach approach (EPOA), leverage social, sexual, and drug- using relationships or behaviors to reach high risk and hidden individuals who may benefit from HIV testing that may otherwise not be captured under traditional testing modalities (e.g., VCT, PITC, or index testing). Programs that have used other modalities (i.e., VCT, Other Community, index testing) to previously report SNS should now report individuals referred for HIV testing

via a referral under the SNS modality. Individuals who agree to both index testing and SNS should be carefully tracked to ensure accurate reporting. If a named contact elicited via the index testing process returns with an SNS coupon the contact should be reported under index testing (either facility or community). For example, a newly diagnosed individual agrees to index testing services and shares information about Partner 1 and Partner 2. The provider also offers SNS, and the index client agrees to recruit individuals in their network. Partner 2 returns to the testing site and has a coupon that is used for SNS. The provider would record Partner 2 as index testing, not SNS, since this is one of the contacts that the index client identified during the elicitation process. Note: if a site only conducts anonymous testing, the site should report the test as SNS if client returns with a coupon.

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

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

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

A. Index: Importantly, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX reference sheet for more information). Index testing is an approach whereby the exposed contacts (i.e., sexual partners, biological children (< 19 years of age), biological siblings of pediatric index clients, and anyone with whom aneedle was shared) of a person living with HIV (i.e., index client), are elicited and offeredHIV testing services. That is, in this context, index testing refers to any HIV testing of contacts of an index client (i.e., a known positive).

Only the following persons count as contacts:

a. Current or past sexual partner(s)
b. Biological children (<19 years of old). Biological children reported under HTS_INDEX should only include:
    - Biological children of an HIV-positive mother, and/or
    - Biological children of male index clients (fathers) when the biological mother is HIV-positive, she is deceased, or her HIV status is not known, not documented, or unable to be obtained.
c. Biological parents (if the index client is a child)
d. Biological siblings of pediatric index clients
e. Anyone with whom a needle was shared.

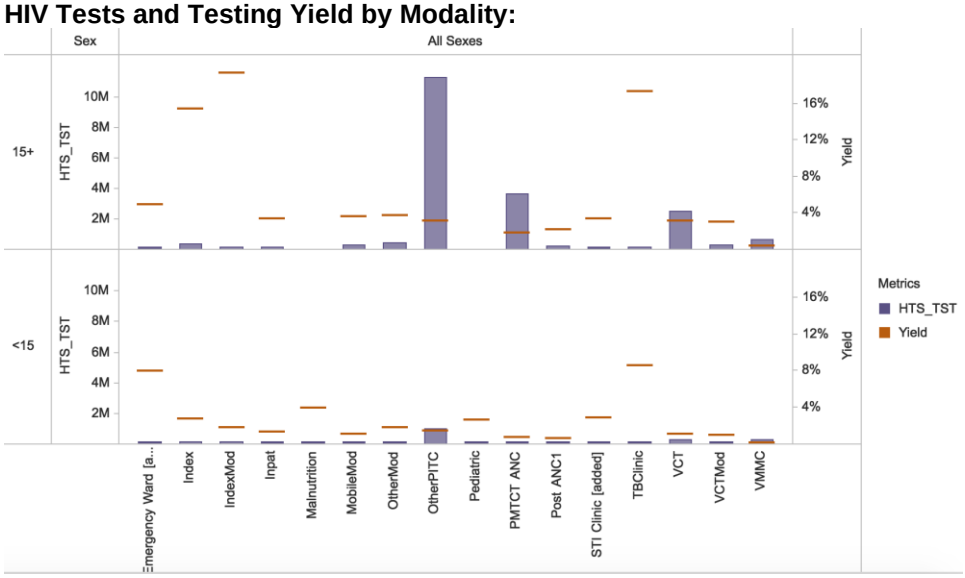
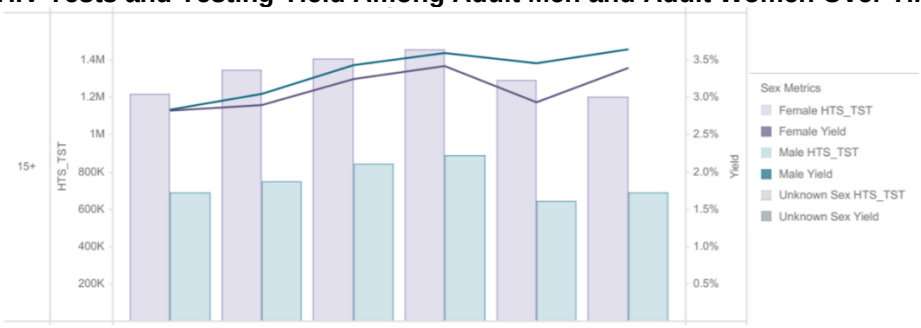
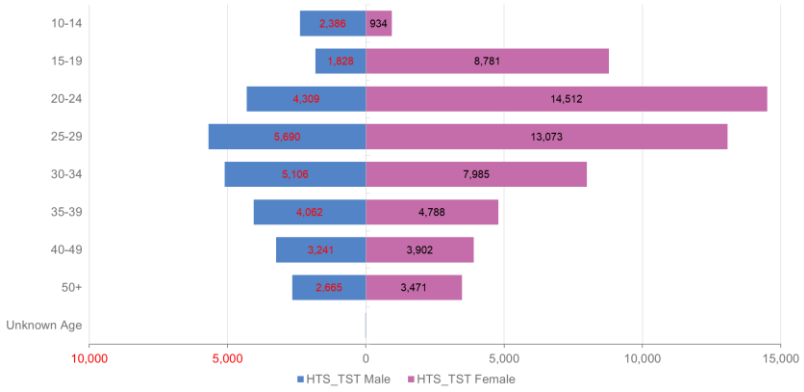
It is important to offer timely HIV testing to biological children of women with an unknown HIV status (i.e., do not delay the child's HIV test to first reach and test the biological mother). It is also imperative to offer HIV testing to children whose biological mothers with HIV or unknown HIV status have died. If the index client is the child, his/her biological mother should be tested, and if positive or deceased, the father should be tested as well. In addition, all biological siblings of the index child should be offered HIV testing services.

In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease, and every newly identified positive becomes a subsequent index client from whom to elicit contacts. While testing the contacts of an index client may occur in mobile, VCT or other community testing venue, this testing should be reported under HTS_INDEX. That is, if an individual could be reported under both HTS_INDEX and another HTS_TST modality, that individual should only be reported once under HTS_INDEX. Again, the index modality under HTS_TST will auto-populate from HTS_INDEX (see HTS_INDEX

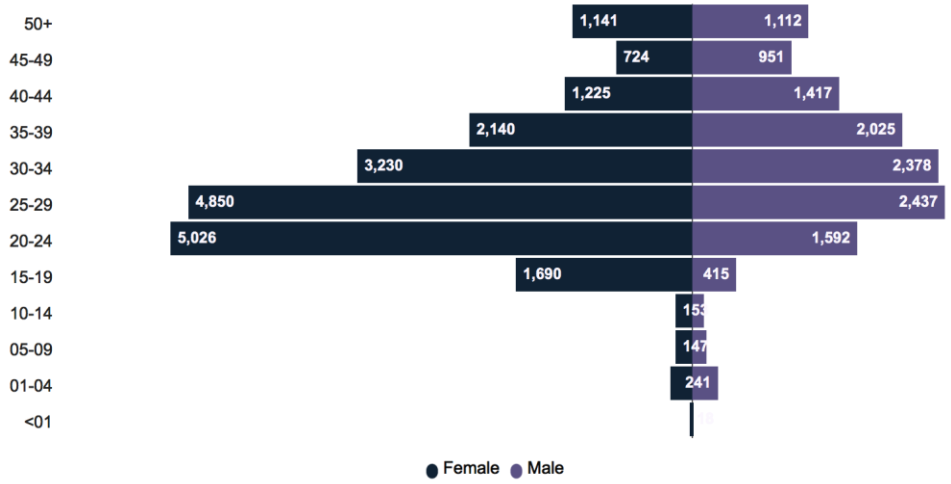
reference sheet for more information).

F. Provider Initiated Counseling and Testing (PITC):
   a. **Emergency:** Includes persons tested or seen in a designated emergency department or ward for the immediate care and treatment of an unforeseen illness or injury.
   b. **Inpatient:** Includes PITC occurring among those patients admitted in the inpatient and surgery wards.
   c. **Malnutrition:** Clinics and inpatient wards predominately dedicated to the treatment of malnourished children. Many children with malnutrition are routinely identified through well child clinics, when they have poor growth* (stunting, wasting, underweight / "falling off the growth curve") and/or a concerning mid-upper arm circumference (MUAC) measurement (Refer to WHO Malnutrition Guidance for more information). All children identified with growth problems should receive HIV testing and evaluation for TB with documentation under the respective MER indicator. 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 if the reason they were referred for HIV testing was due to growth problems. However, the biological children of female index cases should be classified under the appropriate index testing modality if the parents'/siblings' HIV-positive status was the reason they were referred for HIV testing.
   d. **Pediatric <5 Clinic:** Includes PITC occurring in the pediatric <5 clinic only. This modality refers only to children tested in the <5 clinic. Children tested for any other reason should be counted under the respective modality where their testing occurred. Note that this modality does **not** include virologic testing, which is reported under PMTCT_EID, nor rapid HIV testing used to identify HIV exposed infants. This modality should also not include children of index cases who should be classified under the Index modality or malnourished children who should be classified under Malnutrition.
   e. **PMTCT (ANC1 Only):** Pregnant women tested at their 1st antenatal care clinic (ANC) for their current pregnancy (who are also reported under PMTCT_STAT) are reported under this modality. Refer to PMTCT_STAT reference sheet for guidelines on data collection. Individuals counted under PMTCT_STAT who already knew their status should not be reported under HTS_TST.
   f. **PMTCT (Post ANC1: Pregnancy/L&D/BF):** Includes pregnant or breastfeeding women who receive a first test **or** retest after ANC1 ("Post ANC1"), including women who are tested later in pregnancy (>ANC2), during labor & delivery (L&D), and while breastfeeding.
   g. **STI:** Includes persons seen in a designated STI clinic as well as patients seen in the OPD for STI symptoms. This includes suspect and confirmed STI cases. HIV testing may take place in an STI clinic, an OPD, a co-located VCT or other setting. However, if the reason for the HIV testing is the individual is either a suspect or confirmed STI case, then the test should be reported under the STI modality.
   h. **TB:** Includes persons referred for HIV testing because they have presumed or diagnosed TB. Refer to TB_STAT for guidelines on data collection for TB. Individuals counted under TB_STAT who already knew their status should **not** be reported under HTS_TST.
   i. **Other PITC:** This includes any other provider-initiated testing and counseling that is not captured in one of the other testing modalities listed above. For reporting purposes, this includes testing of patients triaged to other clinics within the OPD that see patients for routine/chronic care (i.e., eye, dental, dermatology, diabetes, etc.). This does **not** include patients seen in the OPD for emergency care or an STI. Those patients should be classified under the emergency and STI modalities, respectively.

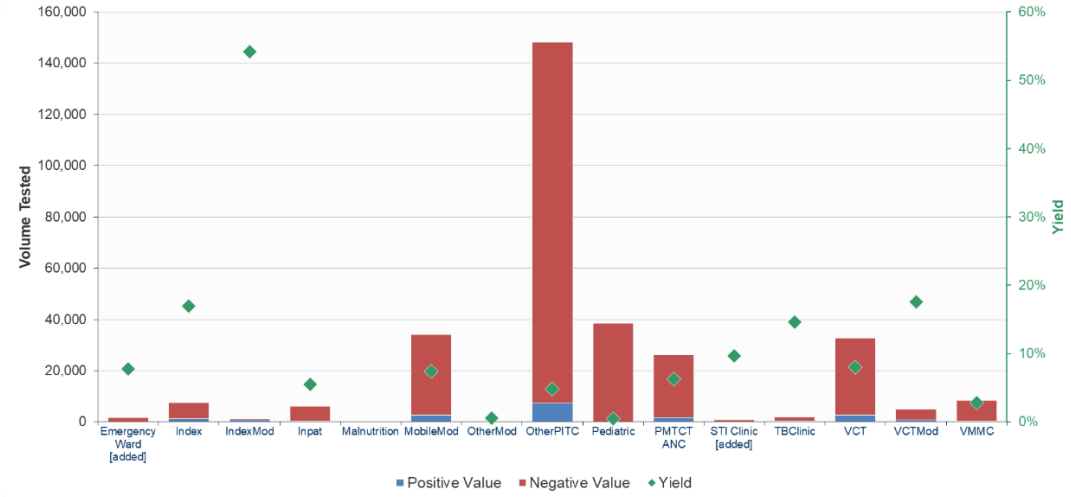
	G. **SNS (Social Network Strategies):** Social network strategies are a set of distinct case-finding approaches that use individuals' high-risk network connections to refer individuals for HIV testing. These approaches, which include enhanced peer outreach approach (EPOA), leverage social, sexual, and drug- using relationships or behaviors to reach high risk and hidden individuals who may benefit from HIV testing that may otherwise not be captured under traditional testing modalities (e.g., VCT, PITC, or index testing). Programs that have used other modalities (e.g., VCT, other community, index testing) to previously report SNS should now report individuals referred for HIV testing via a referral under the SNS modality. Individuals who agree to both Index testing and SNS should be carefully tracked to ensure accurate reporting. If a named contact elicited via the index testing process returns with an SNS coupon the contact should be reported under index testing (either facility or community). For example, a newly diagnosed individual agrees to index testing services and shares information about Partner 1 and Partner 2. The provider also offers SNS and the index client agrees to recruit individuals in their network. Partner 2 returns to the testing site and has a coupon that is used for SNS. The provider would record Partner 2 as index testing, not SNS, since this is one of the contacts that the index client identified during the elicitation process. Note: if a site only conducts anonymous testing, the site should report the test as SNS if client returns with a coupon. H. **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. I. **VCT:** Refers to a clinic specifically intended for HIV testing services that is co-located within a broader health care facility. This data can typically be found in the VCT register. **This should not include testing of patients referred by providers from other clinical services within the facility (TB, ANC, Inpatient, emergency, etc.). Even though the actual test may be administered in the VCT clinic, report those individuals under the serviced delivery modality from which they were referred.** This modality should not include testing of exposed partners and exposed family members of an index case, who should be reported under the Index disaggregate.
PEPFAR-support definition:	Standard definitions of DSD and TA-SDI apply. 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, 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. Additionally, please describe and/or quantify (proportions retested prior to ART, concordance or discordance rates) verification testing occurring prior to ART initiation to minimize misdiagnosis. 2. Please describe processes/methods and/or further quantify (e.g., through use of longitudinal person-centered data) any estimation of linkage to treatment from diagnosis. 3. Recognizing the importance of HIV case finding among individuals with presumptive

	TB, roughly what proportion of individuals reported under the TB testing modality received HTS with presumptive TB? And what proportion received HTS after being diagnosed with active TB disease? 4. Describe the system(s) in place, as well as challenges, for collecting and reporting data on use of rapid diagnostic tests (RDT) within HIV prevention programming (e.g., PrEP, PEP, DREAMS, OVC, VMMC, PMTCT, etc.)* **and** treatment programming. *5.* Approximately what volume of testing reported under HTS_TST supports prevention programming*? And under which testing modality/ies is rapid diagnostic testing reported for the purpose(s) of prevention programming*? **Testing for prevention differs from testing for case finding; see COP/ROP22 Guidance, Section 6.3.5 for additional details on* HIV Testing for Prevention.
Data Visualization & Use Examples:	**HIV Tests and Testing Yield by Modality:**  **HIV Tests and Testing Yield Among Adult Men and Adult Women Over Time:**  **HTS Age/Sex Pyramid by Number Tested:** 

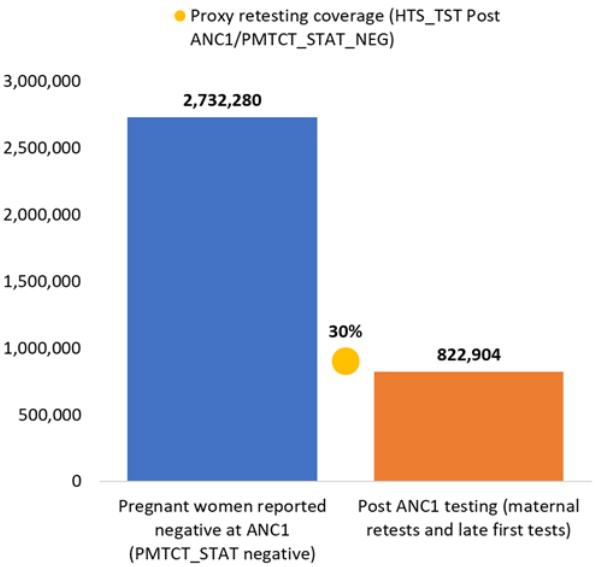
HTS Age/Sex Pyramid by Number Positive:



HTS Positives, Negatives and Yield by Testing Modality:



HTS Post ANC1 Testing Modality, Proxy Maternal Retesting Coverage:



OVC_HIVSTAT

Description:	Percentage of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with HIV status reported to implementing partner.	
Numerator:	Number of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with HIV status reported, disaggregated by HIV status	Data sources for this indicator include HIV test results that are self-reported by OVC (or their caregivers), results of HIV Risk Assessments conducted by implementing partners, registers, referral forms, client records, or other confidential case management and program monitoring tools that track those in treatment and care. Partners are strongly encouraged to confirm HIV and ART status through clinical record confirmation.
Denominator:	Number of orphans and vulnerable children reported under the OVC_SERV "OVC Comprehensive" disaggregate (<18 years old, active and graduated)	Denominator is not collected again as part of this indicator, but is collected under the "OVC Comprehensive" disaggregate of OVC_SERV.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added language to strongly encourage clinical confirmation of OVC's HIV and/or ART status.	
Reporting level:	Facility & Community	
Reporting frequency:	Semi-Annually	
How to use:	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 Comprehensive participants, to assess their risk of HIV infection, and to facilitate access and continuity of treatment for those who are HIV positive. When the implementing partner determines that the child is at risk of HIV infection, the program should refer children for testing and counseling services. When the implementing partner knows the HIV status, the program should ensure that the children are linked to appropriate care and treatment services as an essential element of quality case management. OVC programs should also play an important role in family-centered disclosure, for those who are living with HIV. <u>The goal of monitoring OVC_HIVSTAT is to increase the proportion of children in the OVC Comprehensive program with a known HIV status or for whom an HIV test is not required based on a risk assessment.</u> • While OVC partners are encouraged to work with testing and clinical partners wherever possible to confirm HIV and ART status, this indicator is NOT intended to be an indicator of HIV tests performed or receipt of testing results, as these are measured elsewhere. • This indicator is NOT intended to imply that all OVC require an HIV test. OVC with known positive or negative status do not need to be tested. OVC with unknown HIV status should be assessed for risk, and if determined to be at risk, should be referred or otherwise supported, to access HTS. For younger children who are determined not to be at risk ("test not required based on risk assessment"), reassessment of risk will only be needed in cases where their risk situation changes (i.e., in cases of child sexual abuse). Older children whom the IP thinks may be sexually active should be assessed every reporting period. An HIV risk assessment should always occur prior to HIV testing to determine if a test is required. • Status disclosure to the implementing partner is NOT a prerequisite for enrollment or continuation in an OVC program. OVC programs serve persons of positive, negative, and unknown HIV status appropriate to their needs and vulnerability to HIV. This indicator ensures that IPs are regularly providing outreach to caregivers to identify children's HIV status, encouraging family disclosure, and linking to care and treatment services as needed.	

	• This indicator captures if implementing partners are tracking the HIV status of the OVC that they serve and enrollment in ART for those who are positive. Testing results for OVC who are referred for testing should be reported under HTS_TST based on the service delivery point where they are tested. • This indicator also captures if implementing partners are tracking if the OVC that they serve who report to be living with HIV are successfully linked to and have continuity of treatment and care. ART treatment status should be recorded both at the time of enrollment as well as at regular intervals at least once during the reporting period. • Since this is not a testing indicator, HIV positivity yield should NOT be calculated based on this indicator. Yield calculations should only be made by testing partners. • A helpful way to assess OVC_HIVSTAT performance is to create a "known status proxy" category of known status/risk (by combining those reported positive, negative, and those who have been risk assessed and found to not require a test) and compare this with the OVC_SERV <18 "OVC Comprehensive" disaggregate. This analysis encourages programs to actively follow-up on all instances of "HIV status unknown" by targeting instances of missing data, nondisclosure, and issues with reporting timing. • This indicator is a subset of the OVC_SERV Comprehensive program. Only OVC who were reported under the OVC_SERV <18 "OVC Comprehensive" disaggregate should be reported in the numerator for this indicator. • In previous MER iterations, DREAMS participants who were reported under OVC_SERV were reported under OVC_HIVSTAT where feasible. With the denominator change to include only OVC Comprehensive program participants, do not count non-Comprehensive (i.e. DREAMS or OVC Preventive) participants in the OVC_HIVSTAT numerator.
How to collect:	Data sources for this indicator include HIV test results that are either clinically confirmed or 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. Per COP Guidance, OVC and Clinical IPs should work together as multi-disciplinary teams, including by developing MOUs and data sharing agreements, to ensure that children in need of an HIV test and/or HIV treatment are appropriately served. 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's clinically confirmed or self-reported HIV status semi-annually. **Reporting Scenarios:** **Q1:** *Daniel reports to the community health worker (CHW) that he is negative, but his last test was two years ago. Is Daniel still reported as "Negative", or as "No Status", and needs to be risk assessed?* **A1:** Based on their knowledge of the child from case management records, if the CHW believes that the child has no risk of HIV infection (i.e., no one in the household is HIV+, they are not exposed to violence, child is not sexually active yet) then getting another test done is not necessary and would report them as "Negative". This applies mainly to younger children under age 12 (depends on average age of sexual debut in the country). For adolescents, we recommend getting risk assessed if the test was not conducted in the reporting period. In that same scenario, what if the CHW decides to administer the HIV Risk Assessment to Daniel and finds that an HIV test is not indicated, how should that be reported? This should be reported as "Test Not Required Based on Risk Assessment" because once the CHW decides to conduct a risk assessment, this means that the child's status is in question and should be reported accordingly.

	Q2: *Elizabeth reports to the CHW that she is negative and had an HIV test within the past 6 months, but the CHW knows that she was recently exposed to something that could put her at high risk (e.g., GBV, sexually active), what should the CHW do?* **A2:** Because the CHW thinks that Elizabeth may be at risk of HIV infection, the CHW would conduct the risk assessment and she is no longer reported as "Reported HIV Negative". If found at risk (e.g., GBV exposure) then she should be referred for testing. If determined to be "Test Not Required Based on Risk Assessment" Elizabeth would be captured as "Test Not Required Based on Risk Assessment". If she completes the testing within the reporting period and the caregiver is willing to disclose the result of the test, her response would be captured accordingly. If she is risk assessed and referred for testing, but her caregiver is not able/willing to complete the test or disclose the status within the reporting period it is captured as "No HIV Status". Hopefully by the following reporting period, the caregiver will have completed the referral and disclosed the child's status so it can be captured as positive or negative. It is understandable that the whole process from risk assessment to referral completion and disclosure may not be completed within 6 months and there be movement from "No HIV Status" to "Reported HIV positive" or "Reported HIV Negative" in future reporting periods. **Q3:** *What do we do when a caregiver refuses to disclose their status and the status of their child or refuses to complete an HIV test – even when the HIV risk screening tool indicates that their child is at high risk of HIV infection?* **A3:** A caregiver should never be forced to disclose their or their child's status, the results of an HIV test, or to complete an HIV test. HIV status and completion of an HIV test are not required for enrollment in an OVC program. If a child is believed to be at high risk of HIV and the caregiver is reluctant to disclose results or complete a test, OVC programs should attempt to facilitate a meeting with the caregiver, and persons specially trained on HIV disclosure. OVC programs may also consider enlisting the support of community members with whom the caregiver has greater trust. Until the client chooses to disclose test results, status under OVC_HIVSTAT should be recorded as "No HIV Status." **Q4:** *How do we report on HIV exposed infants who are still too young to have had their final HIV status testing?* **A4:** Because HIV-exposed infants may be tested at multiple points prior to receiving a final HIV status, they should be counted as "no status" until such time that the clinic determines their final status as positive (infected) or negative (not infected). A note can be entered in DATIM in the narrative section indicating the number of children entered as "no status" that are HIV-exposed (i.e., infants during the reporting period who were of undetermined status). It is important for all HIV-exposed infants and their caregivers to be facilitated to make appointments deemed necessary by the clinic. **Q5:** *Jane is an 11-year-old AGYW enrolled in DREAMS, and one of the DREAMS services she receives is also an eligible OVC service. Therefore, she is captured under the OVC_SERV disaggregate "DREAMS." If the implementing partner knows that Jane is HIV negative, should Jane's HIV status be reported under OVC_HIVSTAT?* **A5:** No. Under the new OVC_HIVSTAT definition, only participants enrolled in the OVC comprehensive program should have their HIV status reported. Participants reported under the "DREAMS" or "OVC Preventive" OVC_SERV disaggregates should NOT be captured under OVC_HIVSTAT since the participants counted here are not enrolled in the OVC Comprehensive program. **Q6:** *Nelson is a 14-year-old who has just successfully completed one of the approved primary prevention of HIV and sexual violence curricula. He has disclosed to the course facilitator that he is HIV+. Should his HIV status be reported under OVC_HIVSTAT?*

<table>
<tr><td></td><td>A6: No. Only those children and adolescents who are enrolled in the OVC Comprehensive program are to have their HIV status reported under OVC_HIVSTAT. The course facilitator should check to ensure that the child is linked to a health facility and referred to the OVC Comprehensive program for an assessment to determine whether or not the child and his family are in need of additional support from the OVC Program. If Nelson is enrolled in the OVC Comprehensive program in a future reporting period, then his HIV status would be reported under OVC_HIVSTAT.</td></tr>
<tr><td>How to review for data quality:</td><td>The OVC_HIVSTAT total numerator should equal the OVC_SERV <18 “OVC Comprehensive” disaggregate, including active and graduated. Review any site with the following reporting issues: 1) numerator greater than 100% of OVC_SERV <18 “OVC Comprehensive” disaggregate, and 2) very low coverage of OVC_HIVSTAT (defined as OVC_HIVSTAT numerator divided by OVC_SERV <18 “OVC Comprehensive” disaggregate) which provides data on reporting of status.

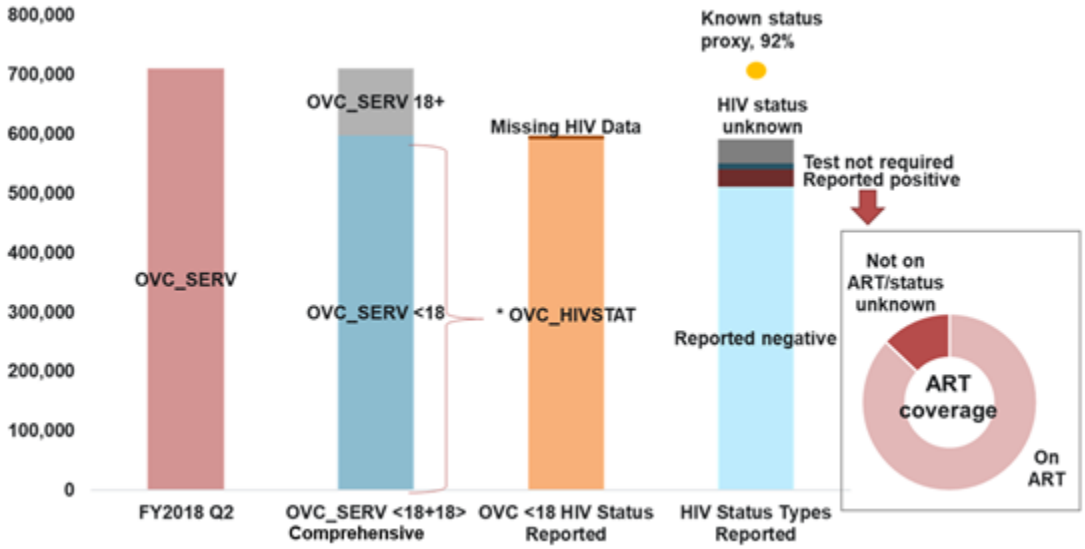
Missing data should be documented under “HIV status unknown” or “Reported HIV positive-Not currently receiving ART or ART status unknown.” Potential reasons for missing data may include: 1) IP was not able to collect information from all caregivers of OVC_SERV<18 Comprehensive participants within the reporting period, 2) IP was not able to locate all the caregivers of OVC_SERV<18 Comprehensive participants (e.g., relocated, migrant work).

Reported HIV positive +
Reported HIV negative +
HIV status unknown +
HIV test not required based on risk assessment
——————————————— = 100%
Number of orphans and vulnerable children <18 reported under the OVC_SERV “OVC Comprehensive” disaggregate</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex/Status Type [Required]</td><td>• Reported HIV positive to implementing partner
  ○ Currently receiving ART, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M
  ○ Not currently receiving ART or ART status unknown, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M
• Reported HIV negative to implementing partner, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M
• Test not required based on risk assessment, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M
• No HIV status reported to the implementing partner (HIV status unknown), by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>See OVC_SERV “OVC Comprehensive” disaggregate”.</td><td>See OVC_SERV “OVC Comprehensive” disaggregate.</td></tr>
</table>
</td></tr>
</table>

Disaggregate descriptions & definitions:	**Age/Sex/Status Type Disaggregate Definitions:**
	• All Status Type disaggregates noted below should be reported by fine age/sex band using the following options: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M
	• **"Reported HIV positive to IP"** includes all OVC <age 18 enrolled in the OVC Comprehensive program who are either clinically confirmed to be HIV-positive and/or self-report to the IP that they are HIV positive based on an HIV test conducted during or prior to the reporting period (regardless of where the test occurred). All OVC in this category should be reported as "**currently receiving ART**" or "**not currently receiving ART or ART Status Unknown**." This also includes OVC < age 18 who report that they are HIV positive based on an HIV test conducted during previous project reporting periods. OVC entered in either category as "Reported HIV positive – currently receiving ART" or "Reported HIV positive – not currently receiving ART or ART Status Unknown" in the previous reporting period should be followed in the current reporting period and their current ART treatment status noted. In order to be counted as "currently receiving ART" the IP should confirm at the last visit preceding the reporting month whether the response to the following questions is "yes" to ensure that this captures more than just initial linkage to care: *Are you taking your ARV pills every day?*
	• **"Reported HIV negative to IP"** includes OVC < age 18 enrolled in the OVC Comprehensive program who are either clinically confirmed to be HIV negative or self-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 the most recent test. For OVC 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 an HIV risk assessment. Potential outcomes reported after the HIV risk assessment include 1) the child is tested and reported as HIV positive and either currently receiving ART or not receiving ART or ART status unknown, or 2) the child is tested and reported as HIV negative, 3) the child is reported as "No HIV Status reported to the IP", or 4) the child is reported as "Test not required based on risk assessment."
	• **"Test not required based on risk assessment"** includes OVC < age 18 enrolled in the OVC Comprehensive program who based on a risk assessment made by the implementing partner do not require a test during the reporting period (formerly known as test not indicated).
	• **"No HIV status reported to the IP"** (HIV status unknown) includes all OVC < age 18 enrolled in the OVC Comprehensive program who do not fit in the above categories and who report to the IP that they do not know their HIV status or for whom HIV status is missing. Potential scenarios for reporting a child in this category include:
	  ○ Final outcome not yet confirmed for HIV-exposed infants
	  ○ Not yet assessed: Child enrolled in program, but not yet assessed for HIV risk.
	  ○ Refuse HIV assessment: Caregiver has been approached but did not agree to let the IP conduct a risk assessment on the child in the reporting period.
	  ○ At risk for HIV: Child has been assessed and is at risk for HIV, but caregiver has not yet taken child to be tested (including if they have refused testing referral or if they have accepted the referral but not yet completed the test).
	  ○ HIV referral completed: OVC has completed HIV test, but result is not available OR caregiver doesn't report results to IP in the reporting period.
	  ○ Refuse report: Caregiver has been approached by IP but have not yet agreed to disclose whether the child has been tested and his/her current HIV status in the reporting period
	  ○ Missing: No available data, including because an IP did not attempt to find out about a child's status.
	
	IPs should aim to move a newly enrolled OVC with HIV Status Unknown through the assessment cascade within the reporting period. A newly enrolled child would initially be considered "HIV Status Unknown" until he/she is risk assessed. If the OVC is found to not be

	at risk at present, he/she will be noted as “Test not required based on risk assessment.” If the OVC is found to be at risk, he/she will be referred for HIV testing and then the program will work with the guardian to disclose the results until he/she can be reported as “Reported HIV Negative”, “Reported HIV Positive – currently on ART” or “Reported HIV Positive – not currently on ART or ART status unknown”. For children reported as “HIV Status Unknown” in the previous reporting period, the IP should ensure that child is risk assessed, referred for testing if needed, and supported to disclose new test results. Children reported as “Test not required based on risk assessment” with no changes in their risk situation for the past six months, don’t need to be reassessed. If the IP believes the child’s risk situation has changed in the last six months, then the child should be reassessed by the implementing partner to determine whether testing is indicated and the results entered as outline above, and the child should receive appropriate follow-up.
PEPFAR-support definition:	Modifications to standard definition of DSD and TA-SDI related to eligible goods and services: <u>Provision of key staff or eligible goods/services for OVC participants receiving care and support services in the community include</u>: This can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group or community level activity (e.g., psychosocial support, child protection services, education, etc.). Partial salary support may include stipends or incentives for volunteers/para-social workers or paying for transportation of those staff to the point of service delivery. For goods or services to be eligible, goods or services (e.g., bursaries, cash transfers, uniforms) can either be paid for out of the implementing partner’s budget or be provided as a result of the IP’s efforts to leverage and mobilize non-project resources. For example, an IP may help OVC program participants fill out and file forms necessary for the receipt of government provided cash transfers, social grants, or bursaries for which they are eligible. Given the focus on long-term local ownership, IPs are encouraged to mobilize goods and services whenever possible. <u>For care and support services, ongoing support for OVC service delivery for improvement includes</u>: the development of activity-related curricula, education materials, etc., supportive supervision of volunteers, support for setting quality standards and/or ethical guidelines, and monitoring visits to assess the quality of the activity, including a home visit, a visit to a school to verify a child’s attendance and progress in school, or observation of a child’s participation in kids clubs.
Guiding narrative questions:	1. Please report the percentage of OVC comprehensive <18 beneficiaries who have a clinically confirmed HIV status vs. a self -reported HIV status for both OVC_HIVSTAT_POS and OVC_HIVSTAT_NEG. 2. Please describe how OVC and clinical IPs are working together to responsibly share this information for clinical confirmation and jointly serving OVC participants. Include any challenges and what is being done to overcome these challenges. 3. If the sum of reported HIV negative + reported HIV positive + Test not required based on risk assessment is less than 90% of OVC_SERV <18 “OVC Comprehensive” disaggregate, please explain why such a high proportion are being reported in the category of “HIV Status Unknown” (i.e., the performance metric described in the “how to use” section). Are there certain partners that are struggling with reporting or understandingthe disaggregates? How is the OU responding? 4. Please explain the breakdown of those reported under “HIV Status Unknown.” What percentage of caregivers refused to disclose a child’s HIV status? What percentage represents those who have been referred for testing but do not yet have results? What percentage represents missing data where an implementing partner failed to document thechild’s HIV status? What are the other reasons? Specifically, for the <01 age band, please report the number who are HEI who have not yet received a final HIV status outcome. 5. For children reported as “Reported HIV Positive - not currently on ART or ART Status Unknown”, what efforts are being undertaken in response? Are there certain partners with low ART coverage, why? Is this an issue related to community case management? Or are partners unable to collect timely confirmation of treatment status (i.e., missing)?

Data Visualization & Use Examples:	**OVC_HIVSTAT Cascade:**



PMTCT_EID

Description:	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	
Numerator:	Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period	The numerator is a measure of sample collection for virologic testing. Throughout the reference guide the term "received a first virologic test" specifically means "had a first sample collected for virologic testing." Age refers to age at specimen collection
Denominator:	PMTCT_STAT_POS + HTS_TST_POS from the Post ANC1: Pregnancy/L&D/BF modality. (see PMTCT_STAT & HTS_TST reference sheets)	Calculated indicator, sum of: PMTCT_STAT POS: 1) Newly Tested Positive, 2) Known Positive at entry (see PMTCT_STAT reference sheet for more details) and HTS_TST_POS: Post ANC1: Pregnancy/L&D/BF modality (see HTS_TST reference sheet for more details)
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added clarifying language on birth testing and the number of days in the 0 – 2 month and 2 –12 month age ranges.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This percentage is a proxy measure, relying on PMTCT_STAT_POS + HTS_TST_POS (Post ANC1: Pregnancy/L&D/BF) as a proxy denominator for total number of HEI. Reviewing infants with a first virologic test (N) against this proxy denominator should be done with caution; see assumptions and limitations in the data quality section below.	
How to collect:	This indicator measures the extent to which HIV-exposed infants receive a first virologic HIV test to determine their HIV status by 12 months of age. The indicator is disaggregated by the age of the infant at the time of sample collection, specifically between birth and 2 months and between 2 and 12 months of age. Only samples collected for the first virologic test for each HIV-exposed infant should be counted in this indicator, including dried blood spots (DBS) and samples collected for POC testing (e.g., Alere, Xpert). Even though there is ongoing exposure of infants to HIV (through breastfeeding), this indicator only measures access to a first test, and not access to all the recommended HIV tests throughout breastfeeding. HIV status of infants at the end of the breastfeeding period and the outcomes of the PMTCT program are measured in PMTCT_FO. If an infant receives a test at birth and again at 6 weeks, only the birth test should be reported in MER. However, it is important for countries with birth testing to develop tracking systems to ensure that all infants with a negative birth test receive the 6-week test. The positive results of HIV infant virologic testing are collected under the PMTCT_HEI_POS indicator. Please see the reference sheet for PMTCT_HEI_POS for more information. Implementing partners should report on all infants whose samples were collected for a first virologic test, even if no test result has been recorded in the patient record/register at the time of reporting. This indicator should be collected from the clinical source (i.e., HIV-exposed infant registers or patient records) to ensure unduplicated patient counting. HIV-exposed infant registers should be used to count exposed infants and samples collected for virologic testing. (If available, information could come from electronic systems). If the standard report does not contain all the required information, individual patient files should be used. Additional supporting information for this indicator can be obtained from standard laboratory	

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

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

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

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

See the PMTCT_HEI_POS indicator reference sheet for a description of considerations and limitations in calculating proxy positivity for HEI (PMTCT_HEI_POS / PMTCT_EID).</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Infant Test by Age at Sample Collection [Required]</td><td>• Infants who had a first virologic test (sample collected) between birth and 2 months of age (0-≤2mo);
• Infants who had a first virologic test (sample collected) between 2 and 12 months of age.</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>See PMTCT_STAT and HTS_TST.</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Infant Test by Age at Sample Collection: For the numerator to be calculated, implementing partners are required to report:
• Infants who had a first virologic test (sample collected) between birth and 2 months of age (0-≤2mo, or 0-60 days): 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 (61-365 days) of age: Age at the time the sample is collected should be reported.</td></tr>
</table>

	Revising the definition of data collection to 0-60 days for ≤2months EID and 61-365 days for 2-12 months EID will prevent double counting of HIV-exposed infants who have a sample collected for EID by 2 months of age.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PMTCT includes: commodities such as test kits, ARVs including infant prophylaxis, lab commodities, or funding for salaries of health care workers. 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/ continuity of treatment, support of mother mentoring programs.
Guiding narrative questions:	1. Provide context for low EID testing coverage by geographic area or partner/implementing mechanism, including any planned activities/remedial actions. For example, PMTCT_EID is lower than previous quarters due to a stock out of DBS reagent. 2. Provide additional monitoring data related to: turn-around time of virologic test results back to the facility and results returned to caregiver.

