Planning and Reporting

PEPFAR

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

October 2016

Contents

INTRODUCTION

Overview

PEPFAR's focus on impact in individuals and communities is the driving force for an effective framework that not only monitors outputs from the program but also key outcomes. PEPFAR is partnering with the international community to drive towards the UNAIDS 90-90-90 global goals, 90 percent of people living with HIV know their HIV status, 90 percent of people who know their HIV status are accessing treatment, and 90 percent of people on treatment have suppressed viral loads. The MER indicators also additional HIV/TB monitoring that will drive implementation of IPT policy. In addition to the treatment indicators the program will continue to measure our prevention goals through VMMC and in 2018 moving the key DREAMS indicators into the MER.

Given the global HIV progress over the past decade, planning, monitoring and resource allocation needs to occur at district and community levels in order to have the most impact. Collection and use of data that represents populations served and geographic areas down to the site level where the services are being offered are critical in understanding current program performance and planning for future performance. The indicators will continue to evolve to reflect the evolution of the USG support to measure both the impact of National and Regional support through host governments down to direct services at the site.

As MER Indicators were being updated the following were taken into consideration:

* Reduction of indicators to focus program monitoring on what matters most
* Standardization of age, sex and key population disaggregation across prevention and clinical cascades to be monitor which populations are being reached with quality and identify those who are not being reached with quality interventions
* Continuous alignment of indicators with multilaterals and partner governments to avoid duplication of data collection where possible and to focus on improved data quality and programmatic quality
* Aligned frequency of reporting across indicators to ensure that results are actionable within the period that they are reported
* Input from community stakeholders, technical experts, implementing partners, and field staff
* Alignment with other PEPFAR data streams such as site improvement monitoring systems, expenditure analysis and the sustainability index

PEPFAR Support to Communities and Sites

Completing the second year of quarterly site level monitoring by all PEPFAR implementing agencies and implementing partners has provided granular data that important differences in patient outcomes and site performance. These results should be used to prioritize sites for in-depth support and monitoring based on outputs and quality outcomes.

Starting in FY17, PEPFAR has revised the minimum technical support needed for all sites and program areas and reporting requirements. Implementing partners should provide differentiated technical and direct support to sites and patients based on site and community level performance and quality by providing a minimum of yearly site level technical assistance. This change is in alignment with the World Health Organization new guidelines that recommend differentiated HIV service delivery models in the era of 'Test and Treat' for stable patients. Many countries are already implementing differentiated models for ART service delivery for stable patients. However, support may need to be more frequent based on site, informed by the POART and SIMS visits and may need to be monitored more frequently. Impact in the highest disease burden areas is still priority in order to prevent new infections. There are now three categories of PEPFAR support that correspond to scale-up, sustained and centrally supported areas. In areas where PEPFAR is supporting scale-up and sustained services they type of support should be Direct Service Delivery (**DSD**) or Technical Assistance-Service Delivery Improvement (**TA-SDI**). In areas where PEPFAR support is not at the site level but is financial national or subnational levels support should be characterized as Central Support (**CS**).

Support in Scale-Up and Sustained areas:
DSD: Individuals will be counted as receiving direct service delivery support from PEPFAR when **BOTH** of the below conditions are met: Provision of key staff or commodities AND support to improve the quality of services through site visits as often as deemed necessary by the partner and country team.
TA-SDI: Individuals will be counted as supported through TA-SDI when the point of service delivery receives support from PEPFAR that meets the second criterion **ONLY**: support to improve the quality of services through site visits as often as deemed necessary by the partner and country team.

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

AND/OR

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

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

Key changes:

During the streamlining process from MER 1.0 to MER 2.0, only essential indicators were maintained in the key PEPFAR reporting requirements. These indicators are truly bellwether for the key programs and may be supplemented with indicators for local level implementation monitoring.

The following areas have notable changes; reporting on age/sex disaggregations reporting frequency, key population program monitoring and TB/HIV, the following sections provide detailed changes,

Disaggregated monitoring

There are 3 categories of MER indicator disaggregations for the MER 2.0, which can be seen in the indicator reference sheets and the data entry screens.

1. **Required**, this indicates that this indicator disaggregate is required for all countries that have programming for this area. Which includes means that the country supports a program area, defined by budget and targets set during the COP process -- then it is required that there also be results. Required program indicators may consist of both DSD and TA results.
2. **Conditional** indicator disaggregates include those for which some additional condition must be filled. In MER 2.0 there are no full indicators that are conditional, but only additional disaggregations that are conditional on additional funding and / or programming. In MER 2.0 there are two main types of conditional indicator disaggregation's; 1) having received additional funds for special programming, i.e., DREAMS funds or 2 having received permission for you SI advisor to complete coarse age disaggregations instead of the finer. This is conditional on approval from S/GAC.
3. **Optional** indicator disaggregates, should be completed by those for which the indicators is useful to determine the success of their program (e.g., KP National and Subnational data) or for which the partner has strong methodological sources (KP catchment area -denominator) or for which it is both relevant and safe to enter the data at the site and/or community level (KP disaggregations for TX_NEW, HTS_TST, please see additional guidance on Key populations changes).

Key populations

In order to better understand the HIV epidemic among key populations and program response, there have been several substantial changes to the data collection for key populations. These changes have positively affected both the KP and PP prevention program indicators as well as the clinical cascade indicators.

For the prevention program, to align PEPFAR indicators better with WHO and UNAIDS, the key populations have been separated MSM and transgender and added Prisoners and other people living in enclosed places.

Where appropriate these key population have also been added as disaggregations to indicators in the clinical cascade including, HTS_TST and TX_NEW. These were not added to TX_CURR or TX_RET or TX_PVLS, specifically as identifying as KP may not be life-long and may change over time and therefore not possible to collect retrospectively. Additional KPs were added as a disaggregation for the PrEP_NEW indicator. To better determine the KPs of interest for each indicator, please review Appendix 1, the key population classification document.

TB/HIV

The TB indicators have been enhanced this year to better correspond to global changes in TB policy and to better reflect the increasing emphasis on outcome. We have maintained TB_STAT and have added a disaggregate to TX_NEW and TB_ART to identify the number of new patients who have TB at the time of enrollment. These will allow us to characterize the HIV testing of TB patients, and the linkage to HIV treatment. Elements of TB_SCREEN have been transformed into a new indicator, TX_TB, which will allow us to document the number of patients who are screened for TB, and the proportion of those who are eventually started on TB therapy. Corresponding to the sharper focus of the End TB Strategy, and the emphasis on TB prevention, we have transformed TB_IPT into a new indicator, TB_PREV, which will now be required. By identifying the proportion that completes or is maintained on continuous preventive therapy, we will be able to monitor relevant outcomes, rather than just the number that initiate TB preventive therapy. These indicators will allow us to document the care cascade from TB screening to the desired outcomes: TB therapy or TB preventive therapy.

Host Country National Program

Monitoring host country HIV program response is critical to understand the achievements and gaps in HIV programs in National and subnational context and by population. These data are used to inform PEPFAR programs and guide PEPFAR resources at all levels. The key program areas for monitoring host country targets and results are: prevention of mother to child transmission programs, key populations, voluntary male medical circumcision and HIV diagnosis and treatment, including viral suppression.

Host Country National Results

At Q4 of the USG fiscal year, results from the host national systems should be reported up until the month recent month of collection. These may not align with end USG fiscal year results. These data should be collected continuously at the subnational level as part of service delivery areas. Data should be in line with GARPR and UNAIDS data, although may differ due to different reporting periods. Results should be consistently reported on the same time period to be able to monitor trends over time.

Host Country National Targets

Developing targets for the next year (FY2017) at the national and subnational data is an important step in understanding the national program and determining geographic investments (including host country, Global Fund and other donors). When PEPFAR better understands the target the national program setting process, then it is better placed to support the program and to fill necessary impactful programmatic gaps. Please describe the target setting process that the host country employs in the narratives and partnering donors).

Host Country Subnational Targets and Results

Data are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU). This data should be entered for all subnational unit, regardless of PEPFAR funding supporting these geographical area; so that the total of the subnational results or targets should equal the total number of National results and targets.

SIMS in relation to MER 2.0

SIMS evaluates the quality of service delivery or program oversight to identify performance issues that may impact patient outcomes or the integrity of reporting for MER targets or disaggregates. Low final scores (reds and yellows) from these CEEs highlight potential issues with service delivery, site performance or oversight, and/or documentation of patient results. The SIMS 2.0 Linkage Reference Table provides a listing of all SIMS 2.0 CEEs that have been directly linked to a given MER indicator; linkage data may be used for data triangulation activities to inform and contextualize MER results.

Expenditure Analysis (EA) & MER 2.0 Alignment

PEPFAR Expenditure Analysis (EA) is conducted annually in order to better understand the costs the USG incurs to provide a broad range of HIV services and support and subsequently use this information to improve program planning. Additional information about EA methodology, process, and timeline can be found in the EA annual Guidance. PEPFAR results reported through the MER are linked to EA program areas to calculate a "unit expenditure" (UE). The UE represents the amount (in USD) PEPFAR spent per beneficiary reached within a program area tied to the relevant indicator. Unit expenditures are only calculated when appropriate indicators are available and align with EA expenditure reporting, and therefore EA uses only a selection of MER indicators.

The general framework of EA-MER underscores 1) The benefit of logic checks that ensure consistency and completeness in MER reporting within and across partners in an OU, and 2) that reporting to EA and MER are aligned – i.e. expenditures are reported in the same locations (at EA SNU level, typically district or province) and program areas in which results are reported *(please note: expenditures can also be reported in SNUs and/or program areas in which results are not reported).*

DREAMS Specific Guidance

In addition to required MER reporting, it is essential that all 10 DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) countries – Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe – ensure that all implementing Partners in DREAMS SNUs report their results for and use data from all 13 DREAMS-related indicators and their required disaggregations. DREAMS countries are encouraged to monitor interventions progress using custom indicators for program components that do not have existing MER indicators (e.g., contraceptive method mix, condom promotion and provision). Appendix 3 includes a full list of the DREAMS-related indicators reported for MER 2.0 and the required disaggregation for each indicator. Please note there are also specific reporting requirements for narratives.

MER 2.0 Indicators

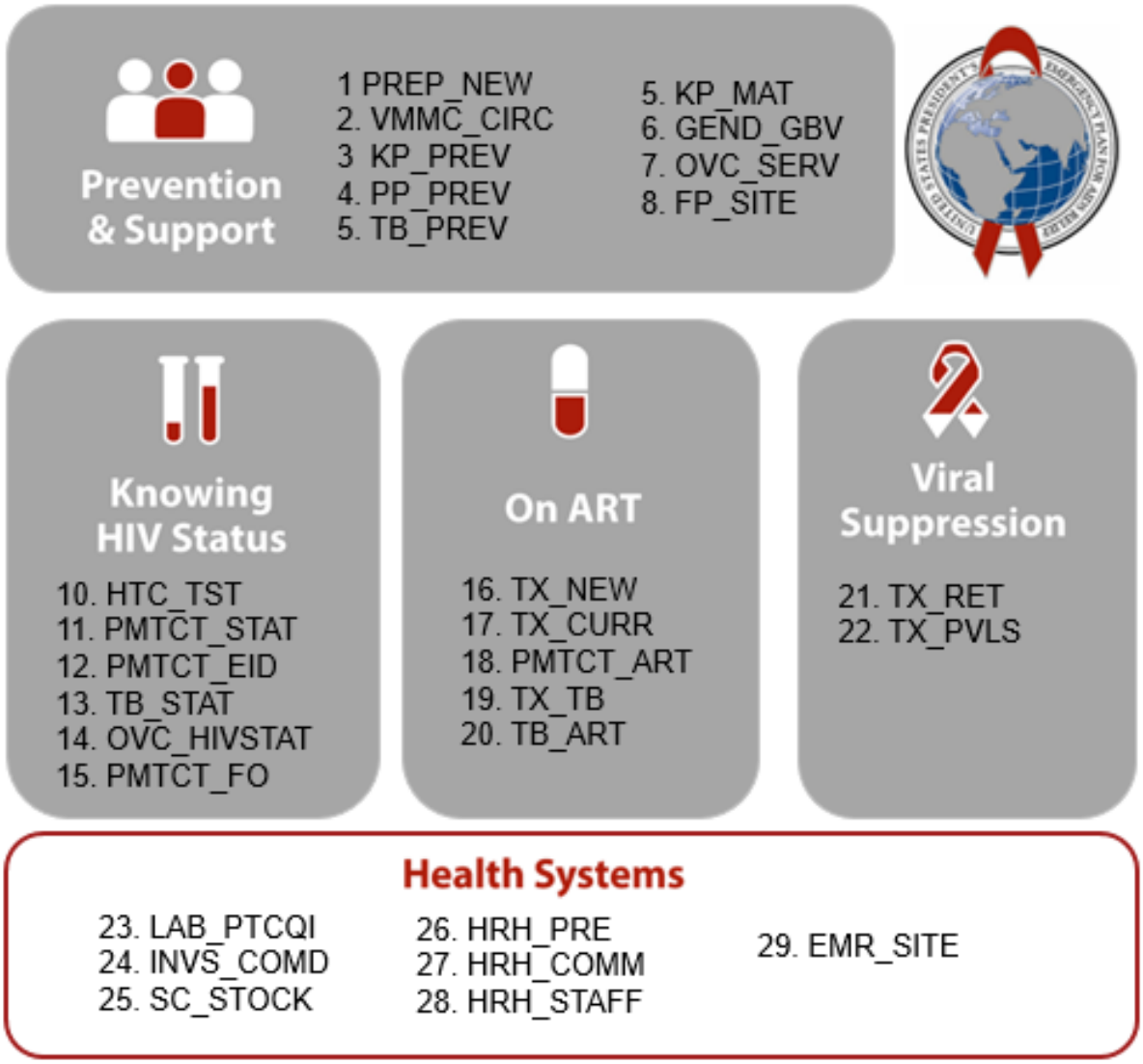
Alignment of reporting frequency by program area (quarterly, semi-annual, annual)

Program Area Group	Indicator Code	Indicator Name	Reporting Frequency
Prevention	PREP_NEW	Number of individuals who have been newly enrolled on (oral) antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period.	Quarterly
Prevention	VMMC_CIRC	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period	Quarterly
90: Knowing Your HIV Status	HTS_TST	Number of individuals who received HIV Testing Services (HTS) and received their test results, disaggregated by HIV result	Quarterly
90: Knowing Your HIV Status	PMTCT_STAT	Percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC), disaggregated by HIV result	Quarterly
90: Knowing Your HIV Status	PMTCT_EID	Percentage of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth, disaggregated by HIV result	Quarterly
90: Knowing Your HIV Status	TB_STAT	Percentage of new and relapse TB cases with documented HIV status, disaggregated by HIV result	Quarterly
90-90: On ART	TX_NEW	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Quarterly
90-90: On ART	TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)	Quarterly
90-90: On ART	PMTCT_ART	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy	Quarterly
Prevention	KP_PREV	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	Semi-Annual
Prevention	PP_PREV	Number of the priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake	Semi-Annual

Prevention	TB_PREV	Proportion of ART patients who completed a standard course of TB preventive therapy within the reporting period	Semi-Annual
Prevention	OVC_SERV	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	Semi-Annual
90: Knowing Your HIV Status	OVC_HIVSTAT	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including status not reported), disaggregated by status type	Semi-Annual
90-90: On ART	TB_ART	Percentage of HIV-positive new and relapsed TB cases on ART during TB treatment	Semi-Annual
90-90: On ART	TX_TB	The proportion of ART patients who were screened who are receiving TB treatment	Semi-Annual
Health Systems	SC_STOCK	Percentage of storage sites where commodities are stocked according to plan, by level in supply system	Semi-Annual
Prevention	KP_MAT	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT)	Annual
Prevention	GEND_GBV	Number of people receiving post-gender based violence (GBV) clinical care based on the minimum package NOTE: The indicator DOES NOT measure delivery of GBV prevention activities.	Annual
90: Knowing Your HIV Status	FPINT_SITE	Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services	Annual
90: Knowing Your HIV Status	PMTCT_FO	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	Annual
90-90-90: Viral Suppression	TX_RET	Percentage of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy (Note: reporting 24 and 36 months is recommended, but optional)	Annual
90-90-90: Viral Suppression	TX_PLVS	Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)	Annual
Health Systems	HRH_PRE	Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre	Annual

Health Systems	HRH_CURR	Number of health worker full-time equivalents who are working on any HIV-related activities i.e. prevention, treatment and other HIV support and are receiving any type of support from PEPFAR at facility and sites, community sites, and at the above-site level	Annual
Health Systems	HRH_STAFF	Number of health worker full-time equivalents who are working on any HIV-related activities i.e. prevention, treatment and other HIV support at PEPFAR-supported facility sites	Annual
Health Systems	EMR_SITE	Number of PEPFAR-supported facility-based service delivery points supported by your organization that have an electronic medical record system	Annual
Health Systems	LAB_PTCQI	Number of laboratories and blood centers/banks: A. Engaged in Continuous Quality Improvement (CQI) activities B. Audited and achieved accreditation C. Performing an HIV-related test and participating in and passing Proficiency Testing (PT)	Annual
Health Systems	INVS_COMD	Number of HIV program related commodities purchased and dollars spent in the last 12 months	Annual

MER 2.0 Infographic



How to read the Indicator Reference Sheet

All indicators are in a standard format in order to easily understand them. Please use this layout as a reference guide to understand how to read the reference sheets.

<table>
<tr><td colspan="5">Indicator Name</td></tr>
<tr><td>Description:</td><td colspan="4">Long name of the indicator</td></tr>
<tr><td>Numerator:</td><td colspan="2">Long name of the numerator</td><td colspan="2">Additional information about numerator definition</td></tr>
<tr><td>Denominator</td><td colspan="2">Long name of the denominator</td><td colspan="2">Additional information about denominator definition</td></tr>
<tr><td>MER 1.0 to 2.0 Change</td><td colspan="4">Highlighting differences from MER 1.0 to 2.0</td></tr>
<tr><td>How to use:</td><td colspan="4">How is data used to monitor the PEPFAR program</td></tr>
<tr><td>How to collect:</td><td colspan="4">How is the data collected (highlight data source, issues with double counting and important components of data collection that ensure data quality) (In general this is in the old MER reference sheets but might be duplicated multiple times and so the language can get cleaned up.</td></tr>
<tr><td>EA & SIMS considerations</td><td colspan="4">Key considerations between MER and other routinely collected PEPFAR data streams</td></tr>
<tr><td>Reporting level</td><td colspan="4">Reported at facility, community,</td></tr>
<tr><td>How often to report:</td><td colspan="4">From the quick reference guide</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Look at SOP from DATIM training for any info</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">From the quick reference guide</td></tr>
<tr><td>Reporting Level</td><td colspan="4"></td></tr>
<tr><td rowspan="4">Data Elements (Components of indicator)</td><td rowspan="2">Numerator: Long name of the numerator</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Denominator (Optional) Long name of the denominator:</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="4">Only list what is different from the standard DSD vs TA definition</td></tr>
<tr><td>DREAMS Local Areas Specific Guidance</td><td colspan="4">Only list what is different in DREAMS SNU’s than in other SNUs</td></tr>
</table>

PEPFAR

Prevention Indicator Sheets

MER 2.0

PrEP_NEW		
Description:	Number of individuals who have been newly enrolled on (oral) antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period.	
Numerator: (Required)	Number of individuals who have received (oral) antiretroviral pre-exposure prophylaxis in the reporting period (PrEP) to prevent HIV infection.	The numerator is generated by counting the number of people newly enrolled in oral PrEP (including WHO specified regimens "tenofovir-containing PrEP" which could be TDF alone, TDF/FTC, or TDF/3TC) during the reporting period, in accordance with the demonstration project guidance or the nationally approved protocol (or WHO/UNAIDS standards).
Denominator	N/A	
MER 1.0 to 2.0 Change	PrEP_NEW is now reported across PEPFAR programs. It is no longer a DREAMS-specific indicator. There will no longer be a denominator collected for PrEP_NEW. Three KP disaggregations were added.	
How to use:	The indicator measures the ongoing growth of PrEP services. This measure is critical to assess progress in the program's response to the epidemic in specific geographic areas, and the uptake and utility of PrEP among persons at substantially increased risk of HIV infection. This indicator permits monitoring trends in use, but does not attempt to distinguish between different modes or regimens of PrEP or to measure the cost, quality or effectiveness of PrEP provided. These will each vary within and between countries and are liable to change over time. PrEP has been shown to reduce incident infections among several populations including serodiscordant heterosexual couples, MSM, PWID, and transgender (TG). The WHO now recommends that oral PrEP containing tenofovir should be offered as an additional prevention choice for people at substantial risk, defined as HIV incidence > 3/100 person-years.	
How to collect:	The numerator can be generated by counting the number of people who are newly enrolled on PrEP in the reporting period, in accordance with national guidelines (or WHO/UNAIDS standards). NEW is a state defined by an individual's beginning in a PrEP program. It is expected that the characteristics of new clients are recorded at the time they newly initiate into a program.	