PMTCT_FO

Description:	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	
Numerator:	Number of HIV-exposed infants with a documented outcome by 18 months of age disaggregated by outcome type. (Note: Collection of 18 month visit outcomes is recommended at 24 months of age, see additional explanation to the right.)	Calculated indicator in DATIM, sum of: HIV-infected, HIV-uninfected, HIV-final status unknown, died without status known. It is recommended to wait to collect the 18 month visit outcomes until the patient is 24 months old for the following reasons: 1) this allows for children who present several months late to their 18 month visit to be included in the numerator and 2) cohort reporting is easiest when monthly reporting by facilities is used and where the birth month and the reporting month are the same calendar month (i.e., for infants born in January 2012, their 24 month reporting month would be January 2014, rather than using the 18 month reporting month of July 2013).
Denominator:	Number of HIV-exposed infants who were born 24 months prior to the reporting period and registered in the birth cohort.	Only those HIV-exposed infants registered in the birth cohort at any time between 0 and 18 months of age (including transfers-ins) who were born 24 months prior to the reporting period are included in the denominator.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Revised “How to review for data quality” section.	
Reporting level:	Facility	
Reporting frequency:	Annually	
How to use:	In settings where national guidelines support breastfeeding of HIV-exposed infants, antibody testing of all HIV-exposed children at 18 months of age and/or 6 weeks after cessation of breastfeeding is recommended to determine final HIV status (‘final outcome’/FO) of HIV-exposed children. To accomplish this goal, it is recommended to identify infants at birth or at the first infant follow-up visit and track them through the end of the breastfeeding period. This indicator measures progress toward ensuring that all infants born to HIV-positive women have an outcome documented. In settings where a mother-infant register is utilized and/or it is common practice for HIV-infected women to breastfeed less than or more than 18 months please describe in the narrative the final outcome time point.	
How to collect:	To report on this indicator PEPFAR supported sites would ideally use registers or facility held cards for HIV exposed infants that collect longitudinal information on follow-up and are organized by birth month of infants. This methodology is referred to as birth cohort reporting. Two examples of birth cohort reporting: 1. In Kenya, this indicator was first piloted by PEPFAR and the Ministry of Health in Western Kenya and is currently integrated into the national HIV summary reporting tool. Data from the facility HIV exposed infant longitudinal follow-up register, which organizes infants by birth-month cohorts, are aggregated into a report summarizing outcomes for infants reaching 24 months of age during each month. 2. In Malawi, clinic staff complete monthly follow up reporting forms as part of the national quarterly supervision visits using data collected directly from HIV-exposed infant cards	

which are kept in a binder that is organized by birth month (no HIV exposed register is used).

As an example, for those infants born in FY 2018, the outcomes would be reported in FY 2020.

FY 2020 (Report results for the entire 12-month reporting period for these indicators at the Q4 reporting cycle)												
Reporting Month (FY18)	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
Birth Month (FY20)	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP

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

How to review for data quality:

By design, the numerator should equal the denominator because "unknown" is an outcome type. This allows for facilities to check that all HIV-exposed infants have an outcome assigned to them during the reporting process.

How to calculate annual total:

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

Disaggregations:

Numerator Disaggregations:

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

Denominator Disaggregations:

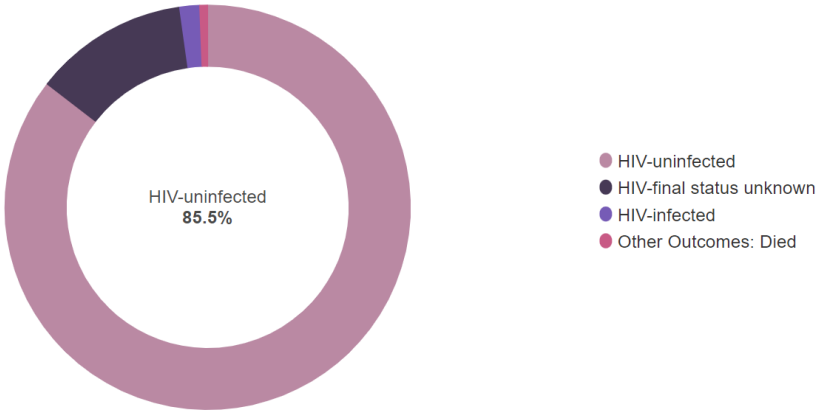
Disaggregate Groups	Disaggregates
N/A	N/A

Disaggregate descriptions & definitions:

Outcome Type:

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

- HIV-infected: Number of HIV-exposed infants identified as HIV-infected at any point during follow-up. HIV-infected includes infants and children with diagnostic virologic or serologic confirmation of HIV-infection (DNA PCR before 18 months; rapid test at 18 months) and those with a presumptive HIV diagnosis where DNA PCR is not available. Site should also maintain data on HIV infected infants and whether they are linked or not linked to ART services, or whether they have no information on patient linkage to ART programs.
- HIV-uninfected: Number of HIV-exposed infants with a negative 18-month antibody test documented. Based on national guidelines, countries should determine if "HIV-uninfected" includes infants with a documented negative antibody test that was done at least 6 weeks after cessation of breastfeeding but before 18 months of age.
- HIV final status unknown: Sum of the following disaggregates (not reported in DATIM but should be documented at site level)
  - In care but no test done: Number of HIV-exposed infants who attended 18-month visit but no antibody test result is documented (unknown FO)
  - Interruption in treatment: Number of HIV-exposed infants who did not attend the 18-month visit (unknown FO)
  - Transferred out (unknown FO): Number of HIV-exposed infants who transferred out between 0 and 18 months without confirmation of HIV-infection (unknown FO)
- Died without status known: Number of HIV-exposed infants who are documented to have died without confirmation of HIV-infection between 0 and 18 months. Note: HIV-

	exposed infants who are HIV infected and later confirmed to have died or transferred out during follow-up are still counted under HIV infected and not died or transferred out. **Every infant in a given cohort should be assigned one outcome only.**
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. 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/ continuity of treatment, 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 continuity of treatment/viral suppression
Data Visualization & Use Examples:	**Proportion of Results from each Final Outcome status:** 

PMTCT_HEI_POS

Description:	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	
Numerator:	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	This indicator excludes confirmatory testing. It includes 2 required sets of disaggregations: 1) disaggregation by age for positive infants based on the infant's age at specimen collection for virologic testing; 2) Confirmation of ART initiation, also disaggregated by age at specimen collection.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Added clarifying language on the number of days in the 0 – 2 month and 2 –12 month age ranges.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures how many HIV-infected infants are identified in a reporting period, disaggregated by age at sample collection and ART initiation status. Identification is by virologic HIV testing: DNA PCR testing of dried blood spots (DBS) or point of care (POC) (e.g., Alere, Xpert) virologic testing. Infants are defined as a child aged between 0 days (newborn) and 12 months of age, and age disaggregation is based on the infant age at the time of sample collection. The infant age reported should not be based on how old the infant was when the result was available to the site but when the sample was collected. This indicator can include infants identified as HIV-infected on any virologic test by 12 months of age and is not limited to infants identified as HIV-infected on their first virologic test. Infants may be HIV-uninfected on their first virologic test, but at a later age be identified as HIV-infected, and they should be counted in this indicator as long as they were aged 0 - 12 months at the time of subsequent sample collection. Confirmatory testing (collection of a second sample for repeat virologic testing after the first virologic test is positive) is excluded. Positive Infants and Linkage to ART: PMTCT_HEI_POS will be used to track how many positive infants are identified in a reporting period, and the "ART initiation confirmed" disaggregate can be compared to PMTCT_HEI_POS positive infants to describe rates of linkage to ART for HIV-infected infants (PMTCT_HEI_POS_ART / PMTCT_HEI_POS). The age disaggregate will also help describe linkage rates for very young infants (0-2mo). The proportion of positive infants confirmed as initiating ART can be used to help identify sites with potential successes or challenges in documentation, linkage, and/or initiation of infected infants. Comparison to TX_NEW age <1: the disaggregate for PMTCT_HEI_POS infants confirmed as initiating ART (sum of 0-2 and 2-12 months) could be compared to "infants <1-year-old initiated on ART (TX_NEW <1)." However, equal values for PMTCT_HEI_POS_ART and TX_NEW age <1 may not be expected, as each indicator may not be counting the same infants. The ART initiation disaggregate within HEI_POS will allow us to report a linked infant ART initiation outcome for each positive infant reported. For more information, see section on "How to review for data quality." Proxy positivity: When quarterly time period results are aggregated, PMTCT_HEI_POS (numerator) may be able to be compared to PMTCT_EID (numerator) for a proxy positivity calculation. This comparison will provide a poor proxy for positivity for sites or areas with a high percent of test results that are unknown. Combining quarters of data for both	

	PMTCT_HEI_POS and PMTCT_EID for this comparison may reduce the portion of test results that are unknown, especially for infants whose sample was collected near the end of a reporting period. It is also important to note that infants reported under HEI_POS will not be exactly the same as infants reported through PMTCT_EID in the quarterly time period for several reasons: 1) PMTCT_EID is limited to first virologic tests whereas HEI_POS reports infants identified on a first or subsequent test 2) PMTCT_EID is limited to infants with a first virologic test sample collected during the reporting period; whereas PMTCT_HEI_POS includes infants whose positive diagnosis was established during the reporting period, but their sample could have been collected in the prior period. Birth cohort monitoring: HIV status of infants at the end of the breastfeeding period and the outcomes of the PMTCT program are measured in the PMTCT Final Outcome indicator, PMTCT_FO. This indicator reports HIV-infected infants identified by virologic HIV testing on any sample collected by 12 months of age: DNA PCR testing of dried blood spots (DBS) or point of care (POC) (e.g., Alere, Xpert) virologic testing. **Limitations and Considerations:** • This indicator does not collect infants with a negative virologic test result or the number of infants whose test result is unknown. As such, “percent unknown” cannot be calculated through the MER indicator, though it is still an important metric for program monitoring. Notifying caregivers of infant test results remains important. • The infants reported as tested under the revised PMTCT_EID indicator are not necessarily the same infants whose positive results would be reported under the new HEI_POS indicator. Dividing HEI_POS by PMTCT_EID will not provide a precise measure of positivity; however, a proxy positivity could be calculated over a longer time period. See “How to Review for Data Quality” for more information. • In MER, there is no way to report that an infant is linked in a quarter different from when the infant received the diagnosis. HEI_POS_ART is a disaggregate of HEI_POS, meaning that the ART status of an infant must be reported in the same quarter in which the infant is reported in HEI_POS. It is important for countries to track infant linkage and ensure that all infants are initiated on treatment as soon as possible, even if it cannot be reported in MER.
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. Please note that PMTCT_HEI_POS should include all HIV-positive infants identified at the facility in the quarter, regardless of entry point (i.e., not just those identified through the PMTCT entry point). Therefore, a PMTCT clinic may need to compile testing data from other entry points at the facility (e.g., inpatient wards, malnutrition program) to report accurately and completely on this indicator. Only HIV-infected infants identified as infected by a virologic HIV test on a sample collected when they were between ages 0 through 12 months should be included in this indicator. Infants who initially were identified negative from a first virologic test but who were later identified as HIV-infected after a later virologic test should be included, as long as the infant was still aged 12 months or less at the time of sample collection. Currently, the most commonly used form of virologic testing or nucleic acid testing (“NAT”) is HIV DNA PCR on dried blood spots (DBS) but this indicator also includes HIV-infected infants identified through POC testing (e.g., Alere, Xpert). Serologic testing or “rapid” testing cannot diagnose HIV infection in infant and so infants with a positive serologic test result and either no

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>How to review for data quality:</td><td>Linkage and ART Initiation:
• Compare the PMTCT_HEI_POS ART initiation confirmed (disaggregate) to the PMTCT_ HEI_POS numerator to calculate linkage to ART. Significantly <100% or >100% linkage of HIV-infected infants to ART may reflect referrals to different sites, program weakness, or poor data quality and requires review to confirm.
• TX_NEW comparison: HEI_POS_ART disaggregate is expected to be close in value to TX_NEW age <1; however, some discrepancies could be expected and significant discrepancies should be reviewed to confirm. These values may differ in part because the age disaggregate definitions for these indicators differs. TX_NEW age is based on age at ART initiation, while PMTCT_HEI_POS is based on age at virologic sample collection. Scenario: An infant’s virologic sample was collected when the infant was 11 months old near the end of Q1. The infant’s positive result was available to the site in Q2 and she started ART in Q2 at 13 months of age. Under PMTCT_HEI_POS in Q2, she would be reported as “Positive, ART initiation confirmed, age 2-12mo;” however, under TX_NEW in Q2 she would be reported in the 1-9-year age group.
Proxy positivity: it is useful to review proxy positivity (PMTCT_HEI_POS / PMTCT_EID) across sites or locations to identify potential outliers for further review. Summing multiple quarters of data is recommended, as quarter-specific comparisons may provide a less accurate proxy. See “How to use” section for more considerations.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Infant age at virologic sample collection, for positive infants [Required]</td><td>• Positive, 0 to ≤2 months
• Positive, 2 to 12 months</td></tr>
<tr><td>Positive, confirmed initiated ART by age at virologic sample collection [Required]</td><td>• Positive, confirmed initiated ART, 0-2 months of age
• Positive, confirmed initiated ART, 2-12 months</td></tr>
</table>
</td></tr>
</table>

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	**Description of infant age at virologic sample collection for positive infants:** For the numerator to be calculated, implementing partners are required to report: • HIV-infected infants identified in a quarter, disaggregated by the age at time of sample collection: 0-2 months of age (0-60 days), or between 2-12 months of age (61-365 days). These values will auto-sum to the numerator. **Description of positive, confirmed initiated ART by age at virologic sample collection:** • Implementing partners are required to note HIV positive infants, disaggregated by age 0-≤2months and between 2-12 months, who are confirmed as initiating ART by: a. Positive, confirmed ART initiation, infant was between 0-2 months of age (0-60 days) at time of virologic sample collection b. Positive, confirmed ART initiation, infant was between 2-12 months of age (61-365 days) at time of virologic sample collection Revising the definition of data collection to 0-60 days for ≤2months and 61-365 days for 2-12 months will prevent double counting of HIV-exposed infants who have a sample collected by 2 months of age.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PMTCT include: commodities such as test kits (e.g., including but not limited to DBS bundles or collection kit, POC/near POC sample collection kits and testing devices), ARVs including infant prophylaxis, lab commodities; or funding for salaries of health care workers. Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/ continuity of treatment, support of mother mentoring programs.	
Guiding narrative questions:	1. Describe the data source used for reporting on this indicator, and any key information about data quality that is important for interpretation of quantitative results. 2. Linkage: (PMTCT_HEI_POS confirmed initiated ART (disaggregation) / PMTCT_HEI_POS total numerator). Please describe rates of linkage of positive infants (including young infants, ages 0-2 based on age of virologic sample collection) by subnational area. Please provide context for areas with low linkage rates, and describe activities aimed at improving infant ART initiation.	

PMTCT_STAT (including PMTCT_STAT_POS)

Description:	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)	
Numerator:	Number of pregnant women with known HIV status at first antenatal care visit (ANC1) (includes those who already knew their HIV status prior to ANC1)	The numerator is the sum of the following two data elements: 1. The number of women with a previously known HIV status (both known HIV positive and known negative) attending their first ANC visit (ANC1) for a new pregnancy over the last reporting period. 2. The number of women attending ANC1 who were tested for HIV and received results
Denominator:	Number of new ANC clients in reporting period	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR-supported antenatal care (ANC) know their HIV status and those newly testing positive are initiated on ART.	
How to collect:	The data source is the ANC register. There is a risk of double counting as a pregnant woman could be tested multiple times during one pregnancy; therefore, partners should ensure a data collection and reporting system is in place to minimize double counting, including a longitudinal ANC register (meaning a register that is able to record all information about one pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy). Subsequent testing during pregnancy and breastfeeding should be counted in the HTS modality: Post ANC1: Pregnancy/L&D/BF. There is also a risk of undercounting if those women who already knew their HIV status prior to attending ANC are not documented, therefore the ANC register should at a minimum document both “previously known positive” and “newly tested positive”. It may be appropriate to report “known negative” women under the “Recent Negative” disaggregate if national guidelines do not require retesting women known to be HIV negative (often women tested in the last 3 months, however exact timing depends on local guidelines). See disaggregate definitions below for additional information. Women reported under the “Newly Tested Positive” and “New Negative” disaggregations will auto-populate the HTS_TST ANC1 modality. Women who are tested later in pregnancy, during L&D, and/or during breastfeeding should be reported under the HTS_TST Post ANC1: Pregnancy/L&D/BF modality.	
How to review for data quality:	The % should never be above 100% at a site, and therefore review of the method of data collection and correction of any errors at sites with greater than 100% coverage is important to ensuring data quality for this indicator. Retesting of HIV-negative women during pregnancy, at L&D, and through the postpartum period is an important program strategy and is collected under the HTS_TST Post ANC1: Pregnancy/L&D/BF modality. Please see the HTS_TST reference sheet for more information on collecting this information.	

<table>
<tr><td>How to calculate annual total:</td><td colspan="2">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">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Status and Age [Required]

<u>Underlined portions auto-populate into the PMTCT (ANC1-ONLY) HTS_TST modality.</u></td><td>• Known Positives: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age
• <u>Newly Tested Positives: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</u>
• <u>New Negatives: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</u>
• Recent Negatives at Entry: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age [Required]</td><td><10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+, Unknown Age</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Status and Age:
• Known Positive at entry: Number of pregnant women attending ANC for a new pregnancy who were tested and confirmed HIV-positive at any point prior to the current pregnancy should be reported as known positive at entry. Pregnant women with known HIV status attending ANC for a new pregnancy may not need retesting if they are already on ART, or they may be required to be retested prior to initiating ART based on national guidelines. Known positives who are re-tested and confirmed to be HIV positive prior to initiating ART should still be documented as known positive at entry.

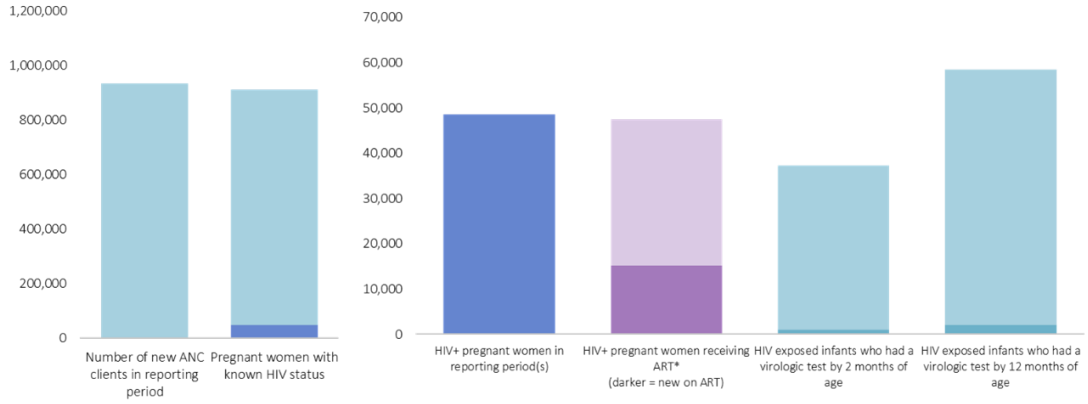
• Newly Tested Positive: The number of women attending ANC1 who were tested for HIV and received a positive result. Women who tested negative prior to this pregnancy and are tested again at ANC1 for this new pregnancy should be counted in this indicator.

• New Negatives: The number of women attending ANC1 who were tested for HIV and received a negative result. Women who tested negative prior to this pregnancy and are tested again at ANC1 should be counted in this indicator.

• Recent Negative at entry: Number of pregnant women attending ANC for a new pregnancy who recently tested HIV negative and are not eligible – according to country clinical guidelines - for another HIV test at ANC1. For example, women who tested negative within three months of attending ANC1 may not be recommended for testing per country clinical guidelines. This is expected to be a less utilized disaggregate.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

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

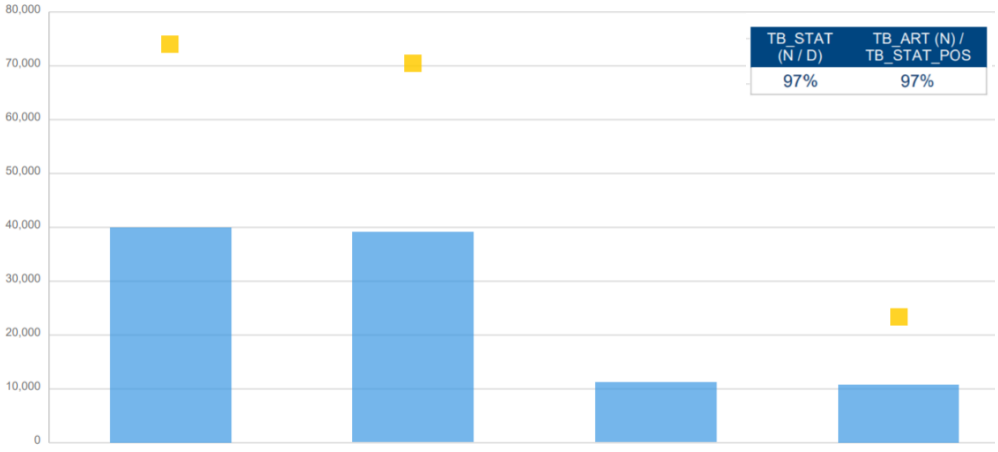
<u>Ongoing support for PMTCT service delivery improvement includes</u>: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/ continuity of treatment, support of mother mentoring programs.</td></tr>
</table>

Guiding narrative questions:	1. Provide context for poor performance in PMTCT_STAT coverage (Numerator/Denominator = STAT coverage) by geographic area, age, or partner/implementing mechanism, including any planned activities/remedial actions. 2. For areas where age disaggregates are NOT completely reported, describe challenges for collecting and/or plan and timeline for collection.
Data Visualization & Use Examples:	**Uptake of ANC Testing and PMTCT Treatment Linkage to EID Cascade:** 

TB_STAT (including TB_STAT_POS)

Description:	Percentage of new and relapse TB cases with documented HIV status	
Numerator:	Number of new and relapsed TB cases with documented HIV status, during the reporting period	The numerator can be generated by counting the number of new and relapsed TB cases with documented HIV test results during the reporting period.
Denominator:	Total number of new and relapsed TB cases, during the reporting period	The denominator can be generated by counting the number of new and relapse TB cases during the reporting period.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Updated narrative questions	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures the performance of the TB program in ensuring that TB cases know their HIV status.	
How to collect:	The numerator and denominator can be obtained from basic management unit TB registers as well as additional data collection sources (i.e., HIV testing registers) that may contain relevant information (i.e., HIV test results, enrollment in HIV care programs). Programs should modify the register as needed to easily capture this information (<1 F, <1 M, 1-4 F, 1-4 M, 5-9 F, 5-9 M, 10-14 F, 10-14 M, 15-19 F, 15-19 M, 20-24 F, 20-24 M, 25-29 F, 25-29 M, 30-34 F, 30-34 M, 35-39 F, 35-39 M, 40-44 F, 40-44 M, 45-49 F, 45-49 M, 50+ F, 50+ M, Unknown age F, Unknown age M) and (Known HIV-positive at service entry). The data source is the TB register. There is a risk of double counting as TB patients could be tested multiple times during their TB treatment, therefore partners should ensure a data collection and reporting system is in place to minimize double counting. There is also a risk of undercounting if those patients who already knew their HIV status prior to attending TB clinic are not documented, therefore the TB register at a minimum should document “Known HIV-positive at service entry; Newly tested HIV-positive; Tested HIV-negative.”	
How to review for data quality:	Only one disaggregation type is used for age and gender (fine age and gender disaggregations) • Denominator ≥ Numerator. • Numerator ≥ subtotal of each of the disaggregations. • Denominator ≥ subtotal of each of the disaggregations	
How to calculate annual total:	Sum results across quarters for both the numerator and denominator.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Status by Age/Sex [Required] ***Underlined portions auto-populate into the TB HTS_TST modality.***	• Known Positives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M • Newly Tested Positives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M 49 M, 50+ F, 50+ M, Unknown Age F/M • New Negatives: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	Age/Sex [Required]	• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
Disaggregate descriptions & definitions:	N/A	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for TB cases receiving HIV-related services includes</u>: funding of test kits, ARVs, ARTs, and lab commodities or funding of salaries or provision of Health Care Workers for TB/HIV-related services. Staff responsible for maintaining patient records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. <u>Ongoing support for TB cases receiving HIV-related services includes</u>: training of TB/HIV service providers, clinical mentoring and supportive supervision of staff at TB/HIV sites, infrastructure/renovation of facilities, support of TB/HIV service data collection, reporting, data quality, QI/QA of TB/HIV services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow up/ continuity of treatment, support of other TB/HIV programs.	
Guiding narrative questions:	1. If coverage for this indicator is less than 95%, please explain why. If there are any age/sex bands that are below the 95% threshold (even if overall reporting is over 95%), please explain why. 2. Please describe how the denominator was determined. 3. Describe the sources for the data that you are reporting (i.e., are the data from just PEPFAR-supported facilities or do the data reflect national-level data, including those from non-PEPFAR supported facilities)?	
Data Visualization & Use Examples:	**TB_STAT and ART Cascade:**	



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

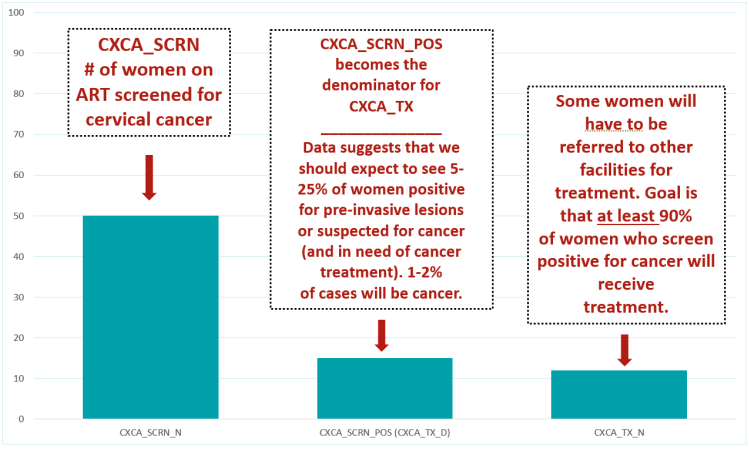
TREATMENT INDICATORS

CXCA_TX

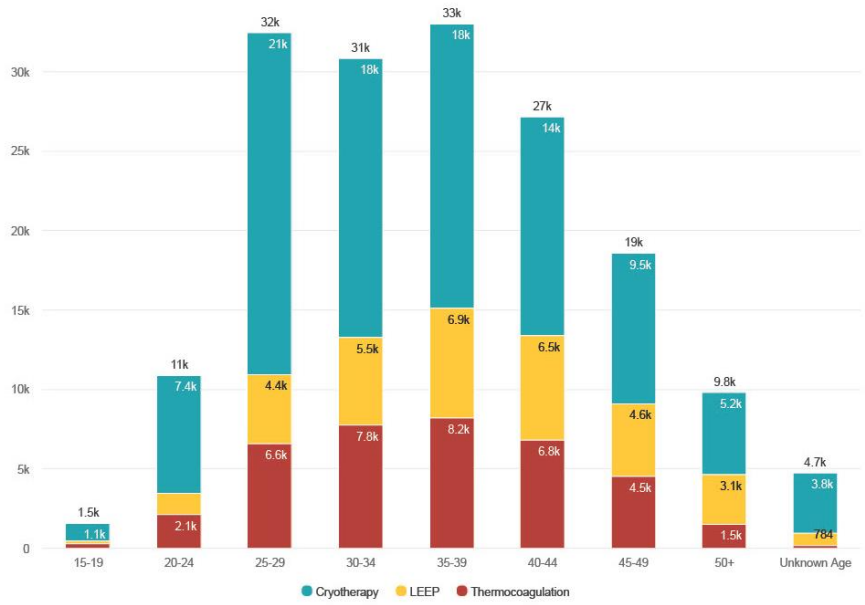
Description:	Percentage of cervical cancer screen-positive women who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	
Numerator:	Number of women with a positive VIA screening test who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	The numerator captures the number of individual women living with HIV (WLHIV) on ART who required treatment for precancerous cervical lesions, who received that treatment.
Denominator:	Number of women living with HIV (WLHIV) on ART at PEPFAR supported sites who are eligible forcryotherapy, thermocoagulation or LEEP, in other words CXCA_SCRN_POS.	See CXCA_SCRN_POS.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+. • Streamlined narrative questions.	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	It is vital that all women living with HIV (WLHIV) on ART requiring treatment for precancerous lesions receive the treatment for which they are eligible. The purpose of this indicator is to monitor whether women requiring (and eligible for) treatment for precancerous lesions received treatment. CXCA_SCRN and CXCA_TX should be analyzed together at the district or sub-regional level that includes sites where both screening and treatment would occur, in order to monitor the percentage of positive women who receive treatment while accounting for patient referrals between facilities. The globally accepted benchmark of at least 90% eligible for treatment of precancerous lesions receiving treatment should be used when monitoring performance (WHO, 2021).	
How to collect:	The primary data sources for this indicator are registers or logbooks in use at the point of precancerous lesion treatment service delivery. Client and facility level data collection tools should include the data elements required for disaggregation. Data for the numerator should be generated by counting the total number of HIV-positive women on ART who received precancerous lesion treatment (cryotherapy, thermocoagulation or LEEP or other) who were eligible for that treatment. Challenges may arise in counting when women are referred for LEEP, but who are found eligible for cryotherapy (or thermocoagulation) upon presenting at the LEEP service delivery point. It is vital that facility level data collection and program monitoring tools capture the data elements necessary to identify this key performance issue, which can lead to data quality issues for this indicator.	
How to review for data quality:	The numerator for this indicator should not be larger than CXCA_SCRN and should be equal to 100% or less of the CXCA_SCRN_POS disaggregate (not including suspected cancer).	
How to calculate annual total:	Sum results across both reporting periods for the numerator.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	Screening Visit Type and Treatment Type by Age [Required]	• 1st time screened, Cryotherapy by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age

		• 1st time screened: Thermocoagulation by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • 1st time screened, LEEP by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • Rescreened after previous negative, Cryotherapy, thermocoagulation or LEEP) by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • Rescreened after previous negative, Thermocoagulation by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • Rescreened after previous negative, LEEP by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • Post-treatment follow-up, Cryotherapy by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • Post-treatment follow-up, Thermocoagulation by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age • Post-treatment follow-up, LEEP by: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	See CXCA_SCRN_POS.	See CXCA_SCRN_POS.

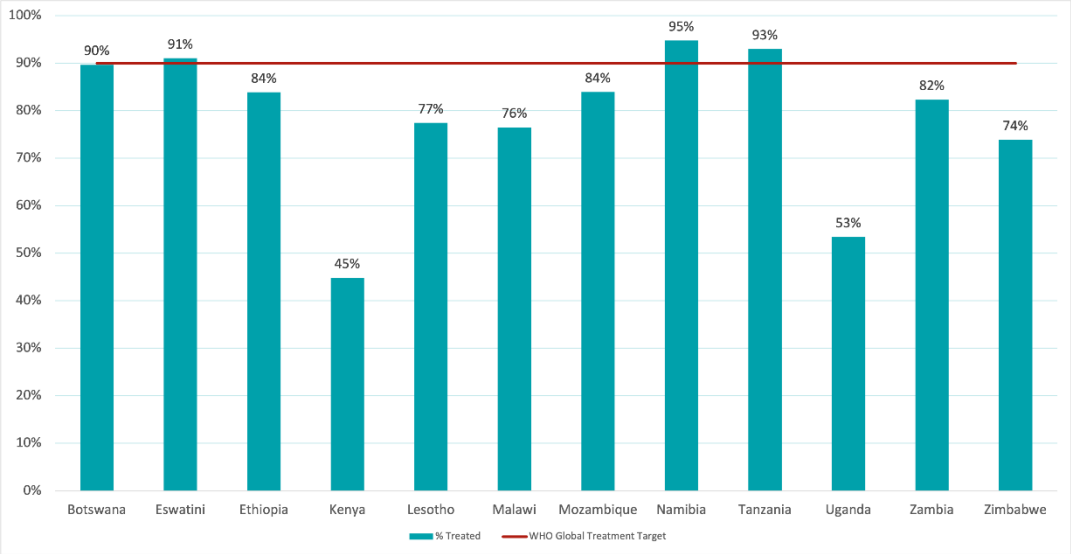
Disaggregate descriptions & definitions:	**Treatment Type**
	• Cryotherapy
	  ○ Outpatient ablative treatment option for small precancerous cervical lesions.
	  ○ By applying a highly cooled metal disc (cryoprobe) to the cervix and freezing the abnormal areas (along with normal areas) covered by it, cryotherapy eliminates precancerous areas on the cervix by freezing.
	• Thermocoagulation
	  ○ Outpatient ablative treatment option for small precancerous cervical lesions.
	  ○ It uses electricity to generate temperatures of 100–120 °C for ablation of cervical lesions and can be used for all stages of cervical cancer.
	• LEEP
	  ○ The primary outpatient treatment for large precancerous cervical lesions.
	  ○ The removal of abnormal areas from the cervix and the entire transformation zone, using a loop made of thin wire powered by an electrosurgical unit; the loop tool cuts and coagulates at the same time; this is followed by use of a ball electrode to complete the coagulation.
	
	Screening Visit Type
	• 1st Time screening
	  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the screening-naïve HIV-positive population – only women being screened for the first time in their lifetime should be counted under this disaggregate.
	• Rescreening after previous negative result
	  ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received a negative result on their most recent screening test.	

	○ WHO recommends that HIV-positive women or women of unknown HIV status who receive a negative cervical cancer screening test result be rescreened every 3-5 years. (WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, second edition. Geneva: World Health Organization; 2021.) ○ As a program matures, countries should consider adding an additional performance indicator which measures whether women that should return for routine rescreening in a given time period are returning in that time period (e.g., number of rescreened women in a given time period, over the number of women who were expected to be rescreened in the same time period). • Post-treatment follow-up screening ○ This disaggregate allows the monitoring of screening service provision (and positivity rate) in the population of HIV-positive women who have received at least one cervical cancer screening test in their lifetime, and who received precancerous lesion treatment due to a positive screening result on their last screening test. ○ Some national guidelines require post-treatment follow-up screening at intervals that differ from the PEPFAR screening algorithm – programs should use additional indicators to monitor the additional follow-up time points, and this should be noted in the narrative.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. For precancerous cervical lesion treatment services, direct service delivery includes: ongoing procurement of critical treatment related commodities such as carbon dioxide or nitrous oxide gas or requisite materials (cryotips, specula, spatulas and swabs, exam gloves, etc.), or funding for salaries of precancerous lesion treatment service providers including program managers, supervisors, and/or coordinators. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. For precancerous cervical lesion treatment services, ongoing support for service delivery improvement includes: clinical mentoring/supportive supervision, cryotherapy, thermocoagulation or LEEP training, guidance development, infrastructure/renovation of facilities, site level QI/QA, routine support of M&E and reporting, or commodities consumption forecasting and supply management.
Guiding narrative questions:	1. Please describe challenges with the provision of same day treatment and/or with the return of women who postpone precancerous lesion treatment. 2. Please provide a summary of the outcomes of all women with suspected invasive cervical cancer. How many were seen at the referral site, how many were found to have invasive cancer? Of those with invasive cancer, how were they treated? Have there been any deaths from cervical cancer among women on ART? What are the barriers to diagnosis and treatment?
Data Visualization & Use Examples:	**HIV/Cervical Cancer Cascade:** 

Treatment Type by Fine Age:



Cervical Cancer Treatment Rate vs. WHO Global Targets (FY21):



PMTCT_ART

Description:	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	
Numerator:	Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy	Auto-Calculated indicator in DATIM, sum of: 1) New on life-long ART, 2) Already on life-long ART at the beginning of the current pregnancy
Denominator:	**PMTCT_STAT_POS** (see PMTCT_STAT)	Collected as part of PMTCT_STAT. Calculated indicator in DATIM, sum of: 1) New Positives, 2) Known Positive at entry (**see PMTCT_STAT, Disaggregate Group Positivity Status for more details**)
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR-supported antenatal care (ANC) know their HIV status and are initiated on ART.	
How to collect:	Data source is the ANC or PMTCT register depending on country context (in many high HIV prevalence settings information on the number of women receiving ART regimens is integrated into the ANC register). There is a risk of double counting, as a pregnant woman receiving ART at ANC should have multiple visits for each pregnancy. Therefore partners should ensure a data collection and reporting system is in place to minimize double counting of the same pregnant woman 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 are already on ART prior to attending ANC are not documented, therefore the ANC register should document both "New on ART" and "Already on ART at the beginning of the current pregnancy". Note: Those women reported in PMTCT_ART including newly enrolled on ART and already on ART at the beginning of pregnancy should also be reported in the TX_NEW and TX_CURR indicators, respectively. Women who are already on ART should not be counted in TX_NEW. PMTCT_ART is about initiation of ART (yes/no) or already on ART (yes/no). This will most likely be captured at ANC1 but may be captured at a future ANC visit. Women initiated on ART during L&D or breastfeeding should not be reported under PMTCT_ART but should still be reported under TX_NEW.	
How to review for data quality:	Review any site with over 100% coverage or very low coverage to ensure they reflect expected results. In general, services should be reported at the site where they are delivered (however PMTCT_ART- "already on treatment" and PMTCT_STAT_POS "known positive at entry" are exceptions, see details under description of disaggregate below). Therefore, coverage at site level must be understood within the context of the service delivery model at that site. For example, in local areas where ART is integrated into ANC and low volume PMTCT sites are only testing for HIV and then referring women to other facilities for ART, the expectation is that for one individual PMTCT_STAT_POS (newly tested) will be documented at one facility and PMTCT_ART (new on ART) would be documented at another facility leading to the appearance of greater than >100% coverage at one site and 0% coverage at another.	
How to calculate annual total:	Sum results across quarters for both the numerator and denominator.	