<table>
<tr><td></td><td colspan="4">Patients are “new” on PrEP only if they are naive to antiretroviral therapy for prevention of HIV infection and have not received oral or topical prophylaxis previously in any program.

Key population disaggregation* see Appendix 1 to support the identification of key populations at ART initiation; If a patient identifies as more than one of the KPs, please enter in all of those that are relevant (therefore KP disaggregations can equal more than the total).

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. As well, if a PREP beneficiary identifies as more than one KP, then the individual should be added to both disaggregations, therefore the KP disaggregations, could be more than the total numerator.

NOTE: both KP-specific and clinical partners have the option to complete these disagg, but only if safe to maintain these files and to report.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Quarterly</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Sum across quarters

Numerator ≥ subtotal of the age/sex disaggregation: The total number people newly enrolled on PrEP (numerator) should be greater or equal to the subtotal of the age/sex disaggregate group.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Use result reported at Q4.</td></tr>
<tr><td>Reporting level</td><td colspan="4">Site level - Facility only</td></tr>
<tr><td>Data Elements (Components of indicator)

(Required)</td><td>Numerator: Number of individuals who have received antiretroviral pre-exposure prophylaxis in the reporting period (PrEP) to prevent HIV infection.</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td></td><td></td><td>Age/Sex <required></td><td>15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49 M, 25-49 F, 50+ M, 50+ F</td><td>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>
</table>

		Key population (**Optional**)	MSM , Transgender (TG), Female Sex worker (FSW)	At the time of initiating PREP, did the patient identify as one or more of the following key populations (if more than one, please add individual to both KP disaggregation): MSM: Men who have sex with men. A male that has sex with men or both and women TG: Person who identifies as transgender. Transgender (male to) female: individual was born a boy, but identifies as a woman: Transgender (female to) male: client was born a girl, but identifies as a man FSW: Female Sex worker. A person whose main source (includes both monetary and non-monetary) of income comes from sex work.
	Denominator N/A	**Disaggregate Groups** N/A	**Disaggregates** N/A	**Description of Disaggregate** N/A
PEPFAR Support definition	Standard definition of DSD and TA used <u>Provision of key staff or commodities for PREP services include</u>: ongoing procurement of critical commodities such "tenofovir-containing PrEP" which could be TDF alone, TDF/FTC, or TDF/3TC or funding for salaries of personnel providing any of the prevention package components (i.e. clinicians, outreach workers, program managers). Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. <u>Ongoing support for HIV prevention among PREP services includes</u>: mentoring and			

	supportive supervision; training; organizational strengthening; QA/QI; program design like development of training curricula, PREP guidance development, or standard operating procedures (SOPs) and follow-up to ensure quality of care; regular assistance with monitoring and evaluation functions and data quality assessments; or supply chain management
DREAMS SNU Specific Guidance	None

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: (Required)	The number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period			
Denominator	*N/A*			
MER 1.0 to 2.0 Change	Age disaggregate improved to align with VMMC technical considerations. Follow-up disaggregation to include device-based VMMC.			
How to use:	Tracks the number of VMMCs conducted during the reporting period and potentially determine 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 often to report:	Report 3 months of results at each reporting cycle			
How to review for data quality:	Numerator ≥ subtotal of each of the disaggregation.			
How to calculate annual total:	Sum across all reporting periods.			
EA/SIMS considerations	To ensure accuracy of HTC unit expenditures, please ensure that all men tested through the VMMC program <u>should also</u> be counted in the general HTC indicator "HTC_TST" VMMC service delivery modality			
Reporting Level	Site level, facility			
Data Elements (Components of indicator)	**Numerator**: The number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Age **(Required)**	0-60 days, 2 months - 9 years, 10-14 years, 15-19 years, 20-24	Age disaggregates for VMMC clients

			years, 25-29 years, 30-49, 50+ years	
		HIV Status and Outcome **(Required)**	Number of HIV-positive clients (tested HIV positive at VMMC site) Number of HIV-negative clients (tested HIV negative at VMMC site) Number of clients with indeterminate HIV status or not tested for HIV at site (regardless of previous documentation).	HIV status of VMMC clients tested at VMMC sites ***(As this is a status indicator and not testing indicator All men tested through the VMMC program <u>should also</u> be counted in the general HTS indicator "HTS_TST" VMMC service delivery modality***)
		Circumcision Technique **(Required)**	Surgical VMMC, device-based VMMC	Surgical VMMC, device-based VMMC
		Circumcision Technique/Follow-up status **(Required)**	Number of VMMC clients who returned at least once for follow-up care within 14 days of surgery. Number of VMMC clients who returned at least once for follow-up care within 14 days of their device placement. Follow up may include device removal.	For Surgical VMMC: Returned at least once for follow-up care within 14 days of surgery; For Device-based VMMC: Returned at least once for follow-up care within 14 days of their device placement. Follow-up may include device removal.

	Denominator *N/A*	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		N/A		
PEPFAR Support definition	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for VMMC include: medical instruments, supplies, or medicines needed for the VMMC procedure, or funding for salaries for HCW who deliver VMMC services. Ongoing support for VMMC service delivery improvement includes: training of VMMC service providers; clinical mentoring and supportive supervision of HCW at VMMC sites; infrastructure/facility renovation; support of VMMC service-related data collection, reporting, data quality assessments (DQA); CQI/EQA of VMMC services at point of service delivery; or commodities consumption forecasting and supply chain management support.			
DREAMS SNU Specific Guidance	DREAMS SNUs set targets and report on results in DREAMS SNUs similarly to non-DREAMS SNUs. No additional DREAMS specific target setting or reporting is required.			

KP_PREV		
Description:	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	
Numerator: (Required)	Number of key populations reached with individual and/or small group-level HIV prevention interventions designed for the target population	The numerator can be generated by counting the number of unique individuals from an activity who are reached with prevention interventions designed for the intended key population.
Denominator (Optional, recommended if available)	Total estimated number of key populations in the catchment area.	Catchment area: The denominator is the estimated number of individuals in the key populations. Programs need to define their geographic catchment area from which key population clients receive HIV prevention services. Country teams should encourage methodological harmonization across their KP partners when estimating KP population size within a catchment area.
MER 1.0 to 2.0 Change	KP type disaggregations changed, three testing service disaggregations were added, and HIV testing or referral of an individual to HIV testing services (HTS) is required to be offered to those who are not known as diagnosed HIV positive. The denominator is now optional, but recommended for those with good estimation metrics (estimating the catchment area should be explained in the narratives).	
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) and will help countries understand the extent and reach of evidence-based KP prevention programs. As stated, this indicator will help determine the reach of key populations (if no denominator) and may help understand the relative saturation (coverage) of PEPFAR-supported KP prevention programs when reliable population size estimates are included as the denominator. Small-group intervention is defined as less than or equal to 25 individual attendees in one setting. **HIV testing services (HTS) or referring an individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this**	

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

The table below lists the prevention interventions that a partner may offer in addition to HTS (or HTS referral).

Prevention Interventions for Key Populations
• **Offer or refer to HTS* (Required)**
• Targeted information, education, and communication (IEC)
• Outreach/Empowerment
• Condoms
• Lubricant
• Offer or refer to STI screening, prevention, and treatment
• Link or refer to ART
• Offer or refer to prevention, diagnosis, treatment of TB
• Offer or refer to screening and vaccination for viral hepatitis
• Offer or refer to Reproductive Health (Family Planning; PMTCT), if applicable
• Refer to medication-assisted therapy (MAT), if applicable
• Offer or refer to needle syringe program (NSP), if applicable
*Partner should also report the number of individuals tested under the indicator "HTS_TST" if HTS was conducted (and results were given) as part of the outreach activity. If it was a documented complete HTS referral to the facility, it can be counted as HTS_TST_TA. Please refer to the HTS_TST indicator definition sheet for details.

How to collect:	Tracking systems must be able to reduce double-counting of individuals in a reporting period. The numerator can be generated by counting the number of de-duplicated individuals who were reached and had completed the appropriate prevention intervention(s) designed for the intended key population. For example, it 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, double-counting of all returning beneficiaries within the Q3-Q4 reporting period (April 1 – September 30) will also need to take place in Q4 reporting if they had already been counted under KP_PREV in Q1-Q2 of the same fiscal year. For example, if an individual had received prevention interventions under KP_PREV through PEPFAR-supported program in January 2017 and was counted as being reached in FY17 Q2 reporting cycle, and this same individual was later reached with prevention services again by PEPFAR-supported program in June 2017, that individual should **NOT** be reported again in the FY17 Q4 reporting period. This de-duplication is critical in order to accurately track the **ANNUAL** number of unique individuals reached by PEPFAR within a given fiscal year. Trend analysis of past performance KP_PREV data will be adversely affected with the change in frequency of KP_PREV reporting from annually to semi-annually if this de-duplication is ignored (i.e. annual number of KP_PREV reported within the same fiscal year would be inflated as the same individual would be counted twice if this de-duplication does not occur at Q4 reporting). If possible, a unique identifier can be assigned. The use of a unique identifier can help programs monitor the frequency of contact/outreach of a single individual over time (i.e. Beneficiary A with unique identifier AW0901 had four documented outreach visits in FY17 but was only counted once under KP_PREV in FY17).
How often to report:	Report 6 months of results at the March (Q2) and November (Q4) reporting cycles.

How to review for data quality:	Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues. Potential data quality issues with KP_PREV are:
	• Numerator
	  ○ **The Numerator is = 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.**
	• **Denominator ≥ Numerator:** The total estimated number of key populations should be greater or equal to the number of key populations provided with individual and/or small group level preventive interventions.

How to calculate annual total:	Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.			
EA/ SIMS considerations	EA has historically calculated unit expenditures for provider-initiated testing and counseling, voluntary-testing and counseling, and community-based testing and counseling. To do this, MER service-delivery disaggregates are mapped into these categories. Incomplete and inconsistent MER service-delivery disaggregates (e.g. disaggregates do not sum to total) will result in data quality concerns related to the corresponding unit expenditures. More details can be found in Appendix 2 on EA-MER Alignment.			
Reporting level	KP_PREV is reported at the site level, both facility and community.			
Data Elements (Components of indicator)	**Numerator (Required)**: Number of key populations reached with individual and/or small group-level HIV prevention intervention(s) that are based on evidence or are facilitators of evidence-based interventions (e.g., IEC)	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		KP Type **(Required)**:	MSM who are SW; MSM who are not SW; TG who are SW; TG who are not SW; Female SW; PWID male, PWID female; People in prisons and other enclosed settings	MSM: Men who have sex with men TG: Person who identifies as transgender SW: Sex worker PWID: People who inject drugs, People in prisons, and other enclosed settings
		Testing Service **(Required)**:	KP known positive; KP was newly tested and/or referred for testing; KP declined testing and/or referral	**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 on whether the HIV-positive client is linked to treatment. **Newly Tested and/or Referred for Testing** – Persons within each key population type for whom HIV testing is indicated because they do not know their HIV status or their last HIV-negative test was more than 3-6 months ago (or more/less frequently as indicated by National Guidelines) should either be offered an HIV test on site or given information about where and when they can access an HIV test at another nearby clinic. Every attempt should be made to ensure the client is linked with HIV testing services that are KP-friendly, and where possible the completed referral should be

				documented (i.e. the client accessed HIV testing). **Note**: Persons who access testing and whose results are newly tested HIV-positive in the reporting period should also be counted under "newly tested" even if they return for additional prevention services during that reporting period. Patients tested positive in previous reporting periods should be counted as Known Positives. **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/priority

				populations with HIV testing as part of the package of HIV prevention services and to provide HIV testing on site or KP-friendly sites, programs should also respect the autonomy of clients to decline this service. Clients who decline testing and/or referral can still receive other prevention services, as long as the benefits of HIV testing were explained and testing or a referral for testing was offered.
	Denominator (Optional): Total estimated number of key populations in the catchment area*. **Estimating the catchment area should be explained in the narratives.*	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		KP Type	MSM who are SW; MSM who are not SW; TG who are SW; TG who are not SW; Female SW; PWID male, PWID female; People in prisons and other enclosed settings	MSM: Men who have sex with men TG: Person who identifies as transgender SW: Sex worker PWID: People who inject drugs
PEPFAR Support definition	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for KP receiving HIV prevention services include</u>: ongoing procurement of critical commodities such as test-kits, condoms, lubricants, or funding for salaries of personnel providing any of the			

	prevention package components (i.e. peer navigators, outreach workers, program managers). Staff responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted. 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.
DREAMS Local Areas Specific Guidance	None

PP_PREV		
Description:	Number of the priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake.	
Numerator (Required):	Number of the priority populations reached with standardized HIV prevention intervention(s) that are evidence-based.	The numerator is the number of individuals from each priority population reached with HIV prevention interventions during the reporting period. For the purposes of reporting, the team will sum the numbers reached in each of the priority populations and report that total (details of the priority populations reached should be explained in the narratives).
Denominator (Optional, recommended if available)	Total estimated number of priority populations in the catchment area.	Catchment area: The denominator is the estimated number of individuals in the priority populations. Programs need to define their geographic catchment area from which priority population clients receive HIV prevention services. Country teams should encourage methodological harmonization across their priority partners when estimating population size within a catchment area.
MER 1.0 to 2.0 Change	Age/sex disaggregations changed, updated the minimum required standardized HIV prevention interventions and included the requirement that HIV testing or referral to HIV testing service must be offered to those who are not known as diagnosed HIV positive. The denominator is now optional, but recommended for those with good estimation metrics (estimating the catchment area should be explained in the narratives).	
How to use:	The indicator represents PEPFAR-supported programming only. This indicator helps to determine reach to priority populations (if no denominator) and may help inform coverage of PEPFAR-supported programming for priority populations when reliable population size estimates are included as the denominator. <u>Priority populations:</u> Priority populations should be defined by each country in the indicator narrative and must have a documented HIV prevalence or incidence greater than the general population of the country. Groups that might be counted as priority populations include: • Adolescent girls and young women • Clients of sex workers • Military and other uniformed services • Mobile populations (e.g., migrant workers, truck drivers) • Non-injecting drug users	

Size estimation: The IP/country team will estimate the size of each of the priority populations in the geographic areas where the IP will implement the program. These areas are chosen based upon epidemiological data with attention to avoiding duplication of activities with those funded by donors (estimating the catchment area should be explained in the narratives).

Package of interventions: Together with the IP, the country team designs a set of interventions for each of the priority populations. In a defined catchment area for the specific priority population, all prevention interventions may not be offered by one IP. However, all required intervention must be available in the catchment area for the priority population. Interventions must adhere to written protocols, include goals and activities, and be designed to promote adoption of key behaviors that support HIV prevention and service uptake among the priority population(s). The interventions should comprise multiple encounters with the same individuals or groups.

HIV testing services (HTS) or referring an individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this indicator.

The table below lists the interventions that must be offered in addition to HTS (or HTS referral).**Required Interventions for Adult Populations**	**Required Interventions for Youth Populations**
• Promotion of relevant prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.	• Promotion of relevant youth-friendly prevention and clinical services and demand creation to increase awareness, acceptability, and uptake of these services.
• Information, education, and skills development to: reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms	• 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.

	and stigma reduction.	
	• Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.	• Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and/or support services to promote use of, retention in, and adherence to care.
	• Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other service outlets.	• Condom and lubricant (where feasible) promotion, skills training, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and/or other youth-friendly, community-based service outlets.
		• Programs targeting adults to raise awareness of HIV risks for young people, promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.
How to collect:	Data collection requires reliable tracking systems that are designed to count the number of one-on-one encounters or participation in group interventions and that reduce double-counting of individuals in a reporting period. Data should be collected at every encounter/point of service and aggregated in time for PEPFAR reporting cycles. This indicator only counts those interventions at the individual and/or group level. A partner may count an individual (with unknown HIV serostatus or self-identified as HIV negative) as having received a prevention intervention if they have provided HTS and/or referral to HTS **AND** at least one of the other listed prevention interventions during the reporting period. If an individual is already known to be HIV positive at the time of service delivery, s/he should receive at least one of the interventions listed in the table (outside of HTS) to qualify as being counted under this indicator. Tracking systems must be able to reduce double-counting of individuals in a	

	reporting period. An individual will be reported when he/she first receives any of the required interventions in the reporting period; if the same individual receives any subsequent interventions during the same reporting period they will be reported as a returning beneficiary and not counted again in the reporting period. Furthermore, double-counting of all returning beneficiaries within the Q3-Q4 reporting period (April 1 – September 30) will also need to take place in Q4 reporting if they had already been counted under PP_PREV in Q1-Q2 of the same fiscal year. . For example, if an individual had received prevention interventions under PP_PREV through PEPFAR-supported program in January 2017 and was counted as being reached in FY17 Q2 reporting cycle, and this same individual was later reached with prevention services again by PEPFAR-supported program in June 2017, that individual should **NOT** be reported again in the FY17 Q4 reporting period. This de-duplication is critical in order 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.
How often to report:	Report 6 months of results at Q2 and Q4. In the Q2 and Q4 narratives should include information pertaining to the results by priority population, and, if possible, describe progress made toward coverage for each one.
How to review for data quality:	Data should be reviewed regularly for the purposes of program management, to monitor progress towards achieving targets, and to identify and correct any data quality issues. Potential data quality issues for PP_PREV: **Denominator is greater than or equal to the Numerator**: The total number of people from priority populations must be greater than or equal to the total number of individuals from priority populations who completed a standardized HIV prevention program. **Numerator is greater than or equal to the subtotal of the age/sex disaggregation**: The number of individuals from priority populations who completed a standardized HIV prevention program should be greater or equal to the sum of the disaggregation by age/sex.

<table>
<tr><td>How to calculate annual total:</td><td colspan="3">Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.</td></tr>
<tr><td>Reporting level</td><td colspan="3">PP_PREV is reported at the site level, both facility and community.</td></tr>
<tr><td rowspan="3">Data Elements (Components of indicator)</td><td rowspan="3">Numerator: Number of the target population who completed a standardized HIV prevention intervention including the minimum components during the reporting period.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex (Required)</td><td>10-14 M, 10-14 F, 15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49 M, 25-49 F, 50+ M, 50+ F</td></tr>
<tr><td>Testing Service (Optional)</td><td>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 on whether the HIV-positive client is linked to treatment.

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

			ensure the client is linked with HIV testing services that are KP-friendly, and where possible the completed referral should be documented (i.e. the client accessed HIV testing). **Note**: Persons who access testing and whose results are newly tested HIV-positive in the reporting period should also be counted under "newly tested" even if they return for additional prevention services during that reporting period. Patients tested positive in previous reporting periods should be counted as Known Positives. **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/priority populations with HIV testing as part of the package of HIV prevention services and to provide HIV testing on site or KP-friendly sites, programs should also respect the autonomy of clients to decline this service. Clients who decline

<table>
<tr><td rowspan="3"></td><td></td><td></td><td>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.</td></tr>
<tr><td rowspan="2">Denominator: Total number of people in each priority population (recommended, if available).</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A
Country teams should encourage methodological harmonization across their priority population partners when estimating priority population size within a catchment area</td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="3">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for priority populations receiving HIV prevention services includes:</u> ongoing procurement of critical commodities such as condoms, teaching materials, or community promotion materials; funding for salaries of personnel 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.

<u>For priority populations receiving HIV prevention, ongoing support services service delivery improvement includes:</u> site supervision; training or assistance with monitoring and evaluation; QI/QC; and development of materials and protocols.</td></tr>
<tr><td>DREAMS Local Area Specific Guidance</td><td colspan="3">None</td></tr>
</table>

TB_PREV	
Description:	Proportion of ART patients who completed a standard course of TB preventive therapy within the reporting period
Numerator:	The number of ART patients who completed a course of TB preventive or at least 6 months of Isoniazid Preventive Therapy (IPT) during the reporting period
Denominator	The number of ART patients who were newly started on TB preventive therapy (or who were continuing TB preventive therapy from the previous reporting period but had received less than 6 months of IPT at the start of this reporting period).
MER 1.0 to 2.0 Change - ART patients who have ever initiated TB preventive therapy	• Indicator title revised to indicate change to completed therapy, and change from ”isoniazid only” to include other TB preventive regimens (e.g., Rifampicin or INH/Rifapentine) • Type of therapy disaggregation to indicate whether ART patients started time-limited IPT, continuous IPT or an alternative regimen • Timing disaggregation added to whether the ART patients initiated TB preventive therapy during the current reporting period or previously • The fine age/sex disaggregations have been dropped in order to align with the TX_TB indicator to which this indicator closely relates.
How to use:	This indicator measures the performance of HIV programs in scaling up TB preventive therapy, with the goal of preventing progression to active TB disease among PLHIV and decreasing ongoing TB transmission in this population. The denominator will inform programs on the pace of scale-up, and the proportion will inform programs on how well preventive therapy itself is being administered. New timing and sex disaggregates will inform programs on how well they are linking those who screen negative for TB to TB preventive therapy, and allow for monitoring of cohorts from initiation to completion of therapy.
How to collect:	The denominator can be generated by counting the total number of patients who were started on TB preventive therapy in the reporting period, or who started the reporting period already on TB preventive therapy (as long as they had taken less than 6 months of therapy). The numerator can be generated by counting the number of PLHIV who are documented as having received at least six months of isoniazid preventive therapy, or completed a standard course of TB preventive therapy. This should include the patients who completed a shorter alternative course, such as three months of isoniazid and rifapentine, as well as those who are on continuous IPT who have taken at least six months. These data should be captured in IPT and/or ART registers as well as additional data collection sources (i.e., patient treatment cards, medical charts, pharmacy records). Programs should modify the registers as needed to easily capture this information.
How often to report:	Report 6 months of results at Q2/SAPR and Q4/APR.

<table>
<tr><td>How to review for data quality:</td><td colspan="3">Only one disaggregation type is used for age (coarse disaggregations).

Data Element ≥ subtotal of each of the disaggregations.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">N/A</td></tr>
<tr><td rowspan="5">Data Elements

(Components of indicator)</td><td rowspan="2">Numerator: ART patients who have ever completed a standard course or at least 6 months of IPT during the reporting period.</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Type of therapy</td><td>1. 6-12 months IPT
2. Continuous IPT
3. Alternative regimen (e.g., 3 month INH and rifapentine)</td></tr>
<tr><td></td><td>Age/Sex (Coarse Disaggregate)</td><td><15 F, 15+ F, <15 M, 15+ M</td></tr>
<tr><td rowspan="3">Denominator: ART patients who were newly started on TB preventive therapy, or who were continuing TB preventive therapy from the previous reporting period</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Type of therapy</td><td>1. 6-12 months IPT
2. Continuous IPT
3. Alternative regimen (e.g., 3 months of INH and rifapentine)</td></tr>
<tr><td>Start of therapy</td><td>1. Started during this reporting period
2. Started in last reporting period</td></tr>
<tr><td></td><td>Age/Sex (Coarse Disaggregate)</td><td><15 F, 15+ F, <15 M, 15+ M</td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="3">Standard definition of DSD and TA-SDI used.

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

<u>Ongoing support for patients receiving routine HIV-related services includes</u>: training of HIV service providers, clinical mentoring and supportive supervision of staff at HIV sites, infrastructure/renovation of facilities, support of HIV service data</td></tr>
</table>

	collection, reporting, data quality, QI/QA of HIV services support, ARV and IPT consumption forecasting and supply management, support of lab clinical
DREAMS SNU Specific Guidance	None

OVC_SERV		
Description:	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV	
Numerator: (Required)	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV.	The numerator is the sum of the following Program participation disaggregations: 1. Active beneficiaries 2. Graduated beneficiaries 3. Transferred beneficiaries 4. Exited without graduation in the reporting period, from the PEPFAR OVC Program • This indicator is a direct (output) measure of the number of individuals receiving PEPFAR OVC program services for children and families affected by HIV/AIDS. • This indicator tracks progress on the number of OVC graduating from PEPFAR OVC programs and also tracks "exited without graduation" (such as loss-to-follow up, aging out without transition plan, moved, or died). • Transferred to existing host-country programs, where the host-country program provides a sustainable response to OVC needs. • Graduation will vary based on local criteria for achieving stability in the household.
Denominator	N/A	
MER 1.0 to 2.0 Change	The following disaggregation for program participation status has been added to capture types of beneficiaries: (1) active beneficiaries, (2) graduated beneficiaries, (3) transferred beneficiaries, and (4) beneficiaries who have exited without graduation. Age/sex disaggregates have been modified.	
How to use:	PEPFAR is mandated to care for children orphaned or made vulnerable by HIV. Mitigating the impact that HIV is having on children and the families that support them is integral to a comprehensive HIV response. *It is important to note that the definition of "affected" children includes, but is not limited to, children infected with HIV.* PEPFAR recognizes that individuals, families, and communities are affected by HIV in ways that may hinder the medical outcomes of HIV-positive persons as well as the emotional and physical development of children orphaned or made vulnerable by HIV/AIDS. A variety of services (per Technical Considerations 2015 and 2016) are supported through PEPFAR to mitigate these effects in order to improve health and well-being outcomes of adults and children. The goal of OVC programs is to build stability and resiliency in children and	

<table>
<tr><td></td><td>families-exposed, living with or affected by HIV/AIDS through rigorous case management and provision and access to health and socio-economic interventions. This indicator, by disaggregating “active”, “graduated”, “transferred”, and “exited without graduation” measures how successful the OVC program is in building children and their families’ resiliency.
This reporting period’s Active = (Last reporting period’s Active + Newly enrolled in this reporting period) – (this reporting period’s Graduated + transferred+ this reporting period’s Exited)
<table>
<tr><td>Beneficiaries</td><td>Q2 FY2016</td><td>Q4 FY2016</td><td>Q2 FY2017</td><td>Q4 FY2017</td></tr>
<tr><td>Active</td><td>500</td><td>460 (500 + 0 new -0 graduated – 10 transferred- 30 exited)</td><td>455 (460+15 new-10 graduated- 10 exited)</td><td>425 (455+20 new – 30 graduated – 10 transferred- 10 exited)</td></tr>
<tr><td>Graduated</td><td>0</td><td>0</td><td>10</td><td>30</td></tr>
<tr><td>Transferred</td><td>0</td><td>10</td><td>0</td><td>10</td></tr>
<tr><td>Exited without graduation</td><td>0</td><td>30</td><td>10</td><td>10</td></tr>
</table></td></tr>
<tr><td>How to collect:</td><td>The data sources are the PEPFAR OVC program registers and program data generated by implementing partners. Implementing partners’ registers need to record names of children and caregivers who meet the criteria for “active beneficiary” or “graduated” or “transferred” or “exited without graduation” to generate the number included in this indicator.

All agencies receiving HKID funding are required to report on this indicator.</td></tr>
<tr><td>How often to report:</td><td>Report 6 months of results at Q2 and Q4.</td></tr>
<tr><td>How to review for data quality:</td><td>Reviewing PEPFAR OVC implementing partners’ results to ensure that there is no double counting and changes by Program Completion Status do not show high deviations from program targets and/or SNU prioritization (scale up, sustained, centrally supported, sustained commodities.</td></tr>
<tr><td>Reporting Level</td><td>Site level: facility and community</td></tr>
<tr><td>How to calculate across reporting periods:</td><td>To calculate data for annual results:

Active beneficiaries: Do not sum across Q2 and Q4 – use cumulative result reported at Q4 for active beneficiaries
Graduated beneficiaries: Add Q 2 and Q4 graduated beneficiaries
Transferred beneficiaries: Add Q2 and Q4 transferred beneficiaries
Exited beneficiaries: Add Q2 and Q4 exited beneficiaries

In sum, the annual results for OVC_SERV age 0-17 =
Total beneficiaries served in FY = Active in Q4 + All exited in Q4 + All exited in Q2</td></tr>
</table>

(All exited in Q4 = Graduated in Q4 + Transferred in Q4 + Otherwise exited in Q4)
(All exited in Q2 = Graduated in Q2 + Transferred in Q2 + Otherwise exited in Q2)

The indicator is generated by counting the number of active beneficiaries who received at least one HKID funded service from facilities and/or community -based organizations (see definition of an 'active beneficiary' below) **and** by counting the number of beneficiaries who graduated from the PEPFAR OVC program successfully **and** by counting the number of beneficiaries who were "transferred" to existing host-country programs **and** by counting the number of beneficiaries who have "exited without graduation" from the PEPFAR OVC program. This reporting period's Active = (Last reporting period's Active + Newly enrolled in this reporting period) – (this reporting period's Graduated + transferred+ this reporting period's Exited)

Beneficiaries	Q2 FY2016	Q4 FY2016	Q2 FY2017	Q4 FY2017
Active	500	460 (500 + 0 new -0 graduated – 10 transferred -30 exited)	455 (460+15 new-10 graduated-10 exited)	425 (455+20 new – 30 graduated –10 transferred- 10 exited)
Graduated	0	0	10	30
Transferred	0	10	0	10
Exited without graduation	0	30	10	10

Data Elements (Components of indicator)

Numerator: Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV

Disaggregate Groups	**Disaggregates**	**Description of Disaggregate**
Age/Sex **(Required)**	<1, 1-9, 10-14M, 10-14F, 15-17M, 15-17 F, 18-24 M, 18-24 F, 25+ M, 25+ F	
Program Participation Status **(Required)**	Active Graduation Transferred Exited without graduation	1) **"Active beneficiary"** is an individual, a child, or parent/caregiver who is scheduled to receive a PEPFAR OVC program services at least once every three months or has received a PEPFAR OVC program services in the last three months. New beneficiaries who only registered in the last

				quarter will be counted as active, even if they have not yet received services. **2) "Graduation**" as defined as • <u>Graduation</u>: this happens when children and parent/caregivers enrolled in PEPFAR OVC programs are deemed stable and no longer in urgent need of externally supported services. **Or** • <u>Aging out:</u> This includes children who have reached the age of 18 and who have <u>a transition plan for successful exiting</u> from the PEPFAR OVC Program. This does not apply to children > 18 years old enrolled in secondary education. This does not include parents/caregivers. **3) "Transferred"** happens when children and families have transitioned to other forms of support programs other than PEPFAR funded OVC programs. These could include country-led programs or other donor funded programs. **4) "Exited without graduation"** This

<table>
<tr><td></td><td></td><td></td><td></td><td>includes children who are lost-to-follow up, aged-out without a graduation plan from PEPFAR OVC program, re-located, or died.</td></tr>
<tr><td></td><td>Denominator
N/A</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td></td><td></td><td>None</td><td>N/A</td><td>N/A</td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="4">Standard definition of DSD and TA-SDI used.

<u>Provision of key staff or commodities for OVC beneficiaries receiving care and support services in the community include</u>: For beneficiaries of OVC services, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group or community level activity (e.g., psychosocial support, child protection services, education, etc) or procurement of critical commodities essential for ongoing service delivery. Partial salary support may include stipends or incentives for volunteers, or paying for transportation of those staff to the point of service delivery.

<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.</td></tr>
<tr><td>DREAMS SNU Specific Guidance</td><td colspan="4">Only DREAMS-funded partners should report on services by area:

Age/Sex/Service: 10-14M, 10-14F, 15-17M, 15-17F, 18-24M, 18-24F, 25+M, 25+F by selected service area: Education support, Parenting/Caregiver programs, Social Protection (including cash transfer), Economic Strengthening, Other service areas in line with PEPFAR 2012 guidance for OVC programming.

**Each service area to be disaggregated by age/sex
All partners providing OVC services in DREAMS SNUs should report, regardless of receipt of DREAMS funds.</td></tr>
</table>

KP_MAT	
Description:	**Number of people who inject drugs (PWID) on medication-assisted therapy (MAT)**
Numerator:	Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months of the reporting period
MER 1.0 to 2.0 Change	Removed language around a minimum of 6 months to harmonize definitions with other similar MER indicators (e.g. TX_CURR) and be consistent with global guidance (*2015 WHO Tool for Setting and Monitoring Targets: Supplement to the 2014 Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care for Key Population Guidelines)*
How to use:	When proper and sufficient dosage is administered, medication-assisted therapy (MAT) is highly effective in reducing opioid use, reducing injecting behaviors that put opioid-dependent people at risk for HIV and improving retention for those who are on ART. Therefore, all people who are dependent on opioids should be offered and have access to this service. The implementation of MAT programs should facilitate and enhance access to HIV-specific services for PWID, such as HIV testing services, provision and/or referral and linkages to ARV treatment programs, PMTCT for female PWID and a range of other prevention and harm reduction services. This indicator provides information on the total number of PWID that are currently receiving medication-assisted therapy at the end of the reporting period. Partners providing MAT referrals only should not use this indicator, unless it also meets the KP_MAT_TA requirement below. Please see key population indicator "KP_PREV" to see if services provided meet reporting criteria for that indicator.
How to collect:	Data for this indicator can be generated by counting the number of individuals who are currently receiving MAT (e.g., using methadone, buprenorphine, or Suboxone [buprenorphine/naloxone] to treat drug dependency) in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. This indicator provides information on the total number of PWID medication-assisted therapy for at least 3 months during a six month period. Patients who died, stopped treatment, transferred out, or are lost to follow-up (i.e. patient not seen for 3 months from last drug pick up) should be excluded from the numerator. The KP_MAT count should equal the number of individuals who ever started MAT minus those patients who are not currently on treatment at the end of the reporting period. Therefore patients on MAT who initiated or transferred-in

<table>
<tr><td></td><td colspan="3">during the reporting period should be counted even if they began MAT towards the end of the reporting period.</td></tr>
<tr><td>How often to report:</td><td colspan="3">Q4 only</td></tr>
<tr><td>How to review for data quality:</td><td colspan="3">This indicator makes use of program data as part of an on-going cohort, similar to that used to monitor ART retention. MAT register and/or patient-level data can be used to determine the number of people starting MAT in the defined period, as a cohort, and the number of those who are still in treatment 6 months after starting MAT.

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.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="3">Use result reported at Q4.</td></tr>
<tr><td rowspan="3">Data Elements (Components of indicator)</td><td rowspan="3">Numerator: Number of people who inject drugs (PWID) on MAT</td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>MAT outcome</td><td>a. Completed therapy
b. Exited without completing therapy in the reporting period (Includes loss-to-follow up or died).</td></tr>
<tr><td>Sex</td><td>Male; Female</td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="3">Standard definition of DSD and TA-SDI used:

<u>Provision of key staff or commodities for PWID on MAT includes</u>: procurement of methadone or any other medication assisted options for the treatment of opioid dependence, or funding for salaries of personnel delivering the service (i.e., HCW, program managers). Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted.

<u>Ongoing support for MAT services for PWID service delivery improvement includes:</u> mentoring and supportive supervision, training, MAT guidance development, site level QA/QI, regular assistance with monitoring and evaluation functions and data quality assessments, or MAT consumption forecasting and supply management.</td></tr>
<tr><td>DREAMS Local Area Specific Guidance</td><td colspan="3">None</td></tr>
</table>

GEND_GBV		
Description:	Number of people receiving post-gender based violence (GBV) clinical care based on the minimum package **NOTE:** The indicator DOES NOT measure delivery of GBV prevention activities.	This indicator uses the number of people receiving post-GBV clinical services to measure service uptake. An increase in the number of people receiving post-GBV care will indicate that more patients are disclosing violence to providers and using the available services. GBV is defined as any form of violence that is directed at an individual based on his or her biological sex, gender identity or expression, or his or her perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.
Numerator (Required):	Number of people receiving post-gender based violence (GBV) clinical care based on the minimum package	• GBV: For PEPFAR, GBV is defined as any form of violence that is directed at an individual based on his or her biological sex, gender identity or expression, or his or her perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. It can affect women and girls, men and boys, and other gender identities. PEPFAR is most likely to address physical and sexual intimate partner violence, including marital rape; sexual assault or rape; female genital cutting/mutilation; sexual violence against children and adolescents; and child marriage. • Because of the challenges associated with ascertaining whether a person who experienced sexual violence did so because of their biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity, ALL persons who experience sexual violence

		and present for care, independent of the cause, or of age and sex, should be counted under this indicator. **Note:** DO NOT report other who has accompanied the individual seeking services (including not perpetrators who receive GBV prevention activities).
Denominator	N/A	
MER 1.0 to 2.0 Change	Age/sex disaggregates modified to align across clinical cascade. Increased focus on the clinical services for gender GBV.	
How to use:	This indicator measures delivery of a basic package of post-GBV clinical services (including PEP and EC). NOTE: This indicator DOES NOT include GBV Prevention activities or non-clinical community-based GBV response (e.g., shelter programs, case management). This indicator will enable PEPFAR to: • To determine the number of individuals that are suffering from GBV and reporting to clinical partners • To assess whether post-GBV clinical services are being used. • Gain an understanding of the uptake of post-GBV clinical services offered across PEPFAR countries. • Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. • Support efforts to assess the impact of post-GBV clinical services by correlating the reach (i.e., number of people served) of these services over time with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as survey data (DHS/PHIA/VACS). • Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.	
How to collect:	Data sources are standard program monitoring tools, such as forms, log books, spreadsheets and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of service delivery (i.e., ANC, PMTCT, ART, etc.) and aggregated in time for PEPFAR reporting cycles. The indicator can be generated by counting the number of persons receiving post-GBV clinical care, disaggregated by the **age group** and **sex of the client receiving the service**, as well as the **type of service** (sexual violence or emotional/physical violence) and PEP provision (see below for disaggregation information). To adequately capture the provision of these services, logs and monitoring forms will need to be used wherever the services are offered. These forms will need to track	

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<tr><td></td><td colspan="4">both the outcome of the initial assessment and the provision of referrals or services. For PEP specifically, registries should collect both the administration of the PEP as well as its completion and the patient's adherence.

Special considerations:
• As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows:
  • 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 often to report:</td><td colspan="4">Report 12 months of results at Q4/APR</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Numerator ≥ subtotal of each of the disaggregation: The number of people receiving post-GBV clinical care should be greater or equal to the sum of each individual disaggregate group.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Use annual result reported at Q4/APR</td></tr>
<tr><td>Reporting level</td><td colspan="4">Collected at site level, both facility and community</td></tr>
<tr><td rowspan="2">Data Elements (Components of indicator) or</td><td rowspan="2">Numerator: Number of people receiving post-GBV clinical care based on the minimum package</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Violence Service Type

(Required)</td><td>SEXUAL Violence; PHYSICAL and/or EMOTIONAL Violence</td><td>- 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.</td></tr>
</table>

				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 NOTES: 1) PEPFAR funds cannot be used to procure EC, 2) EC is legal in all PEPFAR countries except Honduras, so should be available in all countries except for Honduras - Counseling (other than counseling for testing, PEP, STI and EC) - **Physical and/or emotional violence (other Post-GBV care):** GBV can take many forms, and includes physical and emotional violence. The following services should

				be available for persons who have experienced GBV that is not sexual. Services should always begin with an assessment of the client's specific needs and include, as appropriate. The following represents the Minimum Package for other post-GBV care services that must be in place to count under this indicator: - Provision of Clinical Services: (all of the following must be in place and available to count persons—independent of whether people use the specific service) o 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). o STI screening/testing and treatment o 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 o Economic empowerment
		[Disaggregate of Violence Service Type by Age/Sex **(Required)**	<10 F, 10-14 F, 15-19F, 20-24 F, 25-49 F, 50+ F; <10 M, 10-14M, 15-19M, 20-24 M, 25-49 M, 50+ M;	**Sexual violence by** <10 F, 10-14 F, 15-19F, 20-24 F, 25-49 F, 50+ F; <10 M, 10-14M, 15-19M, 20-24 M, 25-49 M, 50+ M; **Physical and/or emotional violence by** <10 F, 10-14 F, 15-19F, 20-24 F, 25-49 F, 50+ F; <10 M, 10-14M, 15-19M, 20-24 M, 25-49 M, 50+ M;
		[Disaggregate of Violence Service Type SEXUAL] PEP **(Required)**	Number of people who completed PEP services (related to sexual violence services provided)	**Post-exposure prophylaxis (PEP):** 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.

	Denominator N/A	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		N/A	N/A	N/A
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.			
DREAMS SNU Specific Guidance	Females: 10-14, 15-17, 18-19, 20-24; Type of Service: sexual violence (post-rape care), physical and/or emotional violence (other GBV care), PEP service provision			

PEPFAR

90: Knowing your HIV Status

MER 2.0

<table>
<tr><td colspan="3">FPINT_SITE Number of HIV service delivery points (SDP) at a site supported by PEPFAR that are providing integrated voluntary family planning (FP) services.</td></tr>
<tr><td>Description:</td><td colspan="2">This indicator is a required indicator for all PEPFAR teams and will be reported up to headquarters once a year at quarter 4.</td></tr>
<tr><td>Numerator: (Required)</td><td>Number of service delivery points supported by PEPFAR that are providing fully integrated voluntary family planning services</td><td>See definition below for a PEPFAR-supported service delivery point. Note: a service delivery point is NOT the same as a site. There can be numerous service delivery points within one site.</td></tr>
<tr><td>Denominator</td><td>Number of total service delivery points at a site supported by PEPFAR</td><td>Not collected through the data entry screened, determined by number of sites reporting service delivery area.</td></tr>
<tr><td>MER 1.0 to 2.0 Change</td><td colspan="2">This has changed from an absolute count of the number of sites to have integrated family planning services to the number of service delivery areas within a site.</td></tr>
<tr><td>How to use:</td><td colspan="2">This output indicator aims to measure progress towards integrating voluntary FP within the PEPFAR platform at the service delivery level. It captures information about whether FP integration is occurring at various HIV service delivery points within PEPFAR supported sites. Many PEPFAR sites will have numerous service delivery points within each site. For example, if one hospital receives PEPFAR support for both the HIV treatment department AND the ANC department, then the FPINT_site total for that one site is 2 service delivery points.