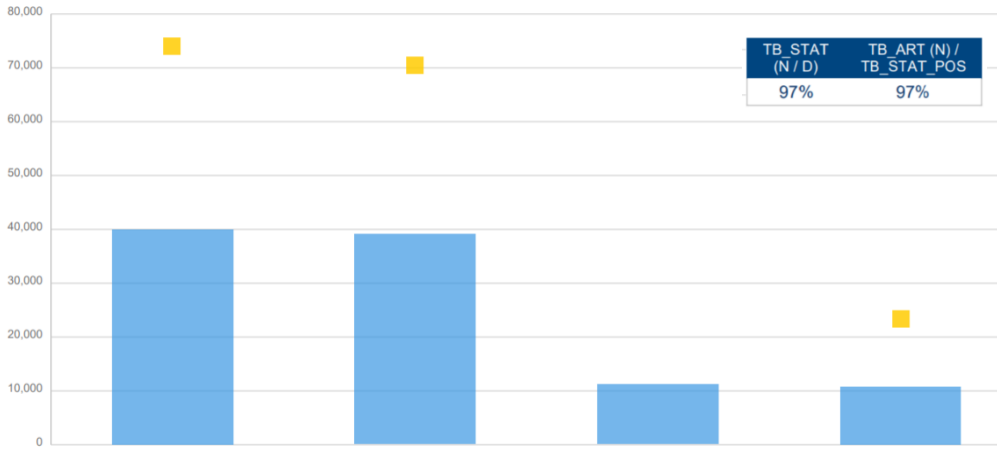
<table>
<tr><td rowspan="4">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Maternal Regimen Type and Age [Required]</td><td>• New on ART by: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age
• Already on ART at the beginning of current pregnancy by: <10, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65+, Unknown Age</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>See PMTCT_STAT_POS.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Maternal Regimen Type:
For the numerator to be calculated, implementing partners are required to report:
• The number of HIV-positive pregnant women newly initiated on ART should only be counted in a regimen category if she actually received the regimen. Referral alone for ART should not be counted. Additionally, a woman who temporarily stopped ART and has started again during the same pregnancy should not be counted as new on treatment.
• The number of HIV-positive pregnant women already on ART at beginning of pregnancy: May be counted even if ART is continuing to be received at another facility. For example, a woman who is already on treatment becomes pregnant and enrolls in ANC/PMTCT because she is HIV-positive but is continuing to receive her ART at a nearby treatment clinic should be counted within this disaggregate. However, if a woman was initiated on ART at another facility during this pregnancy and then transfers-in to the ANC site, she should not be counted (since she was already counted at the first ANC site for this pregnancy).</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

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

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

TB_ART

Description:	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	
Numerator:	Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period	The numerator is generated by counting the total number of TB patients (new and relapse TB cases) with documented HIV-positive status during TB treatment who are newly initiated or already on ART.
Denominator:	**TB_STAT_POS (see TB_STAT)**: Number of registered TB cases with documented HIV-positive status during the reporting period.	Denominator is not collected as part of this indicator, but is TB_STAT_POS.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+.	
Reporting level:	Facility	
Reporting frequency:	Annual	
How to use:	This indicator will measure the extent to which programs effectively link HIV-infected TB patients to appropriate HIV treatment. The HIV status of TB patients is often determined at the TB clinics (and will be captured with TB_STAT), but ART for TB cases is frequently provided by the HIV program. Therefore, provision of ART for this population often implies successful linkage between the TB and HIV program, which should be followed from TB_STAT_POS to TB_ART.	
How to collect:	The numerator is generated by counting the total number of TB patients (new and relapse TB cases) with documented HIV-positive status during TB treatment who are newly initiated or already on ART.	
How to review for data quality:	Only one disaggregation type is used for age/sex. Numerator ≥ subtotal of each of the disaggregation.	
How to calculate annual total:	TB_ART: N/A. Data is reported only once annually at Q4. TB_STAT_POS (See TB_STAT): Sum results across quarters.	
Disaggregations:	**Numerator Disaggregations:**	
	Disaggregate Groups	**Disaggregates**
	ART Status by Age/Sex [Required]	• New on ART: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M • Already on ART: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	TB_STAT_POS (See TB_STAT).	TB_STAT_POS (See TB_STAT).
Disaggregate descriptions & definitions:	**Age Description:** Age is defined as the age at the date of initiation on ART or current age, not the age at the date of reporting.	

	ART Status Definition: This disaggregation should distinguish those who started ART during the reporting period (this should also be reported under TX_NEW) from those who were already on it at the beginning of the reporting period.
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for TB cases receiving HIV-related services includes:</u> funding of test kits, ARVs, ARTs, and lab commodities or funding of salaries or provision of Health Care Workers for TB/HIV-related services. Staff responsible for maintaining patient records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. <u>Ongoing support for TB cases receiving HIV-related services includes</u>: training of TB/HIV service providers, clinical mentoring and supportive supervision of staff at TB/HIV sites, infrastructure/renovation of facilities, support of TB/HIV service data collection, reporting, data quality, QI/QA of TB/HIV services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow up/ continuity of treatment, support of other TB/HIV programs.
Guiding narrative questions:	1. If % coverage for TB_ART / TB_STAT_POS is less than 90%, please explain why. 2. Describe the sources for the data that you are reporting (i.e., are the data from just PEPFAR-supported facilities or do the data reflect national-level data, including those from non-PEPFAR supported facilities)? As above, please describe the sources of the data you are reporting.
Data Visualization & Use Examples:	**TB_STAT and ART Cascade:**  **Fiscal Year** / **Fiscal Quarter** / New/Relapsed TB cases TB_STAT Denominator / TB cases with HIV status TB_STAT Numerator / TB cases with positive HIV status TB_STAT_POS / HIV-positive TB cases on ART TB_ART Numerator **2018** **Q2**: 40,027 / 39,025 / 11,220 / 10,862 **Target**: 73,967 / 70,510 / / 23,309

TX_CURR

Description:	Number of adults and children currently receiving antiretroviral therapy (ART)	
Numerator:	Number of adults and children currently receiving antiretroviral therapy (ART)	Count the number of adults and children who are currently receiving ART.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures the ongoing scale-up and uptake of ART and continuity of treatment 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. Disaggregations by age and sex can help better understand which populations are at epidemic control and which populations are lagging behind. Collection of expanded age data (50-54, 55-59, 60-64, and 65+) is needed for planning appropriate HIV services for older adults as well as integrated service needs. As the treatment cohort continues to age, the ability to monitor lifelong patient outcomes is critical. Finally, disaggregations on ARV dispensing quantity can be used to determine uptake of MMD at PEPFAR sites, in PEPFAR SNUs, and across PEPFAR partners.	

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. Importantly, **patients who have not received ARVs within four weeks (i.e., 28 days) of their last missed drug pick-up should not be counted.**
	
	The following should also be considered:
	• Patients on ART who initiated or transferred-in during the reporting period should be counted.
	• Patients that pick up 3 or more months of anti-retroviral drugs at one visit (i.e., multi-month dispensation) should also be counted as long as they have received enough ARVs to last to the end of the reporting period at a minimum.
	• However, if it is determined that a patient has died, they should immediately be removed from the TX_CURR results.
	• HIV-positive pregnant women who are eligible for and are receiving antiretroviral drugs for their own treatment should be counted. 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 experienced interruption in treatment (IIT). **Patients who have not received ARVs within four weeks (i.e., 28 days) of their last missed drug pick-up should not be counted.** Patients do not need to qualify as IIT before tracing efforts commence. Efforts to trace patients that have missed a clinical visit or drug pick-up should begin immediately following a missed clinical contact.	

<table>
<tr><td></td><td>Patients who have not received ARVs within four weeks of their last missed drug pick-up should be described further in the reporting of the TX_ML indicator. Patients that restart treatment after four weeks or more of being off ARVs should also be counted under TX_RTT in the reporting period in which the patient returns to care and restarts ARVs.

TX_CURR should be reported from both PEPFAR-supported sites in the private and/or public sector. Patients currently receiving treatment from mobile clinics can be reported in two ways. Firstly, if the mobile clinic is associated with (e.g., receives commodities, reports to, is staffed by) a nearby health facility, then these individuals should be reported by that facility. Secondly, if a mobile clinic is stationary for more than 2 reporting periods, it should be added to the PEPFAR facility list with geocodes and data should be reported for this mobile clinic directly.

DO NOT include: Patients who receive ARVs for post-exposure prophylaxis (PEP) or short-term ART only for prevention (PrEP) should not be reported in this indicator.

See Appendix J for a visual representation of TX_CURR, TX_ML, TX_NEW, and TX_RTT.

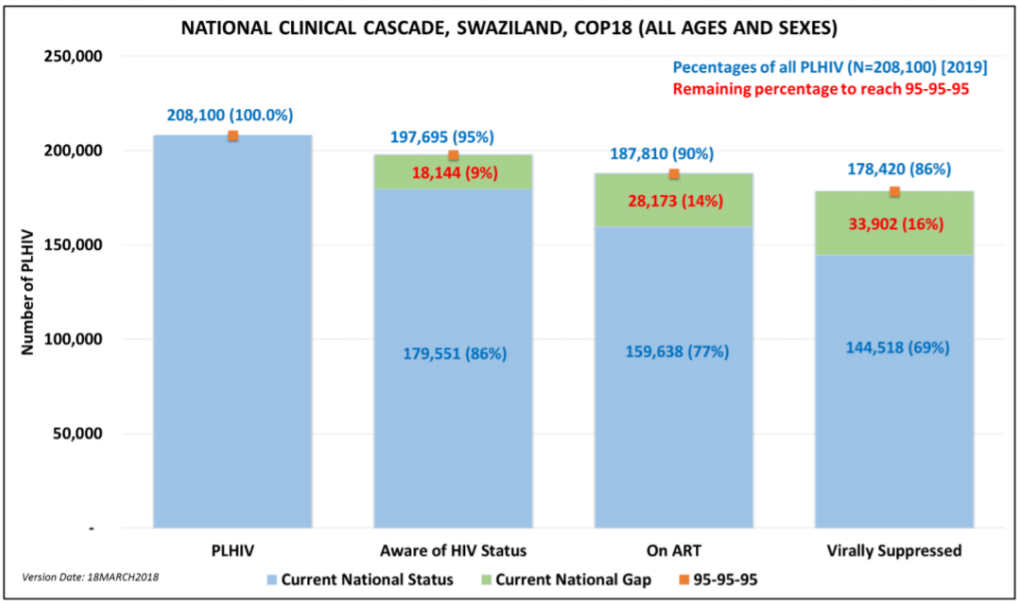
Key Populations (KPs):
Both KP-specific and clinical partners should complete these KP disaggregations, but only if safe to maintain these files and to report. Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery.

The first priority of data collection and reporting of treatment among key populations must be to <u>do no harm</u>. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.</td></tr>
<tr><td>How to review for data quality:</td><td>• Confirm that TX_CURR ≥ TX_NEW.
• Confirm that TX_CURR ≥ TX_RTT.
• Confirm that TX_CURR ≥ Disaggregates for ARV Dispensing Quantity.</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex
[Required]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M</td></tr>
<tr><td>Key Population Type
[Required]</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>ARV Dispensing Quantity by Coarse Age/Sex
[Required]</td><td>• <3 months of ARVs (not MMD) dispensed to patient by: <15 F/M, 15+ F/M, Unknown Age F/M
• 3-5 months of ARVs dispensed to patient by: <15 F/M, 15+ F/M, Unknown Age F/M
• 6 or more months of ARVs dispensed to patient by: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td>Focused Population
[Optional]</td><td>• Focused population</td></tr>
</table>
</td></tr>
</table>

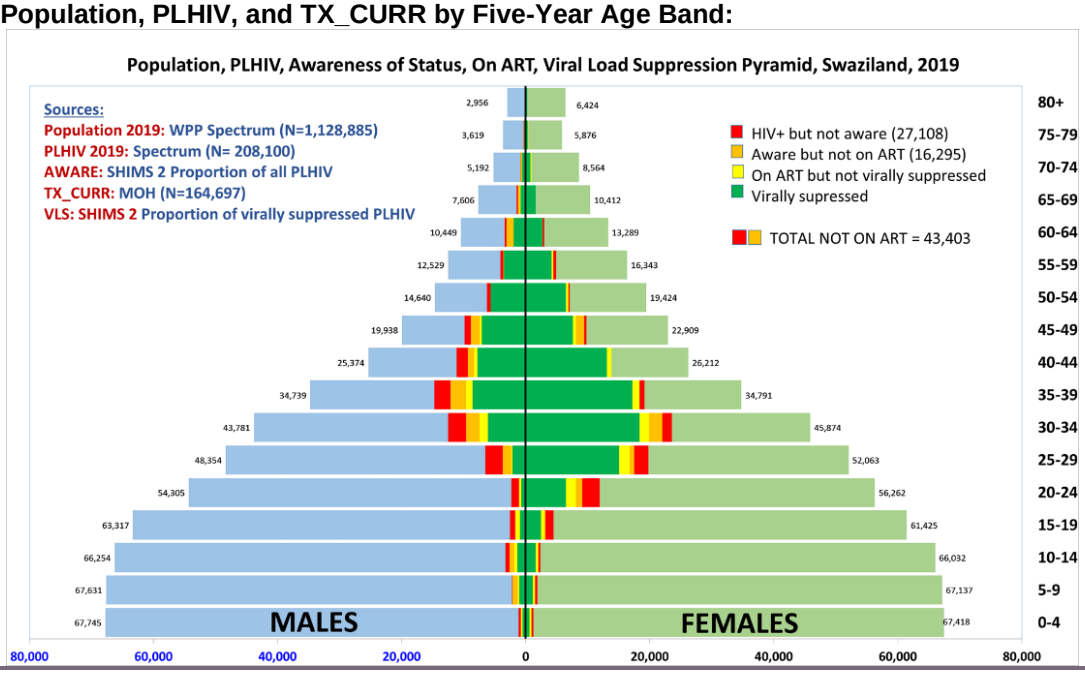
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	**For age /sex disaggregates:** CURRENT is a state defined by treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they 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. **For ARV dispensing quantity by coarse age/sex disaggregates:** Patients should be categorized by the coarse age disaggregates while being further categorized by the months of ARVs dispensed: <3 months of ARVs dispense to the patient, 3-5 months of ARVs dispensed to the patient, or 6 or more months of ARVs dispensed to the patient. **By definition, patients dispensed just one or two months of ARVs are not receiving MMD. However, to ensure data completeness and quality, they are collected herein.** NOTE: MMD should not be confused with multi-month prescriptions. For example, patients receiving 6-month prescriptions that the facility fulfills in two refills of a 3-month supply can be counted as receiving MMD in the 3-5 month MMD disaggregate. Inversely, patients receiving 6-month prescriptions that the facility fulfills in six refills of a 1-month supply would be counted in the <3 months disaggregated and would not be considered as receiving MMD. **Focused population disaggregate:** A focused population is a historically underserved population, including, but not limited to, individuals of a historically underserved race/ethnicity or tribal population. A focused population is not a key population (although individuals may be members of both), but rather a population of significant interest within an OU that is not tracked elsewhere within MER. Country teams may opt to use this disaggregate where relevant and feasible. Prior to entering data, the country team should contact their PEPFAR Program Manager and SGAC_SI@state.gov in order to define one focused population for the OU. This disaggregate should not be used without prior OGAC approval.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PLHIV receiving ART includes: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver HIV treatment services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. Ongoing support for PLHIV receiving ART service delivery improvement includes: clinical mentoring and supportive supervision of staff at HIV sites providing ART, support for quality improvement activities, patient tracking system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management	
Guiding narrative questions:	1. What percentage of clients are picking up their ART drugs on a quarterly basis? On a semi-annual basis? 2. What percentage of clients are being seen for clinical follow-up visits on a quarterly basis? On a semi-annual basis? On an annual basis? 3. Describe differences in MMD uptake across age and sex groups and sites/SNUs.	

Data Visualization & Use Examples:

95-95-95 Cascade Example:



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



TX_ML

Description:	Number of ART patients (who were on ART at the beginning of the quarterly reporting period or initiated treatment during the reporting period) and then had no clinical contact since their last expected contact	
Numerator:	Number of ART patients (currently on ART or newly initiating ART) with no clinical contact or ARV pick-up for greater than 28 days since their last expected clinical contact or ARV pick-up	Clinical contact is defined as any clinical interaction with the patient, such as clinical assessment by a healthcare worker or provision of medication.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	TX_ML (treatment mortality and loss) is intended to: (1) help better understand fluctuations or steady growth in TX_CURR over time, (2) encourage tracing of patients when a patient has had no clinical contact for greater than 28 days since their last expected contact and (3) promote timely identification of patient outcomes among patients known to have missed clinical visits or drug pickups. PEPFAR implementing partners must ensure that immediate programmatic action is being taken to locate patients that have had no clinical contact for greater than 28 days since their last expected clinical contact. Clients should be traced in an active, safe, and confidential way that assures sustained adherence to treatment moving forward. Health care workers should leverage best practices to reach clients experiencing IIT, while protecting confidentiality. In case of death, mortality data should be analyzed and investigated to determine causes of death, where possible. From a public health perspective, treatment adherence and continuity of treatment are essential to achieve and maintain viral suppression and ultimately reduce or eliminate disease transmission. Often, patients who appear to have experienced an interruption in treatment may have died or have self-transferred to another health care facility; as such, it is important to understand and make these distinctions as each one may require different programmatic interventions. Serious attempts should be made to reengage any patient that has not returned for clinical services or drug pick-up and return them to treatment, and mortality data should be analyzed and investigated to determine causes of death amenable to programmatic intervention (e.g., TB, opportunistic infection, cervical cancer). It is important to note that this is not a cohort monitoring indicator. TX_ML is meant to be used in conjunction with TX_CURR to help better understand fluctuations or steady growth of the ART patient population.	
How to collect:	This indicator should not count or report those patients who were already lost and not counted in TX_CURR at the beginning of the reporting period. Clinical contact is defined as reporting to the clinic for ART pick-up or clinical assessment, or a documented community visit with a community health worker or peer from an ART refill group. Attempts to reach and re-engage patients into treatment should be made as soon as a patient misses a clinical visit. When a patient has missed their most recent expected clinical contact, the clinic or other related staff should attempt to reach and reengage the patient as soon as possible. Once a PLHIV has reached 28 days past their expected clinical contact or drug pick-up, s/he should be removed from TX_CURR, the clinic should again attempt to reach and re-engage the	

patient, and his/her current outcome should be determined. The outcomes are defined as not currently on ART at the facility if the patient:

1. Died
2. Interruption in treatment (IIT)
    a. On treatment for <3 months when experienced IIT
    b. On treatment for 3-5 months when experienced IIT
    c. On treatment for 6+ months when experienced IIT
3. Transferred out
4. Refused (stopped) treatment

See Disaggregates and Descriptions section below for definitions of each of these outcomes.

Included in the classification of IIT are the following: patients for whom tracing is not attempted, and patients for whom tracing is attempted but unsuccessful or for whom status cannot otherwise be determined (i.e., patient may have died or may have silently transferred, but status is unknown). Patients should also be reported as IIT if they have been traced and scheduled to return after the end of the reporting period (in other words, they have not returned yet). A facility may wish to further distinguish these classifications, but they are not required for MER reporting. It is assumed that tracing will be attempted for every patient who has missed clinical visits at both <28 days and >28 days since the last expected clinical contact or ARV pick-up.

This indicator seeks to reconcile the status of patients who are TX_CURR during the reporting period and then fall off of ART, i.e., into the classification of >28 day since clinical contact or ARV pick-up status DURING THE REPORTING PERIOD. This includes those ART patients who continue treatment from the prior reporting period (TX_CURR at the beginning of the reporting period), and those who newly initiate in this reporting period (TX_NEW). To reiterate, this indicator should not count or report those patients who were already lost and not counted in TX_CURR at the beginning of the reporting period.

If a patient is re-engaged and restarted ART after >28 days of being off treatment, and remains on treatment until the end of the reporting period, then the patient should be added back to TX_CURR, but should not be counted in TX_ML. The patient may also be reported in TX_RTT provided they were not counted in TX_CURR during the previous reporting period. (See TX_RTT for additional information.) Facilities should make every attempt to continue to contact persons who experienced IIT from a prior reporting period and return them to care, an outcome which would be reflected in the TX_RTT indicator.

Note that TX_ML requires that a patient is on treatment at the beginning of the reporting period or newly initiates treatment during the reporting period, while TX_RTT requires that a patient is not on treatment at the beginning of the reporting period and excludes patients who newly initiate treatment during the reporting period. **Therefore, a patient cannot be counted in TX_ML and TX_RTT in the same reporting period.**

Both TX_ML and TX_RTT have disaggregates on interruption in treatment. The TX_ML IIT disaggregate reflects the amount of time that a patient was on treatment when they experienced an interruption in treatment. The TX_RTT IIT disaggregate reflects the duration of interruption in treatment prior to being returned to treatment.

See Appendix J for a visual representation of TX_CURR, TX_ML, TX_NEW, and TX_RTT. It is widely acknowledged that even where reporting is required, mortality data, especially cause of death, are often underreported or inaccurate. In addition, it may take some time for a clinic to discover that a patient has died. Thus, a clinic may classify a patient as TX_ML_IIT in the quarter the patient gets to >28 days past the expected clinical contact, but later discover that the patient died. If it is later discovered that the patient died, **they do not need to be recounted or reclassified in this indicator in a later quarter**. Data on deaths

<table>
<tr><td></td><td colspan="2">should only be reported, if available, in the quarter when the patient gets to >28 days past the expected clinical contact.
Program data available on deaths and the cause of death disaggregate under this indicator should be triangulated with mortality surveillance, where available, to understand causes of death among PLHIV. For more information on routine mortality monitoring, refer to Appendix H.

Key Populations (KPs):
Reporting on KP Type is now an optional disaggregate for this indicator. Tracking and reporting on KP type will aid the program to provide tailored services by utilizing outcome trends by KP. However, while useful information, it is not required at this time.

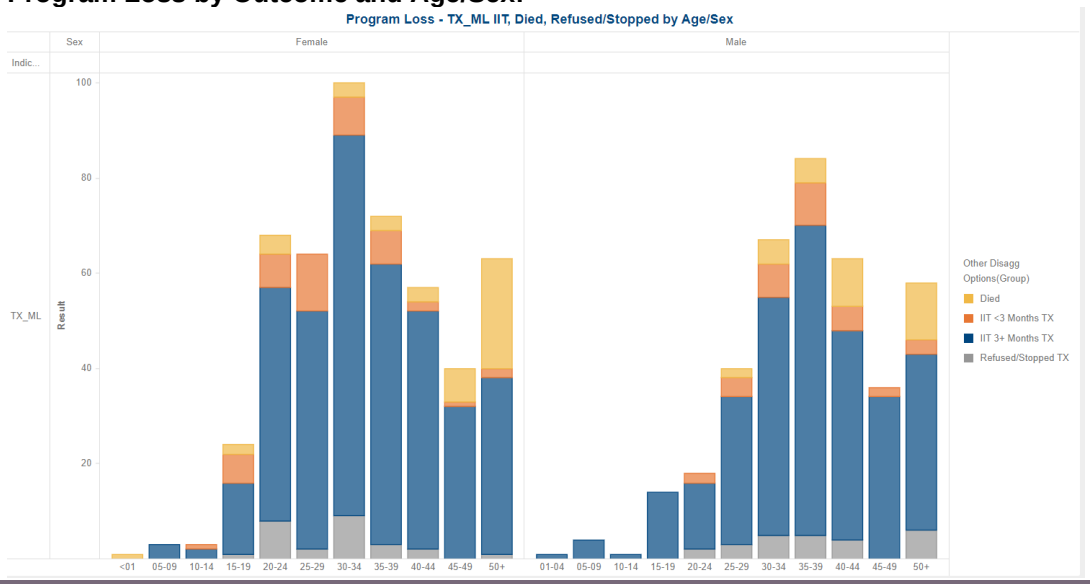
If choosing to report on KP type, it is important to adhere to the following guidance. Both KP-specific and clinical partners can complete these KP disaggregations, but only if it is safe to maintain these files and to report. Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery.

The first priority of data collection and reporting of treatment among key populations must be to do no harm. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Patient trackers, tracing logs, missed appointment reports, and other available sources should be routinely checked. These comparisons will help programs understand where efforts are required to better improve and/or ensure completeness of reporting.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">There should be no annual total. Data for this indicator are intended to provide context for TX_CURR results but the numerator should NOT be summed across reporting periods due to the active movement and potential reclassification of patients.</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Outcome by Age/Sex [Required]</td><td>• Died by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F
• Interruption in Treatment (IIT) by:
○ IIT After being on Treatment for <3 months by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F
○ IIT After being on Treatment for 3-5 months by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F
○ IIT After being on Treatment for 6+ months by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F
• Transferred Out by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F</td></tr>
</table>

		• **Refused (Stopped) Treatment** by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F. 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F
	Key Population Type [Optional]	• **People who inject drugs (PWID)** by Died, Interruption in Treatment for < 3 months, Interruption in Treatment for 3-5 months, Interruption in Treatment for 6+ months, Transferred Out, Refused (Stopped) Treatment • **Men who have sex with men (MSM)** by Died, Interruption in Treatment for < 3 months, Interruption in Treatment for 3-5 months, Interruption in Treatment for 6+ months, Transferred Out, Refused (Stopped) Treatment • **Transgender people (TG)** by Died, Interruption in Treatment for < 3 months, Interruption in Treatment for 3-5 months, Interruption in Treatment for 6+ months, Transferred Out, Refused (Stopped) Treatment • **Female sex workers (FSW)** by Died, Interruption in Treatment for < 3 months, Interruption in Treatment for 3-5 months, Interruption in Treatment for 6+ months, Transferred Out, Refused (Stopped) Treatment • **People in prison and other closed settings** by Died, Interruption in Treatment for < 3 months, Interruption in Treatment for 3-5 months, Interruption in Treatment for 6+ months, Transferred Out, Refused (Stopped) Treatment
	Cause of death by age/sex (sub-disaggregate of the 'died' outcome above) [Optional]	• **HIV disease resulting in TB** by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F • **HIV disease resulting in cancer** by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F • **HIV disease resulting in other infectious and parasitic disease** by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F • **Other HIV disease, resulting in other diseases or conditions leading to death** by: <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F • **Other natural causes** by**:** <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F • **Non-natural causes** by**:** <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F • **Unknown Cause** by <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A

Disaggregate descriptions & definitions:	**Outcome definitions:**
	• **Died:** Patient was confirmed as dead by direct observation or by unambiguous report of family or close contact (neighbors, co-workers, etc.); it should not be presumed.
	• **Interruption in Treatment:** Patient status has not or cannot be assessed (did not attempt to trace or traced but unable to locate). Regardless of whether the patient was on treatment for <3 months, 3-5 months or greater than 6 months, IIT is defined as:
	  ○ Traced patient (unable to locate)**:** Exhaustive attempts (e.g., phone calls, home visits, triangulation with other health facilities) were made to locate the patient, but patient was still not located through these efforts. Exhaustive attempts means completing more than 3 attempts to contact or locate the patient using multiple methods.
	  ○ Traced patient (pending return): Patient was reached and a return appointment has been scheduled, but the patient has not returned to the clinic before the end of the reporting period.
	  ○ Did not attempt to trace patient: No attempt was made to trace the patient during the reporting period.
	• **Transferred Out:** Patient was confirmed to be successfully transferred to another health facility during the reporting period, this includes both "silent transfers" and "down-referrals." A 'down-referral' refers to those instances where a patient is initiated at one facility (counted as TX_NEW and possibly TX_CURR at the initiating facility) and then transferred to a lower level facility for ongoing ART. "Silent transfer" refers to those clients that are lost to treatment at one facility, but have re-entered treatment at another facility without notifying the original departing facility. Through active tracing, the originating facility may learn that a patient has silently transferred.
	• **Refused (Stopped) ART:** Patient was contacted and confirmed to have stopped ART during this reporting period. Reasons that the patient stopped ART should be investigated and well documented in the narratives for this indicator (e.g., stigma and discrimination, faith healing, etc.).
	
	This indicator was originally introduced in FY19 and marked the first time PEPFAR collected mortality information through routine program data. Mortality is an essential measure to assess the impact of the health sector more broadly, and the HIV program in particular. Mortality data should be compared between sites and districts as well as by age and sex to determine the geographic and demographic areas where intensified interventions are most needed. Particularly, determining the cause-of-death (COD) or conditions experienced at the time of death among PLHIV can be used to help identify programmatic gaps and focus resources on interventions aimed at reducing preventable deaths.
	
	Appendix I describes the ICD codes associated with the cause of death categories outlined below.
	
	Cause of death definitions:
	• HIV disease resulting in TB: Any patient with known or presumed TB (pulmonary and/or extra-pulmonary) at the time of death without another identified COD
	• HIV disease resulting in other infectious and parasitic disease: Any patient who died from any infectious cause other than TB; this includes infections not otherwise specified
	• HIV disease resulting in cancer: Any patient with known or presumed cancer at the time of death
	• Other HIV disease, resulting in other diseases or conditions leading to death: Any patient who died from a non-infectious, non-malignant cause that was related to HIV, such as acute HIV infection syndrome, (persistent) generalized lymphadenopathy, hematological and immunological abnormalities, etc.	

	• Other natural causes: Any patient who died from natural causes (including certain cancers and infections, etc.) that were not directly related to HIV disease. • Non-natural causes: Any patient who died from non-natural causes (e.g., trauma, accident, suicide, war, etc.) • Unknown Cause: Patients in whom cause of death was truly not known
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <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.
Guiding narrative questions:	1. Describe patient tracing efforts in more detail. When does patient tracing occur (e.g., within 1 week of missed contact, within 4 weeks of missed contact, etc.)? 2. For all clients that refused (stopped ART), what reasons were cited for refusal [e.g., discrimination by the health facility, unfriendly services, inconvenient services (e.g., long wait times, asked to come back too frequently), faith healing, etc.]? How is the partner or country team working to address these issues and reengage these clients on life-saving ART? 3. What percentage of IIT patients (patients with no clinical contact for ≥ 28 days) received an active follow-up visit during the reporting period? 4. What is being done to address facilities with above average mortality? Or a higher than average number of patients who were untraceable?
Data Visualization & Use Examples:	**Program Loss by Outcome and Age/Sex:** 

TX_NEW

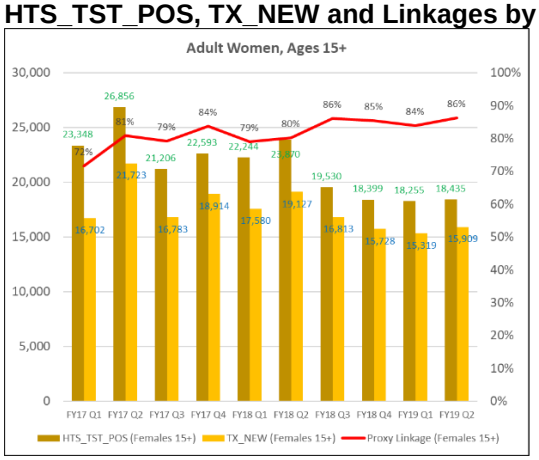
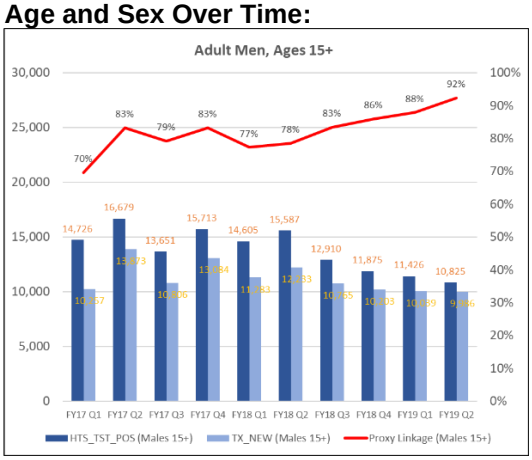
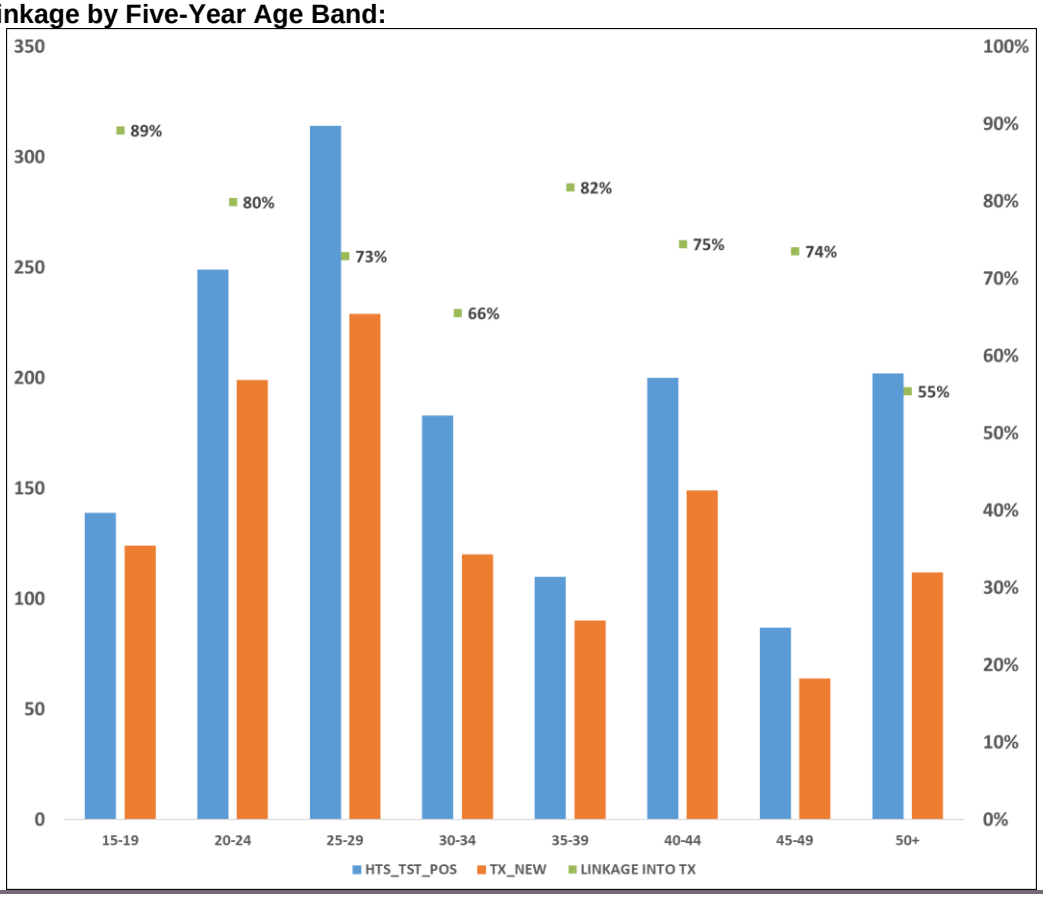
Description:	Number of adults and children newly enrolled on antiretroviral therapy (ART)	
Numerator:	Number of adults and children newly enrolled on antiretroviral therapy (ART)	The indicator measures the ongoing scale-up and uptake of ART programs.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	The indicator measures the ongoing scale-up and uptake of ART programs. This measure is critical to monitor along with number of patients currently on ART in relation to the number of PLHIV that are estimated to be eligible for treatment to assess progress in the program's response to the epidemic in specific geographic areas and populations as well as at the national level. This is particularly critical in the context of current revisions to country-specific ART eligibility. Reporting the number of new patients enrolled on ART at both the national and overall PEPFAR program levels is critical to monitoring the HIV services cascade, specifically the successful linkage between HIV diagnosis and initiating ART. Disaggregation of new on ART by age/sex at ART initiation, and breastfeeding status at ART initiation is important to understand the percentage of new ART initiations coming from priority populations. Note that pregnancy status at ART initiation is captured in the PMTCT_ART indicator.	
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. • Patients who have been off treatment from >28 days and restart ART should be counted in TX_RTT. They should not be counted in TX_NEW. • **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.** HIV-positive pregnant women who are eligible for and are newly receiving antiretroviral drugs for their own treatment are included in TX_NEW. HIV-positive pregnant women initiating lifelong ART through PMTCT (Option B+) will count as "current" on ART under TX_CURR. BF disaggregation: Women who initiate ART while breastfeeding should be counted under this indicator but not in PMTCT_ART. See Appendix J for a visual representation of TX_CURR, TX_ML, TX_NEW, and TX_RTT. **Key Populations (KPs):** Both KP-specific and clinical partners should complete these KP disaggregations, but only if safe to maintain these files and to report. Reporting of the key population disaggregation	

<table>
<tr><td></td><td>should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery.

The first priority of data collection and reporting of treatment among key populations must be to <u>do no harm</u>. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.</td></tr>
<tr><td>How to review for data quality:</td><td>• Numerator ≥ subtotal of each disaggregation: The total number of adults and children newly enrolled on ART should be greater or equal to the sum of all of the age/sex disaggregations and pregnancy/ breastfeeding status.
• Confirm that TX_CURR ≥ TX_NEW.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex
[Required]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M</td></tr>
<tr><td>Breastfeeding status at ART initiation
[Required]</td><td>• Breastfeeding at initiation of ART</td></tr>
<tr><td>Key Population Type
[Required]</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>Focused Population
[Optional]</td><td>• Focused population</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Age/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.