This indicator will enable PEPFAR stakeholders to:
• Gain a basic, but essential, understanding of whether FP services are being integrated in PEPFAR-supported service delivery points.
• Identify gaps, including service contexts, countries, or regions with low levels of HIV/FP integration.

Inherent within this indicator is the principle that integrated HIV/FP program activities must respect a client's right to make informed decisions about his or her reproductive life. This means that clients should have access to an appropriate and comprehensive range of contraceptive options; and/or to safer conception/pregnancy counseling depending upon their fertility desire and intentions. Judgements and personal opinions are not appropriate in a clinic setting.

This indicator will be used to monitor coverage of HIV/FP integration at a global level. Therefore, detailed information on completion of referrals, FP service uptake, types of contraceptive methods offered on site, and other critical components of integrated programs will not be captured through this indicator, but should be maintained at the site or programmatic level.</td></tr>
</table>

How to collect:	**Definition: Voluntary Family Planning Service Provision** In order 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. **Definition: 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. **Definition: Provide Voluntary Family Planning Counseling (including Safe Pregnancy Counseling) (Number 2 above)** Quality voluntary FP counseling should cover a wide range of topics that are client and context specific, and that include both safe pregnancy counseling for individuals who wish to become pregnant as well as contraception for individuals who wish to avoid, space or delay pregnancy. "FP counseling" is not the same as "FP education". Depending upon the type of FP services that are offered at PEPFAR supported site; health providers or community mobilizers may provide EDUCATION and/or COUNSELING on FP. Education activities may include distribution of printed materials, group health education and community outreach efforts among other interventions. Education helps to increase general knowledge on the benefits and importance of FP and increase support for FP use, as well as to link women and their partners to other FP services, including contraceptive method provision. FP counseling is an interpersonal communication between the health provider and client where topics specific to the clients' needs are discussed to help them

determine if they want to use FP and if so; to help them choose and use the FP method of their choice. HIV service providers or all levels can be trained and supported to develop or improve their skills at FP counseling. A wide array of FP counseling materials exist that can be used in PEPFAR settings; including national FP flipcharts, counseling cards and informational handouts
Voluntary FP counseling should follow the standards and best practices outlined in the "Additional References" section below.

Definition: 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.).

Definition: PEPFAR-Supported Service Delivery Point at a site
A PEPFAR-supported service delivery point uses PEPFAR funds to directly provide HIV-related services. It offers one or more HIV-related services including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART); screening and prophylaxis for opportunistic infections (OI); other health services for people living with HIV (e.g. positive health, dignity and prevention (PHDP), nutrition support, etc.), and prevention activities for priority populations (key populations and adolescent girls and young women). It can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). Individual community health workers are not considered to be individual service delivery points. Rather, the organizations with which they are affiliated are considered to be the service delivery point(s).
PEPFAR service delivery points for FP/HIV integration include the following:

1. Care and Treatment (including Pediatric and Adolescent Care and Treatment Services) – this includes services where ART is initiated and monitored.
2. Antenatal and/or Maternity services - this includes FP education and healthy timing and spacing messages in the ANC setting (when a woman in pregnant and receiving PMTCT services and/or FP counseling and method provision post-partum.)
3. Priority Population Prevention services – this includes priority population programming, such as drop in centers and prevention sites focused on adolescent girls and young women (i.e. DREAMS). FP integration can also take place across the clinical cascade for priority populations, including

	care and treatment which would be recorded under care and treatment service delivery point 4. Key Population Prevention services – this includes programming for Men who have sex with men, People who identify as transgender, Sex workers, and People who inject drugs, such as drop in centers. FP integration can also take place across the clinical cascade for key populations, including care and treatment which would be recorded under care and treatment service delivery point. 5. HIV Testing services - includes counselling (pre-test information and post-test counselling); linkage to appropriate HIV services; and coordination with laboratory services to support quality assurance and the delivery of correct results. FP services can be made available with HIV testing services, especially for key populations and adolescent girls and young women as well as for HIV sero-discordant couples. (even if FP integration is targeting key or priority populations, if occurring in HTS the integration should be documented under HTS) **Special Considerations:** **1. HIV/FP Integration Principles** As articulated in the FY14 COP guidance, USG-supported FP and HIV/AIDS programs must adhere to the following principles: • People living with HIV (PLHIV) and their partners should be provided with information on, and be able to exercise voluntary choices about their health, including their reproductive health. • The USG, including PEPFAR, supports a person's right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as use of FP methods, regardless of HIV/AIDS status. • FP use should always be a choice, made freely and voluntarily, independent of the person's HIV status. • **The decision to use or not to use FP should be free of any discrimination, judgment, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.** • 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.
How often to report:	Q4 only
How to review for data quality:	Data should be reviewed regularly for the purposes of program management including monitoring progress towards achieving targets, and identifying and correcting any data quality issues. Follow PEPFAR Guidance for data quality review

	as circulated in Q4 reporting guidance. **Potential data quality issues for FPINT_site:** Indicator counts individual Service Deliver Points at Sites: This indicator counts the number of service delivery points (SDP) **NOT** the number of sites that integrate FP services. See above for SDP definition. Denominator is greater than or equal to the Numerator: The total number of PEPFAR-supported service delivery points (the denominator) must be greater than or equal to the total number of PEPFAR-supported service delivery points that have integrated Family Planning (the numerator). (Note: this denominator is not collected through this indicator, therefore this data quality check would require triangulation with other indicators and additional data sources)
How to calculate across reporting periods:	Only reported at Q4
Reporting level	Site level, Facility - Service Delivery Area (SDA)
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 : what is a PEPFAR supported site for the purpose of this indicator**: A "PEPFAR supported site" for the purpose of this indicator should include any facility site in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period. **Definition: PEPFAR-Supported Service Delivery Point at a site for the purpose of this indicator** A PEPFAR-supported facility-based service delivery point uses PEPFAR funds to provide HIV-related services. It offers one or more HIV-related services including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART) and TB/HIV services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). These can also include fixed locations and/or mobile operations offering routine and/or regularly scheduled services.
DREAMS SNU Specific Guidance	FP/HIV integration is a core component of the DREAMS package of services. FP services (education, counseling and/or method provision) should be made available through HIV prevention and treatment sites for adolescent girls and young women.
Additional Resources	Voluntary FP counseling should follow highest standards of quality and best practices outlined in the documents below: • ***World Health Organization Family Planning Clinical Guidelines and Counseling Tools***

	http://www.who.int/reproductivehealth/publications/family_planning/clinical/en/index.html • ***The Balanced Counseling Strategy Plus (BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings*** is a tool to improve the quality of family planning services and to strengthen the integration HIV prevention, detection, and care into family planning, such as the risk assessment of STIs. • ***Family Planning: A Global Handbook for Providers (***http://www.k4health.org/resources/family-planning-global-handbook-providers) - offers clinic-based health care professionals in developing countries the latest guidance on providing contraceptive methods. Other resources include: • *PEPFAR Blueprint;* http://www.pepfar.gov/documents/organization/201386.pdf • *UNFPA: Preventing HIV and Unintended Pregnancies: Strategic Framework 2013-2015 http://www.unfpa.org/webdav/site/global/shared/documents/publications/ 2012/PreventingHIV_UnintendedPregnancies_SF2011_2015.pdf* • *USAID's Family Planning Guiding Principles and U.S. Legislative and Policy Requirements http://www.usaid.gov/what-we-do/global-health/family-planning/usaids-family-planning-guiding-principles-and-us-0.* • In order to ensure high quality HIV/FP integrated services, a variety of other indicators can be tracked by U.S. government teams at the program management level. A list of relevant indicators is available in the USAID MEASURE Evaluation Handbook of Indicators for Evaluating Family Planning Programs. http://www.cpc.unc.edu/measure/publications/ms-94-01. • Further, MEASURE Evaluation has created a FP/HIV Indicator manual and will be posted to the MEASURE Evaluation website (http://www.cpc.unc.edu/measure/) and the USAID FP/HIV Integration website (https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/promoting-integration-family-planning-hiv-and) once available. For more information on these indicators or questions about developing FP/HIV indicators appropriate to your program, please contact: Jennifer Mason jmason@usaid.gov, Nithya Mani nmani@usaid.gov, and Sarah Yeiser syeiser@usaid.gov.

HTS_TST (Includes HTS_TST_POS)		
Description:	Number of individuals who received HIV Testing Services (HTS) and received their test results	
Numerator: (Required)	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	
MER 1.0 to 2.0 Change	Age/sex disaggregates modified to align across indicators. Service delivery modalities rationalized and simplified to avoid overlap and create mutually exclusive delivery modalities; HTS service delivery modalities reflect both facility and community settings.	
How to use:	This indicator is intended to monitor trends in the uptake of HTS (regardless of the service delivery modality and population group) within a country. The disaggregation by test result provides information about the proportion of persons testing HIV positive and the effectiveness of HTS programs in identifying people living with HIV (PLHIV) over time. Further disaggregations are intended to monitor access to and uptake of HTS by population (age, sex, test result), and HTS setting and service delivery modality. The findings can support national governments and PEPFAR programs to determine the coverage and identify gaps in HTS services. These data may also be useful for projecting programmatic commodities and system needs such as HIV test kits and other staffing resources, although the numerator reflects the number of individuals tested, not the number of tests performed.	
How to collect:	Existing HTS registers, log books, and reporting forms already in use to capture HTS can be revised to include the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems and non-governmental organization records. Data for the numerator should be generated by counting the **total number of individuals who received HTS and their test results.** **Note:** Although several other MER indicators (see below) may report on the HIV status of individuals, actual *testing* of individuals must be reported under HTS_TST. Thus any persons who are *newly tested* as part of the programs linked to the indicators listed below (i.e. PMTCT, TB, VMMC, Prevention services) must be reported as part of the HTS_TST indicator.	

- PMTCT_STAT
- TB_STAT
- VMMC_CIRC
- PP_PREV
- KP_PREV
- OVC_HIVSTAT

Note: Serologic testing of pediatric patients should be counted under HTS_TST. However, HIV virologic testing of HIV-exposed infants should be counted under PMTCT_EID.

For an individual to be counted under this indicator, that individual's HIV diagnosis must be confirmed as per in-country testing algorithms. For example, an HIV-positive rapid HIV test performed at the community- or facility- level must be confirmed with a second test, which may be performed at the same site or at a different facility. If the confirmatory test is performed at a different facility, then this may entail follow-up by implementing partners to confirm the diagnosis before reporting on this indicator.

Note: Testing for verification of HIV status before treatment initiation is different from confirmatory testing, since this is only done for persons who have already been diagnosed HIV-positive following the initial algorithm. All clients diagnosed HIV-positive should be retested with a second specimen and a second operator using the same testing strategy or algorithm before enrolling the client in care and/or initiating ART, but verification retesting is primarily done as a quality assurance activity to ensure those enrolled in treatment services are HIV positive. Thus, these verification retests should not be counted under HTS_TST, since this will have already been counted at the point of the initial confirmatory test.

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 are defined as:

1. Community-based testing - Any testing done outside of a designated health facility

- Index case testing: This refers to an approach focused on testing individuals in the social or sexual networks of HIV-positive persons, including family members, sexual partners, needle-sharing partners, and other high-risk contacts. Index patient testing can be done using novel approaches such as incentivized case finding, peer-driven outreach, and partner notification services. This approach can be done in other

	community-based settings (home-based, mobile, or other community platforms); community index testing includes if the index case finding/tested originated in the community, even if the subsequent testing was done in the facility. Importantly - If an individual could be reported under both index testing and another community modality, that person should be reported only once under community index testing. • Home-based testing: Any testing that occurs in a person's home, including door-to-door testing and targeted home visits • Mobile testing: Including any ad hoc or temporary testing locations, such as a community center, school, or mobile unit (Testing related to VMMC services is not included here. Instead that should be reported under facility based testing) • VCT: Any standalone VCT center that exists outside of a designated health facility (e.g. Drop-in-center, wellness clinic where HTS services are provided, site designated for key populations, etc.) • Other community platforms: Including any other modality not captured above (e.g. Ad hoc testing campaign that does not satisfy the mobile testing definition). OVC testing should be entered under this modality. • Facility-based testing: Any testing occurring inside a designated health facility 2. Index Case Testing ▪ Index Case Testing: This refers to an approach focused on testing individuals in the social or sexual networks of HIV-positive persons, including family members, sexual partners, needle-sharing partners, and other high-risk contacts. Index patient testing can be done using novel approaches such as incentivized case finding, peer-driven outreach, and partner notification services. ▪ Facility index testing includes if the index case finding/tested originated in the facility, even if the subsequent testing was done in the community. ▪ This approach can be done in other facility-based settings as described above, but if an individual could be reported under both index testing and another modality, that person should be reported only once under index testing. 3. Provider Initiated Counseling and Testing in certain clinical settings, including: • Inpatient: Including surgery and any inpatient ward • Pediatrics: Testing for children under 5 in any health facility setting, such as an under 5/EPI (immunization or well child services) clinic. This does not include testing for malnourished children (see below), virologic testing, and non-diagnostic rapid HIV testing which is reported under PMTCT_EID. Children under 5 may be tested in other service delivery modalities as well (OPD), but if an individual could be reported under both "pediatrics" and another facility modality, that person

should be reported only once under pediatrics. Index testing for family members above … age based on pediatrics clinics should be included under index testing.

- Malnutrition facilities: Clinics and inpatient wards predominately dedicated to the treatment of malnourished children. While this service delivery modality may be part of either inpatient or outpatient services, if an individual could be reported under both malnutrition and another service delivery point, report an individual only once and under malnutrition.
- TB: This includes all TB patients originating from TB clinics and contacts of TB patients. Refer to TB_STAT for guidelines on data collection for TB
- PMTCT (ANC Only): HIV testing for pregnant women as part of the PMTCT program at antenatal care clinics (ANC) to align with PMTCT_STAT. Refer to PMTCT_STAT reference sheet for guidelines on data collection.
- VMMC: This is HIV testing for males as part of the VMMC programs both in facility based and mobile outreach programs VMMC programs. Testing is recommended through the VMMC program, although not mandatory. Refer to VMMC_CIRC for guidelines on data collection for VMMC.
- Other PITC: this includes any other PITC modality that is not captured above, such as testing women and their partners or family members in labor and delivery wards; testing done in family planning centers, etc.

b. Voluntary Counseling and Testing (VCT):

- VCT is a form of client-initiated HTS, integrated into facilities that specifically provide this service. This is separate from services offered as part of inpatient or outpatient services as described above. Even though some VCT sites in health facilities might be linked with outpatient or inpatient services, if an individual could be reported under both VCT and another service delivery point, report an individual only once and under the non-VCT modality.

Key Populations

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

Key population disaggregation see Appendix 1 to support the identification of key populations at HTS service delivery; If a patient identifies as more than one of the KPs, please enter in all of those that are relevant (therefore KP disaggregations can equal more than the total);*

NOTE: both KP-specific and clinical partners have the option to complete these disagg, but only if safe to maintain these files and to report.

Age and sex data on KPs tested and receiving their results will not be reported—

these disaggregates are separate and distinct from disaggregates for male/female. Please refer to the KP_PREV and PP_PREV indicator reference sheets for more information on working with KPs.

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

Data Systems and Tools

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

4. This indicator counts the number of individuals tested not the number of test conducted. All efforts to ensure data are collected on individuals vs. number of tests should be made. 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 for verification of HIV-positive diagnosis
    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 at which individuals tested positive was linked with treatment
    e. Site - *site name and ID, district, region, province, and *service delivery modality
5. 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.
6. For an individual to be counted under this indicator, that individual's HIV diagnosis must be confirmed as per in-country testing algorithms. 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.
7. **Note:** Testing for verification of HIV status before treatment initiation is different from confirmatory testing, since this is only done for persons who have already been diagnosed HIV-positive following the initial algorithm. All clients diagnosed HIV-positive should be retested with a second specimen and a second operator using the same testing strategy or algorithm before enrolling the client in care and/or initiating ART, but verification retesting is primarily done for quality assurance of treatment services. Thus, these retests should not be counted under HTS_TST, since this will have already been counted at the point of the initial confirmatory

<table>
<tr><td></td><td colspan="4">test.
8. Patient level Deduplication: adding to the HTS facility and community registers (has patient been tested in the last 3 months). This additional data point in the patient testing registries can help partners de-duplicate at the reporting level.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Report 3 months of results at each reporting cycle. Patients re-tested during the reporting should be de-duplicated prior to data entry into DATIM, entered only once, with their last test result entered.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Only one age disaggregation type is used for age/sex/test result received: The number of individuals newly receiving ART must be disaggregated by age and sex. If possible, the full age/sex disaggregations should be used. If the full age/sex disaggregations are not possible, then, and only then, should the aggregated age/sex disaggregations be used, do NOT complete both age/sex disaggregations.

Numerator ≥ subtotal of each disaggregate group: The total number of individuals receiving HTS (numerator) should be equal to the sum of each individual disaggregation group (age/sex/test result, service delivery modality). If the sum of each individual disaggregation group (age/sex/test result, service delivery modality) is greater than the total number of individuals receiving HTS (numerator), then there were more individuals entered for the disaggregations than for the overall number of individuals receiving HTS and this should be corrected. If the sum of each individual disaggregation group (age/sex/test result, service delivery modality) is less than the total number of individuals receiving HTS, then some data are missing for the disaggregations and this should be corrected.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Sum results across all reporting periods.</td></tr>
<tr><td>Reporting level</td><td colspan="4">HTS is reported at the site level, both facility and community per service delivery area. Data entry screens differ by facility and community levels.</td></tr>
<tr><td rowspan="4">Data Elements (Components of indicator)</td><td rowspan="4">Numerator: Number of individuals who received HIV Testing Services (HTS) and received their test results</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Community Service Delivery Modality

(Required)</td><td>index testing, home-based testing, mobile testing, VCT testing, other community testing platforms</td><td>Only for community-based testing for HTS_TST</td></tr>
<tr><td>Facility Service Delivery Modality/Result Received

(Required)</td><td>Inpatient, pediatric, malnutrition facilities, PMTCT (ANC only), TB, VMMC, other PITC, VCT, index testing;</td><td>Only for facility-based testing for HTS_TST</td></tr>
<tr><td>Service Delivery</td><td>For each service delivery modality listed</td><td>Note: VMMC and PMTCT (ANC</td></tr>
</table>

		Modality/Age/Sex/Result Received (FINE AGE DISAGGREGATIONS) **(Required)**	**above (except Pediatric and Malnutrition facilities which have no age/sex disaggregation)**: <1 Positive, 1-9 Positive, 10-14 M Positive, 10-14 F Positive, 15-19 M Positive, 15-19 F Positive, 20-24 M Positive, 20-24 F Positive, 25-49 M Positive, 25-49 F Positive, 50+ M Positive, 50+ F Positive, <1 Negative, 1-9 Negative, 10-14 M Negative, 10-14 F Negative, 15-19 M Negative, 15-19 F Negative, 20-24 M Negative, 20-24 F Negative, 25-49 M Negative, 25-49 F Negative, 50+ M Negative, 50+ F Negative, <1 Total, 1-9 Total, 10-14 M Total, 10-14 F Total, 15-19 M Total, 15-19 F Total, 20-24 M Total, 20-24 F Total, 25-49 M Total, 25-49 F Total, 50+ M Total, 50+ F Total	only) have only age disaggregation as these service delivery modalities only reach one sex
		Service Delivery Modality/Age/Result Received (COARSE AGE DISAGGREGATIONS) **(Conditional)**	**For each service delivery modality (except Pediatric and Malnutrition facilities which have no age/sex disaggregation)**: <15 positive M, <15 positive F, <15 negative F, <15 negative M, +15M positive, +15 F positive, +15 M negative, +15 F negative, sub-total	Conditional: only use with permission from HQ. Note: VMMC and PMTCT (ANC only) have only age disaggregation as these service delivery modalities only reach one sex
		Key	MSM, Transgender, SW,	OPTIONAL, At the

		Populations **(Optional)**	PWID, People in prisons or other enclosed settings	time of HIV testing, did the patient identify as one of the following key populations: MSM: Men who have sex with men. A male that has sex with men or both and women TG: Person who identifies as transgender. Transgender (male to) female: individual was born a boy, but identifies as a woman: Transgender (female to) male: client was born a girl, but identifies as a man SW: Sex worker. A person whose main source (includes both monetary and non-monetary) of income comes from sex work. PWID: People who inject drugs. Any person who has injected illicit or illegal drugs in the last 6 months.