Focused population disaggregate:
A focused population is a historically underserved population, including, but not limited to, individuals of a historically underserved race/ethnicity or tribal population. A focused population is not a key population (although individuals may be members of both), but rather a population of significant interest within an OU that is not tracked elsewhere within MER. Country teams may opt to use this disaggregate where relevant and feasible. Prior to entering data, the country team should contact their PEPFAR Program Manager and SGAC_SI@state.gov in order to define one focused population for the OU. This disaggregate should not be used without prior OGAC approval.</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 includes</u>: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver HIV treatment services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic)</td></tr>
</table>

	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. If TX_NEW does NOT equal HTS_TST_POS, explain why. 2. If TX_NEW result is markedly different from targets, explain why. 3. Describe your rationale for reporting TX_NEW vs. TX_RTT. How are you ensuring that patients that transferred in, experienced an interruption in treatment (IIT), or stopped treatment are NOT being counted in TX_NEW at the time they reinitiate treatment?
Data Visualization & Use Examples:	**HTS_TST_POS, TX_NEW and Linkages by Age and Sex Over Time:**   **Linkage by Five-Year Age Band:** 

TX_RTT

Description:	Number of ART patients who experienced an interruption in treatment (IIT) during any previous reporting period, who successfully restarted ARVs within the reporting period and remained on treatment until the end of the reporting period.	
Numerator:	Number of ART patients who experienced IIT during any previous reporting period, who successfully restarted ARVs within the reporting period and remained on treatment until the end of the reporting period.	**These are individuals who were previously on ART who restarted ARVs after being off treatment for ≥28 days (and therefore experienced IIT).**
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+.	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	TX_RTT counts those individuals who fulfill all of the following: (1) initiated ART prior to the start of the reporting period, (2) were not on treatment at the beginning of the reporting period after experiencing an interruption in treatment (i.e. more than 28 days since the last expected clinical contact), (3) restarted ARVs during the reporting period, and (4) remained on treatment at the end of the reporting period. Monitoring this indicator may also help to identify those PLHIV who were diagnosed and started ART in the past but have experienced an interruption in treatment (IIT). IIT is defined as no clinical contact or ARV drug pickup for greater than 28 days since the last expected contact. Clinical contact is defined as reporting to the clinic for ART pick-up or clinical assessment, or a documented community visit with a community health worker or peer from an ART refill group. This indicator seeks to encourage ongoing contact with patients who experience IIT and/or to encourage supportive services to facilitate restarting ARV therapy. It also seeks to encourage identification and the return to treatment of those PLHIV with a history of ART but are currently lost or unknown to the health care system. National clinical guidelines typically recommend that patients with ART history are restarted on ARVs, rather than newly initiate clients as if they were treatment-naïve. Nonetheless, many clinics – lacking sufficient clinical history or documentation – newly initiate patients with prior ART history. From a public health perspective, treatment adherence and continuity of treatment are essential to achieve and maintain viral suppression and ultimately reduce or eliminate disease transmission. Serious attempts should be made to reengage and return to treatment any patient that has not returned for clinical services or drug pick-up as soon as the patient does not have their expected clinical contact. Clients should be traced in an active, safe, and confidential way that assures sustained adherence to treatment moving forward. Health care workers should leverage best practices to reach clients experiencing IIT, while protecting confidentiality. Successful reengagement of patients who do not attend an appointment or experience interruption in treatment within the reporting period but return to treatment within the same period will not be counted under TX_RTT but will be reflected in strong quarterly continuity of treatment metrics and/or proxy metrics. TX_RTT can be used to monitor successful reengagement of patients who experienced an interruption in treatment in any previous reporting period, and to identify opportunities for reengaging patients earlier. For all patients eligible to be counted under TX_RTT, it is now required to report duration of treatment interruption before returning to treatment. This can help inform patient reengagement strategies by leveraging best practices at sites that successfully and	

	efficiently bring clients back to care. Additionally, this disaggregate will be helpful for providing high level oversight for clinical outcomes.
How to collect:	When a patient experiences interruption in treatment, (i.e. more than 28 days since their most recent expected clinical contact), the clinic or other related staff should attempt to reach and reengage the patient as soon as possible. A patient is counted under TX_RTT in the reporting period in which s/he returns to treatment and restarts ARVs. In order to be counted under TX_RTT, the patient must be returned to treatment during the current reporting period, and they must remain alive and on treatment until the end of the reporting period. Additionally, a patient should not have been counted under TX_CURR in the previous reporting period. The reason for not being counted under TX_CURR in the previous reporting period could include having experienced IIT in the previous reporting period, having experienced IIT at an earlier time point, or having stopped/refused treatment. A newly initiated patient who experiences IIT and is returned to treatment within the same reporting period should not be counted in TX_RTT. A newly initiated patient who experiences IIT and is not on treatment at the end of a reporting period may be counted in TX_RTT during the next reporting period only if they are successfully returned to treatment during that next reporting period. A patient should not be counted as TX_RTT if they have been traced and returned to treatment within 28 days of the last expected contact (clinical or ARV pick up). **Furthermore, a patient should not be counted as TX_RTT if they do not remain current on ART at the end of the reporting period.** For example, if a patient returns in the current reporting period after experiencing IIT in the previous reporting period, but again experiences IIT by the end of the current reporting period, the patient should not be counted as part of TX_RTT within the same reporting period. • A patient who is counted on TX_RTT must be counted in TX_CURR in the same reporting period. • A patient who was counted in TX_CURR in the previous reporting period cannot be accounted in TX_RTT in the current reporting period. • A patient cannot be counted on TX_NEW and TX_RTT in the same reporting period. • A patient cannot be counted on TX_ML and TX_RTT in the same reporting period. • A patient counted in TX_RTT should have been counted in TX_ML at some point in time, but not necessarily in the previous reporting period. IIT is defined as no clinical contact or ARV drug pickup for greater than 28 days since the last expected contact. Clinical contact is defined as reporting to the clinic for ART pick-up or clinical assessment, or a documented community visit with a community health worker or peer from an ART refill group. Both TX_ML and TX_RTT have disaggregates on interruption in treatment. The TX_ML IIT disaggregate reflects the amount of time that a patient was on treatment when they experienced an interruption in treatment. The TX_RTT IIT disaggregate reflects the duration of interruption in treatment prior to being returned to treatment. See Appendix J for a visual representation of TX_CURR, TX_ML, TX_NEW, and TX_RTT. **Key Populations (KPs):** Both KP-specific and clinical partners should complete these KP disaggregations, but only if safe to maintain these files and to report. Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery.The first priority of data collection and reporting of treatment among key populations must be to **do no harm**. These

<table>
<tr><td></td><td colspan="2">data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">• Confirm that TX_CURR ≥ TX_RTT.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Data for this indicator can be summed across reporting periods.</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex [Required]</td><td>• <1 M/F, 1-4 M/F, 5-9 M/F, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age M/F</td></tr>
<tr><td>Key Population Type [Required]</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>Duration of treatment interruption before returning to treatment [Required]</td><td>○ Experienced treatment interruption of <3 months before returning to treatment
○ Experienced treatment interruption of 3-5 months before returning to treatment
○ Experienced treatment interruption of 6+ months before returning to treatment</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Outcome definitions:
• Duration of treatment interruption: This disaggregate is used to track how long patients who were returned to treatment experienced an interruption in ART by <3 months, 3-5 months, or 6+ months intervals. Duration of interruption in treatment should be measured by the time period between the missed appointment that triggered IIT and the appointment where the patient was restarted on treatment. For example, if a patient misses a clinical contact on March 1, has no clinical contact for 28 days, and returns to treatment on April 1, their total duration of IIT would be 31 days. They would be counted in the <3 month “duration of IIT” disaggregate for TX_RTT.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for PLHIV receiving ART 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="2">1. How long were people off of ARV? What percentage of PLHIV returned to care were off ARVs for 12 months or more? What interventions supported their return to care?
2. What portion of an increase in TX_CURR is attributable to TX_RTT (vs. TX_NEW) in the reporting period?
3. Taken together, what does TX_NEW, TX_ML, TX_CURR, TX_NET_NEW, TX_RTT, and TX_PVLS tell you about the quality of the treatment program at the facility?</td></tr>
</table>

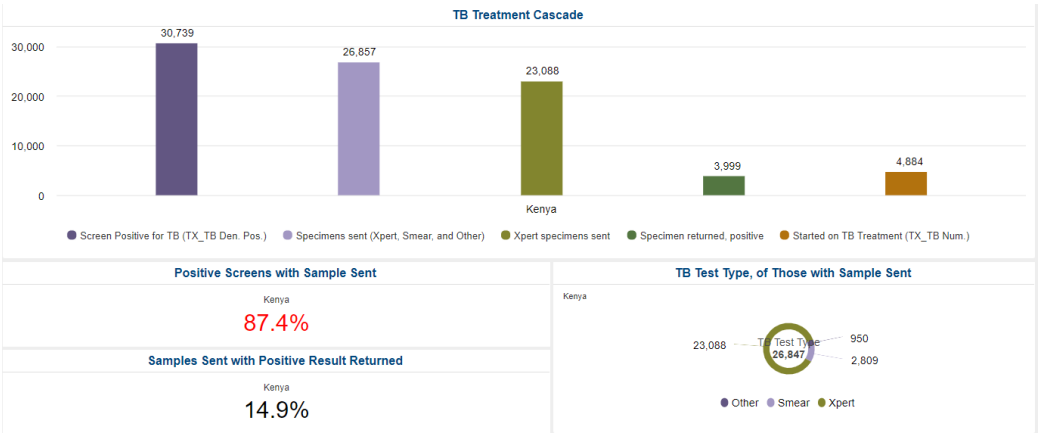
TX_TB

Description:	Proportion of ART patients screened for TB in the semiannual reporting period who start TB treatment.	
Numerator:	Number of ART patients who were started on TB treatment during the semiannual reporting period.	The numerator can be generated by counting the number of screened ART patients who were diagnosed with TB and started on anti-TB therapy during the reporting period.
Denominator:	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	The denominator can be generated by counting the number of ART patients who were screened for TB symptoms at least once during the reporting period.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• Updated Diagnostic Test disaggregate from "GeneXpert MTB/RIF assay" to "mWRD: Molecular WHO-Recommended Diagnostic PCR". This disaggregate still captures information on molecular (PCR) tests for TB but is now inclusive of all recommended market options.	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator documents the TB screening of ART patients as well as the proportion who were diagnosed and started on TB therapy. The disaggregates demonstrate the cascade from screening to testing and can be used to identify gaps and challenges in TB diagnostic activities.	
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 ART patients screened for TB who were diagnosed with TB and started on anti-TB therapy during the reporting period. These data should be captured in ART registers as well as additional data collection sources (e.g., facility-based TB screening registers or forms, TB specimen registers, TB microscopy result registers, GeneXpert data collection systems) that may contain relevant information (e.g., TB screening results, TB specimen testing results). Programs should modify the register as needed to easily capture this information. Documentation of symptom screening is generally collected in patient charts but may also be collected in another aggregate partner-generated data source. Screening for TB and/or initiation of anti-TB therapy might not happen at the same time that ART is started. For PLHIV new to HIV care, those who are diagnosed with TB are usually started on anti-TB therapy before they initiate ART (e.g., 2-8 weeks as per current recommendations). Regardless of when they occur relative to ART initiation, TB screening and initiation of TB therapy should be included for all patients who were currently on ART or who started ART at any time during the reporting period. Further information on how to use and collect these data is provided by WHO in the following guidelines: "Latent Tuberculosis Infection: Updated and Consolidated Guidelines for Programmatic Management."	
How to review for data quality:	Only one disaggregation type is used for age (coarse disaggregates). Numerator ≥ subtotal of each of the disaggregations.	
How to calculate annual total:	TX_TB Denominator is a snapshot indicator (i.e., the APR calculation = Q4) because it is intended to capture a clinical event (screening), and not unique patients. This is why TX_TB Denominator should be compared to TX_CURR, another snapshot indicator. Note that the TX_TB Numerator, if analyzed on its own, could be summed across semiannual time	

<table>
<tr><td></td><td colspan="2">periods to conclude the number of ART patients who were started on TB treatment during the fiscal year.</td></tr>
<tr><td rowspan="8">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>ART Status (Current/New on ART) by Age/Sex [Required]</td><td>• Number of patients starting TB treatment who newly started ART during the reporting period: <15 F/M, 15+ F/M, Unknown Age F/M
• Number of patients starting TB treatment who were already on ART prior to the start of the reporting period: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Start of ART by Screen Result by Age/Sex [Required]</td><td>• New on ART/Screen Positive: <15 F/M, 15+ F/M, Unknown Age F/M
• New on ART/Screen Negative: <15 F/M, 15+ F/M, Unknown Age F/M
• Previously on ART/Screen Positive: <15 F/M, 15+ F/M, Unknown Age F/M
• Previously on ART/Screen Negative: <15 F/M, 15+ F/M, Unknown Age F/M</td></tr>
<tr><td>Specimen Sent [Required]</td><td>Number of ART patients who had a specimen sent for bacteriologic diagnosis of active TB disease.</td></tr>
<tr><td>Diagnostic Test (Disaggregation of Specimen Sent) [Required]</td><td>• mWRD: Molecular WHO-Recommended Diagnostic PCR (with or without other testing)
• Smear microscopy only
• Additional test other than mWRD</td></tr>
<tr><td>Positive Result Returned [Required]</td><td>Number of ART patients who had a positive result returned for bacteriologic diagnosis of active TB disease.</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Age/Sex by ART Status:
• Number of patients starting TB treatment who newly started ART during the reporting period: These individuals initiated TPT within 6 months of being enrolled on ART; data to be submitted by the following disaggregates: <15F/M, 15+F/M Unknown Age F/M
• Number of patients starting TB treatment who were already on ART prior to the start of the reporting period: These individuals initiated TPT at least 6 months (or longer) after being enrolled on ART; data to be submitted by the following disaggregates: <15F/M, 15+F/M, Unknown Age F/M

Age/Sex/Start of ART by Screen Result:
• Age/Sex/New on ART/Screen Positive: The number of patients who started ART in the reporting period and who screened with least one positive symptom during the reporting period.
• Age/Sex/New on ART/Screen Negative: The number of ART patients who started ART in the reporting period and who had all negative symptom screens during the reporting period.
• Age/Sex/Previously on ART/Screen Positive: The number of patients who were on ART prior to the reporting period and who had at least one positive symptom screen during the reporting period.
• Age/Sex/Previously on ART/Screen Negative: The number of ART patients who were on ART prior to the reporting period and who had all negative symptom screens during the reporting period.</td></tr>
<tr><td>PEPFAR-support definition:</td><td colspan="2">Standard definition of DSD and TA-SDI used.

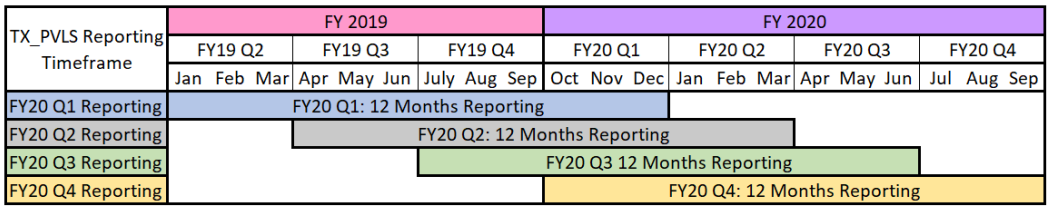
<u>Provision of key staff or commodities for routine HIV-related services includes</u>: ongoing provision of critical re-occurring costs or commodities (such as ARVs, TB preventive</td></tr>
</table>

	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. 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. If there are issues with performance (e.g., if specimens are not sent for all persons who screened positive for TB symptoms, or if the numerator doesn't equal positive specimen returned), what are they and how can they be addressed? 4. Are the patients in the numerator all receiving care from PEPFAR-supported sites? Are they receiving TB and HIV care from the same site? 5. Describe access to GeneXpert testing for ART patients who screen positive for TB.
Data Visualization & Use Examples:	**TB Treatment Cascade:** 

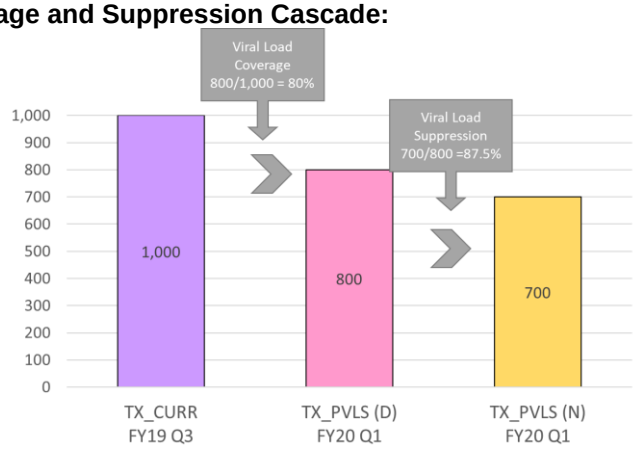
VIRAL SUPPRESSION INDICATORS

TX_PVLS

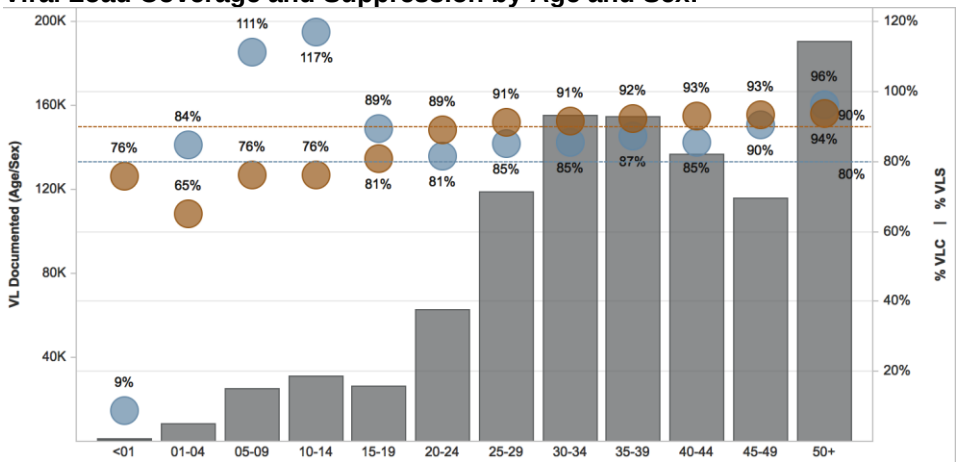
Description:	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	
Numerator:	Number of ART patients with suppressed VL results (<1,000 copies/ml) documented in the medical or laboratory records/LIS within the past 12 months	• If there is more than one VL result for a patient during the past 12 months, report the most recent result. • Only patients who have been on ART for at least 3 months should be considered.
Denominator:	Number of ART patients with a VL result documented in the medical or laboratory records/LIS within the past 12 months.	Only patients who have been on ART for at least 3 months should be considered.
Indicator changes (MER 2.0 v2.6 to v2.6.1):	• The 50+ age band was expanded to 50-54, 55-59, 60-64, 65+. • Added clarifying language on the viral load testing proxy coverage calculation for pregnant women	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	**Viral Load Suppression Outcomes:** This indicator monitors the proportion of documented viral load results from adult and pediatric ART patients who have been on ART for at least 3 months (or according to national guidelines) with a suppressed result (<1,000 copies/ml). This allows ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression. This indicator will provide data on patients who have a viral load (VL) test in the past 12 months and the percentage who were virally suppressed at the most recent test. **Viral Load Testing Coverage:** Comparison of the denominator for this indicator with the result for TX_CURR from 6 months earlier (i.e., two quarters prior) can be used to crudely estimate VL testing coverage supported by PEPFAR. For example, a comparison may be made between the FY20 Q1 denominator for TX_PVLS and FY19 Q3 TX_CURR, given that patients newly initiating ART and included in TX_CURR in FY19 Q4 and FY20 Q1 may not be eligible for a viral load test. In calculating this estimate, it is important to ensure that individuals, not tests are being reported for TX_PVLS. Analyzing both VL testing coverage and suppression rates by geography, sub-population, and implementing mechanisms is essential for program management and quality of care. Real-time review of VL results should trigger an immediate response to follow-up on patients who are not suppressed (i.e., VL ≥1000 copies/mL). **Pregnant Women Viral Load Testing Coverage Considerations** VL testing coverage for pregnant women can be estimated by comparing the TX_PVLS denominator “Pregnant” disaggregate to the sum of the last four quarters of PMTCT_ART “Already on ART” disaggregate. This coverage calculation may underestimate the number of pregnant women that need a viral load test as it does not include pregnant women newly initiating ART. When country level guidance indicates a viral load test for pregnant women newly initiating ART, the coverage denominator should include both PMTCT_ART “New on ART” and PMTCT_ART “Already on ART”. TX_PVLS only includes the most recency viral load test, but a client’s pregnancy and breastfeeding status changes over time. For example, when considering VL testing coverage proxy calculations, a client with a VL test during pregnancy may not be included in the pregnancy disaggregate, if the client's most recent VL test was during breastfeeding or after breastfeeding cessation.	

How to collect:	This indicator should be collected from clinical sources (e.g., electronic or paper patient records), where possible, to ensure de-duplicated patient counting and receipt of results to inform patient care. Ideally, data for this indicator should be collected from an electronic medical records system (EMR) to minimize data collection errors and ensure that results are informing patient care. If data collection from an EMR is not possible, indicator data may be collected from paper-based registers or reports that reflect the VL results. If standard patient registers do not contain all the required information, individual patient records should be reviewed. If a clinical source does not exist or does not contain the desired information, data may be extracted from an electronic laboratory information system (LIS). VL results from an LIS must be linked to back to the individual patients and their record at sites. NOTE: If patient-linked VL results from LIS is used for reporting, it is incumbent that the implementing partner ensure this information is transcribed into the patient record for timely VL results utilization/patient management. The data source used for reporting on this indicator should be specified and data reported should be de-duplicated and used to inform patient care at sites. If the LIS is used, please explain why clinical sources could not be used to report on this indicator in the narrative (see guiding narrative question section below). **VL results should be reported for patients who have been on ART for at least 3 months (or according to national guidelines).** It is important to ensure that the data sources used to collect and aggregate data are updated to be able to report VL results data for patients who have been on ART for at least 3 months. Beginning in FY19, this indicator moved from annual to quarterly collection. The reporting period still covers a 12-month period and may include data from the previous fiscal year (see visual below). For example, when reporting data in FY20 Q1, country teams will be required to report data for FY19 Q2+ FY19 Q3+FY19 Q4+ FY20 Q1.  Both only VL tests with recorded results and VL results that are linked back to patients should be included in the numerator and denominator of this indicator. This indicator should be reported for all PEPFAR-supported treatment sites (i.e., from all reporting TX_CURR). VL monitoring result utilization should be promoted for individual patient, site, and program use. If a PEPFAR-supported treatment site (i.e., a site that has reported TX_CURR) has not collected any samples for VL testing, “0” should be entered for both the numerator and denominator. **Where more than one result is available for the reporting period, the most recent result should be reported.** Programs should describe the method(s) of data collection and the results de-duplication methodology utilized in their narratives. **Key Populations (KPs):** Both KP-specific and clinical partners should complete these KP disaggregations, but only if safe to maintain these files and to report. Reporting of the key population disaggregation should be consistent with what is described under the KP_PREV “How to review for data quality” section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which this person is most identified. See Appendix A to support the identification of key populations at service delivery.

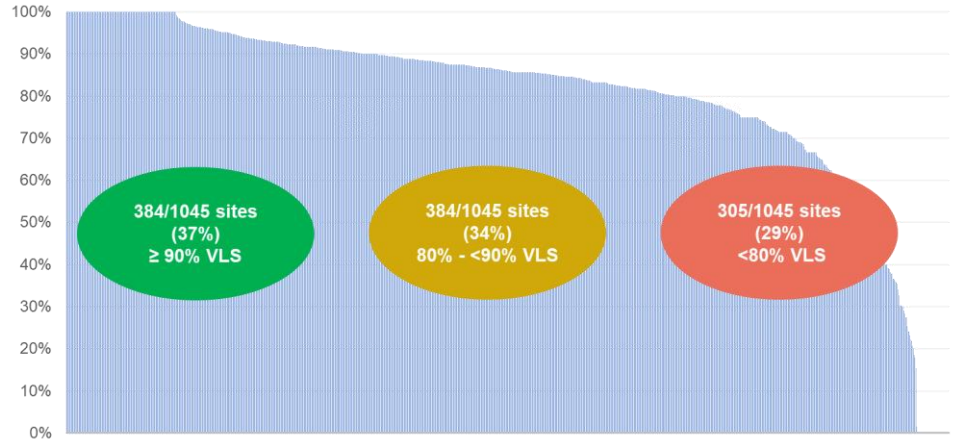
<table>
<tr><td></td><td colspan="2">The first priority of data collection and reporting of treatment among key populations must be to <u>do no harm</u>. These data must be managed confidentially to ensure the identities of individuals are protected and to prevent further stigma and discrimination of key populations.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">• Denominator ≥ Numerator: The number of VL results from adults and children on ART must be greater than or equal to the number of VL results from adult and pediatric ART patients with a VL <1,000 copies/ml.
• Numerator ≥ subtotal of each disaggregation: The total number of VL results from adult and pediatric ART patients with a VL <1,000 copies/ml should be greater than or equal to the sum of all of the results disaggregated by age/sex, pregnancy/breastfeeding status, and test indication.
• TX_CURR ≥ TX_PVLS (D): TX_CURR should be greater than or equal to the number of adults and children on ART with VL results</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td rowspan="8">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Indication by Age/Sex [Required]</td><td>• Routine by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M
• Targeted by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M</td></tr>
<tr><td>Indication by Pregnant/Breastfeeding [Required]</td><td>• Routine by: Pregnant or Breastfeeding
• Targeted by: Pregnant or Breastfeeding</td></tr>
<tr><td>Indication by Key Population Type [Required]</td><td>• Routine by: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); or People in prison and other closed settings
• Targeted by: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); or People in prison and other closed settings</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Indication by Age/Sex [Required]</td><td>• Routine by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M
• Targeted by: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50-54 F/M, 55-59 F/M, 60-64 F/M, 65+ F/M, Unknown Age F/M</td></tr>
<tr><td>Indication by Pregnant/Breastfeeding [Required]</td><td>• Routine by: Pregnant or Breastfeeding
• Targeted by: Pregnant or Breastfeeding</td></tr>
<tr><td>Indication by Key Population Type [Required]</td><td>• Routine by: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); or People in prison and other closed settings</td></tr>
</table>

		• Targeted by: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); or People in prison and other closed settings
Disaggregate descriptions & definitions:	**Indication Disaggregate Definitions:** • *Routine:* Refers to VL tests obtained at standard intervals following ART initiation to monitor virologic response to ART (testing frequencies and interval are dependent on the National guidelines but should be recommended to occur at least annually for patients on ART) and includes follow-up VL tests done after an initial VL result of VL≥1000. • *Targeted:* refers to viral load tests ordered based on a specific clinical indication, (e.g., concern about disease progression or failure to respond to ART).	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for PLHIV on ART who receive VL monitoring includes</u>: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver VL monitoring services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>Ongoing support for PLHIV receiving ART VL monitoring improvement includes</u>: clinical mentoring and supportive supervision of staff at HIV sites providing ART and VL monitoring services, support for quality improvement activities, patient tracking, enhanced adherence counseling system support, routine support of VL related M&E and reporting, VL related commodities consumption forecasting and supply management	
Guiding narrative questions:	1. Briefly describe the VL testing algorithm used in country. Please ensure that the description includes any differences in the VL monitoring algorithm for different sub-populations (e.g., pregnant women, breastfeeding women, children etc.). 2. Specify and briefly describe the data sources used to report on this indicator (e.g., EMR, LIS, DHIS 2 etc.). If the LIS is used, please explain why clinical sources could not be used to report on this indicator. 3. What efforts are made to ensure individuals, not tests are being reported (e.g., processes of de-duplicating data to reflect unique individuals being tested and outcomes). Please describe the de-duplication methodology used, if applicable. 4. Describe the overall coverage of VL testing in the country, with any differences by region or age. 5. Describe any association of ART regimen type with TX_PVLS.	
Data Visualization & Use Examples:	**Viral Load Coverage and Suppression Cascade:**  	

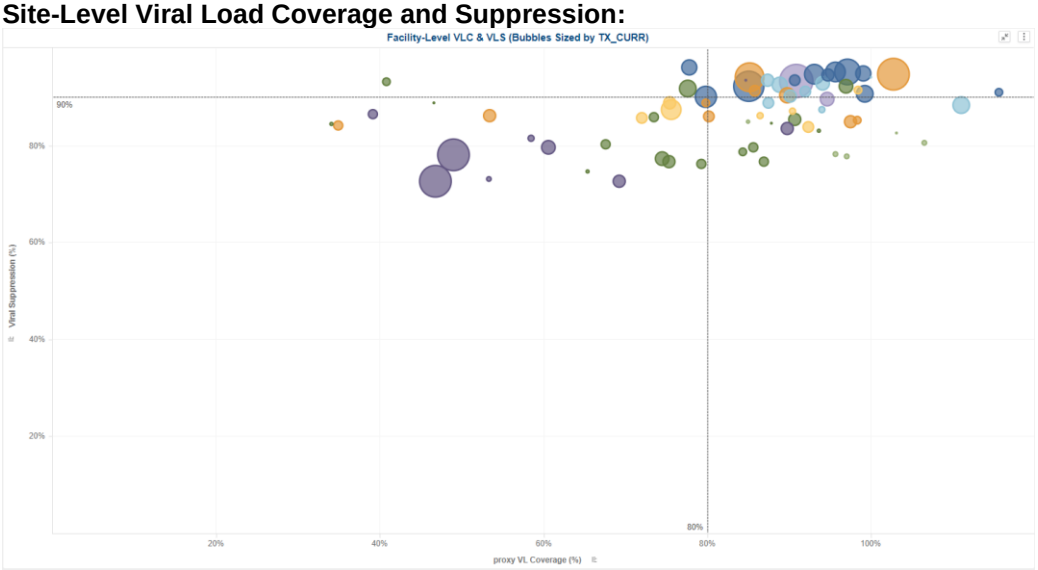
Viral Load Coverage and Suppression by Age and Sex:



Site-Level Viral Load Suppression:



Site-Level Viral Load Coverage and Suppression:



HEALTH SYSTEMS INDICATORS

EMR_SITE

Description:	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery areas: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	
Numerator:	Number of PEPFAR-supported facilities that have an electronic medical record (EMR) system within the following service delivery points: HIV Testing Services, Care & Treatment, Antenatal or Maternity Services, Early Infant Diagnosis or Under Five Clinic, or TB/HIV Services	Answer recorded separately for each service delivery point (or area).
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility by service delivery point (or area).	
Reporting frequency:	Annually	
How to use:	This indicator can be used as a cross-sectional indicator at Q4. It can be used to better understand PEPFAR's investments in Strategic information and to support a broader understanding of data quality challenges for other indicators. Timely access to up-to-date patient information plays a vital role in the provision of effective clinical care by health professionals. Diagnosis and treatment can be improved if health professionals have easy access to accurate and comprehensive medical records of patients.	
How to collect:	**Definition of an Electronic Medical Record (EMR):** An EMR is a longitudinal electronic record of an individual patient's health information that can assist health professionals with decision-making and treatment. Data found in a record may include patient demographics, past medical history, vital signs, examination and progress notes, medications, allergies, immunizations, laboratory test results, other test results. It can also support the collection of data for other uses such as quality management, public health disease surveillance and reporting. EMR can include real-time point-of-care data entry as well as retrospective data entry. An EMR is a digital version of a paper chart that contains key information in a patient's medical history from one service delivery point or site. The implementing partner should indicate whether the PEPFAR-supported service delivery areas have implemented and are actively using an electronic medical record system to assist clinical service provision or patient/program monitoring and reporting. Specifically, for PEPFAR reporting a minimum of 6 months of retrospective data should be included in the EMR. (For example, an ART EMR set up in September 2018 to contain at least 6 months of retrospective data (current patients that have been enrolled on ART) could be counted in the reporting at FY18 APR. **Individual service delivery area/point EMR versus Integrated Health EMR:** EMRs are typically for all health areas, but PEPFAR is interested in better understanding whether EMRs are available for the service delivery areas where PEPFAR focuses its work. If a service delivery area is incorporated in a larger integrated health EMR, then it should be included this indicator. If two or more service areas are in an integrated EMR, both areas should be included in this indicator. A site service delivery area should be reported under this indicator if the EMR is on site (i.e., server and computer entry screen or there is a central server at a hub facility, that includes all data from all the "spokes" for that facility's catchment area. As long as the data for patient management and reporting comes from the EMR system as one source.	

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

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

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

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

HRH_PRE

Description:	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	
Numerator:	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	The numerator is the sum of new health workers from the host country who graduated from a pre-service training institution within the reporting period with full or partial PEPFAR support. Individuals may be in pre-service training over a number of years but can be counted as graduated when they have completed their program. Graduates do not need to attend a formal ceremony – completing the program and receiving documentation is sufficient.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Above-Site	
Reporting frequency:	Annually	
How to use:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up health services. The lack of a sufficient workforce in countries presents a serious challenge to every area of health. The data will tell us the number of new health workers who are available to enter the health workforce each year as a result of PEPFAR support.	
How to collect:	Training under this indicator is defined as “pre-service” training – the training of “new” health workers (see definition below). Training generally occurs prior to the individual entering the health workforce in his or her new position (with the exception of certain training that may occur on-the job but that prepares health workers to function as a new cadre or with an expanded scope of practice in the health system). A health worker who advances to a higher cadre (e.g., a clinical assistant who completes training to become a clinical officer) shall be counted as a “new” health worker for the purposes of this indicator. The HRH goal is to expand the number of workers in the workforce and increase access to care through the advancement of current workers to higher level cadres through additional training and education. Pre-service training institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre’s entry into the workforce. “In-service” and “continuing education” training should not be included in the count for this indicator but continue to be encouraged. These types of training may be captured by other indicators within program areas (e.g., supply chain). In order to count, the duration of training must meet or exceed a minimum of 6 months. For example, community health workers who receive a 3-month training course cannot be counted here. The training duration may be a combination of classroom and practical field time to arrive at six months. A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained	

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>How to review for data quality:</td><td>N/A</td></tr>
<tr><td>How to calculate annual total:</td><td>N/A. Data is reported only once annually at Q4.</td></tr>
<tr><td>Disaggregations:</td><td>Numerator Disaggregations:
<table><tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr><tr><td>By Cadre:
[Required]</td><td>• Doctors
• Nurses
• Midwives
• Social Service Workers
• Laboratory Professionals
• Other</td></tr></table></td></tr>
</table>

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	As a service delivery area indicator, the PEPFAR support categories of DSD and TA-SDI do not apply. To report results for this indicator, it is expected that PEPFAR provides support for this activity as defined below. New health worker graduates of pre-service training institution or program will be counted as PEPFAR supported when PEPFAR is supporting the training of new health worker graduates, including: • Tuition and fees - At least 50% of the students' tuition and fees were or will be provided by PEPFAR for at least six months of their education • Curriculum development - The students received or will receive training where PEPFAR curriculum development was essential to qualify them for their trained role • Infrastructure - The students received or will receive six months or more of education at an institution that could not have supported their education without PEPFAR-supported infrastructure improvements (classrooms, dormitories, utilities) • Faculty support - The students received or will receive six months of more of education at an institution that could not have supported their education without one or more faculty members present and qualified due to PEPFAR support • Practica / internship support - The students would not have received or will not receive adequate practica or internship training without PEPFAR support (including transportation to or sufficient resources at the practicum facility) • Materials / equipment - The students would not have received or will not receive education without materials or equipment (including books and supplies) provided by PEPFAR • PEPFAR educational programs (for non-university-based training institutions) - The students received or will receive their education in a PEPFAR-funded, non-university-based education program for one or more courses without which they would not graduate or be qualified for the intended role	
PEPFAR-support definition:	No additional requirements needed outside of the standard definition.	
Guiding narrative questions:	1. For each cadre, describe nature of education (university, professional school), types of certification/accreditation (e.g., RN, LPN, ADN, BSN, NP, PA). 2. For each cadre, describe how training is leading to employment and service gap filling and aligned to reaching HIV epidemic control.	

LAB_PTCQI

Description:	Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing (POCT) sites engaged in continuous quality Improvement (CQI) and proficiency testing (PT) activities.	
Numerator:	• Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites engaged in CQI activities. • Number of PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites engaged in PT activities. • Number of specimens received for testing at all PEPFAR-supported laboratory-based testing and/or Point-of-Care Testing sites within a testing category.	The numerator is generated by counting the number of PEPFAR-supported laboratory-based testing and point-of-care testing sites for each testing category by their level of engagement in CQI and PT activities; and the number of specimens received for testing at laboratory-based testing and point-of-care testing sites within each testing category.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Annually	
How to use:	• **Monitoring Engagement in CQI and PT:** CQI and PT programs are critical to ensure efficient and quality assured laboratory testing. Monitoring testing sites' levels of engagement in CQI and PT enables the identification of facilities, geographic areas, and implementing partners that may benefit from additional support related to laboratory quality. Engagement in CQI and PT may also be used to monitor progress over time (e.g., progress toward laboratory accreditation) and maintenance of quality assured laboratory testing. ○ **Recommendations for engagement in CQI and PT are outlined below. Implementing partners reporting data that do not meet these recommendations should be prepared to provide detailed explanations and action plans.** ▪ 100% of laboratory-based testing sites participating in CQI and PT. ▪ 100% of HIV Viral Load and IVT/EID laboratory-based testing sites working towards accreditation. ▪ >70% of POCT sites, particularly HIV serology/diagnostic testing sites, participating in CQI and PT; with the goal of all POCT sites participating in CQI and PT. ▪ Year-over-year increases in the proportions of testing sites achieving higher levels of engagement in CQI (e.g., an increase in the proportion of accredited testing sites as compared to the previous year). Once saturation is achieved, it is critical that this indicator be used to monitor maintenance of CQI and PT programs. ▪ >90% of testing sites that conduct a test passing PT for that testing category • **Providing Context for Testing Results:** Levels of engagement in CQI and PT may be used to provide context for testing results at the facility, SNU, or OU levels. Testing results reported in an SNU where a low percentage of testing sites are engaged in CQI, for example, may infer a lower degree of confidence than if the SNU had a high percentage of testing sites engaged in CQI. Please note that enrollment and achievement in CQI and PT programs are proxy indicators for laboratory quality and provide an indication of quality practices rather than a direct measurement of testing quality at the site. • **Monitoring Availability of Laboratory Services:** The number of specimens received for each testing category assesses the extent to which PEPFAR-supported laboratories and/or POCT sites are maintaining or expanding laboratory services. The number of	

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

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

- Performs this test but does not participate in CQI.
- Performs this test and participates in CQI but has not been externally audited.
- Performs this test, participates in CQI, has been externally audited, and achieved a score of 0-1 (≤ 59%).
- Performs this test, participates in CQI, has been externally audited, and achieved a score of 2-3 (60%-89%).
- Performs this test, participates in CQI, has been externally audited, and achieved a score of 4-certified (≥ 90%).