				Person in prisons or other enclosed setting. If client is currently incarcerated, then classify as Person in prison or other enclosed setting.
		Key Populations by Result **(Optional)**	For each KP above: PWID positive, MSM positive, FSW positive, Transgender positive, people in prisons or other enclosed populations positive; PWID negative, MSM negative, FSW negative, Transgender negative, people in prisons or other enclosed populations negative; PWID total, MSM total, FSW total, Transgender total, people in prisons or other enclosed settings total	OPTIONAL, see definitions of key populations above.
PEPFAR Support definition	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities individuals receiving HTS services include</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, or other HIV diagnostic commodities, or funding for salaries of HCW who deliver HTS services including counselors, laboratory technicians, program managers, 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>: this ongoing support for service delivery improvement can include: clinical mentoring/supportive supervision, HTS training, HTS guidance development, infrastructure/renovation of facilities (fixed, mobile, and outreach sites), site level QI/QA, routine support of HTS M&E and reporting, or HIV test kits consumption forecasting and supply management.			
DREAMS SNU Specific Guidance	None			

PMTCT_STAT (Includes 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: **(Required)**	Number of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)	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 ANC for a new pregnancy over the last reporting period. 2) The number of women attending ANC who were tested for HIV and received results (***These women <u>should also</u> be counted in the general HTS indicator "HTS_TST"***)
Denominator	Number of new ANC clients in reporting period	N/A
MER 1.0 to 2.0 Change	Collected at only antenatal care (ANC) sites to better align with upcoming 2016 WHO Consolidated ARV guidelines, reduce burden on data collection, and improve data quality. Age/sex disaggregates for DREAMS SNUs only	
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR supported antenatal care (ANC) know their HIV status and are initiated on ART.	
How to collect:	The data source is the ANC register. There is a risk of double counting as a pregnant woman could be tested multiple times during one pregnancy therefore partners should ensure a data collection and reporting system is in place to minimize double counting including a longitudinal ANC register (meaning a register that is able to record all information about one pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy). There is also a risk of undercounting if those women who already knew their HIV status prior to attending ANC are not documented, therefore the ANC register should at a minimum should document both "previously known positive" and "newly tested positive". Finally "known negative" (ie. women who tested HIV negative prior to current pregnancy) is not reported in DATIM however it may be appropriate to report "known negative" women as part of the numerator if: 1) National guidelines do not require retesting women known to be HIV negative (often women tested in the last 3 months, however exact timing depends on local guidelines) and 2) ANC registers and reporting systems only capture 1st month or 1st ANC visit. ***(As this is a status indicator and not a testing indicator - These women <u>should also</u> be counted in the general HTS indicator "HTS_TST" PMTCT (ANC Only) service delivery modality***)	

<table>
<tr><td>How often to report:</td><td colspan="4">Report 3 months of results at each reporting cycle</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">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</td></tr>
<tr><td>How to calculate across reporting periods:</td><td colspan="4">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>EA/ SIMS considerations</td><td colspan="4">EA: To ensure accuracy of HTS unit expenditures, please ensure that PMTCT_STAT beneficiaries are also be counted in the general HTS indicator “HTS_TST” PMTCT (ANC Only) service delivery modality. More details can be found in Appendix 2 on EA-MER Alignment.</td></tr>
<tr><td>Reporting level</td><td colspan="4">PMTCT_STAT (including PMTCT_STAT_POS) is entered at the facility site level only</td></tr>
<tr><td rowspan="3">Data Elements (Components of indicator)</td><td rowspan="3">Numerator: Number of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Age</td><td>Status disaggregated by Age</td><td>Known status by <10, 10-14, 15-19, 20-24, 25-49, 50+. Record <u>age at the time of ANC registration.</u> If age is not documented or unknown, record as unknown.</td></tr>
<tr><td>Positivity Status (Required)</td><td>Known Positive at Entry, Newly Tested Positive, (sum of positive disaggregates = PMTCT_STAT_POS) Newly Tested Negative</td><td>In addition to the numerator implementing partners are required to report:

<u>Known Positive at entry</u>: 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 <u>known positive at entry</u>. Pregnant women with known HIV status attending ANC for a new pregnancy may not need retesting if they are already on ART, or they may be required to be retesting prior to initiating ART based on national guidelines. Known positives who are re-tested and confirmed to be HIV</td></tr>
</table>

				positive prior to initiating ART should still be documented as known positive at entry. Newly tested positive: The number of women attending ANC who were tested for HIV and received a positive result
		Known/New Status by age	Known Positive at entry and newly tested positive disaggregated by age.	Known positives at entry by <10, 10-14, 15-19, 20-24, 25-49, 50+. Record age at the time of ANC registration. If age is not documented or unknown, record as unknown. New positives by <10, 10-14, 15-19, 20-24, 25-49, 50+. Record age at the time of ANC registration. If age is not documented or unknown, record as unknown.
	Denominator (Required) Number of new ANC clients in reporting period	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Age	Denominator disaggregated by Age	<10, 10-14, 15-19, 20-24, 25-49, 50+. Record age at the time of ANC registration. If age is not documented or unknown, record as unknown.
PEPFAR Support definition	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PMTCT include: commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers. Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.			
DREAMS SNU Specific Guidance	DREAMS SNUs set targets and report on results in DREAMS SNUs similarly to non-DREAMS SNUs. No additional DREAMS specific target setting or reporting is required			

PMTCT_EID (Includes PMTCT_EID_POS)		
Description:	Percentage of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth	
Numerator: (Required)	Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	Calculated indicator in DATIM, sum of: Infants who received a virologic test within 2 months of birth; Infants who received their first virologic HIV test between 2 and 12 months of age;
Denominator	**PMTCT_STAT_POS (see PMTCT_STAT);** Denominator is no longer collected as part of indicator, but rather is calculated as PMTCT_STAT_POS.	Calculated indicator in DATIM, sum of: 1) Newly Tested Positive, 2) Known Positive at entry **(see PMTCT_STAT, Disaggregate Group Positivity Status for more details)**
MER 1.0 to 2.0 Change	Disaggregation language improved to specify 0-2m and 2-12m distinctions. Clarification that 1) PMTCT_STAT_POS is the denominator for this indicator, 2) That the 2 month time point is based on age of collection of dried blood spot, not on date of result return to record. Addition of two new disaggregates: 3) negative results and 4) no result recorded to allow for both the reporting of all tests collected/sent as well as all tests with a final result documented in the patient record at the time of reporting.	
How to use:	This indicator measures the extent to which infants born to HIV-positive women receive virologic testing to determine their HIV status within the first 2 months and for those not tested by 2 months, how many were tested between 2 and 12 months of age. Additionally, the yield of HIV testing at 2 months of age maybe a useful proxy of early mother-to-child transmission rates if coverage of testing is > 80%. Only the first test for each HIV exposed infant should be counted in this indicator. Even though there is ongoing exposure of infants to HIV (through breastfeeding), this indicator is only measures early access to testing, and not repeat testing of exposed infants. HIV status of infants at the end of the breastfeeding period and the outcomes of the PMTCT program would be measured in PMTCT_FO.	

<table>
<tr><td>How to collect:</td><td colspan="4">This indicator should be collected from the clinical source (ie. HIV-exposed infant registers or patient records) to assure unduplicated patient counting and receipt of results to inform patient care. HIV-exposed infant registers should be used to count exposed infants and virologic test results. (If available information should 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 log books or electronic systems), but the virologic test results must be able to be linked to a specific patient.

Only virologic tests should be included in this indicator. A virologic test is a test used for HIV diagnosis in infants up to 18 months of age. The most commonly used form of virologic testing is HIV DNA PCR on dried blood spots (DBS). 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. <u>Additionally, only the first test should be counted for each infant, even if they have had more than one virologic test done during the reporting period.</u>

The numerator is divided into tests collected/sent before 2 months of age and those collected/sent between 2 and 12 months of age. Age is documented at the time the DBS is collected and not when the result is returned. It is likely that at the time of reporting there will be tests that have been collected/sent but for which no result is documented in the register or patient record. Partners should report all tests collected/sent even if no result has been recorded in the patient record/register at the time of reporting.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Report 3 months of results at each reporting cycle</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Review all sites with >100% coverage of testing at 12 months and/or 100% positivity (EID_POS). In general the % tested should not be above 100% at a site, however it is possible that some women identified in PMTCT_STAT_POS might deliver within a reporting period but the infant may not receive virologic test until the following period as there is not always a 1:1 correspondence between POS women identified and infants delivered in a reporting period.</td></tr>
<tr><td>How to calculate across reporting periods:</td><td colspan="4">Sum results across all reporting periods</td></tr>
<tr><td>Reporting level</td><td colspan="4">PMTCT_EID (including PMTCT_EID) is entered at the facility site level only</td></tr>
<tr><td>Data Elements (Components of indicator)</td><td>Numerator: Number of infants who had a virologic HIV test within 12 months of birth during the</td><td>Disaggregate Groups

InfantTest

(Required)</td><td>Disaggregates

Infants who received a virologic test within 2 months of birth; Infants who received</td><td>Description of Disaggregate

For the numerator to be calculated, implementing partners are</td></tr>
</table>

	reporting period		their first virologic test between 2 and 12 months of age	required to report: Infants who received a virologic test within 2 months of birth: Age at the time the DBS is collected should be reported. Infants who received their first virologic test between 2 and 12 months of age: Age at the time the DBS is collected should be reported.
		Results **(sum of postiive disaggregates =PMTCT_EID_POS)** **(Required)**	Infants with a positive virologic test result within 2 months of birth; Infants with a negative virologic test result within 2 months of birth; Infants with a positive virologic test result between 2 and 12 months of birth; Infants with a negative virologic test result between 2 and 12 months of birth; Infants with a test collected/sent but no result recorded within 2 months of birth; Infants with a test collected/sent but no result recorded between 2 and 12 months of birth	For PMTCT_EID_POS to be calculated, implementing partners are required to report: Infants who received a positive/negative virologic test within 2 months of birth: Age at the time the DBS is collected should be reported. Infants who a positive/negative virologic test between 2 and 12 months of age: Age at the time the DBS is collected should be reported.
PEPFAR Support definition	Standard definition of DSD and TA-SDI used.			

	Provision of key staff or commodities for PMTCT include: commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers. Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.
DREAMS SNU Specific Guidance	None

TB_STAT (includes TB_STAT_POS)		
Description:	Percentage of new and relapse TB cases with documented HIV status	
Numerator (Required)	Number of new and relapse 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 (Required)	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.
MER 1.0 to 2.0 Change	Indicator revised so Age/Sex disaggregates aligned across clinical cascade: • Now includes an option for "known HIV+ at service entry" • Finer age disaggregates no longer required • Disaggregates have been added to denominator	
How to use:	This indicator measures the performance of the TB program in ensuring that TB cases know their HIV status.	
How to collect:	The numerator and denominator can be obtained from basic management unit TB registers as well as additional data collection sources (i.e. HIV testing registers) that may contain relevant information (i.e. HIV test results, enrollment in HIV care programs). Programs should modify the register as needed to easily capture this information (<15 M, 15+ M, <15 F, 15+ F)) and (Known HIV-positive at service entry). The data source is the TB register. There is a risk of double counting as TB patients could be tested multiple times during their TB treatment, therefore partners should ensure a data collection and reporting system is in place to minimize double counting. There is also a risk of undercounting if those patients who already knew their HIV status prior to attending TB clinic are not documented, therefore the TB register at a minimum should document "Known HIV-positive at service entry; Newly tested HIV-positive; Tested HIV negative". ***(As this is a status indicator and not a testing indicator - These patients <u>should also</u> be counted in the general HTS indicator "HTS_TST" TB service delivery modality***)	
How often to report:	Report quarterly results at each reporting cycle.	

<table>
<tr><td>How to review for data quality:</td><td colspan="4">Only one disaggregation type is used for age and gender (coarse age and gender disaggregations)
Denominator ≥ Numerator.
Numerator ≥ subtotal of each of the disaggregations.
Denominator ≥ subtotal of each of the disaggregations.</td></tr>
<tr><td>Reporting level</td><td colspan="4">Site level, facility</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Sum across all quarters</td></tr>
<tr><td rowspan="4">Data Elements (Components of indicator)</td><td rowspan="4">Numerator: Number of new and relapse TB cases with documented HIV test results, during the reporting period.</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Age/Sex (Coarse Disaggregate)

(Required)</td><td><15 M <, 15+ M, <15 F, 15+F</td><td></td></tr>
<tr><td>Result

(Required)</td><td>Known HIV-positive at service entry; Newly tested HIV-positive; Tested HIV- negative</td><td>(sum of positive disaggregates = TB_STAT_POS)</td></tr>
<tr><td>Age/Sex/Result (Coarse Disaggregate)

(Required)</td><td><15 M Known HIV-Positive at service entry, <15 M Newly tested HIV-Positive, <15 F Known HIV-Positive at service entry, <15 F Newly tested HIV-Positive, 15+ M Known HIV-Positive at service entry, 15+ M Newly Tested HIV-Positive, 15+ F Known HIV-Positive at service entry, 15+ F Newly Tested HIV-Positive, <15 M Negative, <15 F Negative, 15+ M Negative, 15+ F Negative</td><td></td></tr>
</table>

	Denominator: Total number of new and relapsed TB cases, during the reporting period.	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Age/Sex (Coarse Disaggregate) **(Required)**	<15 M <, 15+ M, <15 F, 15+F	
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 include</u>: funding of test kits, ARVs, ARTs, and lab commodities or funding of salaries or provision of Health Care Workers for TB/HIV-related services. Staff responsible for maintaining patient records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. <u>Ongoing support for TB cases receiving HIV-related services includes</u>: training of TB/HIV service providers, clinical mentoring and supportive supervision of staff at TB/HIV sites, infrastructure/renovation of facilities, support of TB/HIV service data collection, reporting, data quality, QI/QA of TB/HIV services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow up/retention, support of other TB/HIV programs.			
DREAMS SNU Specific Guidance	None			

OVC_HIVSTAT

Description:	Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including status not reported), disaggregated by status type	
Numerator (Required)	Number of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including result not reported), disaggregated by status type	
Denominator (Required)	Number of orphans and vulnerable children reported under OVC_SERV (<18 years old) [Denominator is not collected again, as part of this indicator but is collected under the indicator OVC_SERV]	Number of beneficiaries (<18 years old including "active", "graduated", "transferred", and "exited without graduation") served by PEPFAR OVC programs for children affected by HIV/AIDS at Q4.
MER 1.0 to 2.0 Change	This is a new indicator for MER 2.0 and OUs are required to report on it during FY17. This indicator formerly called OVC_ACC (MER 1.0) and OVC_KNOWNSTAT (in the original MER 2.0 documentation) was changed to OVC_HIVSTAT to reflect that HIV status is self- reported to the implementing partner by the OVC or OVC caregiver.	
How to use:	This indicator will be tracked through routine program monitoring and annually through the Q4 POART process. Since report of HIV status is essential to effective case management, the OVC TWG will gauge progress at OU level to ensure that OVC implementing partners are proactively promoting reporting of HIV status for all enrolled children and ensuring that those who are positive are enrolled and retained in ART treatment. **Rationale:** Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC beneficiaries, and to facilitate access and retention in ART treatment for those who are HIV positive. When the implementing partner knows the HIV status, the program can contribute to ensuring that the children are linked to appropriate care and treatment services, all essential elements of quality case management. OVC programs can also play an important role in family-centered disclosure, for those who are HIV positive. • This indicator is NOT intended to be an indicator of HIV tests performed or receipt of testing results, as these are measured elsewhere and test results are frequently unavailable to community organizations due to health facility concerns about patient confidentiality. • This indicator is NOT intended to imply that all OVC beneficiaries require an HIV test. OVC with known positive or negative status do not need to be tested. Only OVC with no HIV status in the reporting period should be assessed for HIV risk. • 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 captures if implementing partners are tracking the self-reported HIV status of the orphans and vulnerable children they serve and enrollment in ART for those who are positive. Testing results for OVC who are referred for testing should be reported under HTS_TST based on the service delivery point where they were tested • This indicator also captures if implementing partners are tracking if the orphans and vulnerable children they serve who report to be HIV positive are successfully linked to and retained in treatment and care. • This indicator is a subset from OVC_SERV. Only OVC who were reported under OVC_SERV <18 atQ4 should be included in the denominator for this indicator. • Since this is not a testing indicator, HIV positivity yield should not be calculated based on this indicator. Yield calculations should only be made by testing partners.
How to collect:	Data sources for this indicator include HIV test results that are self-reported by OVC (or their caregivers), results of HIV Risk Assessments conducted by implementing partners, registers, referral forms, client records, or other confidential case management and program monitoring tools that track those in treatment and care. Implementing partners will record the OVC beneficiary's self-reported HIV status annually. "Reported HIV positive to IP" includes beneficiaries <age 18 who report to the IP that they are HIV positive based on an HIV test conducted during or prior to the reporting period (regardless of where the test occurred). All entries for "reported HIV positive to IP" should be further disaggregated as "currently receiving ART" or "not currently receiving ART." This also includes beneficiaries <age 18 who report that they are HIV positive based on an HIV test conducted during previous project reporting periods. "Reported HIV negative to IP" includes beneficiaries <age 18 who report that they are HIV negative to the IP based on an HIV test conducted during the reporting period (regardless of where the test occurred). For a child who reports multiple tests within the current period, use most recent test. "No HIV status reported to the IP" includes beneficiaries who fall into one of the below described categories: • "Test not indicated" – includes beneficiaries who based on a risk determination made by the implementing partner do not require a test during the reporting period. (*Forthcoming Operational Considerations for OVC Programs and HTS will include further information on determining whether a test is indicated)* • "Other reasons" – includes all beneficiaries (OVC_SERV <age 18) not entered in above categories. This may include for example, children for whom testing was indicated but did not test, or children who were tested

<table>
<tr><td></td><td colspan="4">but did whose result was not reported to the partner as well as children whose HIV status was not reported to the implementing partner for any other reason.

OVC entered as ""Reported HIV positive to IP" in the previous reporting period, should continue to be reported as positive during the current reporting period and their enrollment in ART noted. Beneficiaries < age 18 entered as "Reported HIV negative to IP" during the previous reporting period and children entered as "No HIV test reported to the IP" in the previous reporting period should be reassessed by the implementing partner to determine whether testing is indicated and the results entered as outline above.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Report semi-annual.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">The OVC_HIVSTAT numerator (OVC <18 years who have reported to the OVC implementing partner that they are HIV positive) should not exceed the denominator , OVC_SERV (<18 years) and the numerator should be larger or equal to the number of OVC who are HIV positive and enrolled in ART. Review any site with the numerator greater than 100% of OVC_SERV or very low coverage of OVC_HIVSTAT or the number enrolled in ART is greater than the numerator.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Use result reported at Q4/APR.</td></tr>
<tr><td>Reporting Level</td><td colspan="4">Site level, community</td></tr>
<tr><td rowspan="2">Data Elements (Components of indicator)</td><td rowspan="2">Numerator: Number of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner (including result not reported), disaggregated by status type</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Status type</td><td>1. Reported HIV positive to implementing partner
a. Currently receiving ART
b. Not currently receiving ART
2. Reported HIV negative to implementing partner
3. No HIV status reported to the implementing partner
a. Test not indicated based on HIV</td><td>In addition to the numerator, implementing partners are required to report:
1. <u>Reported positive and on ART</u>: Among OVC reported to be HIV positive, if they are currently receiving ART at the end of the reporting period or not;
2. <u>Reported negative</u>: OVC who report being HIV negative in the reporting</td></tr>
</table>

			risk assessment b. Other reasons	period 3. Reported no HIV status: OVC who report unknown status or do not disclose their HIV status to the implementing partner. Among this group, how many had test not indicated based on the HIV risk assessment conducted by the implementing partner
PEPFAR Support definition	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for OVC beneficiaries receiving care and support services in the community include: For beneficiaries of OVC services, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group or community level activity (e.g., psychosocial support, child protection services, education, etc.) or procurement of critical commodities essential for ongoing service delivery. Partial salary support may include stipends or incentives for volunteers, or paying for transportation of those staff to the point of service delivery. For care and support services, ongoing support for OVC service delivery for improvement includes: the development of activity-related curricula, education materials, etc., supportive supervision of volunteers, support for setting quality standards and/or ethical guidelines, and monitoring visits to assess the quality of the activity, including a home visit, a visit to a school to verify a child's attendance and progress in school or observation of a child's participation in kids clubs.			
DREAMS SNU Specific Guidance	None			

PMTCT_FO		
Description:	Percentage of final outcomes among HIV exposed infants registered in a birth cohort	
Numerator: (Required)	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 (Required)	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.
MER 1.0 to 2.0 Change	Implementing partners should only report on this indicator in if PEPFAR supported sites already utilize paper-based or electronic HIV-exposed or mother-infant register and/or facility held records (cards/charts) that allow for longitudinal reporting. For COP16, no targets are required for this indicator, and the number of disaggregates has been reduced and simplified.	
How to use:	In settings where national guidelines support breastfeeding of HIV-exposed infants, antibody testing of all HIV-exposed children at 18 months of age and/or 6 weeks after cessation of breastfeeding is recommended to determine final HIV status ('final outcome'/FO) of HIV-exposed children. To accomplish this goal, it is recommended to identify infants at birth or at the first infant follow-up visit and track them through the end of the breastfeeding period. This indicator measures progress toward ensuring that all infants born to HIV-positive women have an outcome documented. In settings where a mother-infant register is utilized and/or it is common practice for HIV-infected women to breastfeed less than or more than 18 months please describe in the narrative the final outcome time point.	
How to collect:	To report on this indicator PEPFAR supported sites would ideally use registers or facility held cards for HIV exposed infants that collect longitudinal information on follow-up and are organized by birth month of infants. This methodology is referred to as birth cohort reporting.	