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

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

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

DEFINITIONS (LABORATORY-BASED TESTING SITES):

Laboratory:

A. Having dedicated physical laboratory infrastructure
B. Having dedicated trained laboratory professionals performing testing
C. Conducting laboratory testing in one or more of the following areas:
    a. Diagnosis of HIV infection with rapid test kits, EIA, WB or other molecular methods
    b. Infant Virologic Testing / Early Infant Diagnosis (IVT/EID)
    c. HIV viral load
    d. TB diagnostics: Xpert, AFB, or culture
    e. CD4 testing
    f. Rapid Test for Recent Infection

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

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

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

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

A. Strengthening Laboratory Management Towards Accreditation (SLMTA)

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

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

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

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

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

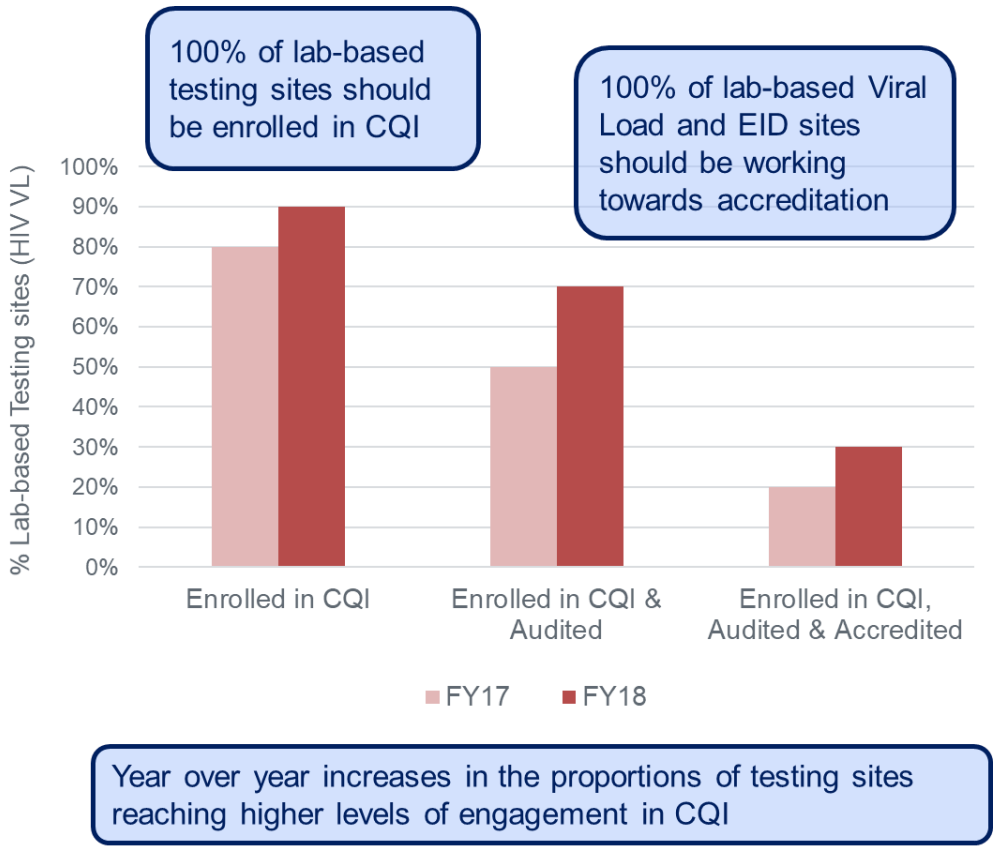
Specimen received for testing:
A specimen is received for testing if its arrival at the laboratory-based testing site was recorded in a register/log book and/or LIS within the reporting timeframe. A specimen received for testing may or may not have been tested/analyzed.

DEFINITIONS (POINT-OF-CARE TESTING SITES):

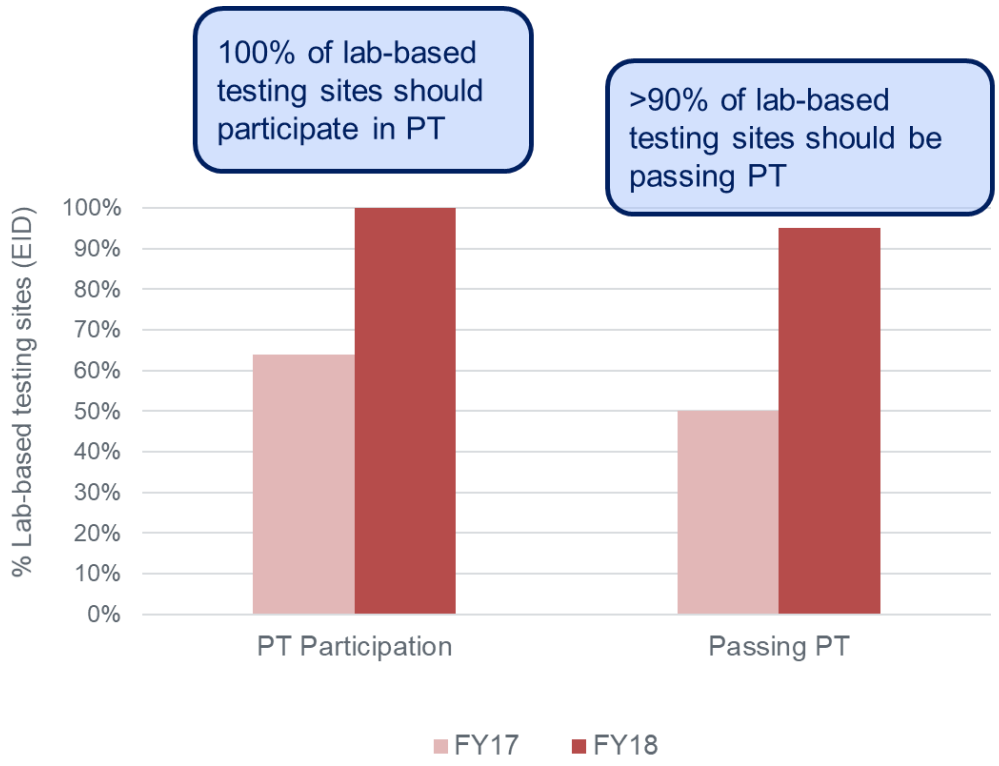
POCT site:
A. The site performs testing near or at the place of interaction with the patient/client.
B. The site performs testing in an environment which does not have a formal laboratory infrastructure.
C. Testing at the POCT site is performed by healthcare workers who may not be laboratorians.
D. Conducting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

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

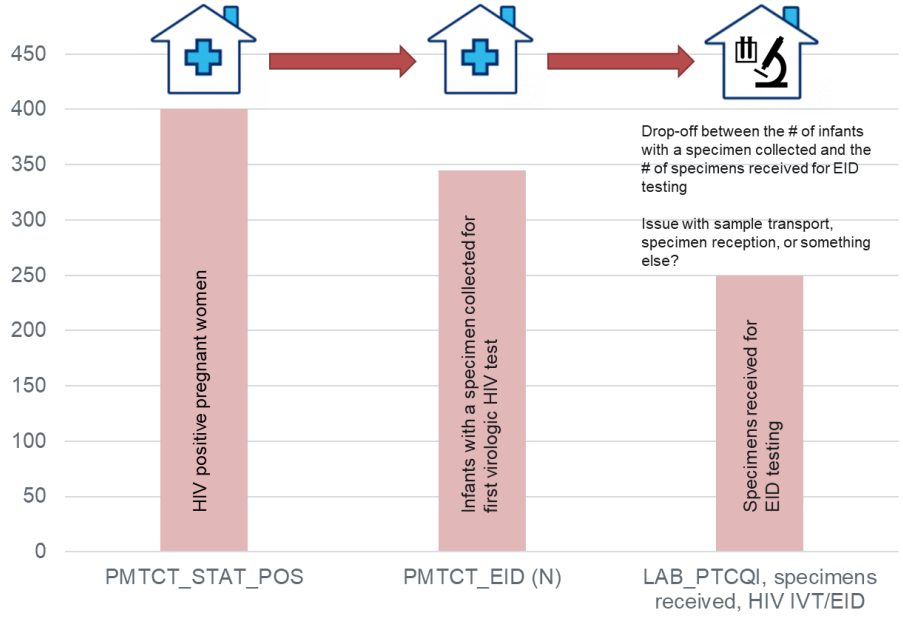
Disaggregations:	Numerator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	CQI at laboratory-based testing sites by test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4, Rapid Test for Recent Infection) [Required]	1. How many sites perform 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?
	CQI at point-of-care-based testing sites by test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4, Rapid Test for Recent Infection) [Required]	1. How many POCT sites perform this test but do not participate in CQI? 2. How many POCT sites perform this test and participate in CQI, but have not been externally audited or certified? 3. How many POCT sites perform this test, participate in CQI, and have been externally audited & achieved a score of 0-1 (≤ 59%)? 4. How many POCT sites perform this test, participate in CQI, have been externally audited & achieved a score of 2-3 (60%-89%)? 5. How many POCT sites perform this test, participate in CQI, have been externally audited & achieved a score of 4-certified (≥ 90%)?
	PT at laboratory-based testing sites by test category: HIV serology/diagnostic testing, HIV IVT/EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture, CD4, Rapid Test for Recent Infection) [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, Rapid Test for Recent Infection) [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, Rapid Test for Recent Infection) [Required]	Number of specimens received for testing at all PEPFAR-supported laboratory-based testing sites within a testing category

	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	• For both CQI and PT disaggregate groups, testing category disaggregations are only applicable if specific test category is performed by the laboratory. • The most recent PT panel with a score must be satisfactory/acceptable/successful to be counted as a passing score.	
PEPFAR-support definition:	Standard definition of DSD and TA-SDI used.	
Guiding narrative questions:	1. In the narrative, please define how the specimen volume was counted (i.e., specimen log, LIS, etc.).	
Data Visualization & Use Examples:	**Monitoring Engagement in CQI Example:**  	

Monitoring Engagement in PT Example:



Interfacing of the Clinic and Laboratory Example:



SC_ARVDISP

Description:	The number of adult and pediatric ARV bottles (units) dispensed by ARV drug category at the end of the reporting period	
Numerator:	Number of ARV bottles (units) dispensed within the reporting period by ARV drug category	Number of bottles of ARVs by category dispensed to patients
Denominator:	N/A	
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	Facility	
Reporting frequency:	Semi-Annually	
How to use:	This indicator measures the number of ARV bottles of several types of ARVs dispensed from a facility. These data should be used to help understand uptake, transition and maintenance of patients to optimized ARV regimens, as well as the phasing out of non-optimal regimens. By reviewing trends over time by each ARV category, programs should monitor coverage of DTG-based regimens relative to other regimens down to the implementing partner and facility level. In addition, data from this indicator should prompt action to investigate any specific sites dispensing regimens which may not be supported by the WHO Standard Treatment Guidelines (STGs).	
How to collect:	This indicator should be collected from facility dispensing registers, reported at the facility level, based on data available to the facility-based implementing partner, and could include: host government-supported Logistics Management Information System (LMIS). Operating Units (OUs) should work with IPs supporting facilities and/or the supply chain partners to access the facility dispensing registers or the LMIS to consolidate dispensing data by facility and ARV category. Data should be reported, as indicated, in the categories below: TLD 30-count bottles dispensed TLD 90-count bottles dispensed TLD 180-count bottles dispensed TLE/400 30-count bottles dispensed TLE/400 90-count bottles dispensed TLE 600/TEE bottles dispensed DTG 10 90-count bottles dispensed LPV/r 100/25 tabs 60 tabs/bottle dispensed LPV/r 40/10 (pediatric) bottles dispensed NVP (adult) bottles dispensed NVP (pediatric, (not including NVP 10) bottles dispensed Other (adult) bottles dispensed (as described below) Other (pediatric) bottles dispensed (as described below) This indicator should be reported from PEPFAR-supported facilities which provide treatment or report on treatment indicators, specifically: TX_NEW, TX_CURR, PMTCT_ART, and TB_ART. If an OU or a facility in given OU, does not report on any of these indicators, then they are not required to report on SC_ARVDISP. **ARV Dispensation Data Versus 'Issues Data'** If data on ARV dispensation are not available, 'issues data' may be used for reporting. 'Issues data' is defined as bottles of ARVs provided to facilities from a distribution center. If 'issues data' are used for reporting, include the following in the narrative section: (1) an explanation for doing so and (2) what steps will be taken to provide ARV dispensation data in the future. If data on ARV dispensation are incomplete at end of the reporting period, use	

<table>
<tr><td></td><td>EITHER ‘issues data’ or ‘dispensed data’. If availability of dispensed data does not align with the PEPFAR reporting period, use the data available from that reporting period and include the following in the narrative: (1) rationale for the data discrepancy and (2) which months are included in the data reported.

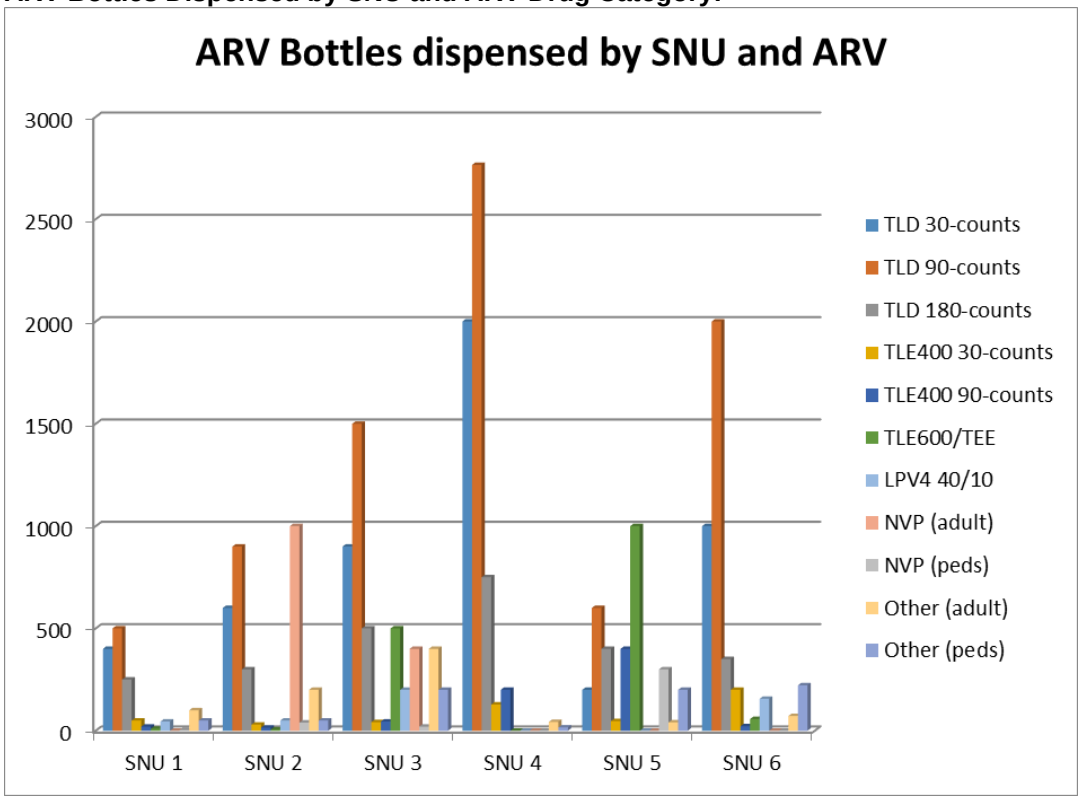
If an OU does not support any of the ARV drug categories in the disaggregates list, enter zero for each ARV category and provide an explanation in the narrative.

Do not include any commodities dispensed for PrEP services in reporting on this indicator. PrEP commodities include but are not limited to: Emtricitabine/Tenofovir 200/300 mg, Lamivudine/Tenofovir 300/300 mg, Dapivirine Vaginal Ring (DVR), and cabotegravir (CAB-LA).</td></tr>
<tr><td>How to review for data quality:</td><td>At each facility: ensure that the number of drugs dispensed is not greater than the stock issued to the site.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across reporting periods. This indicator represents the number of ARV bottles dispensed during each reporting period. At Q2, report the total number of bottles dispensed in the first six months of the fiscal year (i.e., Q1 and Q2). At Q4, report the total number of bottles dispensed in the last six months of the fiscal year (i.e., Q3, and Q4).</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Drug Categories
[Required]</td><td>• TLD 30-count bottles
• TLD 90-count bottles
• TLD 180-count bottles
• TLE/400 30-count bottles
• TLE/400 90-count bottles
• TLE 600/TEE bottles
• DTG 10 90-count bottles
• LPV/r 100/25 tabs 60 tabs/bottle
• LPV/r 40/10 (pediatric) bottles
• NVP (adult) bottles
• NVP (pediatric) bottles
• Other (adult) bottles (as described below)
• Other (pediatric) bottles (as described below)</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>For Drug categories:

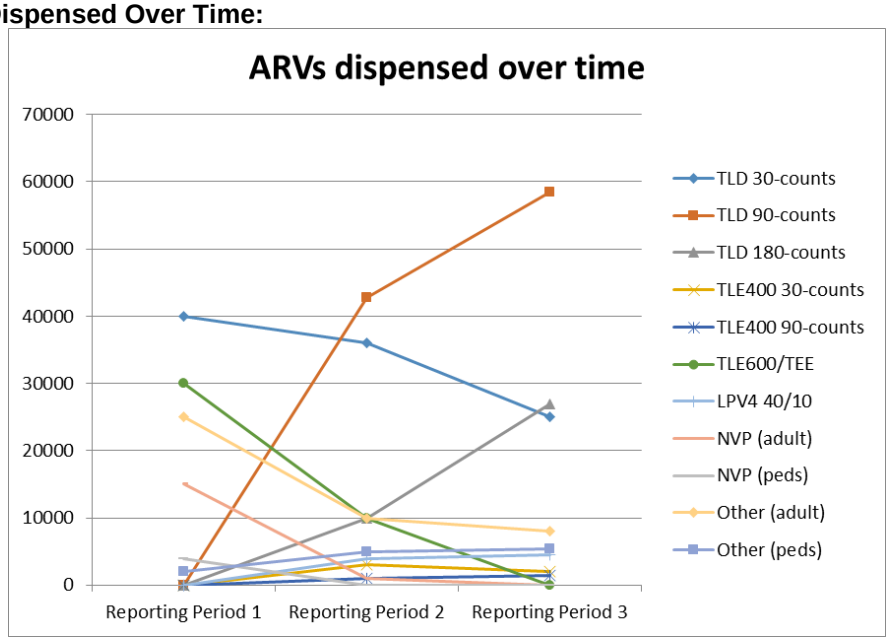
Products included in the “Other” category consist of, first, commodities not listed in the product-specific disaggregates and, second, those which are used for <u>second- and third-line treatment only</u>. These are expected to be a much smaller proportion of the total than Dolutegravir-based regimens. Indicative products belonging in the “Other (adult)” and “Other (pediatric)” lists are below but are not exhaustive.

Other (adult) bottles (Examples of adult bottles are below but are NOT EXHAUSTIVE.)
• Atazanavir/Ritonavir 300/100
• Lopinavir/Ritonavir 200/50 mg

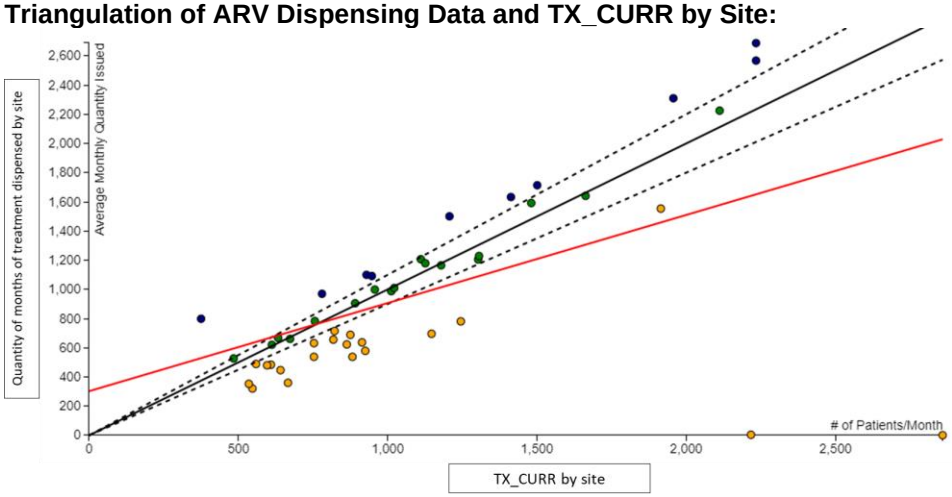
Other (pediatric) bottles (Examples of pediatric bottles are below but are NOT EXHAUSTIVE.)
• Darunavir 75 mg
• Raltegravir 100 mg (Granules for suspension)</td></tr>
</table>

PEPFAR-support definition:	**Nonstandard definition of DSD and TA-SDI:** **All facilities that report on TX_CURR (whether DSD or TA_SDI) are required to report on this indicator. Reporting is required regardless of which entity (PEPFAR, Global Fund, host country, etc.) supports the procurement of drugs for the facility.**
Guiding narrative questions:	1. What data source(s) are used for this indicator? Specify whether the quantities reported are those which are dispensed to the patients (preferred) or issued to the facilities from a distribution center. 2. Describe data on ARV dispensation data are reported through the system and how orders are calculated? a. Is the system managed through an 'informed push'? Is it a pull system? Is ARV dispensation data reported actual or is it an average/calculated/estimated? b. If an LMIS is available, how often do facilities report into the LMIS (e.g., monthly, quarterly)? 3. How does SC_ARVDISP compare to TX_CURR? What is the ratio between the two? 4. How do the quantities associated with 90 and 180 count bottles align with multi-month dispensation data? 5. If more frequent dispensation data are available (monthly or quarterly LMIS data, for example), especially data from the SC-FACT reporting system (as was recommended in the COP guidance), utilize that to further explain the data reported.
Data Visualization & Use Examples:	**ARV Bottles Dispensed by SNU and ARV Drug Category:** 

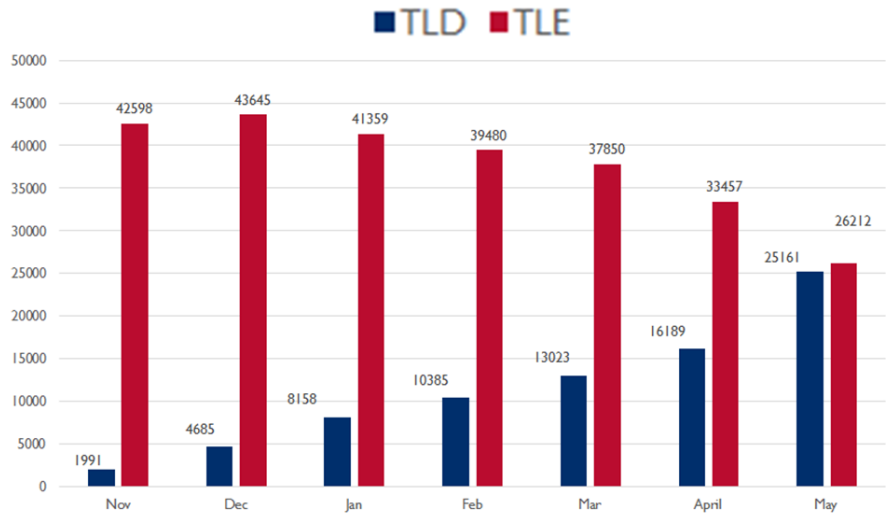
ARVs Dispensed Over Time:



Triangulation of ARV Dispensing Data and TX_CURR by Site:



Monitoring TLD Transition:



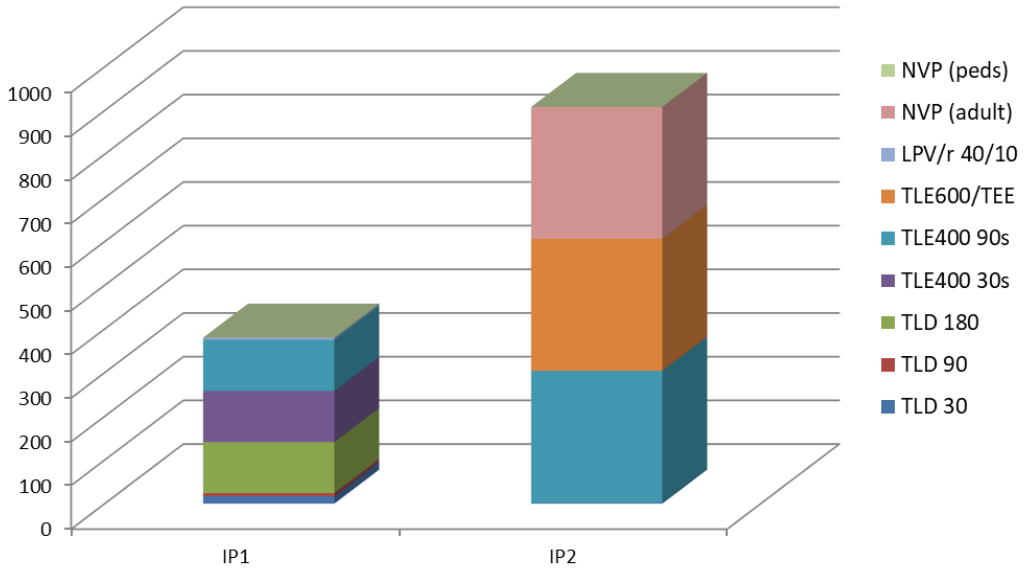
SC_CURR

Description:	The current number of ARV drug units (bottles) at the end of the reporting period by ARV drug category	
Numerator:	The number of ARV drug units (bottles) at the end of the reporting period by ARV drug category	
Denominator:	N/A	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None	
Reporting level:	PEPFAR-supported facilities as well as intermediate or central warehouses and/or locations where ARVs are held in inventory)	
Reporting frequency:	Semi-Annually	
How to use:	This indicator measures the number of ARV drug units available at the time of reporting. This can serve as an indication of the current stock levels at PEPFAR-supported facilities. The indicator is designed to provide insight into the 'on-the-shelf' availability of crucial products, required for HIV treatment. Data from this indicator may be coupled with SC_ARVDISP to determine how long the quantity of stock will last based on past ARV dispensation records. Similarly, data from this indicator can be used with forecasting data to illustrate that either sufficient stock are available for future or an upcoming need by ARV category exists. Data from SC_CURR can be used in many ways, such as: (1) to justify a change in the supply plan (i.e., if one ARV drug category is overstocked while another is understocked), (2) to illustrate if a ARV drug category is not being dispensed as anticipated, (3) to determine if an ARV drug category is overstocked, (4) to determine where ARVs may be overstocked, (5) to identify bottlenecks or sites where stock is available and, when coupled with SC_ARVDISP, not dispensed. Data can also be used to examine the relationship between facilities dispensing to patients and sites providing ARVs to dispensing sites (i.e., warehouses) to determine if quantities held at any site are reasonable.	
How to collect:	This indicator should be collected from facility dispensing registers or stock records, reported at the site level, based on data available to the facility-based implementing partner, but could include host government-supported Warehouse or Logistics Management Information System(s) (LMIS) as well. Operational Units (OUs) should work with IPs supporting facilities and/or the supply chain IPs to access facility dispensing registers or the LMIS to consolidate dispensing data by site and ARV category for reporting. Data should be reported, as indicated, in the categories below: TLD 30-count bottles TLD 90-count bottles TLD 180-count bottles TLE/400 30-count bottles TLE/400 90-count bottles TLE 600/TEE bottles DTG 10 90-count bottles dispensed LPV/r 100/25 tabs 60 tabs/bottle dispensed LPV/r 40/10 (pediatric) bottles NVP (adult) bottles NVP (pediatric), (not including NVP 10) bottles Other (adult) bottles (as described below) Other (pediatric) bottles (as described below) This indicator should be used to describe any anticipated stock-outs, ARV gaps, or are	

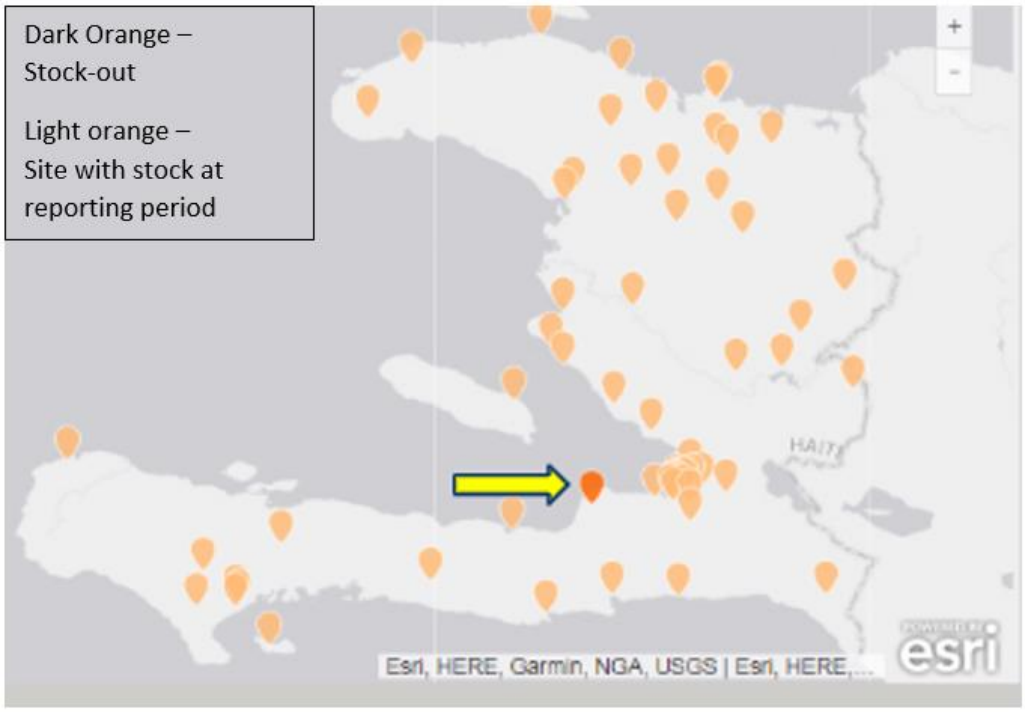
<table>
<tr><td></td><td>unable to extend their treatment coverage due to supply constraints. In addition, programs should utilize monthly data on each ARV drug category, when available, especially if those data are collected for donor organization and collaboration (such as the PPMR-HIV or SC-FACT).
If any OU does not support one of the drugs in the disaggregate list, report zero and note it in your narrative.
Do not include any commodities dispensed for PrEP services in reporting on this indicator. PrEP commodities include but are not limited to: Emtricitabine/Tenofovir 200/300 mg, Lamivudine/Tenofovir 300/300 mg, Dapivirine Vaginal Ring (DVR), and cabotegravir (CAB-LA).</td></tr>
<tr><td>How to review for data quality:</td><td>N/A</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator measuring the number of units of ARV drugs currently available at the end of reporting period.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Drug Categories
[Required]</td><td>TLD 30-count bottles
TLD 90-count bottles
TLD 180-count bottles
TLE/400 30-count bottles
TLE/400 90-count bottles
TLE 600/TEE bottles
DTG 10 90-count bottles
LPV/r 100/25 tabs 60 tabs/bottle
LPV/r 40/10 (pediatric) bottles
NVP (adult) bottles
NVP (pediatric) bottles
Other (adult) bottles
Other (pediatric) bottles</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Products included in the “Other” category consist of, first, commodities not listed in the product-specific disaggregates and, second, those which are used for <u>second- and third-line treatment only</u>. These are expected to be a much smaller proportion of the total than Dolutegravir-based regimens. Indicative products belonging in the “Other (adult)” and “Other (pediatric)” lists are below but are not exhaustive.

Other (adult) bottles (Examples of adult bottles are below but are NOT EXHAUSTIVE.)
Atazanavir/Ritonavir 300/100
Lopinavir/Ritonavir 200/50 mg
Other (pediatric) bottles (Examples of pediatric bottles are below but are NOT EXHAUSTIVE.)
Darunavir 75 mg
Raltegravir 100 mg (Granules for suspension)</td></tr>
<tr><td>PEPFAR-support definition:</td><td>Nonstandard definition of DSD and TA-SDI:

All facilities that report on TX_CURR (whether DSD or TA_SDI) are required to report on this indicator. Reporting is required regardless of which entity (PEPFAR, Global Fund, host country, etc.) supports the procurement of drugs for the site.</td></tr>
</table>

	All warehouses that supply drugs to PEPFAR-supported sites are required to report on this indicator.
Guiding narrative questions:	1. What data source(s) are used to report on this indicator? Specify whether the data source is: the LMIS, Forecasting software or database, the central medical stores warehouse information system, the PPMR-HIV (Procurement Planning and Monitoring Report for HIV), and/or another source. 2. Report when the quantification was done and if the forecast or supply plan have been updated recently, if so, provide a date and whether or not the data from SC_CURR informed that action. 3. Describe the drug distribution period (e.g., monthly, bi-monthly, etc.)? 4. If the SC_CURR data plus an outside forecast or quantification demonstrates that a stock out will occur for any medication at the central or intermediate levels, please describe why and what is being done to mitigate that stock out or if it was planned, i.e., a product no longer recommended in the standard treatment guidelines. 5. If the data shows waste, please describe why and what is being done to mitigate this event as well as any plans for environmentally safe destruction. Likewise, if funding is unavailable for destruction, please describe that. 6. Are stock-outs a problem at the time of report? Use the data to determine why the stock-out occurred. If data outside SC_CURR and SC_ARVDISP are used to determine why the stock-out occurred, please describe that analysis and actions taken to mitigate. 7. During the reporting period, have stock-outs been a problem? 8. Use the data to show any anticipated gaps, needed shipments, under- or overstocks, or stock appropriate situations based on current and expected consumption/dispensed to patients.
Data Visualization & Use Examples:	**Count of Sites Reporting Stock-out by Product and IP:** 

Sites with Stock-Outs vs. Stock:



HOST COUNTRY INDICATORS

DIAGNOSED_NAT

Description:	Percentage of people living with HIV who know their HIV status
Numerator:	Number who know their HIV status
Denominator:	Number of people living with HIV (PLHIV Estimate)
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	Diagnosed is the first 90 of the global targets. To ensure people living with HIV receive the care and treatment required to live healthy, productive lives, and to reduce the chance of transmitting HIV, it is critical that they know their status. In many countries, targeting testing and counselling at locations and populations with the highest HIV burden will be the most efficient way to reach people living with HIV and ensure they are aware of their status. This indicator captures the efficacy and coverage of HIV testing interventions. This indicator is harmonized with GAM indicator "People living with HIV who know their HIV status."

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

Disaggregations:

Numerator Disaggregations:

Disaggregate Groups	Disaggregates
Age/Sex [Required]	• <15 F/M, 15+ F/M
Sex-Only	• Female • Male

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

TX_CURR_NAT

Description:	Percentage of people living with HIV receiving antiretroviral therapy
Numerator:	Number of PLHIV on ART at the end of the reporting period
Denominator:	Number of people living with HIV (PLHIV Estimate)
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	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 GAM indicator "People living with HIV on antiretroviral therapy." **It is imperative that country teams use the host country indicator narrative to describe what definition of interruption in treatment/loss to follow-up is being used for TX_CURR reporting. Does the host country result assume an IIT/LTFU definition of <28 days or <90 days?**
How to collect:	This indicator measures the progress towards providing antiretroviral therapy to all people living with HIV. The data source for this indicator is ART program monitoring tools, such as ART patient registers, pharmacy dispensing records, and summary reporting forms. The number of adults and children receiving treatment can be obtained through data from facility- based antiretroviral therapy registers or drug supply management systems. Data should be collected continuously and aggregated on a monthly or quarterly basis to obtain subnational and national totals. The most recent full year of data should be used for annual reporting. Data should be collected from health facility recording and reporting forms, program data, health information system. This indicator can be generated by counting the number of adults and children receiving antiretroviral therapy at the end of the reporting period. This value should equal the number of adults and children who have ever started antiretroviral therapy minus those not currently on treatment prior to the end of the reporting period. This will exclude those who died, stopped treatment or were experienced interruption in treat 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.

<table>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex (Fine)
[Required, if possible]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M</td></tr>
<tr><td>Age/Sex (Coarse)
[Conditional, if finer is not possible]</td><td>• <15 F/M, 15+ F/M</td></tr>
<tr><td>Sex-Only
[Conditional, if both fine age/sex and coarse age/sex are not possible]</td><td>• Female
• Male</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Data entered by:</td><td>PLHIV Estimates</td><td>Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [PLHIV estimates submitted in the PEPFAR Implementation and Planning Attributes].</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">This data should be entered in DATIM by the USG country team.</td></tr>
<tr><td></td><td colspan="2">1. Does the host country TX_CURR result assume an IIT/LTFU definition of <28 days or <90 days? Describe the data systems and methods of aggregation used at the national and subnational levels to report treatment data.
2. Outline any work that the host country government has done to ensure that the reported figures are accurate (i.e., data quality assessments, results adjustment, etc.).
3. Discuss progress towards aligning host-country age/sex disaggregations to standard five-year age and sex bands?
4. For targets, please describe the host country target setting process.</td></tr>
</table>

VL_SUPPRESSION_NAT

Description:	Percentage of people living with HIV who have suppressed viral loads at the end of the reporting period
Numerator:	Number of people living with HIV and on ART [in the reporting period] who have a suppressed viral load (<1000 copies/mL)
Denominator:	Number of people living with HIV (PLHIV Estimate)
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	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 GAM indicator "People living with HIV who have suppressed viral loads."
How to collect:	The numerator can be generated by counting the number of adults and children receiving antiretroviral therapy who have a suppressed viral load at the end of the reporting period. Count the patient if, during the reporting months, viral load has been recorded and is <1000 copies/mL. For countries with other thresholds (e.g., undetectable <50 copies/ml or <400 copies/ml), preliminary evidence from several studies suggests the proportion of those with 50 copies/ml or above and less than 1000 copies/ml is small, so no adjustment is required. The testing threshold value should be reported in the narrative for countries with thresholds other than <1000 copies/ml. Viral-load testing should be routine rather than targeted (e.g., when treatment failure is suspected). If multiple viral-load tests are done annually for a person, only the last routine test result should be reported. Results from targeted viral loads should not be reported. If viral-load testing coverage is less than 75% of those receiving antiretroviral therapy in the reporting year, results should be interpreted with caution. Tools for measuring viral load may vary across countries. Routine viral-load suppression tests from clinical and program data should be reported where available. In countries where such data are not available, results from HIV population-based surveys or drug-resistance surveys based on a random sample of people on antiretroviral therapy may be reported. Countries should report the source of the numerator and denominator data, and data from both sources should be reported if available, although clinical and program data are preferred. If results from a survey are used, that should be included when reporting. Where clinical and program data are available from routine monitoring systems, results will be recorded in patient files or in a laboratory system. Data should be de-duplicated where patients receive multiple viral-load tests in a year. If an HIV population-based or drug-resistance survey is used in place of routine program monitoring data, measurement of viral load should be done for the entire population of HIV-positive individuals where ARV is detected in specimens. Self-reported treatment status has been shown to be of limited quality. Therefore, viral-load estimates among those who report receiving antiretroviral therapy should not be used.

<table>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex (Fine)
[Required, if possible]</td><td>• <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M</td></tr>
<tr><td>Age/Sex (Coarse)
[Conditional, if finer is not possible]</td><td>• <15 F/M, 15+ F/M</td></tr>
<tr><td>Sex-Only
[Conditional, if both fine age/sex and coarse age/sex are not possible]</td><td>• Female
• Male</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>PLHIV Estimates</td><td>Denominator is not collected as part of indicator, but rather is submitted in DATIM during COP planning [PLHIV estimates submitted in the PEPFAR Implementation and Planning Attributes].</td></tr>
<tr><td>Data entered by:</td><td colspan="2">This data should be entered in DATIM by the USG country team.</td></tr>
<tr><td>Guiding narrative questions:</td><td colspan="2">1. Describe the data systems and methods of aggregation used at the national and subnational levels to report treatment data.
2. Outline any work that the host country government has done to ensure that the reported figures are accurate (i.e., data quality assessments, results adjustment, etc.).
3. Discuss progress towards aligning host-country age/sex disaggregations to standard five-year age and sex bands?
4. For targets, please describe the host country target setting process.</td></tr>
</table>

PMTCT_STAT_NAT

Description:	Percentage of pregnant women with known HIV status
Numerator:	Number of pregnant women attending antenatal clinics (ANC) and/or had a facility-based delivery and were tested for HIV during pregnancy, or already knew they were HIV positive
Denominator:	Number of pregnant women who attended ANC or had a facility-based delivery in the past 12 months
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	The risk of mother-to-child transmission (MTCT) can be significantly reduced by providing ARVs to the mother during pregnancy, delivery and (if applicable) breastfeeding. This indicator provides information on coverage of the first step in the prevention of mother-to-child transmission (PMTCT) cascade. High coverage enables early initiation of care and treatment for HIV-positive mothers. The total number of identified HIV-positive women provides the facility-specific number of pregnant women with HIV to start a facility-based PMTCT cascade. This indicator is harmonized wit GAM indicator "Percentage of pregnant women with known HIV status."
How to collect:	For the numerator and denominator: The data source is ANC, PMTCT and L&D program monitoring tools, such as patient registers and summary reporting forms. Numerator: Count all women who were enrolled in ANC during the 12-month reporting period whose HIV status is known positive, or who received an HIV test result (positive or negative) during ANC. Reconcile with all women in the L&D register who whose date of delivery was in the 12 months reporting period and whose HIV status at L&D was known positive, or who received an HIV test result (positive or negative) at ANC or L&D to avoid double counting. The numerator is a composite of the following two data components: 1. The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period 2. The number of women attending ANC, L&D who were tested for HIV and received results The numerator can be summed from categories a-d below: a. Number of pregnant women with unknown HIV status attending ANC who received an HIV test and result during the current pregnancy b. Pregnant women with known HIV infection attending ANC for a new pregnancy c. Number of pregnant women with unknown HIV status attending L&D who received an HIV test and result during their current pregnancy d. Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested for the first time in the current pregnancy and received results. A "status" is defined as a confirmed test result from a test during this pregnancy (either positive or negative) or already known HIV infection at antenatal clinic entry. An indeterminate test result should not be counted or reported as a part of this indicator. For the denominator: Count all women who were enrolled in ANC during the 12-month reporting period OR delivered at the facility (recorded in the L&D register), reconciling the latter with the former using the ANC No. to avoid double counting. As per global guidance (see GARPR link above), it is expected that the national program can reconcile information collected from ANC with L&D records. However, in MER 2.0 the

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>Disaggregations:</td><td>Numerator Disaggregations:<table><tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr><tr><td>Disaggregated by Status [Required]</td><td>• Known positives
• New positives
• New negatives</td></tr></table>Denominator Disaggregations:<table><tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr><tr><td>None</td><td>None</td></tr></table></td></tr>
<tr><td>Data entered by:</td><td>This data should be entered in DATIM by the USG country team.</td></tr>
<tr><td>Guiding narrative questions:</td><td>1. Narratives should include information on how national and subnational totals have been derived for both results and targets.
2. Provide context for poor performance in PMTCT_STAT coverage (Numerator/Denominator = STAT coverage) by geographic area. Include any planned activities/remedial actions.</td></tr>
</table>

PMTCT_ART_NAT

Description:	Percentage of HIV-positive pregnant women who received antiretroviral medicine (ARV) during pregnancy to reduce the risk of mother-to-child transmission
Numerator:	Number of HIV-positive pregnant women who delivered and received ARV to reduce the risk of mother-to- child transmission during pregnancy and delivery.
Denominator:	Estimated number of HIV-positive pregnant women
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	The risk of mother-to-child transmission can be significantly reduced by providing ARVs for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretroviral medicines to the mother or child if breastfeeding, and the use of safe delivery practices and safer infant feeding. The data will be used to track progress towards global and national goals of eliminating mother-to-child transmission; to inform policy and strategic planning; for advocacy; and for leveraging resources for accelerated scale-up. It will help measure trends in coverage of antiretroviral prophylaxis and treatment, and when disaggregated by regimen type, will also assess progress in implementing more effective antiretroviral therapy regimens. As the indicator usually measures ARVs dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases. This indicator is harmonized with GAM indicator "Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of MTCT of HIV."
How to collect:	For the numerator: the source of this information is national program records aggregated from program monitoring tools, such as patient registers and summary reporting forms. The numerator can be generated by counting the number of HIV-positive pregnant women who received antiretrovirals to reduce MTCT in the reporting period, by regimen. For the denominator: Two methods can be used to estimate the denominator: an estimation model, such as Spectrum, using the output, number of pregnant women needing PMTCT; or, if Spectrum estimates are not available, by multiplying the number of women giving birth in the past 12 months (which can be obtained from estimates of the central statistics office, UN Population Division or pregnancy registration systems) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in ANC and appropriate adjustments related to coverage of ANC surveys).
Disaggregations:	**Numerator Disaggregations:**

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

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
None	None

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

VMMC_CIRC_NAT

Description:	Number of males circumcised during the reporting period according to national standards
Numerator:	Number of males circumcised during the reporting period according to national standards
Denominator:	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	There is compelling evidence that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions in which heterosexual activity plays a significant role in HIV transmission. This indicator is harmonized with GAM indicator "Number of male circumcisions performed according to national standards during the past 12 months." Males should be provided with circumcision as part of the VMMC for HIV prevention program and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia, or other WHO normative guidance (in the case of device-based VMMC), and per national standards by funded programs/sites in the reporting period meet the definition for the numerator. Males who are provided with circumcision using a medical device by funded programs/sites in the reporting period also meet the definition for the numerator as long as the device used is recognized or pre- qualified by WHO.
How to collect:	This indicator measures the progress in scaling up male circumcision services and should be calculated by counting male clients documented as having received VMMC within the reporting period from VMMC Registries or clients' medical records maintained by programs at Priority SNU level. Data should be collected from health facility recording and reporting forms, program data, health information system, or data maintained at Priority SNU level.
Disaggregations:	**Numerator Disaggregations:**

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

Denominator Disaggregations:

Disaggregate Groups	Disaggregates
N/A	N/A

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

VMMC_TOTALCIRC_NAT

Description:	Percentage of men ever circumcised
Numerator:	Total number of men ever circumcised
Denominator:	Total population of men in the corresponding age category
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	There is compelling evidence that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions in which heterosexual activity plays a significant role in HIV transmission. This indicator is harmonized with GAM indicator "Percentage of men 15–49 that are circumcised."
How to collect:	Estimates derived from population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Surveys or other representative surveys); this indicator will help to determine male circumcision prevalence. The total number of men circumcised should include all men circumcised regardless if circumcised at birth, as part of the VMMC program or at any other time during their lifetime. The denominator for this indicator is the number of male populations estimates, disaggregated by age (<15, 15-29, 30+). This information is collected under the population estimates indicator in the IMPATTS (Implementation and Planning Attributes). A guide to indicators for male circumcision programs in the formal health care system. Geneva, World Health Organization/UNAIDS, 2009. http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf
Disaggregations:	**Numerator Disaggregations:**

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

Denominator Disaggregations:

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

Data entered by:	This data should be entered in DATIM by the USG country team.
Guiding narrative questions:	1. Narratives should include information on how national and subnational totals have been derived for both results and targets.

HRH_STAFF_NAT

Description:	Number of health workers who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) based out of PEPFAR-supported facility sites.
Numerator:	Number of health workers who are working on any HIV-related activities (i.e., prevention, treatment and other HIV support) based out of PEPFAR-supported facility sites.
Denominator:	N/A
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	Report at all PEPFAR-supported site: This indicator is the number of occupied positions working on HIV based out of PEPFAR facility sites.
Reporting frequency:	Annually
How to use:	This indicator is the total number of staff working on HIV based out of PEPFAR facility sites. This includes staff engaged in community work, but who are supported and based out of a PEPFAR supported facility. This includes but is not limited to Community Health Workers (CHWs) engaged in outreach, ARV delivery, or working as Linkage Officers, Peer Navigators, or Adherence Group coordinators. This is NOT a cumulative total, but a one-time count undertaken during the final quarter. Only filled staff positions at respective facility should be counted. For this indicator, a “PEPFAR supported site” should include any facility site in the PEPFAR geographic organizational hierarchy list in DATIM, which also reported any site-level programmatic target or result during the same reporting period. Omit facilities which were previously supported by PEPFAR but were not assigned any targets nor reported any results for any program area during the same reporting period. Include all health care workers irrespective of whether any or all are receiving PEPFAR support. We do NOT need any workers reported at the community level for this indicator; workers supported by the government or other organizations, but not based out of a PEPFAR supported facility should not be reported. HIV/AIDS has placed significant demands on the already constrained health workforce in many low-income countries. The rapid scale-up of ART is placing additional demands on the health workforce. In the majority of PEPFAR countries, there are overall shortages of HRH, particularly in rural and remote areas, leading to insufficient numbers of health workers according to internationally recommended levels (2.3 doctors, nurses, midwives/1,000 population). Many countries experience HRH shortages and/or imbalances by population densities (e.g., HRH shortages in rural areas) that are not related to population health needs, including HIV epidemiology. Addressing density, distribution, and overall utilization of HRH is important in increasing access to HIV services. This indicator allows PEPFAR to analyze the availability of staff to provide HIV services at PEPFAR supported facilities. Data should be reviewed against site target achievement and investment. The first year of data collection will serve as an Integral benchmark for continued analysis. Teams can also look at this indicator in conjunction with data from the HRH Inventory that captures number of PEPFAR supported workers at PEPFAR-supported sites. This will allow PEPFAR to conduct analysis to determine if the number of PEPFAR-supported staff is appropriate vis-à-vis the number of other staff at the facility providing HIV services. There is no universal benchmark against which to measure these data and no ideal PEPFAR to non-PEPFAR ratio. However, over time we would hope to see a decrease in the number of PEPFAR-supported staff. As this happens countries should carefully monitor

<table>
<tr><td></td><td>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>A “PEPFAR supported site” for the purpose of this indicator includes any facility site in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period.

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

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

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

If possible, avoid collecting data across a period which spans across a major budgetary change or a health worker graduation and placement period.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>By Cadre Category Type: [Required]</td><td>• Clinical
• Pharmacy
• Laboratory
• Management
• Social service
• Lay
• Other HCWs</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Data entered by:</td><td>This data should be entered in DATIM by the USG country team.</td></tr>
<tr><td>Guiding narrative questions:</td><td>1. For all categories of workers, including other, please provide description of specific cadres in the narrative when reporting.</td></tr>
</table>

KP_MAT_NAT

Description:	Percentage of people who inject drugs (PWID) on medication assisted therapy
Numerator:	Number of people who inject drugs (PWID) on medication assisted therapy
Denominator:	Estimated number PWID
Indicator changes (MER 2.0 v2.6 to v2.6.1):	None
Reporting level:	National and Sub-national: Data should be entered for all SNUs, regardless of PEPFAR-funded support for these geographical areas; so that the total of the sub-national number should equal the total number of national number.
Reporting frequency:	Annually
How to use:	Medication assisted therapy programs should be an access point for PWID and the program should refer and link to ARV treatment programs, PMTCT for female PWID and a range of other prevention services. It is important to know how many people are reached in order to monitor how well programs are reaching PWIDs with medication-assisted treatment. This information can be used to plan and make decisions on how well the PWID audience is being reached with medication-assisted treatment. If a small percentage of the intended audience is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarters staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models. This indicator is harmonized with GAM indicator "Percentage of people who inject drugs receiving opioid substitution therapy."
How to collect:	The numerator is generated by counting the total number of individuals who have been on treatment for at least 6 months since initiation of medication-assisted treatment (e.g., using methadone or buprenorphine to treat drug dependency) at any point in time within the reporting period. The numerator should equal the number of adults who initiated and remain on medication-assisted treatment for at least 6 months prior to the end of the reporting period.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Sex [Required]	• Female • Male

Denominator Disaggregations:

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

Data entered by:	This data should be entered in DATIM by the USG country team.
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.

MONITORING SPECIAL INITIATIVES

DREAMS

Relevant DREAMS guidance and resources include:

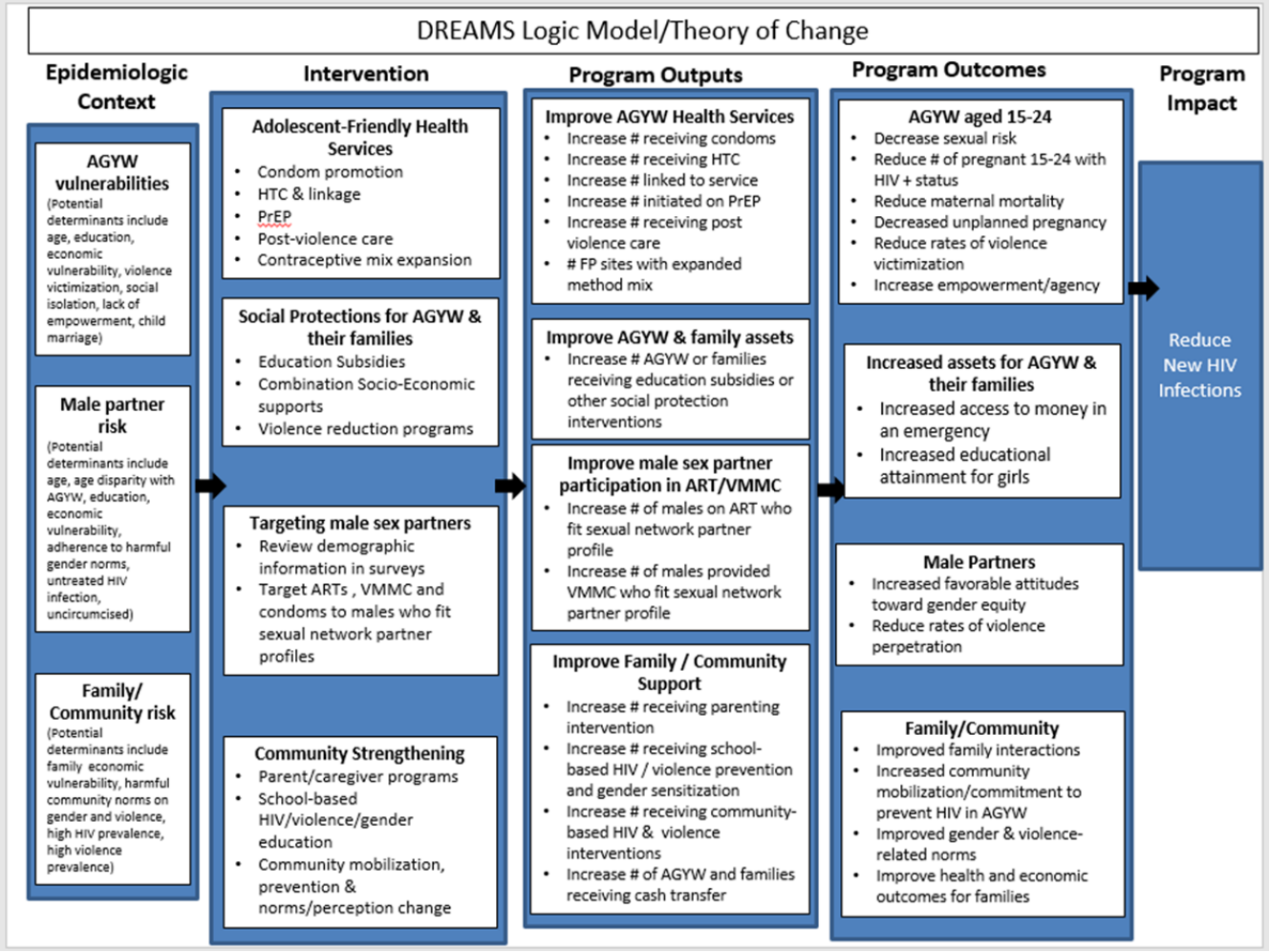
- Current DREAMS Guidance: details the rationale behind DREAMS and the interventions implemented as part of the DREAMS core package
  - Access via: PEPFAR Solutions Platform
- DREAMS Program Completion and Saturation Document: addresses when DREAMS as a package of comprehensive interventions can be considered complete at the individual level, and how OUs can document that DREAMS has saturated at the SNU level among all relevant age groups of AGYW
  - Access via: PEPFAR Solutions Platform, Appendix E of the DREAMS Guidance
- AGYW_PREV Indicator Reference Sheet: details reporting guidance on the newest DREAMS indicator that monitors layering within DREAMS programs
  - Access via: DATIM Data Entry Form Screenshot Repository (DATIM login is required)

The DREAMS Monitoring & Evaluation (M&E) Framework provides a conceptual model for the monitoring and evaluation of DREAMS implementation and outlines key questions and data sources. It is both a reference and resource for the fifteen DREAMS countries.

DREAMS M&E Framework		
	Key Questions	**Data Sources**
MONITORING: How well are we implementing DREAMS?	• Are we reaching targets for DREAMS indicators? • Are we reaching the most vulnerable AGYW? • Is layering happening as intended for all AGYW receiving DREAMS services? • Are programs being implemented evidence-based and of high quality? • Are sex partners of AGYW being linked to VMMC, testing, and treatment services as needed?	• PEPFAR MER indicators • Semiannual AGYW_PREV & DREAMS narratives (submitted in DATIM) • OU layering databases & custom indicators • Population Council implementation science projects
EVALUATION: Is DREAMS making a difference?	• Is there a reduction in new diagnoses and/or infections among females 15-24 in DREAMS geographic locations? • Are there changes in other outcomes important to the lives of AGYW (e.g. secondary school enrollment and completion, GBV, teen pregnancy)? • Have layered DREAMS interventions mitigated vulnerability and led to improved health outcomes for AGYW?	• Directly observed changes in incidence through special studies • Modeling of new diagnoses in ANC settings • Recency testing • Survey data (PHIAs, IBBS, VACs, DHS, OVC essential surveys) • Administrative data (e.g. school enrollment and matriculation, pregnancy rates) • Evaluative assessment of socio-economic, behavioral and health outcomes among AGYW and young men (before, during, after DREAMS interventions)

Logic Model

As illustrated within the PEPFAR DREAMS Guidance, DREAMS follows a logic model that guides how programs are monitored and evaluated. The logic model lays out the epidemiologic and sociologic context that puts AGYW at higher risk of HIV infection, interventions proposed to address these contextual factors, expected outputs and outcomes of these interventions, and the overall projected impact of those interventions when implemented jointly. The logic model is purposely high level as it applies to all 15 DREAMS countries, but may be adapted to fit specific country plans, context, and M&E frameworks.



Reporting Requirements

To monitor and evaluate DREAMS programming and progress, 13 MER indicators are reviewed on a quarterly, semi-annual, and annual basis per PEPFAR MER v2.6.1 guidelines and are required for reporting by DREAMS countries. DREAMS programming should be taken into account when setting targets for all of the DREAMS-related indicators. It is essential that all implementing partners in DREAMS SNUs set targets with finer age/sex disaggregates. The table below details the specific disaggregates of each indicator that are used by HQ and field staff to monitor DREAMS programming. Results from these indicators are also used to inform evaluation of DREAMS programming and implementation.

DREAMS countries are also required to complete semi-annual narratives about AGYW_PREV and DREAMS implementation (both found in DATIM under AGYW_PREV). DREAMS countries are encouraged to monitor interventions progress using custom indicators for program components that do not have existing MER indicators (e.g. education support, contraceptive method mix, condom promotion and provision). AGYW_PREV is a semi-annual indicator introduced for reporting beginning in FY19. AGYW_PREV is a DREAMS-specific indicator meant to track layering within DREAMS, specifically the percentage of active DREAMS beneficiaries that have completed the DREAMS primary package of evidence-based services/interventions to ensure that they remain HIV-free. This indicator will require that all DREAMS countries have a system to track individual AGYW's receipt of DREAMS services including unique identifiers for all AGYW.

This indicator is entered at the community level by the USG team, not implementing partners, reflecting that successful implementation of layering involves multiple implementing partners over time. Please see the AGYW_PREV indicator reference sheet for detailed information on this indicator.

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

Narrative Requirements

Each DREAMS OU should submit one narrative response per country to the questions below based on input from all agencies and implementing partners. These narratives will be submitted in DATIM semi-annually (at Q2 and Q4). These questions refer to the DREAMS Program Completion and Saturation Document.

1) Describe your process for determining the DREAMS program completion status of each DREAMS beneficiary. How many DREAMS beneficiaries have reached program completion (cumulatively and in the reporting period)? How often are AGYW monitored to record program completion progress?
2) Describe your process for determining saturation within each DREAMS SNU. What data sources are you using to estimate the DREAMS saturation denominator for each age group? What is the saturation status of each current DREAMS SNU?

FAITH AND COMMUNITY INITIATIVE

The aim of the PEPFAR Faith and Community Initiative is to address gaps toward achieving HIV epidemic control and ensuring justice for children, leveraging PEPFAR's partnership with faith-based organizations and communities. Through this partnership, PEPFAR will support innovative approaches to reaching young men, adolescent girls and young women, and HIV positive children with HIV prevention and treatment services. In fulfillment of quarterly, semi-annual, and annual reporting requirements, PEPFAR Faith and Community Initiative implementing partners are able to demonstrate how demand creation in churches and/or mosques impact HIV case-finding, linkage and continuity of HIV services among men and children within each country's priority SNUs. PEPFAR OUs and implementing partners are requested to monitor PEPFAR Faith and Community Initiative impact on HIV case finding, treatment linkage, continuity of treatment, and sexual violence mitigation among children for the target populations within priority SNUS and districts by periodically analyzing DATIM-reported prevention and clinical cascade MER indicators.

Reporting Requirements

Priority Data Needs	Indicators	
Priority #1 – Reaching Men and Children		
Activity #1: Demand creation in faith infrastructures and communities	Service delivery quality and partnerships (SIMS CEE AS-04-01, Public-Private-Partnership Advocacy, Q1 and Q2)	
	Semi-annual Reaching Men & Children narrative (OU and IP performance summaries narratives in DATIM)	
Activity #2: Expanding targeted prevention, HIV self-testing, index testing, linkage, continuity of treatment and viral load suppression	HTS_SELF HTS_TST (including HTS_TST_POS) TX_NEW TX_CURR TX_ML TX_RTT TX_PVLS VMMC_CIRC PrEP_NEW	• Disaggregations: Age/sex: ○ Men (ages 15-19; 20-24; 25-29; 20-24; 25-29; 30-34, 35-39; 40-44, 45-49; 50+); ○ Children (ages: 1-4, 5-9, 10-14)
	Semi-annual Reaching Men & Children narrative (OU and IP performance summaries narratives in DATIM)	
Activity #3: Decreasing stigma and non-adherence related to faith healing in congregations	Service delivery quality and partnerships (SIMS CEE AS-04-01, Public-Private-Partnership Advocacy, Q1 and Q2)	
	Semi-annual Reaching Men & Children narrative (OU and IP performance summaries narratives in DATIM)	

Priority #2 – Strengthening Justice for Children (JfC)	
Activity #1: Education about sexual violence for faith, traditional, and other community leaders	Semi-annual JfC narratives referenced in DATIM
Activity #2: Evidence-based interventions through faith and traditional structures to complement DREAMS and OVC activities	Semi-annual JfC narratives referenced in DATIM
	AGYW_PREV: Age/sex: Females 10-14, 15-19, 20-24, 25-29 Required Service Disaggregate: Violence Prevention
Activity #3: Require child safeguarding policies for all implementing partners (primes/subs) receiving funding under this initiative	Semi-annual JfC narratives referenced in DATIM
	SIMS CEE #: S_01_04 Child Safeguarding
Activity #4: Engagement of the justice sector	Semi-annual JfC narratives referenced in DATIM

Narrative Requirements

Priority #1: Reaching Men and Children

Narratives for priority #1 should be completed by both OU and implementing partners.

- **Each FCI OU should submit one narrative response per country to the questions below based on input from all agencies. These narratives will be submitted in DATIM semi-annually (at Q2 and Q4),**
- **Each FCI-supported implementing partner should submit one narrative response per partner to the questions below in DATIM, semi-annually (at Q2 and Q4).**

ACTIVITY #1: DEMAND CREATION IN FAITH INFRASTRUCTURES AND COMMUNITIES

- Did the IP or IPs participate in meetings with other IPs/sub-awardees/Parent Bodies at least quarterly?
  - Name the clearly defined action items that were the outcome of the partner meeting. Are there protocols in place for managing roles and responsibilities of the partners?
- What types of faith leaders/workers (pastors/imams, expert clients, CHWs, peer educators, nurses, clinicians, lay workers) received support (monetary or non-monetary) for disseminating the *New Messages of Hope* based on PEPFAR research insights, in faith communities?
- Describe the number and types of media that were used to disseminate *New Messages of Hope* by Parent Body or inter-faith structure (e.g., social media platforms, radio, or billboard spots)?
- Were there any challenges disseminating the 6 topics from *New Messages of Hope* using Parent Body (national to local) structures, or inter-faith (district) structures?
- In priority SNUs for case-finding, please document the type of congregation (by religious affiliation or denomination) and number of congregations that deployed/received *New Messages of Hope* during sermons, messages, or programs. How did performance compare with targets in the work-plan, for number of congregations reached with 3-6 topics from *New Messages of Hope*?

ACTIVITY #2: EXPANDING TARGETED PREVENTION, HIV SELF-TESTING, INDEX TESTING, LINKAGE, CONTINUITY OF TREATMENT AND VIRAL LOAD SUPPRESSION

- What types of faith leaders/workers (pastors/imams, expert clients, CHWs, peer educators, nurses, clinicians, lay workers, etc.) received support (monetary or non-monetary) for HTS? This includes

support for disseminating HIV self-tests and supporting linkage and continuity of treatment in faith communities?
- What number of HIV tests and/or of self-tests were distributed through faith community/FBO sources?
- What monitoring approaches were used for HTS, including those who used self-tests to track linkage to facility for confirmatory testing and ARV initiation, or for prevention?
- What number of persons with positive test results, including from self-tests from FBO sources, reported to a facility for confirmatory testing or verification?
- Please describe the number of congregations (by religious affiliation or denomination) that developed and deployed support for linkage and continuity of treatment. How did the number of persons receiving support for linkage/continuity of treatment compare with targets in the work plan?

ACTIVITY #3: DECREASING STIGMA AND NON-ADHERENCE RELATED TO FAITH HEALING IN CONGREGATIONS

- What type of faith structures (e.g., national, regional, district, and zonal offices; local church congregations; district interfaith councils, etc.) newly implemented evidence-informed interventions or educational programs?
- Which evidence-informed interventions or educational programs were used (by religious affiliation or denomination)?
- Were there any challenges to implementing these interventions or programs within faith structures? Were any religious groups resistant to these interventions? If yes, please describe.
- How did performance compare with targets in the work plan, for number of congregations reached with interventions or programming?

Priority #2: Strengthening Justice for Children (JfC)

Each FCI OU should submit one narrative response per country to the questions below based on input from all agencies and implementing partners. These narratives will be submitted in DATIM semi-annually (at Q2 and Q4),

ACTIVITY #1: DEMAND CREATION IN FAITH INFRASTRUCTURES AND COMMUNITIES

- What types of leaders were educated (faith, traditional, school, civic, other)?
- Were there any challenges to implementing the educational module?

ACTIVITY #2: EVIDENCE-BASED INTERVENTIONS THROUGH FAITH AND TRADITIONAL STRUCTURES TO COMPLEMENT DREAMS AND OVC ACTIVITIES

- What types of organizations newly implemented evidence-based interventions (faith, traditional, both)? Which interventions?
- Were there any challenges to implementing these evidence-based interventions within these types of organizations?

ACTIVITY #3: REQUIRE CHILD SAFEGUARDING POLICIES FOR ALL IMPLEMENTING PARTNERS (PRIMES/SUBS) RECEIVING FUNDING UNDER THIS INITIATIVE

- What type of faith structures newly implemented evidence-informed interventions or educational programs?
- Which evidence-informed interventions or educational programs were used (by religious affiliation or denomination)?
- Were there any challenges to implementing these interventions or programs within faith structures? Were any religious groups resistant to these interventions? If yes, please describe.
- How did performance compare with targets in the work plan, for number of congregations reached with interventions or programming?
- What types of organizations implemented new or strengthened their existing child safeguarding policies (faith, traditional, school, other)?
- Were there any challenges to implementing or strengthening these policies?

ACTIVITY #4: ENGAGEMENT OF THE JUSTICE SECTOR

- What are the main barriers to responding to cases of sexual violence against children within the criminal justice chain of action (i.e., reporting, registering cases, gathering evidence, arrests, court cases, prosecution, sentencing, etc.)? What is being done to address barriers through this initiative?
- What professional training was conducted to improve the criminal justice response to sexual violence against children? Who was trained (e.g., law enforcement, probation officers, judicial officers, etc.)? What were they trained on (mandatory reporting, child interviews, collection of evidence, etc.)?
- What systems-level changes have been made to improve the handling of cases of sexual violence against children (e.g., child friendly courts, eliminating reporting fees, operationalizing laws)? What administrative data are you tracking to determine the impact of system changes (e.g., increased number of cases reported, decreased time to move case through system, etc.)?

MENSTAR

In July 2018, PEPFAR launched the MenStar Coalition, bringing together seven founding partners to expand the diagnosis and treatment of HIV infections and reduce new infections in men across PEPFAR bilateral countries. Through MenStar, PEPFAR plans to reach an additional 1 million men ages 24-35 years with HIV treatment, and support over 90% of men in this age group to be virally suppressed to effectively interrupt HIV transmission.

Reporting Requirements

To measure impact under the MenStar Coalition, PEPFAR country teams are expected to report results under the standing MER indicators, collected quarterly or semi-annually. Indicators of particular interest to track progress of the MenStar Coalition include the following: HTS_TST, HTS_TST_POS, HTS_SELF, TX_NEW, TX_NET_NEW, TX_PVLS, and TX_CURR. Data should be disaggregated by the appropriate age band, sex, and testing modality as per the S/GAC issued MER guidance.

The analysis of these indicators for men ages 24-35 years will allow the initiative to:

- Track the progress of MenStar activities towards coverage goals
- Identify and prioritize MenStar geographies
- Identify opportunities for course-correction, as needed

Routine monitoring of quarterly performance (including trends) will be conducted by PSNU, implementing partner, and site. These analyses should be used to pinpoint sites and partners with high male testing coverage, yield, and linkage as well as identify areas where targets for reaching men are not being met, with a particular focus on sites/PSNUs where the proportion of adult men to women testing and diagnoses are particularly low. These analyses should be used to identify successful solutions on finding and reaching men that will subsequently be taken to scale.

Continuous analysis of performance on these indicators, disaggregated by age/sex is key to understanding progress towards MenStar's objectives. Country teams are encouraged to conduct the following types of analysis when analyzing achievements contributing to MenStar:

- Quarterly analysis of the treatment cascade, specifically for men 24-29 and 30-34 years old with an eye towards linkage and continuity of treatment proxies to better understand where the biggest gaps are
- Trend Analysis of HTS Positivity among Men 15+ years as well as specifically 24-29 and 30-34 years old
- Analysis of performance against targets along the clinical cascade, specifically for men 24-29 and 30-34 years old
- Analysis of testing modalities to identify those that are most successful in finding/reaching men 24-29 and 30-34 years old, with a particular focus on index testing and self-testing (where applicable)
- Analysis of the HIV Testing and Counseling portfolio with an eye towards increasing volume of male diagnoses, yield of positivity, and linkage to treatment

Narrative Requirements

Each MenStar OU should submit one narrative response per country to the questions below based on input from all agencies and implementing partners. These narratives will be submitted in DATIM semi-annually (at Q2 and Q4),

1) How are you adapting your program to be more client-centered and addressing the insights/research on barriers for why men are not accessing testing & treatment services as described in the COP guidance? Please provide an indication of what's working for increasing the number of men who are virally suppressed.
2) What changes are you making at the facility-level to ensure a better service delivery experience for men 24-35 years old (e.g., modifying clinic operations; empathy/compassion training for providers; extended clinic hours; shorter wait times; men's corners; male-friendly services; branded cues within the clinics including signage, uniforms, scripts, accreditation; patient education tools)? Please provide an indication of which of these changes are having the most impact on improving service delivery for men.
3) How are you ensuring continuity of treatment for male clients 24-35 years on treatment (e.g., adherence counseling and tools targeted at men; decongestion of clinics through external pick up points; community adherence and continuity of treatment groups)? Please provide an indication of which of these tactics are working for increasing continuity of treatment of male clients.
4) Are there any other solutions not referenced above that are successfully bringing more men in for testing and treatment services?
5) Have any policy changes resulted in an increase of men 24-35 years accessing HIV testing & treatment services (e.g., transition to TLD; self-testing; optimized case-finding; annual viral load; MMS; DSD; extended clinic hours)?

CERVICAL CANCER SCREENING AND TREATMENT

Starting in FY18, PEPFAR refocused its support for the implementation of cervical cancer screening and treatment of precancerous cervical lesions in ART clinics among women with HIV on ART. All countries utilizing PEPFAR resources for cervical cancer services are expected to adhere to the PEPFAR cervical cancer clinical guidance and report on the following indicators: CXCA_SCRN and CXCA_TX and their associated indicator narratives.

APPENDICES

APPENDIX A: KEY POPULATIONS CLASSIFICATION DOCUMENT

Key Population Classification (core)	
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 beneficiary. The complete form should be offered to all beneficiaries, regardless of providers' assumptions about whether the beneficiary is a member of a key population group or not. Beneficiaries should be able to decline answering any question. Taking part in this assessment should never be a requirement to receive services. Note: all script in normal text should be read out loud to the beneficiary; italicized text is instruction to the provider. **Health Care Provider script to Beneficiary:** "I will be asking you some questions about sex and drug use. I understand these may be sensitive topics, but your responses are important to 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 decline to answer any question and still receive the service you've come here for today."	
1. Do you identify as a man, woman, or prefer something else?	□ MAN □ WOMAN □ OTHER/PREFER TO SELF-IDENTIFY: _____ □ PREFER NOT TO ANSWER
2. What was your assigned sex at birth: male, female, or other?	□ MALE □ FEMALE □ OTHER: _____ □ PREFER NOT TO ANSWER
3. Do you have sex with men, women, or both?	□ MEN ONLY □ WOMEN ONLY □ BOTH MEN AND WOMEN □ PREFER NOT TO ANSWER
4. Is selling sex your main source of income?	□ YES □ NO □ PREFER NOT TO ANSWER
5. In the last 6 months, have you injected a drug that was not prescribed to you by a medical provider?	□ YES □ NO □ PREFER NOT TO ANSWER

Key Population Classification	
If beneficiary answers ***Male* to Q2** and answers ***Men Only*** or ***Both Men and Women*** to **Q3**, then classify as MSM	□
If beneficiary answers **Q1 and/or Q2** in a way that how they self-identify does not match the sex assigned at birth, then classify as TG	□
If beneficiary answers **Yes to Q4**, then categorize as SW	□
If beneficiary answers **Yes to Q5**, then classify as PWID	□
If beneficiary is currently incarcerated, then classify as Person in Prison	□
If beneficiary identifies as none of the above categories, then classify as NONE	□
Final Classification: (*mark *ALL* that apply*) □MSM □TG □SW □PWID □Person in Prison □NONE *Some beneficiaries may belong to more than one category.	

APPENDIX B: CALCULATED INDICATORS REFERENCE TABLE

Note: This appendix may be updated mid-year as new calculations are developed for ongoing analyses. Please visit https://datim.zendesk.com/hc/en-us/sections/200929315-MER for the latest list of calculated indicators.