	Two examples of birth cohort reporting: 1. In Kenya, this indicator was first piloted by PEPFAR and the Ministry of Health in Western Kenya and is currently integrated into the national HIV summary reporting tool. Data from the facility HIV exposed infant longitudinal follow-up register, which organizes infants by birth-month cohorts, are aggregated into a report summarizing outcomes for infants reaching 24 months of age during each month. 2. In Malawi, clinic staff complete monthly follow up reporting forms as part of the national quarterly supervision visits using data collected directly from HIV-exposed infant cards which are kept in a binder that is organized by birth month (no HIV exposed register is used). As an example for those infants born in FY 2015, the outcomes would be reported in FY 2017. FY2017 (Report results for the entire 12 month reporting period for these indicators at the Q4 reporting cycle) ***Reporting Month (FY 2017)*** *Oct* ↓	*Nov* ↓	*Dec* ↓	*Jan* ↓	*Feb* ↓	*Mar* ↓	*April* ↓	*May* ↓	*June* ↓	*July* ↓	*Aug* ↓	*Sept* ↓ ***Birth Month (FY 2015)*** *Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*April*	*May*	*June*	*July*	*Aug*	*Sept* 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 often to report:	Report results for the entire 12 month reporting period for these indicators at the Q4 reporting cycle.
How to review for data quality:	By design this indicator should equal 100% if all outcomes are known regardless of outcome type. This allows for facilities to check that all HIV-exposed infants have an outcome assigned to them during the reporting process. Data utilization requires reviewing the disaggregated data to understand the specific outcomes of interest. In settings where HIV-exposed infant registers do not allow for documentation of all disaggregated outcomes, country teams should report only on available disaggregates even if the aggregate indicator is less than 100%**,** however this should be specified in the narrative. The denominator should include those “Transferred In” and those “Transferred Out” as long as for “Transferred In” there is documentation that HIV-exposed infants were registered at their original site in the birth cohort at any time between 0 and 18 months of age and were born 24 months prior to the reporting

	period. "Transferred Out" should be reported under HIV status unknown. The inclusion of Transfers-In/Out provides a quality check to ensure that all exposed infants have an outcome assigned to them during the reporting process such that the sum of the numerator disaggregation equals the denominator. However this may lead to outcomes for >100% of HIV positive pregnant women (PMTCT_STAT_POS) identified at a site so this comparison should not be used as a logic check.			
How to calculate across quarters	N/A, Only reported annually			
Data Elements (Components of indicator)	**Numerator**: **(Required)** Number of HIV-exposed infants with a documented outcome by 18 months of age disaggregated by outcome type. (to reduce reporting burden, collection of 18 month outcomes is recommended at 24 months of age)	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Outcome Type **(Required)**	HIV-infected, HIV-uninfected, HIV-final status unknown, died without status known	For the numerator to be calculated, implementing partners are required to report: **HIV-infected** = Number of HIV-exposed infants identified as HIV-infected at any point during follow-up. HIV-infected includes infants and children with diagnostic virologic or serologic confirmation of HIV-infection (DNA PCR before 18 months; rapid test at 18 months) and those with a presumptive HIV diagnosis where DNA PCR is not available. Site should also maintain data on HIV infected infants and whether they are linked or not linked to ART services, or whether they have no information on patient linkage to ART programs. **HIV-uninfected** = Number of HIV-exposed infants with a negative 18 month antibody test documented. Based on national guidelines, countries should determine if "HIV-uninfected" includes infants with a documented negative antibody test that was done at least 6 weeks after

				cessation of breastfeeding but before 18 months of age. **HIV final status unknown** = Sum of the following disaggregates (not reported in DATIM but should be documented at site level) • In care but no test done: Number of HIV-exposed infants who attended 18 month visit but no antibody test result is documented (unknown FO) • Lost to follow-up = Number of HIV-exposed infants who did not attend the 18 month visit (unknown FO) • Transferred out (unknown FO) = Number of HIV-exposed infants who transferred out between 0 and 18 months without confirmation of HIV-infection (unknown FO) **Died without status known** = Number of HIV-exposed infants who are documented to have died without confirmation of HIV-infection between 0 and 18 months. Note: HIV-exposed infants who are HIV infected and later confirmed to have died or transferred out during follow-up are still counted under HIV infected and not died or transferred out. **Every infant in a given cohort should be assigned one outcome only**.

PEPFAR Support definition	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for PMTCT include: commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers. Ongoing support for PMTCT service delivery improvement includes: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.
DREAMS SNU Specific Guidance	None

PEPFAR

90-90: On ART

MER 2.0

TX_NEW	
Description:	Number of adults and children newly enrolled on antiretroviral therapy (ART)
Numerator (Required)	Number of adults and children newly enrolled on antiretroviral therapy (ART)
Denominator	*N/A*
MER 1.0 to 2.0 Change	Age/Sex disaggregates aligned across clinical cascade; TB disaggregate added to the indicator Key population added to the indicator
How to use:	The indicator measures the ongoing scale-up and uptake of ART programs. This measure is critical to monitor along with number of patients currently on ART in relation to the number of PLHIV that are estimated to be eligible for treatment to assess progress in the program's response to the epidemic in specific geographic areas and populations as well as at the national level. This is particularly critical in the context of current revisions to country-specific ART eligibility. Reporting the number of new patients enrolled on ART at both the national and overall PEPFAR program levels is critical to monitoring the HIV services cascade, specifically the successful linkage between HIV diagnosis and initiating ART. Disaggregation of new on ART by age/sex at ART initiation, pregnancy status at ART initiation, and breastfeeding status at ART initiation is important to understand the percentage of new ART initiations coming from priority populations.
How to collect:	Facility ART registers/databases, program monitoring tools, or drug supply management systems. · The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards). · Patients who known to transfer in from another facilities, or who temporarily stopped therapy and have started again should not be counted as new patients. · NEW is a state defined by an individual initiating ART during the reporting period. It is expected that the characteristics of new clients are recorded at the time they newly initiate life-long ART. For example patients who receive post-exposure prophylaxis (PEP), short term ART only for prevention (PREP), or ART starter pack alone should not be used to count individuals reached with this indicator. TB/ HIV disaggregation: At initiation of ART, number of patients with a confirmed diagnoses of TB (new and relapsed) and/or on TB treatment collected from TB/HIV registers;

<table>
<tr><td></td><td colspan="4">Key population disaggregation* see Appendix 1 to support the identification of key populations at ART initiation; If a patient identifies as more than one of the KPs, please enter in all of those that are relevant (therefore KP disaggregations can equal more than the total);

NOTE: both KP-specific and clinical partners have the option to complete these disagg, but only if safe to maintain these files and to report.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Report 3 months of results for these indicators at each quarterly reporting cycle.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">• Confirm that TX_CURR ≥ TX_NEW
• Only one age disaggregation type is used for age/sex:
o The number of individuals newly receiving ART must be disaggregated by age and sex. If possible, the full age/sex disaggregations should be used. If the full age/sex disaggregations are not possible, then, and only then, should the aggregated age/sex disaggregations be used, do NOT complete both age/sex disaggregations.
• Numerator ≥ subtotal of each disaggregation
o The total number of adults and children newly enrolled on ART should be greater or equal to the sum of all of the age/sex disaggregations and pregnancy/ breastfeeding status</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Sum across all reporting periods</td></tr>
<tr><td>Reporting Level</td><td colspan="4">Site level, facility only</td></tr>
<tr><td>Data Elements (Components of indicator)</td><td rowspan="2">Numerator: Number of adults and children newly enrolled on antiretroviral therapy (ART)</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Age/Sex (Fine Disaggregate)

(Required)</td><td><1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49 M, 25-49 F, 50+ M, 50+ F</td><td>Age is defined as the age of the patient at the <u>date of initiation on ART</u>, not the age at the <u>date of reporting</u>.</td></tr>
<tr><td></td><td>Age/Sex (Course Coarse Disaggregate)

(Conditional)</td><td><1, <15 M, <15 F, 15+ M, 15+ F</td><td>This disaggregation should only be entered if finer age disaggregates are <u>not</u> available.</td></tr>
</table>

		TB/HIV status **(Required)**	TB/HIV status	At initiation of ART, number of patients with a confirmed diagnoses of TB (new and relapsed) and/or on TB treatment
		Pregnancy and breastfeeding status **(Required)**	Pregnant at initiation of ART; Breastfeeding at initiation of ART	Pregnancy and Breastfeeding status is defined as the status at the date of initiation on ART, not the status at the date of reporting.
		Key population **(Optional)**	MSM, Transgender, SW, PWID, People in prisons or other enclosed settings	At the time of HIV testing, did the patient identify as one of the following key populations: MSM: Men who have sex with men. A male that has sex with men or both and women TG: Person who identifies as transgender. Transgender (male to) female: individual was born a boy, but identifies as a woman: Transgender (female to) male: client was born a girl, but identifies as a man SW: Sex worker. A person whose main source (includes both monetary and non-monetary) of income comes from sex work. PWID: People who inject drugs. Any person who has injected illicit or illegal drugs in the last 6 months.

				Person in prisons or other enclosed setting. If client is currently incarcerated, then classify as Person in prison or other enclosed setting.
	Denominator*:* *N/A*	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		N/A	N/A	N/A
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.			
DREAMS SNU Specific Guidance	None			

TX_CURR	
Description:	Number of adults and children currently receiving antiretroviral therapy (ART)
Numerator: (Required)	Number of adults and children currently receiving antiretroviral therapy (ART)
Denominator	N/A
MER 1.0 to 2.0 Change	Age/Sex disaggregates aligned across clinical cascade. Changes to quarterly to align with TX_New
How to use:	This indicator measures the ongoing scale-up and uptake of ART and retention in ART programs as a critical step in the HIV service cascade and assesses progress towards coverage of ART for all eligible HIV-positive individuals when reviewed against the number of PLHIV that are estimated to be eligible for treatment. It allows us to track the response to the epidemic in specific geographic areas and among specific populations as well as at the national level.

How to collect:	This indicator should be collected from facility ART registers/databases, program monitoring tools, and drug supply management systems.
	
	Count the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period.
	
	The current on ART count should equal the number of adults and children with HIV infection who ever started ART minus those patients who are not currently on treatment at the end of the reporting period.
	• Patients on ART who initiated or transferred-in during the reporting period should be counted.
	• Patients who have received enough ARVs to last to the end of the reporting period should be counted including those patients that pick up several months of antiretroviral drugs at one visit
	• HIV-positive pregnant women who are eligible for and are receiving antiretroviral drugs for their own treatment are included. HIV-positive pregnant women initiating lifelong ART through PMTCT (Option B+) will count as “current” on ART under this indicator. These include HIV-infected pregnant women who:
	  ○ Have newly initiated ART during the current pregnancy
	  ○ Are already on ART at the beginning of the current pregnancy
	
	Patients excluded from the Current on ART count are patients who died, stopped treatment, transferred out, or are lost to follow-up (LTFU). LTFU is defined as a patient who has not received ARVs in the last 90 days (three months) following their last missed appointment or missed drug pick-up. (Note: As models of service delivery change to reflect longer visit intervals for stable patients, it is important to emphasize the definition of LTFU applies to both missed visits or missed drug pick-up, but does not apply who have not received ARVs in the last

	90 days (three months) following their last attended appointment or attended drug pick-up. As that interval between scheduled visits for stable patients maybe longer than 3 months. This indicator should be reported from both PEPFAR supported sites in the private or public sector. Patients currently receiving treatment from mobile clinics can be reported in two ways. Firstly if the mobile clinic is associated (receives commodities, reports to, is staff by) a nearby health facility, then these individuals should be reported by that facility. Secondly, if a mobile clinic is stationary for more than 2 reporting periods, it should be added to the PEPFAR facility list with geocodes and data should be reported for this mobile clinic directly. **For age /sex disaggregates**: CURRENT is a state defined by treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Age represents an individual's age at the end of the reporting period or when last seen at the facility. For example, a 14-year-old child will be counted as currently receiving treatment in the <15 age category at the end of reporting period "A". During reporting period "B" the child turns age 15 and so at the end of this reporting period the child will be counted under the 15+ age category. **DO NOT include:** Patients who receive ARVs for post-exposure prophylaxis (PEP) or short term ART only for prevention (PREP) should not be reported in this indicator.
How often to report:	Quarterly; report total currently in treatment as of the last day of the reporting period

How to review for data quality:	• Confirm that TX_CURR ≥ TX_NEW
	• Only one age disaggregation type is used for age/sex
	  ○ The number of individuals newly receiving ART must be disaggregated by age and sex. If possible, the full age/sex disaggregations should be used. If the full age/sex disaggregations are not possible, then, and only then, should the aggregated age/sex disaggregations be used, do NOT complete both age/sex disaggregations.
	• Numerator ≥ subtotal of age/sex disaggregation
	  ○ The total number of adults and children newly enrolled on ART should be greater or equal to the sum of the age/sex disaggregations
	• Net new of TX_CURR between reporting periods should be less than TX_NEW in that time period

How to calculate annual total:	*PEPFAR will use the Q4/APR number*
EA/SIMS considerations	EA: To calculate accurate unit expenditures by age (e.g. Adult on ART and Children on ART), consistent reporting of TX_CURR age disaggregates across partners is necessary. More details can be found in Appendix 2 on EA-MER Alignment.

<table>
<tr><td>Reporting Level</td><td colspan="4">Site level, only facility</td></tr>
<tr><td rowspan="5">Data Elements (Components of indicator)</td><td rowspan="2">Numerator (Required): Number of adults and children currently receiving antiretroviral therapy (ART)</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Age/Sex (Fine Disaggregate)

(Required)</td><td><1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49 M, 25-49 F, 50+ M, 50+ F</td><td>Age is defined as the age of the patient at the <u>date of reporting</u>, not the age at the <u>date of initiation on ART</u>.</td></tr>
<tr><td></td><td>Age/Sex (Coarse Disaggregate)

(Conditional)</td><td><15 M, <15 F, 15+ M, 15+ F</td><td>This disaggregation should only be entered if finer age disaggregates are <u>not</u> available.</td></tr>
<tr><td rowspan="2">Denominator:
N/A</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="4">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>DREAMS SNU Specific Guidance</td><td colspan="4">None</td></tr>
</table>

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: (Required)	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: (Required)	**PMTCT_STAT_POS (see PMTCT_STAT);** Denominator is no longer collected as part of indicator, but rather is calculated as PMTCT_STAT_POS.	Collected as part of PMTCT_STAT. Calculated indicator in DATIM, sum of: 1) New Positives, 2) Known Positive at entry **(see PMTCT_STAT, Disaggregate Group Positivity Status for more details)**
MER 1.0 to 2.0 Change	Collect only ART disaggregates and collected only at antenatal care (ANC) sites to better align with 2016 Consolidated WHO ARV guidelines, reduce burden on data collection, and improve data quality. Denominator is no longer collected as part of indicator, but rather is calculated as PMTCT_STAT_POS. Reporting frequency is quarterly to align with other PMTCT indicators. Reporting frequency is quarterly to align with other PMTCT indicators.	
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR supported antenatal care (ANC) know their HIV status and are initiated on ART.	
How to collect:	Data source is the ANC or PMTCT register depending on country context (in many high HIV prevalence settings information on the number of women receiving ART regimens is integrated into the ANC register). There is a risk of double counting as a pregnant woman receiving ART at ANC should have multiple visits for each pregnancy therefore partners should ensure a data collection and reporting system is in place to minimize double counting of the same pregnant women across visits including a paper based longitudinal ANC or PMTCT register (meaning a register that is able to record all information about 1 pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy) or an electronic medical record/patient tracking system. There is also a risk of undercounting if those women who already on ART prior to attending ANC are not documented, therefore the ANC register should document both "New on ART" and "Already on ART at the beginning of the current pregnancy". Women who initiate ART while breastfeeding should not be counted under this indicator, and should instead be reported as part of the TX_NEW indicator (see TX_NEW, disaggregate group pregnancy/breastfeeding status). Note: Those women reported in PMTCT_ART including newly enrolled on ART and already on ART at the beginning of pregnancy should also be reported in the TX_CURR indicators.	
How often to report:	Report 3 months of results at each reporting cycle	

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 understand 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. Compare the number of HIV-positive pregnant women newly initiating ART (PMTCT_ART disaggregate) and the number individuals newly initiated on ART (TX_NEW disaggregate) who are pregnant (disaggregation of the new on treatment indicator). It is expected that women are new ART initiations are reported in both indicators, however the data source is often different (ANC/PMTCT register for PMTCT_ART and ART register for TX_NEW) and to discrepancies can provide better understanding of data quality.			
How to calculate across reporting periods:	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			
EA/SIMS considerations	EA: EA has historically excluded PMTCT_ARV (MER1.0) from Adult on Treatment UEs, and calculated a separate PMTCT Women on Treatment UE. To ensure accuracy of the Adult on Treatment UE, any beneficiaries reported in PMTCT_ART (MER2.0) should also be reported in the TX_CURR indicators.			
Reporting Level	Site level, facility only			
Data Elements (Components of indicator)	**Numerator (Required)**: Number of HIV-positive pregnant women who received ART to reduce risk of mother-to-child-transmission during pregnancy	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Maternal Regimen Type **(Required)**	New on ART, Already on ART at the beginning of the current pregnancy **(sum of disaggregates = PMTCT_ART_Num)**	For the numerator to be calculated, implementing partners are required to report: <u>The number of HIV-positive pregnant women newly initiated on ART</u> (These should also be counted in "TX_NEW" see TX_NEW, Disaggregate group breastfeeding/pregnancy status)<u>:</u> 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. <u>The number of HIV-positive pregnant women already on ART at beginning of pregnancy:</u> Maybe counted even if ART is continuing to be received at another facility. For example a woman, who is already on treatment, becomes pregnant and enrolls in ANC/PMTCT because she is HIV-positive but is continuing to receive her ART at a nearby treatment clinic <u>should be counted</u> 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 <u>should not be counted</u>. (since she was already counted at the first ANC site for this pregnancy)
PEPFAR Support definition	Standard definition of DSD and TA-SDI used. <u>Provision of key staff or commodities for PMTCT include</u>: commodities such as test kits, ARVs, lab commodities, or funding for salaries of health care workers. <u>Ongoing support for PMTCT service delivery improvement includes</u>: training of PMTCT service providers, clinical mentoring and supportive supervision of PTMCT service sites, infrastructure/renovation of facilities, support for PMTCT service data collection, reporting, data quality, QI/QA of PMTCT services support, ARV			

	consumption forecasting and supply management, support of lab clinical monitoring of patients, supporting patient follow-up/retention, support of mother mentoring programs.
DREAMS SNU Specific Guidance	None

TB_ART				
Description:	The number of HIV-positive new and relapsed TB cases on ART during TB treatment			
Numerator:	Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period			
MER 1.0 to 2.0 Change	Indicator revised with the following: 1. Denominator was removed 2. HIV treatment disaggregate revised to be already on ART/new on ART. 3. Finer Age/Sex disaggregates aligned across clinical cascade 4. Timing of ART (<8 weeks etc.) removed			
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 often to report:	Report 6 months of results at Q2 and Q4.			
How to review for data quality:	Only one disaggregation type is used for age/sex. Numerator ≥ subtotal of each of the disaggregation.			
How to calculate annual total:	Sum numerator across both reporting periods.			
Reporting Level	Site level, facility only			
Data Elements (Components of indicator)	**Numerator (Required)**: Number of TB cases with documented HIV-positive status who start or continue ART during the reporting period	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Age/sex **(Required)**	<1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49 M, 25-49 F, 50+ M, 50+ F	Age is defined as the age at the date of initiation on ART or current age, not the age at the date of reporting.
		Age/Sex (Coarse Disaggregate) **(Conditional)**	<15 M, 15+ M, <15 F, 15+F	This disaggregation should only be entered if finer age disaggregates are not available.
		Current/New on	Currently on ART;	This disaggregation

		ART **(Required)**	New on ART	should distinguish those who started ART during the reporting period (this should also be reported under TX_NEW) from those who were already on it at the beginning of the reporting period.
PEPFAR Support definition	Provision of key staff or commodities for TB cases receiving HIV-related services include: ongoing provision of critical re-occurring costs or commodities (such as ARVs) or funding of salaries or provision of Health Care Workers for TB/HIV clinic services. Where TB and HIV services are not integrated, this can include support for system/personnel critical to patient referral, transfer or tracking that ensures patient linkage between the TB and HIV programs/facilities that is required to accomplish the delivery of the service. Staff responsible for maintaining patient records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. Ongoing support for TB cases receiving HIV-related services includes: Clinical mentoring and supportive supervision of staff at ART sites, Quality Improvement services support, patient tracking/referral system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management.			
DREAMS SNU Specific Guidance	None			

TX_TB			
Description:	The proportion of ART patients who were screened who are receiving TB treatment.		
Numerator:	The number of ART patients who were started on TB treatment during the reporting period.		
Denominator:	The number of ART patients who were screened for TB at least once during the reporting period.		
MER 1.0 to 2.0 Change	• This indicator is new, and incorporates elements of TB_SCREEN and TB_ART; as such, there is no direct comparator from MER 1.0		
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		
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 patients as well as patients currently on ART. The numerator can be generated by counting the number of those patients who were diagnosed with TB and started on TB therapy during the reporting period. These data should be captured in ART registers as well as additional data collection sources (i.e., facility-based TB screening registers or forms, TB specimen registers, TB microscopy result registers, GeneXpert data collection systems) that may contain relevant information (i.e., TB screening results, TB specimen testing results). Programs should modify the register as needed to easily capture this information. * Screening for TB and/or initiation of TB therapy might not happen at the same time that ART is started. Regardless of when they occur relative to ART initiation, TB screening and initiation of TB therapy should be included for all patients who are currently on ART or who started ART **at any time** during the reporting period.		
How often to report:	Report 6 months of results at Q2/SAPR and Q4/APR. Ensure that each PLHIV is counted only once during the reporting period.		
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:	The annual total for the numerator can be summed from Q2 and Q4		
Data Elements (Components of indicator)	Numerator: The number of ART patients who were started on TB treatment during the reporting period.	**Disaggregate Groups**	**Disaggregates and Description**
		Current/New on ART	1. The number of patients starting TB treatment who newly started ART during the reporting period 2. The number of patients starting TB treatment who were already

			on ART prior to the start of the reporting period
		Age/Sex (Coarse Disaggregate)	<15 F, 15+ F, <15 M, 15+ M
	Denominator: The number of ART patients who were screened for TB.	**Disaggregate Groups**	**Disaggregates and Description**
		Screen Result	1. Positive: The number of ART patients who at least one positive screen during the reporting period. 2. The number of ART patients who had all negative screens during the reporting period.
		Specimen Sent	1. Number of ART patients who had a specimen sent for bacteriologic diagnosis of active TB disease.
		[Disagg of Specimen Sent] Diagnostic Test	1. GeneXpert MTB/RIF assay (with or without other testing) 2. Smear microscopy only 3. Additional test other than GeneXpert
		Age/Sex (Coarse Disaggregate)	<15 F, 15+ F, <15 M, 15+ M
	For DSD for HIV-related services, the provision of key staff and/or commodities can include ongoing provision of critical re-occurring costs or commodities (such as laboratory supplies, GeneXpert cartridges etc) and/or delivery of TB symptom screening and bacteriological testing to the counted individuals, such as through funding of salaries or provision of Health Care Workers for TB services. Staff responsible for maintaining patient records are included in this category however staff responsible for fulfilling reporting and routine M&E requirements are not included. For DSD and TA for TB/HIV-related services, TB and HIV clinical care facilities and community-based services will be counted as supported by TA/QI whenPEPFAR provides established presence and/or routinized, frequent (at least quarterly) support for the services by PEPFAR at the point of service delivery, clinical mentoring and supportive supervision of staff providing TB/HIV services, Quality Improvement services, routine support of M&E, TB screening and bacteriologic testing, commodities consumption forecasting and supply management, or specimen transport and result return.		

PEPFAR

90-90-90: Viral Suppression

MER 2.0

TX_RET		
Description:	Percentage of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy (Note: reporting 24 and 36 months is recommended, but optional)	
Numerator: **(Required)**	Number of adults and children who are still on treatment at 12 months after initiating ART	The numerator is defined as the number of adults and children who are still on treatment twelve months after initiating ART. For example, if the PEPFAR reporting period is 1 October 2016 to 30 September 2017, countries will calculate this numerator by using all patients who started ART any time during the 12-month period from 1 October 2015 to 30 September 2016. The 12-month outcomes are defined as 1) on ART and 2) not on ART because patient died, stopped ART or was lost to follow-up (LTFU), (including silent transfers). **On ART** is defined as those patients who had received enough ARVs to last to the end of the reporting period. See example below for more details. **LTFU** is defined as a patient who has not received ARVs in the last 90 days (three months) following their last missed appointment or missed drug pick-up. **Died:** Patients that are documented death during the previous 12 months period**.** **Stopped ART:** Patient intentionally stops ART, usually, but not always in discussion with the clinical team. **Known Transfers:** Patients who have transferred in with a known treatment initiation date that falls within the reporting period should be counted. Conversely, patients who transferred out of the facility should not be counted in the numerator (or denominator, see below) **Note:** this indicator does not collect adherence information, but only retention, therefore The numerator does not require patients to have been on ART continuously for the 12-month period. Patients may be included in the numerator (and denominator) if they have missed an appointment or drug pick-up or temporarily stopped treatment during the 12 months since initiating treatment, as long as they are recorded as still being on

		treatment at month 12. For example. A patient who started ART in September 2016 would be considered "on ART at 12 months" (in September 2017) if: • The patient visited the facility and received ARVs in September 2017; **OR** • The patient had enough ARVs to last through the end of September 2017 (month 12) based on the last drug pick-up (e.g., patient received 60 days of drug on August 15th, or patient received 90 days of drug on July 1st, etc.). However, the patient would NOT be considered "on ART at 12 months" if: • The patient did NOT have enough ARVs to last through the end of September 2017 (e.g., patient received 30 days of drug on August 1st); **OR** • The patient had died, transferred out, stopped ART, or was lost to follow-up at the end of September 2017.
Denominator (Required)	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died and those who have stopped ART. Does not include transfer outs.	The denominator is defined as the number of all adults and children who were initiated on treatment in the 12-month period before the reporting period. The denominator includes those "New" on ART as well as those who "Transferred In" if they have a cohort-start date within the reporting period of interest. However, transfers-out should be taken out of both the denominator as well as the numerator. It is assumed that if a patient transfers out from an ART facility, that patient will be a "transfer in" at a new ART facility. For example, for the reporting period October 1, 2016 to September 30, 2017, this will include all patients who started ART during the 12-month period from October 1, 2015 to September 30, 2016. This includes all patients, both those on ART as well as those who have died, stopped ART or were lost to follow-up (LTFU). Only sites that have been operational for at least 24 months prior to the end of the reporting period should report. PEPFAR country teams may use the USG FY reporting period as the timeframe for the 12-month cohort. Teams may also wish to 'lag' by 1-3 months the cohort-months comprising the annual cohort, in order to allow sufficient time for reporting from data sources (i.e., implementing partners and/or national systems).

MER 1.0 to 2.0 Change	Age/Sex disaggregates aligned across clinical cascade. 24 and 36 months were added as optional time periods to monitor changes to retention of these patients as models of service delivery change for stable patients on ART (the definition of stable varies across contexts, but often excludes patients on ART for less than 12 months) (Note: As models of service delivery change to reflect longer visit intervals for stable patients, it is important to emphasize the definition of LTFU applies to both missed visits or missed drug pick-up, but does not apply who have not received ARVs in the last 90 days (three months) following their last attended appointment or attended drug pick-up. As that interval between scheduled visits for stable patients maybe longer than 3 months.)
How to use:	This indicator measures the proportion of individuals who have been retained on antiretroviral therapy (ART). ART is viewed by the scientific community and PEPFAR not only as essential for decreasing morbidity and mortality, but also as a highly effective approach to prevent HIV transmission. High retention is one important measure of program success, specifically in reducing morbidity and mortality, and is a proxy for overall quality of the ART program. Monitoring the program level retention is a critical quality of service indicator at the site, national and PEPFAR program levels as it can highlight barriers to health seeking behaviors and/or gaps in access to and provision of health services.
How to collect:	Information should come from electronic systems (EMR) if possible. Where electronic systems do not exist ART registers/databases and cohort/group analysis forms can be used to count patients that have been retained after 12, 24 or 36 months on ART. This indicator should NOT be estimated. This indicator should be calculated directly from information gathered in standard cohort ART registers or electronic patient level databases. Sites are required to disaggregate retention by pregnancy and breastfeeding and specific age/sex disaggregates (see data element below). In order to collect this information ART registers, cohort/group analysis forms, and EMRs must document age, sex, pregnancy status, and breastfeeding status on the date of ART initiation. Of note, for reporting purposes a three-month grace period should be observed following drug pick-up, before concluding a patient is actually LTFU. However, while practical, if follow-up of patients is delayed till LTFU is official the majority of clients who do not present by three months of last missed appointment/drug pick-up are very unlikely to return thereafter. Therefore, for patient management, the facility should make every effort to contact a patient as soon as s/he misses an appointment and/ or drug pick-up (by phone, via community health worker) rather than waiting for the prescribed 90 days. This is particularly important when patients are routinely seen every three to six months (a patient

<table>
<tr><td></td><td colspan="4">may not have been seen for up to nine months if the facility adheres to the waiting period before attempting contact). LTFU is an ambiguous outcome that may often include patients who have self-transferred (silent transfer, without proper documentation or referral from their original primary care facility) or have died for which there is no documentation. Every effort should be made to document the more concreate outcomes for those not on ART (i.e. died, stopped ART, transfer out) to make the information more useful.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Report 12 months of results at Q4</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">• TX_RET Denominator ≥ TX_RET Numerator
• Denominator ≥ subtotal of each disaggregation
○ The total number of adults and children who initiated ART in the past 12 months should be greater or equal to the sum of the disaggregations by (1) Pregnancy/breastfeeding status and (2) age/sex
• Numerator ≥ subtotal of each disaggregation
○ The total number of adults and children still on treatment at 12 months should be greater or equal to the sum of the disaggregations by (1) Pregnancy/ breastfeeding status and (2) age/sex
• Number of PEPFAR supported sites that report TX_RET vs number of sites that report TX_CURR by region to determine completeness of reporting</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">Use result reported at Q4/APR; Numerator should be divided by denominator to determine % retained;
% retained for pregnant and breastfeed women; as well as children <15 % retained should be calculated separately and used to assess these programs.</td></tr>
<tr><td>Reporting level</td><td colspan="4">Site level, facility only</td></tr>
<tr><td rowspan="4">Data Elements (Components of indicator)</td><td rowspan="4">Numerator (Required):
Number of adults and children in the cohort, who are still on treatment at 12 months after initiating ART.</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Longer term retention

(Optional)</td><td>24, 36 month</td><td>Although optional, it is recommended for sites to include their longer term ART retention numbers (including 24 and 36 months);</td></tr>
<tr><td>Pregnant/Breast Feeding

(Required)</td><td>Pregnant; Breastfeeding</td><td>Pregnancy and Breastfeeding status is defined as the status at the date of initiation on ART, not the status at the date of reporting.</td></tr>
<tr><td>Age/Sex (Fine Disaggregate)</td><td><1, 1-9, 10-14 M, 10-14 F,</td><td>Age is defined as the age at the date of initiation</td></tr>
</table>

			15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49,M 25-49F, 50+ M, 50+ F	on ART, not the age at the date of reporting.
		Age/Sex (Course Disaggregate)	<15 M, <15 F, 15+ M, 15+ F	This disaggregation should only be entered if finer age disaggregates are not available.
	Denominator: Total number of adults and children who initiated ART in the in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up during the subsequent 12 months.	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Longer term retention **(Optional)**	24, 36 month	Although optional, it is recommended for sites to include their longer term ART retention numbers (including 24 and 36 months);
		Pregnant/Breast Feeding **(Required)**	Pregnant; Breastfeeding	Pregnancy and Breastfeeding status is defined as the status at the date of initiation on ART, not the status at the date of reporting
		Age/Sex (Fine Disaggregate) **(Required)**	<1, 1-9, 10-14 M, 10-14 F, 15-19 M, 15-19 F, 20-24 M, 20-24 F, 25-49,M 25-49F, 50+ M, 50+ F	Age is defined as the age at the date of initiation on ART, not the age at the date of reporting.
		Age/Sex (Course Disaggregate) **(Conditional)**	<15 M, <15 F, 15+ M, 15+ F	This disaggregation should only be entered if finer age disaggregates are not available.
PEPFAR Support definition	Standard definition of DSD and TA-SDI used Provision of key staff or commodities for PLHIV receiving ART include: the provision of key staff and/or commodities can include ongoing procurement of critical commodities, such as ARVs, or funding for salaries of HCW who deliver HIV treatment services. Staff who are responsible for the completeness and quality of routine patient records (paper or electronic) can be counted here; however, staff who exclusively fulfill MOH and donor reporting requirements cannot be counted.			

	Ongoing support for PLHIV receiving ART service delivery improvement includes: clinical mentoring and supportive supervision of staff at HIV sites providing ART, support for quality improvement activities, patient tracking system support, routine support of ART M&E and reporting, commodities consumption forecasting and supply management
DREAMS SNU Specific Guidance	None

TX_PVLS		
Description:	Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)	
Numerator: (Required)	Number of adult and pediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and /or supporting laboratory results within the past 12 months	If there is more than one VL test during the last 12 months, report the most recent test.
Denominator (Required)	Number of adult and pediatric ART patients with a viral load result documented in the patient medical record and /or laboratory records in the past 12 months.	
MER 1.0 to 2.0 Change	Revised Indicator combines TX_VIRAL and TX_UNDETECT. The indicator now requires the suppressed viral load result to be documented in the clinic patient record and only use the laboratory system for results if it can be linked back to the individual patient file. Age/Sex disaggregates align across the clinical cascade.	
How to use:	This indicator monitors the proportion of documented viral load tests from adult and pediatric ART patients with a suppressed result (<1,000 copies/ml), allowing ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression. Comparison of the denominator for this indicator with the result for TX_CURR can be used to estimate viral load testing coverage supported by PEPFAR.	
How to collect:	This indicator should be collected from the clinical source to assure unduplicated patient counting and receipt of results to inform patient care. Information should come from electronic systems (EMR) if possible. Where electronic systems do not exist patient registers can be used to count patients and VL collected/sent VL test (denominator) or VL results (numerator). If the standard registers or reports do not contain all the required information, individual patient files should be reviewed. To determine if a lab test was collected/sent additional supporting information for this indicator can be obtained from standard laboratory information systems (including electronic systems or paper-based registries or logbooks), but the viral load test submission and result must be able to be linked to specific patient. **NOTE:** IF the patient file does not include this information (collected/sent VL test or VL results) but the information was reported from the laboratory information system; then it is strongly recommended that IP ensure that this information is transcribed to the patient file for improved quality care and treatment services. This indicator should be reported for all PEPFAR supported treatment sites (reported TX_CURR and TX_NEW) with VL monitoring to promote site level use and reporting of patient viral suppression information. If a PEPFAR supported treatment site has not conducted any viral load testing, a 0 should be entered for both the denominator, as well as the numerator. Where more than one result is	

<table>
<tr><td></td><td colspan="4">available for the reporting period, the most recent result should be reported. If viral load sample has been sent for testing, but no result has been recorded, this should not be included in the numerator or denominator of this indicator. Programs should describe the method(s) of data collection in their APR narratives, along with describing methodology for de-duplication of results.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Report 12 months of results at Q4</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">• Denominator ≥ Numerator
o The number of viral load tests performed from adults and children on ART must be greater than or equal to the number of viral load tests from adult and pediatric ART patients with a viral load <1,000 copies/ml.

• Numerator ≥ subtotal of each disaggregation
o The total number of viral load tests from adult and pediatric ART patients with a viral load <1,000 copies/ml should be greater than or equal to the sum of all of the disaggregation by age/sex, pregnancy/breastfeeding status, and test indication.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">This will be collected only at Q4/APR</td></tr>
<tr><td>Reporting Level</td><td colspan="4">Site level, facility only</td></tr>
<tr><td rowspan="2">Data Elements (Components of indicator)</td><td rowspan="2">Numerator (Required): Number of adults and pediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and /or laboratory records/systems within the past 12 months</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>Indication (Required)</td><td>Routine, Targeted, Not Documented</td><td>Routine; Refers to viral load tests obtained at standard intervals following ART initiation to monitor virologic response to ART (Timing is dependent on the National guidelines, but should be recommended to occur at least annually).

Targeted; refers to viral load tests obtained based on a specific clinical indication, e.g., concern about disease progression or failure to respond to ART. This includes repeat</td></tr>
</table>

				viral loads done after a VL>1000. Not documented; not indicated in the patient file, registry, or log book whether this test was targeted or routine.
		Pregnant/Breast Feeding Indication **(Required)**	Pregnant Routine; Breastfeeding Routine; Pregnant Targeted; Breastfeeding Targeted	
		Age/Sex/Indication (Fine Disaggregate) **(Required)**	<1 Routine, 1-9 Routine, 10-14 M Routine, 10-14 F Routine, 15-19 M Routine, 15-19 F Routine, 20-24 M Routine, 20-24 F Routine, 25-49 M Routine, 25-49 F Routine, 50+ M Routine, 50+ F Routine, <1 Targeted, 1-9 Targeted, 10-14 M Targeted, 10-14 F Targeted, 15-19 M Targeted, 15-19 F Targeted, 20-24 M Targeted, 20-24 F Targeted, 25-49 M Targeted, 25-49 F Targeted, 50+ M Targeted, 50+ F Targeted;	
		Age/Sex/Indication (Coarse Disaggregate) **(Conditional)**	<15 M Routine, 15+ M Routine, <15 F Routine, 15+F Routine, <15 M Targeted, 15+ M Targeted, <15 F Targeted, 15+F Targeted	This disaggregation should only be entered if finer age disaggregates are <u>not</u> available.

	Denominator (Required): Number of adult and pediatric ART patients with a viral load result documented in the patient medical record and /or laboratory records in the past 12 months.	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Indication **(Required)**	Routine, Targeted, Not Documented	Routine; Refers to viral load tests obtained at standard intervals following ART initiation to monitor virologic response to ART (Timing is dependent on the National guidelines, but should be recommended to occur at least annually). Targeted; refers to viral load tests obtained based on a specific clinical indication, e.g., concern about disease progression or failure to respond to ART. Not Documented; not indicated in the patient file, registry, or log book whether this test was targeted or routine.
		Pregnant/Breast Feeding Indication **(Required)**	Pregnant Routine ; Breastfeeding Routine; Pregnant Targeted ; Breastfeeding Targeted	

		Age/Sex/Indication (Fine Disaggregate) **(Required)**	<1 Routine, 1-9 Routine, 10-14 M Routine, 10-14 F Routine, 15-19 M Routine, 15-19 F Routine, 20-24 M Routine, 20-24 F Routine, 25-49 M Routine, 25-49 F Routine, 50+ M Routine, 50+ F Routine, <1 Targeted, 1-9 Targeted, 10-14 M Targeted, 10-14 F Targeted, 15-19 M Targeted, 15-19 F Targeted, 20-24 M Targeted, 20-24 F Targeted, 25-49 M Targeted, 25-49 F Targeted, 50+ M Targeted, 50+ F Targeted; <1 Not documented, 1-9 Not documented, 10-14 M Not documented, 10-14 F Not documented, 15-19 M Not documented, 15-19 F Not documented, 20-24 M Not documented, 20-24 F Not documented, 25-49 M Not documented, 25-49 F Not documented, 50+ M Not documented, 50+ F Not documented	
		Age/Sex/Indication (Coarse Disaggregate)	<15 M Routine, 15+ M Routine, <15 F Routine, 15+F Routine, <15 M Targeted, 15+ M Targeted, <15 F Targeted, 15+F	This disaggregation should only be entered if finer age disaggregates are <u>not</u> available.

		(Conditional)	Targeted; <15 M Not documented, 15+ M Not documented, <15 F Not documented, 15+F Not documented	
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			
DREAMS SNU Specific Guidance	None			

PEPFAR

Health Systems

MER 2.0

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 only 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	
MER 1.0 to 2.0 Change	No change from MER 1.0	
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/institutions 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. **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. Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted. A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. 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.