Name	Description	FY 2022 Calculation
Cross-Cutting Calculations		
ART Coverage	Percentage of PLHIV on ART	TX_CURR_SUBNAT PLHIV where TX_CURR_SUBNAT is the host-country reported TX_CURR at the relevant subnational level.
Yield	Within a testing program, the percentage of positives found out of those who were tested and received their test results. Yield can be used for general testing as well as targeted testing for PMTCT, TB, etc.	General testing yield: HTS_TST_POS (HTS_TST_POS + HTS_TST_NEG) PMTCT Yield: PMTCT_STAT_POS PMTCT_STAT
AGYW_PREV		
AGYW_PREV Total Denominator	Number of active DREAMS participants that have started or completed any DREAMS service/intervention as of the end of the reporting period	Sum of the following age/sex/layering disaggregates: 1. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions but no additional services/interventions 2. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions AND at least one secondary service/intervention 3. Number of active DREAMS participants that have completed at least one DREAMS service/intervention but not the full primary package 4. Number of active DREAMS participants that have started a DREAMS service/intervention but have not yet completed it
AGYW_PREV Total Numerator	Number of active DREAMS participants that have completed at least the DREAMS primary package of services/interventions as of the end of the reporting period	Sum of the following age/sex/layering disaggregates: 1. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions but no additional services/interventions 2. Number of active DREAMS participants that have fully completed the DREAMS primary package of services/interventions AND at least one secondary service/intervention

CXCA_SCRN		
CXCA_SCRN Total Numerator	Number of HIV-positive women on ART screened for cervical cancer	Sum of Screening Visit Type and Result by Age
CXCA_SCRN_POS	Number of HIV-positive women on ART screened for cervical cancer	Sum of positive for cervical cancer disaggregates Example: CXCA_SCRN_POS = "1st time screened" Positive + "Rescreened after previous negative" Positive + "Post-treatment follow-up" Positive
CXCA_TX		
CXCA_TX Total Denominator	Number of women with a positive VIA screening test who are HIV-positive and on ART eligible for cryotherapy, thermocoagulation or LEEP who received cryotherapy, thermocoagulation or LEEP	Equal to CXCA_SCRN_POS
CXCA_TX Total Numerator	Number of women living with HIV (WLHIV) on ART at PEPFAR supported sites who are eligible for cryotherapy, thermocoagulation or LEEP, in other words CXCA_SCRN_POS.	Sum of Age/Sex/HIVStatus/ TreatmentType/ScreenVisitType disaggregates
GEND_GBV		
GEND_GBV Total Numerator	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	Sum of Violence Service Type by Age/Sex, all disaggregates
GEND_GBV PhysicalEmotional Violence	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package for physical and/or emotional violence	Sum of Violence Service Type by Age/Sex, Physical/Emotional Violence disaggregates
GEND_GBV SexualViolence	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package for sexual violence	Sum of Violence Service Type by Age/Sex, Sexual Violence disaggregates
HRH_PRE		
HRH_PRE Total 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	Sum of Cadre disaggregates
HTS_INDEX		
HTS_INDEX Total Numerator	The total number of contacts who were tested for HIV and received their results (Step 4).	Sum of facility and community results. Example: HTS_INDEX Total Numerator = HTS_INDEX (Community) Age/Sex/Result + HTS_INDEX (Facility) Age/Sex/Result
HTS_INDEX Numerator - Index Cases Offered	Step 1: This is the number of index clients (newly diagnosed positive or previously known positives who may	Sum of facility and community results.

	or may not be on ART) who were offered (e.g., counseled on) index testing services (regardless of whether or not those services were accepted by the index client).	Example: HTS_INDEX Age/Sex/IndexCasesOffered = HTS_INDEX (Community) Age/Sex/IndexCasesOffered + HTS_INDEX (Facility) Age/Sex/IndexCasesOffered
HTS_INDEX Numerator - Index Cases Accepted	Step 2: This is the number of index clients who accepted (e.g., agreed to) provision of index testing services by a provider (including, counseling on index testing, elicitation of current or past sexual partners/partner notification etc.).	Sum of facility and community results. Example: HTS_INDEX Age/Sex/IndexCasesAccepted = HTS_INDEX (Community) Age/Sex/IndexCasesAccepted + HTS_INDEX (Facility) Age/Sex/IndexCasesAccepted
HTS_INDEX Numerator - Contacts	Step 3: This is the number of contacts provided by the index client as a result of accepting index testing services. The index client provides the age (<15 or >15) and sex (male or female) of the contact(s).	Sum of facility and community results. Example: HTS_INDEX AgeAggregated/Sex/Contacts = HTS_INDEX (Community) AgeAggregated/Sex/Contacts + HTS_INDEX (Facility) AgeAggregated/Sex/Contacts
HTS_INDEX Numerator – Contacts test results	Step 4: This is the number of contacts who were tested for HIV and received their results (positive and negative).	Sum of facility and community results. Example: HTS_INDEX Age/Sex/Result = HTS_INDEX (Community) Age/Sex/Result + HTS_INDEX (Facility) Age/Sex/Result
HTS_INDEX_KNOWNPOS Total Numerator	The total number of known positive contacts reported under Step 4 (contacts tested for HIV and received their results). Note that known positives should not be retested.	Sum of facility and community age/sex/result known positive disaggregates. Example: HTS_INDEX_KNOWNPOS = HTS_INDEX (Facility) Age/Sex/Result Known Positive + HTS_INDEX (Community) Age/Sex/Result KnownPositive
HTS_INDEX_NEWNEG Total Numerator	The total number of newly tested negative contacts reported under Step 4 (contacts tested for HIV and received their results).	Sum of facility and community age/sex/result newly identified negative disaggregates. Example: HTS_INDEX_NEWNEG = HTS_INDEX (Facility) Age/Sex/Result Newly Identified Negative + HTS_INDEX (Community) Age/Sex/Result Newly Identified Negative

HTS_INDEX_DOCNEG	The total number of individuals, under the age of 14, with a recently documented negative HIV test result.	Sum of Sum of facility and community age/sex/result recently documented negative disaggregates. HTS_INDEX_DOCNEG = HTS_INDEX (Facility) Age/Sex/Result Documented Negative + HTS_INDEX (Community) Age/Sex/Result Documented Negative
HTS_INDEX_NEWPOS **Total Numerator**	The total number of newly tested positive contacts reported under Step 4 (contacts tested for HIV and received their results).	Sum of facility and community age/sex/result newly identified positive disaggregates. Example: HTS_INDEX_NEWPOS = HTS_INDEX (Facility) Age/Sex/Result Newly Identified Positive + HTS_INDEX (Community) Age/Sex/Result Newly Identified Positive
HTS_RECENT		
HTS_RECENT **Total Numerator**	Number of newly diagnosed HIV-positive persons who received a test for recent infection with a documented result.	Sum of HTS_RECENT Age/Sex/RTRI Result/Modality disaggregates. Note: "RTRI Result" refers to a Rapid Test for Recent Infection result of Recent or Long Term
HTS_RECENT **Recent Infection**	Number of newly diagnosed HIV-positive persons who received a rapid test for recent infection with a result of "recent" during the reporting period.	Sum of HTS_RECENT Age/Sex/RTRI Result/Modality "Recent" disaggregates.
HTS_RECENT **Long-term Infection**	Number of newly diagnosed HIV-positive persons who received a rapid test for recent infection with a result of "long-term" during the reporting period.	Sum of HTS_RECENT Age/Sex/RTRI Result/Modality "Long-term" disaggregates.
HTS_SELF		
HTS_SELF **Total Numerator**	Number of individual HIV self-test kits distributed.	Sum of Age/Sex/HIVSelfTest disaggregates.
HTS_TST		
HTS_TST **Total Numerator**	Number of individuals who received HIV Testing Services (HTS) and received their test results	Sum of HTS Modality and Result by Age/Sex Note: This calculation includes both fine and coarse age data when both are reported. This calculation also includes both facility and community data at the above-site level.
HTS_TST_POS	Number of individuals who received HIV Testing Services (HTS) and received a positive test result	Sum of HTS Modality and Result by Age/Sex, positive results Note: This calculation includes both fine and coarse age data when both are reported. This calculation also includes both facility and community data at the above-site level.

HTS_TST_NEG	Number of individuals who received HIV Testing Services (HTS) and received a negative test result	Sum of HTS Modality and Result by Age/Sex, negative results Note: This calculation includes both fine and coarse age data when both are reported. This calculation also includes both facility and community data at the above-site level.
HTS_TST Index & IndexMod testing modalities	Number of newly tested individuals who were identified and tested using Index testing services and received their results.	Copied from HTS_INDEX newly identified positive and newly identified negative. Facility index testing results are copied to the Index testing modality, while community index testing results are copied to the IndexMod testing modality. Example: HTS_TST Index Female 15-19 Positive = HTS_INDEX (Facility) Female 15-19 Newly identified positive HTS_TST IndexMod Female 15-19 Positive = HTS_INDEX (Community) Female 15-19 Newly identified positive
HTS_TST PMTCT testing modality	The number of women attending ANC1 who were tested for HIV and received results	Copied from PMTCT_STAT newly identified positive and newly identified negative Example: HTS_TST PMTCT ANC1 Female 15-19 Positive = PMTCT_STAT Female 15-19 Newly identified positive
HTS_TST TB testing modality	Number of new and relapsed TB cases who were tested for HIV and received results, during the reporting period	Copied from TB_STAT newly identified positive and newly identified negative Example: HTS_TST TB Clinics Female 15-19 Positive = TB_STAT Female 15-19 Newly identified positive
HTS_TST VMMC testing modality	The number of VMMC clients who were tested for HIV at a VMMC sites and received results	Copied from VMMC_CIRC positive and negative clients Example: HTS_TST VMMC Male 15-19 Positive = VMMC_CIRC Male 15-19 HIV positive clients
KP_MAT		
KP_MAT **Total Numerator**	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months within the reporting period	Sum of sex disaggregates

KP_PREV		
KP_PREV **Total Numerator**	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	Sum of Key Population disaggregates
PMTCT_FO		
PMTCT_FO **Total Numerator**	Number of HIV-exposed infants with a documented outcome by 18 months of age disaggregated by outcome type.	Sum of Outcome Type disaggregates
OVC_HIVSTAT		
OVC_HIVSTAT **Total Denominator**	Number of orphans and vulnerable children reported under the OVC_SERV "OVC Comprehensive" disaggregate (<18 years old, active and graduated)	Sum of OVC_SERV, OVC Comprehensive disaggregates <18 OVC_HIVSTAT (D) = OVC_SERV, OVC Comprehensive Active OVC <18 +OVC_SERV, OVC Comprehensive Graduated OVC <18
OVC_HIVSTAT **Total Numerator**	Number of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with HIV status reported	Sum of Status Type by pediatric age/sex disaggregates OVC_HIVSTAT (N) = [Of those positive: Currently receiving ART] + [Of those positive: Not Currently receiving ART or ART Status Unknown] + [Reported HIV Negative to IP] + [Test not required based on risk assessment] + [No HIV status reported to the IP (HIV Status Unknown)]
OVC_HIVSTAT_POS	Number of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with positive HIV status reported	Sum of Status Type by pediatric age/sex disaggregates, positive results OVC_HIVSTAT_POS (N) = [Of those positive: Currently receiving ART] + [Of those positive: Not Currently receiving ART or ART Status Unknown]
OVC_HIVSTAT_NEG	Number of orphans and vulnerable children (<18 years old) enrolled in the OVC Comprehensive program with negative HIV status reported	Sum of Status Type by pediatric age/sex disaggregates, negative result OVC_HIVSTAT_NEG (N) = [Reported HIV Negative to IP]
OVC_SERV		
OVC_SERV **Total Numerator** **(FY 2021 and forward)**	Number of participants served by PEPFAR OVC programs for children and families affected by HIV	The numerator is the sum of the following disaggregates: The numerator is the sum of the following Program Participation Status disaggregates: 1. OVC Comprehensive Active and Graduated participants (children and caregivers) 2. DREAMS participants

		3. OVC Preventive participants Note: This calculation applies only to FY 2021 and forward. Previous iterations of OVC_SERV are calculated differently.
OVC_SERV_ACTIVE	The number of children and caregivers that received at least one service in each of the preceding two quarters OR received at least one service in the preceding quarter if registered during the reporting period	Sum of all OVC Comprehensive "Active" disaggregates
OVC_SERV_GRADUATED	At Q2: The number of children and caregivers that graduated from the OVC program in previous two quarters. At Q4: The number of children and caregivers that graduated from the OVC program in the past four quarters.	Sum of all OVC Comprehensive "Graduated" disaggregates
OVC_SERV_OVER_18	Number of participants (active and graduated) aged 18 or older	Sum of Age/Sex/ProgramStatus disaggregates 18+
OVC_SERV_UNDER_18	Number of participants (active and graduated) under the age of 18	Sum of Age/Sex/ProgramStatus disaggregates >18
PMTCT_ART		
PMTCT_ART Total Denominator	Number of pregnant women with known HIV positive status at first antenatal care visit (ANC1) (includes those who already knew their HIV positive status prior to ANC1). This is collected through the positive disaggregations of PMTCT_STAT.	The sum of PMTCT_STAT New Positives and Known at Entry Positives.
PMTCT_ART Total Numerator	Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy	Sum of "Maternal Regimen Type and Age" disaggregates
PMTCT_ART Coverage	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	PMTCT_ART numerator PMTCT_ART denominator
PMTCT_EID		
PMTCT_EID Total Denominator	The number of HIV-positive pregnant women identified in the reporting period, which is used as a proxy measure for the number of HIV-exposed infants.	Sum of Known and New positives from: PMTCT_STAT_POS: Age/Sex/KnownNewResult HTS_TST_POS: PMTCT PostANC/Age Aggregated/Sex/Result, PMTCT PostANC/Age/Sex/Result
PMTCT_EID Total Numerator	Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period.	Sum of age disaggregates
PMTCT_EID Less_Equal_Two_Months	Number of infants who had a first virologic HIV test (sample collected) between 0 and 2 months of age during the reporting period.	Equals value reported for 0-2 months age band

PMTCT_EID Two_Twelve_Months	Number of infants who had a first virologic HIV test (sample collected) between 2 and 12 months of age during the reporting period.	Equals value reported for 2-12 months age band
PMTCT_EID Coverage	Percentage of infants born to HIV-positive women who received a first virologic HIV test (sample collected) by 12 months of age	PMTCT_EID numerator PMTCT_EID denominator
PMTCT_HEI_POS		
PMTCT_HEI_POS Total Numerator	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected by 12 months of age.	Sum of Age disaggregates. Example: PMTCT_HEI_POS (N) = 0 to 2 months positive + 2 to 12 months positive
PMTCT_HEI_POS_2MO	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected before two (2) months of age.	Sum when Age/HIVStatus disaggregate is "<= 2 months, Positive"
PMTCT_HEI_POS_12MO	Number of HIV-infected infants identified in the reporting period, whose diagnostic sample was collected between two and 12 months of age.	Sum of Age/HIVStatus/ARTStatus disaggregate "2 - 12 months, Positive"
PMTCT_HEI_POS_ART	Number of HIV-infected infants identified in the reporting period, who were confirmed to have initiated ART at virologic sample collection.	Sum of positive, confirmed initiated ART by age at virologic sample collection disaggregate
PMTCT_STAT		
PMTCT_STAT Total Denominator	Number of new ANC clients in reporting period	Sum of age disaggregates
PMTCT_STAT Total 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)	Sum of age and status disaggregates
PMTCT_STAT KnownatEntry_POSITIVE	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.	Sum of Known at Entry Positive age disaggregates
PMTCT_STAT NewlyIdentified_Negative	The number of women attending ANC1 who were tested for HIV and received a negative result.	Sum of Newly Identified Negative age disaggregates
PMTCT_STAT NewlyIdentified_POSITIVE	The number of women attending ANC1 who were tested for HIV and received a positive result.	Sum of Newly Identified Positive age disaggregates
PMTCT_STAT_POS Total Numerator	Number of pregnant women with known HIV positive status at first antenatal care visit (ANC1) (includes	The sum of PMTCT_STAT New Positives and Known at Entry Positives.

	those who already knew their HIV positive status prior to ANC1)	
PP_PREV		
PP_PREV **Total Numerator**	Number of priority populations reached with standardized HIV prevention intervention(s) that are evidence-based	Sum of age/sex disaggregates
PrEP_CT		
PrEP_CT **Total Numerator**	Number of individuals, excluding those newly enrolled, that return for a follow-up visit or re-initiation visit to receive pre-exposure prophylaxis (PrEP) to prevent HIV during the reporting period	Sum of age/sex disaggregates
PrEP_NEW		
PrEP_NEW **Total Numerator**	Number of individuals who were newly enrolled on pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period.	Sum of age/sex disaggregates
SC_ARVDISP		
SC_ARVDISP **Month of Treatment Proxy**	The number of months of treatment included in each ARV bottle dispensed. 30-count bottle = 1 month of treatment 60-count bottle = 3 months of treatment 180-count bottle = 6 months of treatment Adult drug categories where the pill count is not specified refer to 30-count bottles. Pediatric drug categories and "Other" are excluded from this calculation.	Total Months of Treatment = (30-count bottles x 1) + (90-count bottles x 3) + (180-count bottles x 6)
TB_ART		
TB_ART **Total Denominator**	Number of registered TB cases with documented HIV-positive status during the reporting period. (TB_STAT_POS)	Equal to the annual cumulative of TB_STAT_POS
TB_ART **Total Numerator**	Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period	Sum of ART Status by Age/Sex disaggregates
TB_ART Coverage	Proportion of HIV-positive new and relapsed TB cases on ART during TB treatment	$\frac{\text{TB\_ART numerator}}{\text{TB\_ART denominator}}$
TB_PREV		
TB_PREV **Total Denominator**	Number of ART patients who were initiated on any course of TPT during the previous reporting period	Sum of ART Start by Age/Sex disaggregates.

TB_PREV **Total Numerator**	Among those who started a course of TPT in the previous reporting period, the number that completed a full course of therapy (for continuous IPT programs, this includes the patients who have completed the first 6 months of isoniazid preventive therapy (IPT), or any other standard course of TPT such as 3 months of weekly isoniazid and rifapentine, or 3-HP).	Sum of ART Start by Age/Sex disaggregates.
TB_PREV Coverage **(TPT Coverage)**	Proportion of ART patients who started on a standard course of TB Preventive Treatment (TPT) in the previous reporting period who completed therapy	TB_PREV numerator TB_PREV denominator
TB_STAT		
TB_STAT **Total Denominator**	Total number of new and relapsed TB cases, during the reporting period	Sum of age/sex disaggregates
TB_STAT **Total Numerator**	Number of new and relapsed TB cases with documented HIV status, during the reporting period	Sum of age/sex/status disaggregates
TB_STAT_POS	Number of new and relapsed TB cases with any documented HIV positive status (both new and known at entry), during the reporting period	Sum of age/sex/status disaggregates, known at entry positive and newly identified positive
TX_CURR		
TX_CURR **Total Numerator**	Number of adults and children currently receiving antiretroviral therapy (ART)	Sum of age/sex disaggregates
Patients receiving MMD	Patients that pick up 3 or more months of anti-retroviral drugs at one visit (i.e., multi-month dispensation or MMD)	Sum of MMD by age/sex disaggregates, 3-5 months and 6 or more months
TX_NET_NEW	The quarterly net increase or decrease in ART patients.	TX_CURR current quarter - TX_CURR previous quarter by age/sex group. Note: TX_NET_NEW calculations across time periods where age bands have changed (such as between FY18 Q4 and FY19 Q1) may need to be calculated manually.
Net New Needed	The total number of net new on treatment needed per year to reach 95% by 2030	[(PLHIV*.95) - TX_CURR_SUBNAT] # of years until goal where TX_CURR_SUBNAT is the host-country reported TX_CURR at the relevant subnational level.
Continuity of Treatment Proxy	A measure of the overall gain or loss in patients compared to the expected number of patients of treatment. The expected number of patients on treatment assumes 100% continuity of treatment for both newly enrolled (TX_NEW) and previously enrolled (TX_CURR) patients.	TX_CURR (TX_CURR previous + TX_NEW) where expected TX_CURR assumes 100% continuity of treatment for both newly enrolled (TX_NEW) and previously enrolled (TX_CURR) patients.

TX_CURR_ARVDisp_less_three_mo	Patients that pick up less than months of anti-retroviral drugs at one visit (i.e., multi-month dispensation or MMD)	Sum of MMD by age/sex disaggregate less than three months of ARV dispensed
TX_CURR_ARVDisp_three_five_mo	Patients that pick up between three to five months of anti-retroviral drugs at one visit (i.e., multi-month dispensation or MMD)	Sum of MMD by age/sex disaggregate three to five months of ARV dispensed
TX_CURR_ARVDisp_six_more_mo	Patients that pick up more than six months of anti-retroviral drugs at one visit (i.e., multi-month dispensation or MMD)	Sum of MMD by age/sex disaggregate more than six months ARV dispensed
TX_ML		
Total Numerator	Number of ART patients (currently on ART or newly initiating ART) with no clinical contact or ARV pick-up for greater than 28 days since their last expected clinical contact or ARV pick-up	Sum of Outcome by Age/Sex disaggregates.
TX_ML_IIT_less_three_mo	Number of ART patients with no clinical contact or ARV pick-up for greater than 28 days after being on treatment for less than three months.	Sum of IIT Less than Three Months disaggregate.
TX_ML_IIT_three_five_mo	Number of ART patients with no clinical contact or ARV pick-up for greater than 28 days after being on treatment for three to five months.	Sum of IIT 3 to 5 Months disaggregate.
TX_ML_IIT_more_six_mo	Number of ART patients with no clinical contact or ARV pick-up for greater than 28 days after being on treatment for more than six months.	Sum of IIT More than Six Months disaggregate.
TX_ML Died	Number of ART patients with no clinical contact or ARV pick-up due to death.	Sum of IIT Died Disaggregate
TX_ML_Refused_Stopped	Number of ART patients who refused or stopped ART treatment	Sum of IIT No Clinical Contact – Refused Stopped Treatment Disaggregate
TX_ML_Transferred_Out	Number of ART patients who transferred out of treatment	Sum of IIT Transferred out Disaggregate
TX_NEW		
Total Numerator	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Sum of Age/Sex and Age Aggregated/Sex disaggregates
Linkage Proxy	Estimate of the percentage of people who test HIV positive and are linked to treatment. This metric is not calculated at the individual level.	$\frac{\text{TX\_NEW}}{\text{HTS\_TST\_POS}}$
TX_PVLS		
Total Denominator	Number of ART patients with a VL result documented in the medical or laboratory records/LIS within the past 12 months.	Sum of Age/Sex/Indication and Age Aggregated/Sex/Indication disaggregates.
Total Numerator	Number of ART patients with suppressed VL results (<1,000	Sum of Age/Sex/Indication/HIVStatus and Age

	copies/ml) documented in the medical or laboratory records/LIS within the past 12 months	Aggregated/Sex/Indication/HIVStatus disaggregates.
Viral Load Suppression	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months	TX_PVLS numerator TX_PVLS denominator
Viral Load Test Coverage	Percentage of patients eligible for viral load testing who have received a viral load test. Length of time on treatment may vary by ART regiment and/or national guidelines.	TX_PVLS denominator (TX_CURR from 2 quarters prior)
TX_RTT		
TX_RTT **Total Numerator**	Number of ART patients who experienced IIT during any previous reporting period, who successfully restarted ARVs within the reporting period and remained on treatment until the end of the reporting period.	Sum of age/sex disaggregates
TX_TB		
TX_TB **Total Denominator**	Number of ART patients who were screened for TB at least once during the semiannual reporting period.	Sum of Start of ART by Screen Result by Age/Sex
TX_TB **Total Numerator**	Number of ART patients who were started on TB treatment during the semiannual reporting period.	Sum of Current/New on ART by Age/Sex
VMMC_CIRC		
Total Numerator	Number of males circumcised	Sum of Age disaggregates
VMMC_CIRC **Follow-up Total**	Number of males who received a circumcision and reported a follow-up status	Sum of FollowUp/Surgical, within 14 days + FollowUp/Surgical, not within 14 days + FollowUp/DeviceBased, within 14 days + FollowUp/DeviceBased, not within 14 days
VMMC_CIRC **Follow-up Surgical**	FollowUp/Surgical: Number of males who received a surgical circumcision and reported a follow-up status	Sum of FollowUp/Surgical, within 14 days + FollowUp/Surgical, not within 14 days (Note: "Within 14 days" is abbreviated as "Yes" while "Not within 14 days" is abbreviated as "No".)
VMMC_CIRC **Follow-up Device Based**	FollowUp/DeviceBased: Number of males who received a device-based circumcision and reported a follow-up status	Sum of FollowUp/DeviceBased, within 14 days + FollowUp/DeviceBased, not within 14 days (Note: "Within 14 days" is abbreviated as "Yes" while "Not within 14 days" is abbreviated as "No".)

APPENDIX C: DQA OF NATIONAL AND PARTNER HIV TREATMENT AND PATIENT MONITORING SYSTEMS

The following appendix is an excerpt from the "Data Quality Assessment of National and Partner HIV Treatment and Patient Monitoring Systems" implementation tool. This tool was developed in collaboration with WHO, UNAIDS, the Global Fund, and PEPFAR to ensure that there is one agreed upon methodology for conducting data quality assessments of treatment numbers.

The objectives of DQA are:

1) to assess the quality of reported data by using standard indicator definitions to recreate the reported numbers for selected indicators and compare with the numbers reported by the national data collection system, such as DHIS2 (District Health Information Software), and by partners;
2) to verify the quality of and to improve the reported HIV patient monitoring data and systems at the facility level;
3) to cross-validate a sample of patient records and manually count patient records and describe any systematic data quality challenges with applied indicator definitions and data recording and to recommend actions to improve data quality;
4) to determine the percentage of people receiving ART nationally over- or undercounted (and sub-nationally when feasible or the country needs this) and use this to reset the numbers at both the site level and within the national data collection system in addition to ensuring accurate reporting in any reporting systems moving forward; and
5) to update national reporting data and national epidemiological estimates for improved planning.

The DQA requires six steps:

1) Setting up a country-based implementation team of stakeholders to agree on the scope and methods and to support the implementation and dissemination of the results of the DQA;
2) To agree on the sampling required and the indicators to include in the assessment and to finalize the site-level instruments;
3) Assessing at the site level to collect data, including assessing the HIV patient monitoring system and recreating the numbers of people receiving and initiating ART;
4) Conducting a desk review to identify challenges in national reporting (can take place simultaneously with step 3);
5) Analyzing the results and resetting the site-level and national numbers of people receiving and initiating ART; and
6) Developing a communication strategy and disseminating the updated values.

A two-stage phased approach for implementing a DQA is recommended to assist countries in giving priority to scaling up DQA activities over time and to prepare countries to implement larger-scale DQA when significant data quality issues are identified or when the country needs or wants to review and adjust treatment data at the subnational level.

The scope of the two phases is as follows.

- **Phase 1**: in the initial phase, the DQA will be implemented within a nationally representative number of ART sites in which the six steps indicated above will be implemented with a view to validate the number of people on ART and if necessary reset the national ART number as needed, as well as strengthen the overall HIV patient monitoring system.

- **Phase 2**: implementation of the second phase DQA is in response to identified DQA challenges in the phase 1 DQA which warrant further investigation and review of HIV treatment data in a larger number of ART sites or within the context of implementing a DQA strategy in which DQA activities are scaled up over time. Countries completing the first phase of DQA and finding a verification factor (recreated/reported times 100) of less than 90% or greater than 110% within the sample should transition to the second phase in which the exercise is expanded to additional ART sites for an overall representation of 80% of the people currently receiving ART for the reporting period being reviewed. This should be done for a more in-depth review of data quality and to reset ART numbers at these

sites and the site-level systems as needed following the same steps identified above. This second phase can be conducted by the Ministry of Health and implementing partners with site staff.

In addition, with larger site sample sizes, countries can also consider analyzing and adjusting subnational ART data based on country need and interest in this phase.

DQA Step 1: Set up a multi-stakeholder implementation team

Institutionalizing routine assessment and monitoring of the quality of reported data is an integral part of an effective HIV program. Data quality is especially important given the use of this data to plan for program implementation, the use of global resources and to affirm progress towards epidemic control. As such it is critical there is full ownership and support for DQA from Ministries of Health and partners. Within this context, the specific roles and responsibilities of country stakeholders are detailed below.

Before starting any data collection or review processes, the Ministry of Health and the country team will inform other national and local authorities, such as the district health office, of this assessment and engage them, seeking their involvement in the data validation activities and other subsequent activities to improve data quality.

Roles and responsibilities

- Ministries of Health: Ministries of Health are responsible for leading the implementation and overall coordination of the DQA in collaboration with partners, including PEPFAR, the Global Fund, WHO and UNAIDS.

- WHO: WHO will coordinate changes to the guidance on DQA to ensure consistency in implementation across all partners. In addition, WHO will provide technical support to Ministries of Health for implementation and convene stakeholders to support the Ministry of Health on using the results and data and improving the system as necessary.

- PEPFAR: PEPFAR headquarters staff will provide technical assistance to interagency country teams for the development of their specific DQA protocols. In addition, some in-person technical support will be provided from PEPFAR headquarters staff.

  PEPFAR field staff from each of the PEPFAR-supported agencies (such as the United States Centers for Disease Control and Prevention, United States Agency for International Development and Department of Defense) are required to participate in planning and implementation of the DQA. PEPFAR field teams should work within the interagency country team to select sites from all ART sites in the country and draft the DQA schedule, draft notification letters to relevant stakeholders and notify implementing partners and site staff before DQA visits. PEPFAR field staff should also participate in developing the final DQA report and remediation plan and should ensure that implementing partners and sites receive additional technical assistance and remediation, as necessary. Lastly, PEPFAR field staff should coordinate with Ministries of Health to ensure that divergent numbers identified in PEPFAR-supported sites are corrected in the health ministry reporting system and are reported correctly at the next PEPFAR quarterly reporting cycle.

- Global Fund: The Technical Advice and Partnerships Department of the Global Fund Secretariat will work closely with the country teams for respective countries to support the implementation of DQA and the use of the findings for programs.
  The Global Fund will also provide funding and technical assistance for implementing DQA by mobilizing technical resources in the monitoring and evaluation technical assistance pool, local Global Fund agents and quality assurance providers for health facility assessments and data quality reviews. The Global Fund country teams will coordinate with national AIDS programs and in-country partners to ensure that the correct national numbers are used for quantifying ARV drugs, laboratory reagents and key performance indicators.

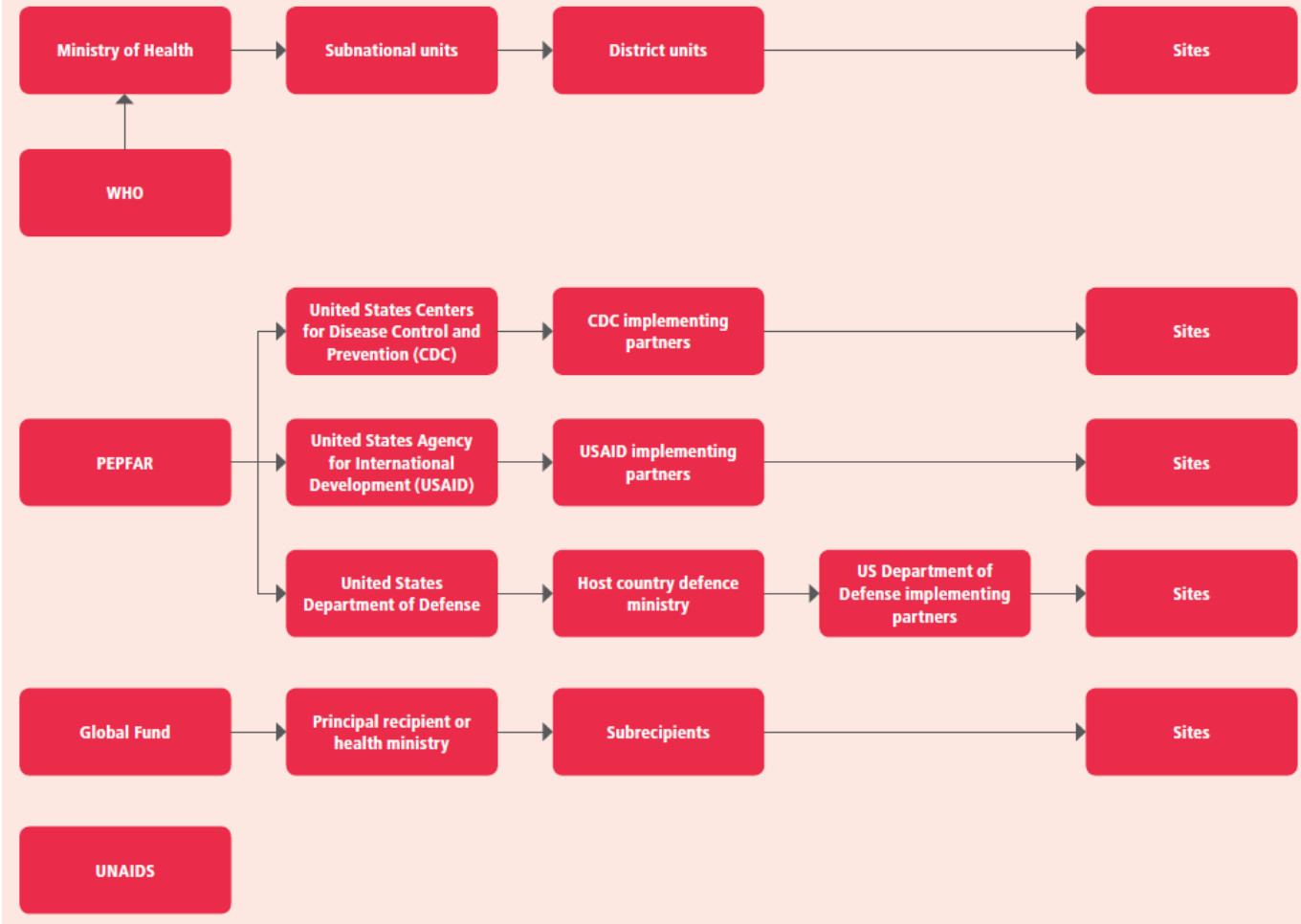
- UNAIDS: UNAIDS will support its national counterparts responsible for ART reporting to ensure partner buy-in and alignment with the adjustments. In addition, UNAIDS will support country estimates

teams to adjust their current and historical numbers of people receiving ART used in their Spectrum models to reflect the DQA results and produce accurate epidemiological estimates.

- Interorganizational country team: The interagency country team includes the Ministry of Health, UNAIDS, WHO, PEPFAR, the Global Fund and other representatives or stakeholders based in the country that will work collaboratively to carry out the DQA. Within this group, one or more individuals should be chosen as the team leads to oversee the assessment teams and take a leadership role in the site selection, assessment and remediation.

- Providers of ART (referred to as implementing partners by the United States Government): Implementing partners will work alongside the country team to support implementation of the DQA at sites they are supporting, including facilitating communication regarding the assessment and DQA activities at the site level.

FIG. 1. STAKEHOLDERS INVOLVED IN DQA AT THE GLOBAL AND COUNTRY LEVELS



DQA Step 2: Decide on the sampling frame and indicators and finalize the instruments

A key aim is to implement a sampling frame that is practical and implements objectives 1 and 2 and provides results for objectives 4 and 5 of DQA, to provide coordinated national and partner-specific assessment.

The primary sampling framework will therefore implement initial stratification by three domains:

- National representation: to validate and correct as required the national numbers of people receiving and initiating ART

- PEPFAR-supported sites: to validate PEPFAR-supported sites, including specific implementers as required; and
- Potentially Global Fund–supported districts if relevant: to assess districts supported by the Global Fund (if these are not distinct, the national strata can be used).

Within these domains, and given the needs of the government and the availability of funds and timing, additional strata can be sampled if required, including:

- By facility type or facilities with paper versus electronic patient monitoring records;
- Of particular programmatic importance: for example, two or three districts might be oversampled to meet the particular needs of a partner or meets the concerns of the Ministry of Health; and
- To measure the reporting adjustments at the subnational level (recommended for the second phase of DQA).

This should be balanced against the sample size implications of increasing the number of strata. In implementing the sampling approach, the following steps are followed.

I. Create a sampling frame: a list of all ART sites nationally. In the second phase of DQA, countries may consider disaggregating this list by subnational unit (such as region or district). The sample frame should include the following information:
    a. Site name and location, such as province, district, etc.;
    b. The number of people currently receiving ART in the past calendar year – to validate the primary indicator of currently receiving ART;
    c. The number of new ART initiators in the most recent reporting time frame (such as quarter or year) – to validate the indicator of new ART initiators;
    d. Domains (such as PEPFAR support, Global Fund support, etc.); and
    e. Any additional strata of interest (such as facility type, paper versus electronic, etc.).

II. Decide on the number of ART sites to be sampled nationally and by strata in phase 1. This is a country decision usually based on the objectives of the DQA, feasibility, cost and whether the objective is to develop a correction factor, achieving an acceptable relative margin of error at the national and subnational levels and within specific strata of interest. The interorganizational country team should determine the appropriate sample size based on country priorities for the specific objectives of the DQA and precision of the desired estimates, available resources, feasibility and time considerations. Countries may assess data quality in a limited sample of sites to obtain understanding of data quality issues to determine whether a correction factor is needed or sites with 80% of the people receiving ART should have their numbers of people receiving ART reset. However, a relative margin of error of 10% for a 90% confidence interval is recommended as a minimum level of acceptable precision for the national correction factor for the number of people receiving ART (see subsection 3.5).

III. ART sites should be selected for the assessment by probability sampling, such as simple random sampling, stratified random sampling, systematic random sampling or probability proportional to size sampling, in which size would be based on the number of people facilities reported to be receiving treatment. To obtain a national correction factor, a qualified statistician should perform the sampling of sites and the country team should archive all the programs and/or tools used to select the sites, specifically the sampling frame, site selection probabilities and relevant design information, since certain designs require the use of sampling weights during the analysis phase.

IV. Some countries may have sites that are very small (such as fewer than 100 people receiving ART) or may be difficult to access because of geographical remoteness or political instability. In these cases, the interorganizational country team may consider excluding some or all of these sites from the evaluation because of logistical considerations. In general, if these sites represent less than 10% of the population receiving ART in the country, countries may choose to exclude these clinics from the sampling frame. In this case, the exclusion from the sampling frame needs to occur before site selection. The final report should include a list of all excluded facilities and reasons for their exclusion. The reported number of people receiving ART from these sites should not be adjusted using the ratio method, since these sites would not be part of the sampling frame and target population. These sites can be included in the second phase of DQA.

DQA Step 3. Site-level assessment

I. **Site-assessment:** For this activity in both phases 1 and 2, the interorganizational country team uses standardized processes to review existing information on people receiving ART that is routinely collected through facility- or community-based patient monitoring systems and site assessment tools. DQA activities use a set of standardized tools and data collection instruments (see the annexes) developed specifically for the treatment indicators, although these may be adapted to fit local contexts or to accommodate additional indicators. Data quality should be assessed at the sites for both treatment indicators (number of people currently receiving ART and number of people initiating ART) disaggregated by age and sex.

Selected facilities will be contacted to identify a date and time for the DQA visit. Countries may use their own template for notifying the sites of the visit and should include the following information: the purpose of the visit, proposed visit dates and a request for key staff to be present for the visit.

The site-level assessment visit will consist, at minimum, of the following activities:

- Introductory discussions with key staff of the site and implementing partners;
- Review and completion of informed consent;
- Review and completion of the patient monitoring system checklist;
- Site walk-through and assessment of record systems to determine patient and data flow from the point of initial data capture (patient files) to data aggregation and reporting (registers and monthly aggregate tools) and to identify gaps and opportunities to improve data quality;
- Recount of reported numbers for selected indicators disaggregated by age and sex and comparison against the numbers reported to the Ministry of Health routinely as well as PEPFAR, for example in DHIS2 and DATIM (Data for Accountability, Transparency and Impact Monitoring), which may include reviewing paper charts, registers, EMR systems, pharmacy records or other record systems;
- Cross-validation of a sample of paper charts, registers, EMR systems, pharmacy records or other record systems; depending on the result, a physical count using patient charts should be conducted if needed; and
- Outbrief with key site and implementing partner staff to summarize key findings from the visit.

Past experience with implementing DQA in countries indicates that one site per day on average is feasible for completing these activities. In terms of human resource, cost and time requirements, this varies significantly according to the number of facilities sampled and patient files reviewed as well as the geographical distribution of facilities and country context. As broad guidance, however, a recent exercise implemented in 84 facilities required a team of 31 data collectors and supervisors over 25 days and 24 data entry clerks over 20 days.

II. **Data collection and analysis:** To assure the quality of collected data for review interorganizational country teams are expected to apply standard data quality assurance practices during data collection. This includes double data entry when possible or having two teams enter a sample of the data to check the quality. At the least, data capture will be conducted in pairs with one partner monitoring the data entry of the other. This will ensure that the data collection team is not introducing any error during the review process. The process for each activity is outlined below.

Primary activity (required):

Recreating selected indicators and validating the report:

a. Site staff members first describe the site's data systems, reporting process and methods for calculating each indicator during the discussions.
b. The assessment team calculates the selected indicators according to the current definitions, attempting to replicate the procedures used by each site to aggregate and report quarterly totals. If sites report the indicator using a definition that differs from the standard definition, this alternative definition will be known as the site definition and will be documented using the site questionnaire. The reporting and site method for the indicator should be used when recreating the reported number. However, if time and other constraints are present, recreating the standard definition is the priority activity.

c. The recreation of the selected indicators should use the same data source the sites use to report the indicator. For instance, if the sites use the ART register to report the number of people currently receiving ART, the recreation should also use the ART register. Some sites may use the patient charts or other data sources, such as ARV drug pick-up records to report on the number of people currently receiving ART. If this is the case, the recreation should be based on the tools used by the site for reporting.
d. This recreation may include computing patient tallies and confirming results from facility registers, patient databases, pharmacy logs and laboratory records and should review the most recently reported data.
    i. When recreating indicators in facilities with an electronic database, and where indicators were calculated by the site using that electronic system, ask the site staff or database manager for the software report or query used to run the calculations, and validate the consistency of that query with partner and/or Ministry of Health definitions for the respective indicator, when possible. Reports are often routine and so definitions and queries used at sites will often be the same across sites using the same electronic systems.
    ii. A random sample of inactive patient charts (such as 10 charts) should be selected and reviewed to assess misclassification and determine how many may actually still be active. If this review identifies issues with the classification of inactive patient charts, physically counting patient charts should be considered (as described in the section on other data validation activities).
e. The assessment team then compares the calculated results from the reported and site (if this exists) method recreation with the reported value and discuss differences (if any). The measure for comparison will be the verification factor (recreated/reported times 100) and confidence interval, which explains how much of the reported data can be verified. A verification factor within 90% to 110% is within acceptable levels but should still be recorded, reported and reviewed by the Ministry of Health and country team to adjust national ART data.
f. Discrepancies between the reported and recreated values (percentage difference) are computed, described and discussed with each site. To the extent possible, the reasons for possible differences between the values computed during the site visit and the values reported by that site are further investigated and described (see other data validation activities for the details of methods that can be used). If immediate remediation is needed, action plans should be developed with the sites and options for correcting the data should be discussed.

To support the primary data validation activity and implement the final step of assessing the discrepancies between reported and recalculated ART numbers, at least one of the data validation activities below should be conducted alongside the DQA. These activities will inform the DQA by providing additional information on the completeness and accuracy of the data sources and reporting tools.

Other data validation activities:

1. Site-level cross-validation: the process of checking the completeness and accuracy of site level source documents by cross-referencing identified data elements in routine reporting source documents (typically patient charts) with other reporting documents, such as the ART register, pharmacy records or EMR system.
    a. The assessment team randomly samples a number of patient charts from the ART register beginning with the start of the time period being reviewed. Assessment teams should define the number of charts to be selected and the specific sampling method (such as every fifth person) during the planning stages of the assessment.
    b. The following are options for selecting the number of charts.
        i. Select 10% of the charts from active patients receiving treatment. If at least 10% of the charts reviewed are inconsistent with the register, an additional 10% of patient charts are reviewed to better understand the consistency. For example, if 1000 people are active, then 10% (100/1000) of the charts should

be reviewed. If 10 or more charts are inconsistent with the register, then the number of charts reviewed is increased by 100.

ii. A random sample of charts may be selected to estimate the completeness and accuracy with a high degree of statistical precision (narrow confidence interval). This often requires a larger sample size and can be calculated using a sample size calculator. For instance, the HIVQUAL sampling method could be used.

c. Selected data elements such as the last ARV drug pick-up date and last clinic visit will be compared between data sources (such as ART register, EMRs, pharmacy records etc.) using a data verification tool, which will be adapted to the country data systems. The number and types of data elements to be reviewed will be determined by the country team.

d. The data collected will be used to calculate the percentage of discordance between the source document (patient charts) and other data from reporting tools such as the pharmacy system, EMRs and/or ART register.

e. For this activity, teams have access to patient records and charts or personally identifying health information, and the teams therefore apply a standardized practice to data extraction, making sure to cover the name, age, address and phone number of each patient. The patient identifiers such as name, date of birth and sex are used to identify the records for this activity, confirming the same patient across different data sources. These identifiers are not removed from the facility and are not part of the data collected. The identifiers are destroyed before leaving the health facility. Only aggregated data are captured. All data abstraction occurs in a private area, away from patients, and covered (such as closing the folder) if patients are present.

f. This activity seeks to determine agreement (and the percentage difference) among reporting tools at the same site, to describe reasons for the discrepancies observed and to make recommendations, if possible, for improvement.

2. Physical count using patient charts: in instances where the validity of the indicators produced from site-level reporting tools or from cross-validation are of significant concern, the patient files can be checked and physically counted to confirm the “actual” total of people actively receiving ART. Examples of when a physical count might be beneficial include: when source documents used for reporting appear to be significantly incomplete or when there are larger data quality concerns, such as issues with appropriately accounting for people experiencing interruption in treatment (IIT) and/or deaths.

g. The assessment team should identify patient charts that fall into the following categories and review the charts to confirm the patient status and count the patients whose charts or medical records fall into each category (the definition of these categories may vary from country to country).

i. Active: people actively receiving ART: currently have enough medication that will last until their next scheduled visit.

ii. Missed appointment: missed their last appointment but are within seven days of their missed appointment.

iii. Defaulters: missed their appointments but do not qualify as IIT within the three-month window following their missed appointment.

iv. Interruption in treatment: missed appointments and are outside the three-month window following their missed appointment.

v. Transfer out: initiated care and treatment at the current facility.

vi. Deceased: died.

vii. Transfer in: initiated care and treatment services at another health facility.

h. People who are deceased, transferred out or experienced interruption in treatment are not considered actively receiving ART. All other people are considered active.

i. People may also be actively visiting the facility during the physical recount, so their charts may not be in the file room or charts may be kept in other locations within the health facility such as tuberculosis, maternal and child health clinics etc. The assessment team should ensure that a comprehensive chart count and review is performed.

j. The count of people actively receiving ART should be compared with the number reported by the clinic.
k. The number of people actively receiving ART reported may differ from the physical recount. However, this number should be within acceptable error bounds because of flow in and out of the facility.

3. Interruption in treatment (IIT) assessment: in facilities that utilize electronic systems for patient monitoring and tracking, queries on recent interruptions in treatment can generate a list of patients meeting the IIT criteria. Verification of IIT status in the patient chart can provide an additional opportunity for validating the accuracy of the electronic system.
    l. The assessment team works with site staff to query the electronic system to generate a list of people that have been marked as IIT based on standard definitions.
    m. The assessment team pulls each person's chart from the list generated and confirms whether the person is still actively receiving treatment based on chart documentation. In some cases, the pharmacy system might need to be queried as well, since people might bypass clinical visits but still pick up medication from the pharmacy.
    n. People misidentified as IIT will be totaled and used to calculate a percentage of variance.

Assessing and correcting errors in the reported data that result in incorrect counts of people receiving treatment at sites because of interruptions in treatment, transfer out and death using one of the latter two data validation activities above is a critical step for adjusting the national ART data.

The assessment teams use standardized data collection sheets to collect qualitative and quantitative data from each site. All quantitative information is consolidated using tables (spreadsheets) and shared among participating staff. Implementing partners are asked to maintain the results of all DQAs in a centralized database to demonstrate routine monitoring of data quality and quality improvement over time.

The assessment team works with site-level staff to summarize the results and identify the potential root causes of poor data quality at that site. The results will be used to develop site-specific action plans for improving the quality of data and correcting the problems discovered in the activity. The lessons learned will be summarized across all sites and shared during quarterly meetings with the Ministry of Health and partners.

DQA Step 4. Desk review of ART data submitted to the national level

A desk review of the quality of existing ART data reported to the national level should be undertaken to evaluate the dimension of data quality. At a minimum, aggregated ART data at the national level should be checked for the completeness and timeliness of ART reports, and this should be quantified. Monthly or quarterly reports on the number of people receiving ART reported by ART sites to the national level should be reviewed in addition to the number of submitted reports and the number of ART sites expected to report for the reporting period covered. Reports from previous years can also be reviewed for a longer-term view of reporting trends.

The desk review is intended to assess errors in reporting and aggregation caused by missing or delayed reports and, when feasible, duplicate reports. For the latter, if possible, EMRs should be used to estimate the number of duplicate reports because of silent patient transfer across ART sites and assess interruption in treatment at the national level.

DQA Step 5. Analyze the results and reset the numbers or people receiving ART for the site and nationally

I. **Data management:** The data collected and analyzed as part of this assessment will be shared by all partners and the Ministry of Health. These data may be collected using a combination of paper and electronic forms. Data that are collected on paper forms will be kept in the possession of the field team leads throughout the field exercise. Upon completion of fieldwork, team leads will be responsible for destroying all personal identifying data forms and transporting all aggregated data back to the main office. All aggregated data will be entered into an electronic format such as Microsoft Access, Excel or similar software. The database used will be password protected and will be available on computers that are only accessible to the project team.

The data taken from the site will not include any patient identifiers. Patient identifiers may be used at the sites to identify charts. However, this information will be destroyed before leaving the site.

The data collected will be backed up on password protected and, where available, encrypted computers at the country office or the Ministry of Health. The results of the DQA will be shared with partners for activity monitoring purposes. However, the raw data files will not be distributed beyond the country team. The data collected on paper forms may be kept for up to five years and then destroyed.

II. **Correction factor to apply to the national numbers of people receiving ART:** A key output from the DQA is a quantitative understanding of the likely level of under- or overreporting of the number of people receiving treatment nationally during the assessment period. Misreporting of this number can arise from the following.

Incorrect reporting from the facility and aggregation at the national level. Aggregation of facility level reports to count the number of people receiving treatment at any given time can be subject to error if facility reports are delayed or missing and not adjusted for or if reports for the facility are entered in duplicate. This type of error can result in either over- or undercounting the actual number of people receiving treatment. The numbers of people receiving treatment should be corrected to account for missing facility reports or reports that have been mistakenly entered in duplicate. The desk review in step 4 assesses this.

Incorrect counting of people receiving treatment at the facility level. In addition to simple errors in aggregation of data between patient records and reporting forms, incorrect counts of the number of people receiving treatment may arise from a failure to properly define “currently receiving ART”, from failure to remove people who have died or disengaged from care or who have transferred facilities or from incomplete or backlogged patient records, registers, charts or files. Errors of this type can result in either over- or undercounting the actual number of people receiving treatment at a facility. The correct number can be determined by recreating the reported number using patient records and registries (see subsection 3.3, Step 3: site-level assessment for details).

People who simultaneously seek care at more than one facility. The number of people receiving treatment can be incorrectly counted if people are simultaneously registered at and considered to be receiving treatment by two facilities.

This error will always result in over-counting the number of people receiving treatment. The correct number can be determined by comparing electronic records, where available, across facilities, reviewing possible matches to determine whether they are the same person and then assigning a single location for counting purposes. When this comparison can be done with only a subset of the people receiving treatment, a correction factor could be calculated and applied in addition to the correction factor from step i below, if there is agreement that the same level of duplication is occurring in facilities not included in the comparison. If insufficient information is available to determine the unique identity of individuals, this correction factor should not be used.

To the extent possible, all sources of errors should be considered when reporting on the number of people receiving treatment for the current and historical reporting periods.

The following steps are used to calculate that national reset value in the year in which the DQA was done.

Step i. Estimate the ratio of the number of people verified to be receiving treatment from the DQA to the number of people facilities reported to be receiving treatment and confidence interval using the method.

Step ii. Multiply the total number of people reported to be receiving treatment from the sites included in the sampling frame by the above ratio and by the upper and lower bound ratio estimates. This will yield adjusted national estimates along with an upper and lower bound estimate.

Step iii. Correct for duplication across facilities if possible (where comparison across facilities has been done using EMRs), by applying the cross-facility duplication adjustment to all sites. If duplicates are resolved at the time of the validation, the cross-facility duplication correction should only be applied to the numbers of people receiving treatment in sites without EMRs.

Step iv. If applicable, apply additional correction factors to the adjusted estimate.

The following steps are used to calculate the historical value in years before the DQA.

One approach to adjusting the previous year's data (assuming that errors in reporting are directly linked to patient load) is to identify the year since 2010 with the largest percentage increase in the numbers of people reported to be receiving treatment and then calculate an interpolated adjustment factor (either linear or exponential) for each year until the year before the DQA was done.

Other approaches could be considered based on whether the country believes that miscounting is likely to be associated with different partner-level support in clinics, the type of reporting system (paper versus electronic) or patient load at the clinic. These approaches would require historical understanding of how these facilities attribute changes over time.

DQA Step 6. Disseminating, notifying and reporting results

A primary aim of the work will be to adjust the number of people receiving ART at the facility level and further correct any strategic information used for planning and reporting. Clear documentation of the assessment, the results and the decision about the correction factor will be critical for explaining changes to ministry officials and development partners. The country report will therefore inform the process of updating estimates rapidly after the report is provided.

Once a nationally representative adjustment factor has been calculated, it needs to be reviewed and agreed by stakeholders. Clear and transparent messaging about the change in the values should be agreed by the interorganizational team and disseminated widely. The corrected treatment values for the year in which the review was done should be submitted through the UNAIDS Global AIDS Monitoring online tool for the year of the assessment. The adjusted ART data also need to be corrected in the national (or subnational) Spectrum estimates file. This will require correcting the historical years as well as the current year. See the section above on national correction factors to determine how this is done.

Based on the findings from the above methods, the interorganizational country team will produce a brief report summarizing any systematic problems with defining indicators and data recording, reporting and aggregation from the facility to the national level (where relevant), data quality challenges and recommendations to improve the quality of aggregate data reporting and the system that generates the data in the future. This report should be shared with all stakeholders in the interorganizational country team, including implementing partners and Ministries of Health. For more examples and templates to support your DQA, please visit: https://apps.who.int/iris/bitstream/handle/10665/274287/WHO-CDS-HIV-18.43-eng.pdf?sequence=5&isAllowed=y

APPENDIX D: SITE AND SNU ATTRIBUTES AND EPIDEMIOLOGIC ESTIMATES

Overview: PEPFAR collects administrative, epidemiologic, and service-related data about facilities and subnational units (SNUs) that helps to better illuminate where services should be provided, where services are actually provided, who is delivering these services, and what is the service capacity. Some of these attributes are routinely collected in form of MER indicators (e.g., EMR_SITE), others are collected at the time a facility is added to a master facility list and subsequently DATIM (e.g., facility name, geographic coordinates), and others are collected during the annual PEPFAR planning cycle.

Through the collection of these data, PEPFAR strives to have more complete information available on service provision and facility infrastructure. Use of these data facilitates improved decision-making when country programs are determining what services should be targeted by geographic locations to the populations in greatest need of these services.

Signature Domain Attributes: Signature domain data elements are those elements that can be used to identify and locate a site or SNU and are those data elements that should not change significantly over time. Much like a person's signature can ensure his or her identity; the signature domain attributes would ensure a health facility's identity.

Attribute	Definition	Points of Collection	Response Options
Unique Facility ID	Auto-generated, unique code that distinguishes one facility from another	Facility	Variable
Facility Name	Official, registered name of the facility	Facility	Variable
Geographic Coordinates	Physical location of the facility; represented as latitude and longitude	Facility	Variable
Administrative Areas	District, province, or other administrative levels	Country-Specific	Variable
Type of Facility	Classification of each facility by type	Facility	-Hospital -Primary Health Center -Health Post -Dispensary/Pharmacy -Standalone Laboratory -Mobile Health Clinic -Temporary Facility -Other Facility
Ownership or Managing Authority *Multiple response options can be selected and analyzed for this attribute*	Entity that owns (has exclusive legal rights to the facility) or manages (coordinates its service delivery) the heath facility	Facility	-Government: MOH -Government: Other -University -NGO or Non-Profit -Private -Faith-Based

Service Domain Attributes: Service domain data elements describe the basic services, infrastructure, and human resources at a facility; therefore, service domain data are critical for planning and resource allocation. Compared with signature domain data, these data tend to change more frequently, so greater effort is required to keep information current.

Attribute	Definition	Points of Collection	Response Options
SNU-Level Planning Prioritization	COP planning prioritization definitions as described in the COP guidance	PEPFAR Priority SNU-level (e.g., district)	-Attained -Scale-Up Saturation -Scale-Up Aggressive -Sustained -Centrally Supported -Sustained: Commodities -Not PEPFAR-Supported
Do the staff at this facility provide services such as HIV testing, HIV treatment, and PrEP in the community?	Understanding community service provision conducted by facility-based staff	Facility	-Yes -No
Clinic Hours	Hours that the clinic is open to provide HIV-testing and/or treatment services	Facility	-Standard shift (Standard workday as described by government)

			-Extended hours to accommodate evolving population health needs (e.g., men, adolescents) -24-hour
Special Interventions Site Tag #1 *Include text entry field for name (e.g., HTS surge) and brief description of intervention*	Tag to identify which sites are receiving intensified interventions or monitoring	Facility	Yes (selected only for those sites that are implementing special intervention, surge, etc.)
Special Interventions Site Tag #2 *Include text entry field for name (e.g., HTS surge) and brief description of intervention*	Tag to identify which sites are receiving intensified interventions or monitoring	Facility	Yes (selected only for those sites that are implementing special intervention, surge, etc.)
Special Interventions Site Tag #3 *Include text entry field for name (e.g., HTS surge) and brief description of intervention*	Tag to identify which sites are receiving intensified interventions or monitoring	Facility	Yes (selected only for those sites that are implementing special intervention, surge, etc.)
EMR_SITE	See EMR_SITE	Facility by Service Delivery Area	-Yes -No -N/A
FPINT_SITE	See FPINT_SITE	Facility by Service Delivery Area	Number of SDP by service delivery area
HRH_STAFF_NAT	See HRH_STAFF_NAT	Facility	Number by Cadre: Clinical, Pharmacy, Laboratory, Management, Social service, Lay, Other HCWs

Epidemiologic Estimates:

Attribute	Definition	Points of Collection	Response Options
Population Estimates	Number of people living in a country or geographic area as determined via Census or other method of civil registration	National PEPFAR Priority SNU-level (e.g., district)	Total population estimate disaggregated by: • Fine Age/Sex • Coarse Age/Sex
PLHIV Estimates	Estimated number of people living with HIV infection as determined by using a survey or some other globally consistent estimation method	National PEPFAR Priority SNU-level (e.g., district)	Total number of adults and children living with HIV disaggregated by: • Fine Age/Sex Coarse Age/Sex
HIV Prevalence Estimates	Estimated proportion of the adult population living with HIV infection	National PEPFAR Priority SNU-level (e.g., district)	The prevalence of HIV in the adult population disaggregated by: • Coarse Age/Sex • Sex
KP Estimates	Estimated number of key populations living with HIV infection as determined by using a survey or some other globally consistent estimation method	National PEPFAR Priority SNU-level (e.g., district)	Number of people engaging in defined behaviors or belonging to defined groups, associated with increased risk of HIV infection disaggregate by: • MSM • FSW • PWID • Transgender people • People in prisons or other closed settings

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

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

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

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

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

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

APPENDIX F: GLOBAL OVC GRADUATION BENCHMARKS MATRIX

GLOBAL ORPHANS AND VULNERABLE CHILDREN
GRADUATION BENCHMARKS MATRIX
Updated 07-06-2018

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

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

1. DOMAIN - HEALTHY

1.1 KEY OBJECTIVE - INCREASE DIAGNOSIS OF HIV INFECTION

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

DATA SOURCES AND DEFINITIONS:

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

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

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

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

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

DATA SOURCES AND DEFINITIONS:

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

1.3. KEY OBJECTIVE - REDUCE RISK OF HIV INFECTION

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

[4] OVC may be aged 20 or under if they are completing secondary education or an approved economic intervention intended to secure the livelihood of an OVC aging out of the program

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

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

DATA SOURCES AND DEFINITIONS:

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

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

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

DATA SOURCES AND DEFINITIONS:

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

2. DOMAIN - STABLE

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

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

DATA SOURCES AND DEFINITIONS:

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

3. DOMAIN - SAFE

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

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

DATA SOURCES AND DEFINITIONS:

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

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

DATA SOURCES AND DEFINITIONS:

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

4. DOMAIN - SCHOOLED

4.1. KEY OBJECTIVE - INCREASE SCHOOL ATTENDANCE AND PROMOTION

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

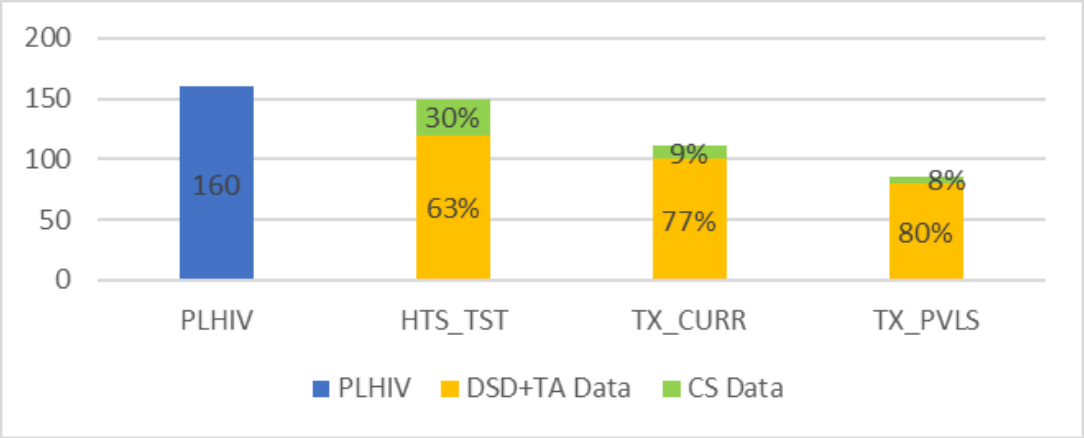
DATA SOURCES AND DEFINITIONS:

- School administrators confirmed that school-age children/adolescents are enrolled in school and have not missed more than 20% of school days per month during the last six months when school was in session
- School administrators confirmed that school-age children/adolescents progressed from one grade to the next grade or graduated in the last school year

APPENDIX G: CENTRAL SUPPORT

Central Support Overview: PEPFAR and global partners are looking to fill gaps in data to enhance epidemiologic and programmatic data in support of OUs pursuits of epidemic control. Central Support (CS) data has been identified as a data classification, that does not overlap with TA or DSD, which could fill these gaps and would add to our understanding of an OU's epidemic – highlighting successes and areas needing support. CS data collection is done in conjunction with DSD/TA data collection, to help provide additional context to services being provided, and the status of the epidemic. In addition to a broader understanding of an epidemic, collection of CS data provides insight into services and funding provided outside of the DSD/TA service definitions through support of Host Country governments.

Definition of Central Support: Centrally supported sites are sites located in areas where PEPFAR is solely providing financial support at the national, regional or district level, with site-level support through annual visits. The purpose of this collection activity is to understand further, how close countries are to Epidemic Control, or how they are maintaining Epidemic Control, with the inclusion of Central Support (CS) data. This chart provides an example of how the inclusion of CS data can provide a different view of the epidemic at the OU level.



As evidenced in the chart above, Inclusion of CS results allows us to see that this OU is closer to the 95-95-95 goals than previously evidenced with only DSD/TA data.

Data Type vs. Prioritization

- Central Support Data Type: The CS data type, in comparison to the DSD and TA data types, should be reported from sites where PEPFAR is **solely providing financial support** at the national, regional or district level, and site support is through annual visits. Collection of this data allows for insight into programs not directly supported (but financially supported) by PEFPAR.
- Central Support Prioritization: Prioritization levels are determined for SNUs during COP planning, based on where an SNU sits in reaching 95/95/95 goals. CS prioritization is given when site specific activities have transitioned to government or other support.[7]
    - CS Prioritization does not mean all data should be collected under the CS data classification. SNUs with a CS prioritization currently collect data under DSD, TA, and CS data types.
    - Please review the most recent COP Guidance for further information on the Central Support prioritization.

Central Support Reporting Requirements

- Indicators: Centrally Supported site-level data should be reported for each of the six required indicators for centrally supported data: HTS_TST, TX_NEW, TX_CURR, TX_PVLS, PMTCT_STAT, PMTCT_ART
- Disaggregates: CS results should be disaggregated at the most complete, and specific level possible. Complete reporting on the age/sex disaggregates that sum to the total numerator is necessary for

[7] COP/ROP 21 Guidance for All Countries

accurate monitoring and review of programmatic framework. If reporting on additional disaggregates is not feasible, please contact SGAC_SI at SGAC_SI@state.gov and copy your PEPFAR Program Manager.

- Frequency: CS Indicators should be reported on at least an annual basis. CS Indicators are available for quarterly reporting for OUs with available data. If available, CS indicators should be reported on a quarterly basis. If reporting annually, CS indicators should be summed (except for TX_CURR) so that Q4 data is equal to the annual cumulative.
- Implementing Mechanisms (IM):
  - Data **will not** be deduplicated across CS, DSD/TA. Ensure that you are only submitting applicable data under CS or DSD/TA.
  - The same IM can be used for DSD/TA data reporting, with the appropriate CS/DSD/TA tab being utilized in the DATIM entry screens.
  - IMs used for central support are determined on country-by-country basis, and these decisions should have been made during COP discussions.
- Data Entry in DATIM:
  - Required indicators for CS reporting will reflect an option for "CS" reporting where OUs can report site-level results for centrally supported sites. A snapshot of the tab from the DATIM data entry screen is provided below.

Details on central support reporting – including the designation of centrally supported SNUs, reporting frequency, and reporting mechanisms - should be decided during COP discussions. Further questions on CS reporting should be directed to your PPM, who can reach out to your DUIT Liaison for additional support as needed.

Central Support Reporting Examples

Central Support PSNU with DSD, TA, and CS Data Types

*Mock data for example purposes only, does not represent a PEPFAR OU.

PSNU	Partner	Implementing Mechanism	HTS_TST			TX_NEW			TX_NEW		
			DSD	TA	CS	DSD	TA	CS	DSD	TA	CS
Centrally Supported District	Department of Health	1111			2,011			2,011			2,611
	NGO Partner B	2222	14								-
	NGO Partner A	3333	188			188			289		
		3334	56	12		56	12		312	170	

Data reported for an SNU prioritized as Central Support:

Majority of data reported through the DOH – Mechanism 1111 falls within the CS Data classification

NGO Partner B reports DSD and TA data in a CS prioritized PSNU that does not fall within CS data classification

The example above illustrates summarized results by IM and data type for the PSNU. The data reported by Department of Health reflects results from centrally supported sites within the PSNU. NGO Partner A reports results from sites within the same PSNU that receives DSD or TA support. Therefore, the results summary reflects a mix of DSD, TA, and CS support at the PSNU-level.

The following example provides a snapshot of results by different data types at the site-level:

Site	Implementing Mechanism	HTS_TST			PMTCT_STAT		
		DSD	TA	CS	DSD	TA	CS
Site A	1111	178					246

The site-level example reflects both DSD and CS results from the same site. However, there are differences in the type of support by program area. PEPFAR is directly assisting with the implementation of testing, but is

only providing financial support for PMTCT_STAT. Since PMTCT_STAT activities are still being conducted, but without direct PEPFAR assistance, this data is collected under the CS data type.

Technical Assistance results vs. Central Support results

- Technical assistance data type should be used when PEFPAR is providing ONLY support to improve quality of services through site visits.
- Central support data type should be used when PEPFAR is ONLY providing financial support at an above-site level.

Questions on Central Support Reporting

Please reach out to SGAC_SI@state.gov for any questions or further clarification on your reporting Central Support Data for your OU.

APPENDIX H: MONITORING MORTALITY AMONG PLHIV

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

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

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

Deaths among ART patients that occur in the health facility: Deaths occurring within the health facility should be immediately recorded in the ART register and/other relevant tracking register, which may or may not already include cause of death. The Medical Certificate of Death and Cause of Death (MCCD) should be filled to ascertain COD and is also a data source for obtaining mortality-related data for patients who died in the facility. If filled according to WHO/ICD guidelines, and coded correctly, the underlying cause of death (UCOD) will be identified. When filled correctly, the MCCD will also include a sequence of events leading to the immediate cause of death. It will also list conditions that are not in the causal chain but are related to the cause of death. If these are entered electronically (through the WHO DHIS mortality module or alternative electronic system), these fields (Part I, a-d, and Part II) can all be coded and/or searched.

MCCD forms are typically embedded in national death reporting forms, which include demographic information and other country-specific requirements for registration. Completed death reporting forms should be sent to the national registration authorities for legal registration. Even without COD, recording and reporting all deaths among HIV-infected patients, and the general population, as well as knowing mortality rates, etc., is valuable.

Deaths among ART patients that occur outside the health facility: Deaths that occur outside the facility should be confirmed by unambiguous report of family or close acquaintance (i.e., it should not be presumed). COD in community settings is commonly ascertained through verbal autopsy. Verbal autopsy is a method of gathering health-information about a patient that has died in order to determine their probable COD; it typically includes an interview with a caregiver to elicit known diagnoses, signs, and symptoms experienced by the deceased as well as an open narrative describing the circumstances of the death. Where a system for verbal autopsy is in place, PEPFAR teams should coordinate with local authorities to identify the best COD information available (e.g., reported conditions, open narrative, probable COD assigned). Where such a system is not in place, verbal autopsy could be introduced or, for purposes of this indicator, unvalidated family reporting can be accepted to determine cause of death. For more information on verbal autopsy, see the WHO verbal autopsy standards.

Caveats:
It is widely acknowledged that even where reporting is required, mortality data, especially cause of death, are often underreported or inaccurate. Where high quality MCCD is available, PEPFAR teams can expect to find UCOD according to the standard definitions provided. However, where systems are weak, teams may need to use whatever COD information is available for reference to best describe conditions co-existing at the time of death. For verbal autopsy, it should also be noted that since verbal autopsy results are generally considered valid only at the population level, teams are likely to be able to elicit information about conditions coexisting at the time of death rather than a specific UCOD. For reference, the National Center for Health Statistics at CDC

compiled a status table below, that describes the completeness of mortality and COD reporting in several PEPFAR countries.

Country	National death registration coverage rate, based on country	Source of National death registration coverage rate	National death registration with COD coverage rate (From either from MCCD or VA)	Source of National death registration with COD coverage rate	National death registration coverage rates, based on official UNSD Data	Year(s) for Official UNSD Data	Latest year that death registration data was submitted to UNSD from 2019 Population and Vital Statistics Report
Angola	-	-	-	-	-	-	-
Botswana	76.3%	http://www.statsbots.org.bw/sites/default/files/publications/Vital%20Statistics%20%202015.pdf	-	-	75%	2014	2014
Burundi	-	-	-	-	-	-	-
Cameroon	-	-	-	-	-	-	-
Cote d'Ivoire	-	-	-	-	-	-	-
DRC	-	-	-	-	-	-	-
Eswatini	55%	Unofficial	40%		less than 75%	2010-2015	-
Ethiopia	-	-	-	-	-	-	-
Ghana	19% (2013)	http://www.statsghana.gov.gh/docfiles/publications/CRVS%20Assessment%20Report%20Final_%2018.04.17.pdf	Limited	http://www.statsghana.gov.gh/docfiles/publications/CRVS%20Assessment%20Report%20Final_%2018.04.17.pdf	25%	2014	2013
Kenya	41%	Report: Mortality Trends in Kenya 2012-2016: Cause of death, trends, and data quality (March 2018)	33.1% (with MCCD)	Report: Mortality Trends in Kenya 2012-2016: Cause of death, trends, and data quality (March 2018)	45.6%	2014	2016
Lesotho	-	-	-	-	less than 75%	2010-2015	2012
Malawi	<10%	Unofficial	<10%	Unofficial	less than 50%	2008	-
Mozambique	-	-	-	-	-	-	-
Namibia	88.5%	http://pubdocs.worldbank.org/en/184451466711154296/1617304-Namibia-ID4D-Web.pdf	-	-	70%	2008	
Nigeria	12.5%	Unofficial	-	-	-	-	-
Rwanda	30% (2014/2015)	NISR (2015), referenced in 2016 report: https://www.unicef.org/rwanda/RWA_resources_crvscafinal.pdf	"practically no reliable CoD recorded"	https://www.unicef.org/rwanda/RWA_resources_crvscafinal.pdf	less than 75%	2010-2015	2012
South Africa	96% (2011-2016)	http://www.statssa.gov.za/publications/P03093/P030932016.pdf	92% (2015)	http://www.who.int/gho/mortality_burden_disease/registered_deaths/en/	75-89%	2008	2014
Tanzania	~16% (2017)	Unofficial	8% (VS)	2018 article: http://www.vitalstrategies.org/vital-stories/tanzania-cause-92-deaths-unknown-solution-better-data/	less than 75%	2010-2015	-
Uganda	<1% (2014)	https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Uganda-Investment-Case.pdf	-	-	-	-	-
Zambia	20% (2016)	Country Presentation made in 2018, by DNRPC (Department of National Registration, Passport and Citizenship)	20%	All registered deaths require a COD, rate assumed	-	-	-
Zimbabwe	-	-			-	-	-

For additional information on the quality of mortality and cause of death data, please see the resources below.

- WHO Analyzing mortality levels and causes-of-death http://www.who.int/healthinfo/anacod/en/
- CRVS Knowledge Gateway Learning Centre: Modules 4 & 5https://crvsgateway.info/Learning-Centre~22

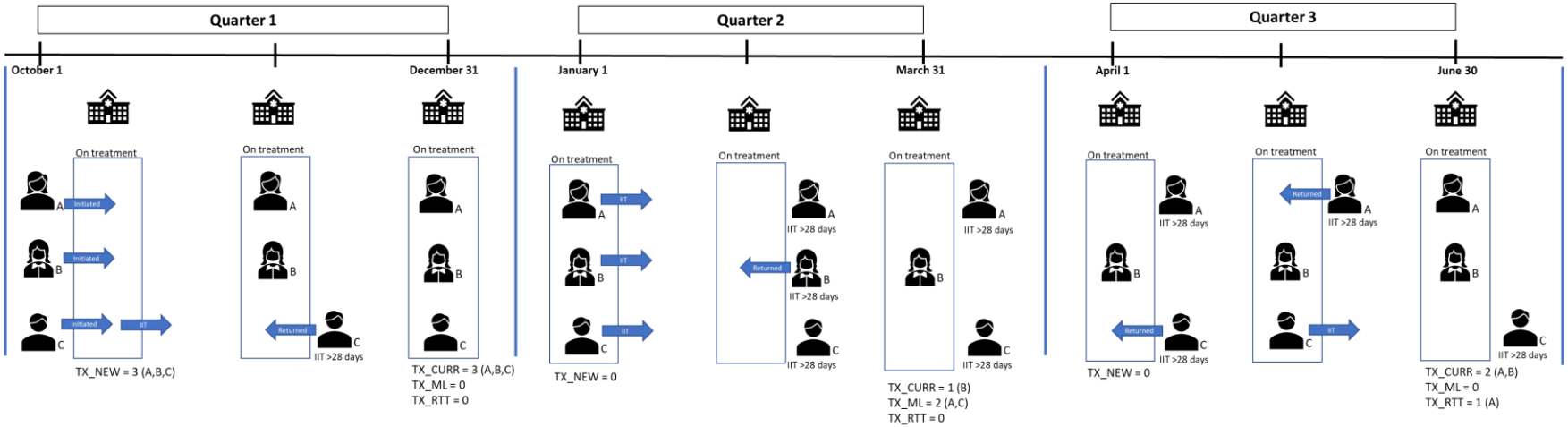
APPENDIX I: PROPOSED HIV-SPECIFIC SHORT CAUSE OF DEATH LIST

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

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

APPENDIX J: VISUAL REPRESENTATION OF TX_CURR, TX_ML, TX_NEW, AND TX_RTT

The following visual represents hypothetical scenarios of patients A, B, and C moving in and out of treatment over the course of three quarters. Refer to the indicator reference sheets for TX_CURR, TX_ML, TX_NEW, and TX_RTT for the full definition of each indicator and additional guidance. When considering scenarios like the ones below, programs should continuously review data to note patterns of patient initiation and interruption in treatment and adjust programs to meet the needs of newly initiating clients.



Quarter 1: Patient C was newly initiated on treatment. During the reporting period, Patient C did not attend an appointment and had no clinical contact for 28 days after that appointment. Patient C was then contacted and came in for an appointment. At the end of the reporting period, Patient C is on treatment.

- Patient C is counted in TX_CURR because they were on treatment at the end of the reporting period.
- Patient C is not counted in TX_ML because they restarted treatment after >28 days of being off treatment and are on treatment at the end of the reporting period.
- Patient C is not counted in TX_RTT because patients are excluded from TX_RTT in the quarter on which they initiated treatment. A patient cannot be included in TX_NEW and TX_RTT in the same reporting period.

Quarter 2: Patients A, B, and C started the reporting period on treatment, but all did not attend an appointment and had no clinical contact for 28 days after that appointment. Patient B was successfully contacted and came in for an appointment. At the end of the quarter, Patient B is on treatment.

- Patient B is counted in TX_CURR because they are on treatment at the end of the reporting period.
- Patient B is not counted in TX_ML because they are on treatment by the end of the reporting period.
- Patient B is not counted in TX_RTT because they were on treatment at the end of the **previous** reporting period.
- Patients A and C are counted in TX_ML because they started the reporting period on treatment but experienced an interruption in treatment and were not on treatment at the end of the reporting period. Patients A and C are eligible to be counted in TX_RTT in the **next** reporting period if they 1) are successfully re-engaged during the **next** reporting period and 2) are on treatment at the end of the **next** reporting period.

Quarter 3: Patients A and C started the reporting period not on treatment. Patient A was successfully contacted and came in for an appointment. Patient C was contacted and came in for an appointment but experienced an interruption in treatment again during the reporting period. By the end of the reporting period, Patients A and B are on treatment.

- Patients A and B are counted in TX_CURR because they are on treatment at the end of the reporting period.
- Patient A is counted in TX_RTT because they were not on treatment at the end of the **previous** reporting period, were returned to treatment during the reporting period, and were on treatment at the end of the reporting period.
- Patient C is not counted in TX_ML in this reporting period because Patient C did not start the reporting period on treatment. Patient C is not counted in TX_RTT because Patient C did not remain on treatment until the end of the reporting period.

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