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- 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 graduates networks.
</td></tr>
<tr><td>How often to report:</td><td colspan="4">Reporting is done once a year. Data should be collected continuously at the institution level (or community level). Data analysis and review should be done regularly to monitor progress towards achieving the targets, and to identify and correct any data quality issues.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">N/A</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">N/A</td></tr>
<tr><td>Reporting Level</td><td colspan="4">OU Implementing mechanism</td></tr>
<tr><td rowspan="4">Data Elements (Components of indicator)</td><td rowspan="2">Numerator (required): Number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>By cadre (required)</td><td>Doctors, nurses, midwives, social service workers, laboratory professionals, other</td><td>This is not an exhaustive list of all health workers and position titles may vary from country to country.</td></tr>
<tr><td rowspan="2">Denominator
N/A</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>N/A</td><td>N/A</td><td>N/A</td></tr>
</table>

PEPFAR Support definition	As an above site indicator, the PEPFAR support categories of DSD and TA-SDI do not apply. To report results for this indicator, it is expected that PEPFAR provides support for this activity as defined below. New health worker graduates of pre-service training institution or program will be counted as PEPFAR supported when: PEPFAR is supporting the training of new health worker graduates, including: • Tuition and fees - At least 50% of the students' tuition and fees were or will be provided by PEPFAR for at least six months of their education • Curriculum development - The students received or will receive training where PEPFAR curriculum development was essential to qualify them for their trained role • Infrastructure - The students received or will receive six months or more of education at an institution that could not have supported their education without PEPFAR-supported infrastructure improvements (classrooms, dormitories, utilities) • Faculty support - The students received or will receive six months of more of education at an institution that could not have supported their education without one or more faculty members present and qualified due to PEPFAR support • Practica / internship support - The students would not have received or will not receive adequate practica or internship training without PEPFAR support (including transportation to or sufficient resources at the practicum facility) • Materials / equipment - The students would not have received or will not receive education without materials or equipment (including books and supplies) provided by PEPFAR • PEPFAR educational programs (for non-university-based training institutions) - The students received or will receive their education in a PEPFAR-funded, non-university-based education program for one or more courses without which they would not graduate or be qualified for the intended role • Please refer to the HRH flowchart and worksheet for further information (https://www.pepfarii.net/twg/hrh/SitePages/Home.aspx)
DREAMS SNU Specific Guidance	None

HRH_CURR	
Description:	Number of health worker full-time equivalents who are working on any HIV-related activities i.e. prevention, treatment and other HIV support and are receiving any type of support from PEPFAR at facility and sites, community sites, and at the above-site level.
Numerator and denominator	*Not applicable: This indicator is neither a numerator nor a denominator.*
	Definition For this indicator, health workers who receive any type of support from PEPFAR, including monetary (i.e., salary, overtime, stipends) and non-monetary support should be counted. **Monetary:** PEPFAR monetary support includes any monetary contribution toward a total salary and stipend payments. **Non-monetary support** includes any type of non-currency support for which PEPFAR incurs an expense that provide a tangible benefit to the health worker and / or their work; examples include but are not limited to: mobile phone credits, meals, general modes of transportation like bicycle or motorbike, job aids or equipment that can be used outside of HIV or in other jobs (such as in private practice), or other in-kind support. This indicator is the number of full-time equivalent positions (FTE) working on HIV ("HIV FTE"). Calculate part-time positions working exclusively on HIV, or full-time positions working on several areas including HIV and other illnesses, as fractions, based on hours worked relative to full-time equivalency hours. Full time equivalency hours should be the standard listed in the cadre's scheme of service and/or Ministry of Health guidelines. The methodology for calculating this is consistent with Expenditure Analysis (EA) Guidance. - For example, four PEPFAR-supported health workers who each work on average 25% of the work week (independent of variations in the hours worked per week by each worker) on HIV would contribute 1.0 FTE. - PEPFAR may support a doctor's full salary who works full-time with time distributed among five communities – you would then allocate her time as 0.2 FTEs per site. This would also apply to workers who split their time between community and facility. Only count the year in which PEPFAR expended resources to provide the support; for example, providing a bike for a community worker would only be counted the year the bike was received.

MER 1.0 to 2.0 Change	HRH_CURR was previously reported at the facility site and community site levels by type of cadre and type of support. Above site workers are now included in this indicator.
How to use:	Many countries experience HRH shortages and/or imbalances by population density (e.g., HRH shortages in rural areas) that are not related to population health needs, including HIV epidemiology; addressing density and distribution of HRH is important in increasing access to HIV services. In many PEPFAR countries, there are overall shortages of HRH, particularly in rural and remote areas, leading to insufficient numbers of health workers according to internationally recommended levels (2.3 doctors, nurses, midwives/1,000 population). There are also countries where there is large overproduction of health workers, with medical unemployment in urban areas, and at the same time with shortages in rural areas. Furthermore, different types of health workers receive different types and amounts of support that may vary by geographic location, cadre, workload, and other factors. Understanding the ways in which different cadres are supported is important for mobilizing differential models of service delivery under different circumstances. This indicator measures the person-time that PEPFAR-supported health workers contribute to providing HIV services at facility and community sites. It allows us to track our level of support and continuously calibrate it based on impact. It also allows us, over time, to measure the transition from PEPFAR support to host country support.
How to collect:	Data on total numbers of positions or FTEs supported should be tracked by implementing partner's record-keeping systems, for example, personnel databases, human resources records, and financial records that show salary or stipend payments, including information on non-monetary support to volunteers. Leverage the same records and systems partners already use to report dollar amounts for EA reporting, to identify PEPFAR support of HRH. Hours worked on HIV may be estimated using staff work-week scheduling calendars and HIV clinic/lab opening hours, and speaking with facility in-charges. For community sites, hours worked on HIV can be estimated using average beneficiary consultation times, and average number of consultations. For non-monetary supported personnel, partners should cross-reference expense reports and registers against the cadre types who received the corresponding non-monetary benefits. For example, receipts showing meals were provided during meetings could be cross-referenced with the attendance listed in the minutes for community lay workers. Facility and community workers are reported by IM, Site ID, facility and community site affiliation, and cadre type. All PEPFAR-supported workers at the facility and community should be reported. Above-site support may include Ministry of Health or other government staff who

	work at the district or provincial level, or at the national level, including Ministry of Health office, National Reference Laboratories, or at national research centers not otherwise providing HIV services directly to beneficiaries.	
How often to report:	**Annual:** Data should be reported in the fourth quarter of the year from retrospective review of HRH and expenditure systems or records. We recommend using the HRH inventory tool, which facilitates FTE calculations by further breaking out the broad cadre categories into more specific cadre types (such as doctors, nurses, lab technicians, etc.).	
Deduplication	When more than one PEPFAR implementing mechanism is supporting an overlapping group of health workers at the same site, partners must work with their strategic information (SI) advisors to undertake deduplication similar to other indicators. Identify which health worker support is fully duplicated (both mechanisms funding the same staff), partially duplicated (some staff are funded by one mechanism, some staff funded by both, and some funded by none), or not duplicated (both mechanism fund completely different staff). For example if one mechanism funded 5.0 FTE among five staff, and a second mechanism funded 2.5 FTE among the same five staff persons, a deduplication adjustment of -2.5 FTE must be made in DATIM.	
How to calculate annual total:	Data should capture health workers for whom PEPFAR provided support in the same reporting period (fiscal year), and who have not been transitioned by the end of the fiscal year. Unfilled positions or vacancies should not be included.	
Reporting Level	Above site (OU Implementing partners/ Priority SNU), site level, both facility and community	
Data Elements (Components of indicator)	**Disaggregate Groups (Required)** By cadre category (For facility and community level)	**Description of Disaggregate** **Clinical** Clinical workers are those who provide a direct clinical service to clients: (Clinical professionals, including doctors, nurses, midwives, clinical officers, medical and nursing assistants, auxiliary nurses, auxiliary midwives, testing and counseling providers. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.) **Clinical support** Clinical Support workers are those who support clinical services at the site but do not directly provide services to clients: (Pharmacists, medical technologists, laboratorians, lab and pharmacy technicians) **Management** Management workers are those who provide support to the site for administrative needs but not directly provide services to clients:

		(Facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support.) **Social service** Social Service workers are those who have advanced training in social services and provide services directly to clients: Social service workers including social workers, child and youth development workers, social welfare assistants. **Lay** Lay workers are those who have non-clinical training and provide services directly to clients: (Health workers who provide important services for the continuum of care within facilities and/or communities. These include (but are not limited to) adherence support, mother mentors, cough monitors, expert clients, lay counselors, peer educators, community health workers and other community-based cadres) **Other** Workers who do not fit into any of the categories above. For all categories of workers, please provide description of specific cadres in the narrative when reporting.
	By cadre category (for above-site)	**Management central level** Management central level are those staff supporting management functions at national level. Examples may be development and implementation of policies, guidelines, quality standards, health or HIV budgeting and financing. The work of these staff have a national scope and affect all (or multiple) districts or regions. **Management local area** Management local unit are those staff supporting management functions for one geographic area at the sub-national level. Examples may include district-level health planning and coordination, district-level quality improvement, training or mentoring (e.g. district health office, provincial coordinating authority) **Faculty** Faculty (Tutors and Trainers) are those staff working at pre-service institutions and training centers/departments. **Epi/surveillance** Epi/Surveillance staff are those collecting and/or analyzing HIV epidemiologic data at the above site level. This may include making national or district-level estimates of PLHIV or key

		populations, incidence modeling, ANC or sentinel surveillance, integrated behavioral and biological surveys, drug resistance estimates. **Other** Other types of staff not covered by the above categories.
	(Required) By site-level cadre and by type of support provided by PEPFAR to the staff	For each cadre category supported by PEPFAR at the site level, further disaggregate the HIV FTE by the type of support provided by PEPFAR. The total HIV FTE should equal the sum of the HIV FTE by three types of support. Do not disaggregate above-site cadre category FTE by type of support. Salary – *Total number of HIV FTE positions for which PEPFAR is providing any level of financial support toward their regular salary.* Include all HIV FTE (all person-time spent on HIV) if any amount of salary support is provided, even if they also receive support from sources other than PEPFAR. This represents the total FTE that are "touched" by PEPFAR salary support. PEPFAR salary support is any ongoing monetary contribution bench marked toward a total salary which is benchmarked toward, a government salary scale or international salary standard). A salary is characterized by being disbursed at regularly scheduled intervals in expected denominations. Stipend – *Total number of HIV FTE positions for which PEPFAR does not provide salary support but does provide monetary payments in connection with the provision of HIV services*. Stipend payments are not necessarily disbursed in regularly scheduled intervals, and are not necessarily commensurate with, nor benchmarked toward, a government salary scale or international salary standard. These include one-time reimbursements for expenses connected to travel or training (per diems); and supplementary payments, for example, for overtime worked due to HIV case burden. Payment could be made at regular intervals depending on agreement. Non-monetary only – *Total number of HIV FTE positions for which PEPFAR provides only non-monetary support.* Report if PEPFAR provides only non-monetary forms of support that do not involve currency, in connection with or in support of the provision of HIV services. These include mobile phone credits, meals, general modes of transportation like bicycle or motorbike, job aids or equipment that can be used outside of HIV or in other jobs (such as in private practice), or other in-kind support. Include volunteers who work on HIV and receive only non-monetary support from PEPFAR.

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

PEPFAR Support definition	As an above site 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 (as defined in the "type of support") for the cadres listed above.
DREAMS SNU Specific Guidance	None

HRH_STAFF		
Description:	Number of health worker full-time equivalents who are working on any HIV-related activities i.e. prevention, treatment and other HIV support at PEPFAR-supported facility sites	
Numerator	Total number of health care workers working in HIV service delivery at PEPFAR-supported facility sites	This indicator is the number of full-time equivalent positions (FTE) working on HIV ("HIV FTE") at PEPFAR facility sites. Calculate part-time positions working exclusively on HIV, or full-time positions working on several areas including HIV and other illnesses, as fractions, based on hours worked relative to full-time equivalency hours. Full time equivalency hours should be the standard listed in the cadre's scheme of service and/or Ministry of Health guidelines. This is NOT a cumulative total, but a one-time count undertaken during the final quarter. Only filled staff positions at respective facility should be counted. A "PEPFAR supported site" for the purpose of this indicator should include any facility site in the PEPFAR geographic organizational hierarchy list in DATIM, which also reported any site-level programmatic target or result during the same reporting period. Omit community sites. Omit facilities which were previously supported by PEPFAR, but were not assigned any targets nor reported any results for any program area during the same reporting period. Include all health care workers irrespective of whether any or all are receiving PEPFAR support (PEPFAR support is captured in HRH_CURR.)
Denominator	*N/A*	
MER 1.0 to 2.0 Change	New indicator	
How to use:	HIV/AIDS has placed significant demands on the already constrained health workforce in many low-income countries. The rapid scale-up of ART is placing additional demands on the health workforce. In the majority of PEPFAR countries, there are overall shortages of HRH, particularly in rural and remote areas, leading to insufficient numbers of health workers according to internationally recommended levels (2.3 doctors, nurses, midwives/1,000 population). Many countries experience HRH shortages and/or imbalances by population densities (e.g., HRH shortages in rural areas) that are not related to population health needs, including HIV epidemiology. Addressing density, distribution, and overall utilization of HRH is important in increasing access to HIV services.	

	This indicator allows PEPFAR to analyze the availability of staff to provide HIV services at PEPFAR supported facilities. Data should be reviewed against site target achievement and investment. The first year of data collection will serve as an Integral benchmark for continued analysis. Teams can also look at this indicator in conjunction with HRH_CURR that captures number of PEPFAR supported workers at PEPFAR-supported sites. This will allow PEPFAR to conduct analysis to determine if the number of PEPFAR-supported staff is appropriate vis-à-vis the number of other staff at the facility providing HIV services. There is no universal benchmark against which to measure these data and no ideal PEPFAR to non-PEPFAR ratio. However, over time we would hope to see a decrease in the number of PEPFAR-supported staff. As this happens countries should carefully monitor any changes total number of staff working in HIV service delivery at sites and quality of services.
How to collect:	To guide quality of data collection, a data collection template has been provided and posted to PEPFAR.net that gathers key data on the inventory or numbers of health care workers at each facility supporting HIV service delivery. PEPFAR team or Implementing Partners (IP) should collect and report on this data during the last quarter of the year. The data collection template is a component of a rapid site level health workforce assessment tool developed by the PEPFAR HRH TWG, aligned with the first objective of the PEPFAR HRH Strategy. Where possible utilization of the entire rapid site-level health workforce assessment tool is encouraged to get a more comprehensive set of site-level HRH data that goes beyond what is required for HRH_STAFF. Designate one IP per site to collect HRH_STAFF. If more than one IP is working at the same PEPFAR supported facility, teams should determine which IP will collect data for HRH_STAFF and/or undertake the fuller rapid HRH site-level assessment. Country teams need to collect data from all PEPFAR-supported irrespective of PEPFAR's financial support of health workers at a particular site (as captured by HRH_CURR.) Number of health workers reported should be expressed as full-time equivalency (FTE) positions as outlined in data collection template, including part-time health workers or health workers who work part-time on HIV, expressed as fractions of FTE corresponding to estimated hours worked on HIV per week out of total hours per week prescribed as full-time for that cadre in the national scheme of service, or other Ministry of Health guidelines. - Report HRH who are actually 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.			
How often to report:	**Annual** Data should be reported in the fourth quarter of the year as a compilation of cross-sectional snapshots at each site.			
How to review for data quality:	N/A			
How to calculate annual total:	This will be collected only at Q4/APR			
Reporting Level	**Site level, facility only** For the purpose of this indicator 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.			
Data Elements (Components of indicator)		**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregates**
	Total number of health care workers working in HIV service delivery at facility sites **(Required)**	By cadre **(Required)**	Clinical Clinical Support Management Social Service Lay Other	Clinical workers are those who provide a direct clinical service to clients: (Clinical professionals, including doctors, nurses, midwives, clinical officers, medical and nursing assistants, auxiliary nurses, auxiliary midwives, testing and counseling providers. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.) Clinical Support workers are those who support clinical services at the site but do not directly provide services to clients: (Pharmacists, medical technologists, laboratorians, lab and pharmacy technicians) Management workers are those who provide support to the site for administrative

				needs but not directly provide services to clients: (Facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support.) Social Service workers are those who have advanced training in social services and provide services directly to clients: Social service workers including social workers, child and youth development workers, social welfare assistants. Lay workers are those who have non-clinical training and provide services directly to clients: (Health workers who provide important services for the continuum of care within facilities and/or communities. These include (but are not limited to) adherence support, mother mentors, cough monitors, expert clients, lay counselors, peer educators, community health workers and other community-based cadres) Other – workers who do not fit into any of the categories above.
PEPFAR Support definition	As an above site 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 to the HIV service delivery area. A "PEPFAR supported site" for the purpose of this indicator 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. Every PEPFAR-supported site should report total number of health care workers working in HIV service delivery.			
DREAMS SNU Specific Guidance	*Only list what is different in DREAMS SNU's than in other SNUs*			

EMR_Site	
Description:	Number of PEPFAR-supported facility-based service delivery points supported by your organization that have an electronic medical record system
Numerator:	Number of PEPFAR-supported facility-based service delivery points supported by your organization that have an electronic medical record system. (Record answer separately for each service delivery point)
Denominator	N/A (This is not collected as part of this indicator; however should be the total number of PEPFAR supported active service delivery points (those sites that reported either targets or results for the service delivery area at each site).
MER 1.0 to 2.0 Change	This is a new indicator for MER 2.0 and is the first MER SI indicator to capture PEPFAR strategy information systems investments.
How to use:	This indicator can be used as a cross-sectional indicator at Q4. It can be used to better understand our investments in Strategic information; and to support the understanding of data quality for other indicators. Timely access to up-to-date patient information plays a vital role in the provision of effective clinical care by health professionals. Diagnosis and treatment can be improved if health professionals have easy access to accurate and comprehensive medical records of patients.
How to collect:	- The partner should indicate whether the **PEPFAR-Supported** service delivery areas listed below have implemented and are actively using an electronic medical record system (also known as electronic patient tracking systems). (EMR/EPTS) to assist clinical service provision or for patient or 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 can be set up in Sept 2016, and contain at least 6 months of retrospective data (current patients that have been enrolled on ART) and can be included for Q4 reporting. - The partner should indicate whether the **PEPFAR-Supported** service delivery areas listed below have **NOT** implemented an EMR/EPTS - This should be used if the site has this service delivery area, but the partner does not support these services; OR the site does not include this service (N/A). **NOTE:** If a service is offered at the site but integrated into another service delivery point do not record N/A, but rather document whether the EMR/EPTS at that site is inclusive of those services *(for example this site does not have PEPFAR funded targets for the service delivery area).* Definition of an Electronic Medical Record (EMR):

	An EMR/EPTS is a ***longitudinal*** electronic record of an individual patient's health information that can assist health professionals with decision-making and treatment. Data found in a record may include patient demographics, past medical history, vital signs, examination and progress notes, medications, allergies, immunizations, laboratory test results, other test results. It can also support the collection of data for other uses such as quality management, public health disease surveillance and reporting. < WHO: Global Observatory for eHealth > EMR can include real-time point-of-care data entry as well as retrospective data entry. An electronic medical record (EMR) is a digital version of a paper chart that contains key information in a patient's medical history from one service delivery point or site. Individual SDP 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 focusses its work (presented in the disaggregation below). If a service delivery area is incorporated in a larger integrated health EMR, then it should be included this indicator. If two or more service areas are in an integrated EMR, both areas should be included in this indicator. A site service delivery area should be included in this indicator if the EMR is on site (Server and Computer entry screen or there is a central server at a hub facility, that includes all data from all the "spokes" for that facility's catchment area. As long as the data for patient management and reporting comes from the EMR system as one source. Registries: Some sites maintain types of e-Register (which might provide basic functionality like reporting, default tracing, etc), however, if they do not capture ***longitudinal*** clinical information, they should not be included in this indicator.			
How often to report:	Reported at Q4			
How to review for data quality:	If a site does not report ART (PEPFAR-supported ART site), then it should not be included as having a function-able, working ART EMR; but should be included in N/A. Number of service delivery area with an EMR should not exceed the number of service delivery areas reporting results/targets.			
How to calculate annual total:	This indicator can be used as a cross-sectional indicator at Q4, to determine the number of function-able, working EMR supporting clinical management and data reporting in the PEPFAR- support sites.			
Reporting Level	Site level, facility only			
Data Elements (Components of indicator)	Number of PEPFAR-supported facility service delivery points supported by your organization that have an electronic medical record system.	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		Service delivery point	**HIV testing Services** **Care and Treatment** **ANC** **EID** **HIV/TB**	See "how to collect"

PEPFAR Support definition	As an above site 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 to the HIV service delivery area. PEPFAR does NOT have to have supported the development of the EMR at the site to be counted. EMRs supported by other donors or Ministries of Health should be included in this indicator. It is highly recommended that service delivery areas that have functional EMRs use these both for patient management as well as reporting. **Definition : what is a PEPFAR supported site for the purpose of this indicator**: A "PEPFAR supported site" for the purpose of this indicator should include any facility site in the PEPFAR master facility list in DATIM which also reported any programmatic target or result during the same reporting period. **Definition: PEPFAR-Supported Service Delivery Point at a site for the purpose of this indicator** A PEPFAR-supported facility-based service delivery point uses PEPFAR funds to provide HIV-related services. It offers one or more HIV-related services including but not limited to: HIV testing and counseling; prevention of mother-to-child transmission of HIV (PMTCT); anti-retroviral treatment (ART) and TB/HIV services. Examples include different HIV services within clinics, hospitals, health facilities and community-based organizations (government, private or NGO). These can also include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. PEPFAR service delivery points for EMR 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. 2. Treatment services – this includes services where ART is initiated and monitored. 3. Antenatal/maternity services– HIV Testing and treatment in an ANC and/or maternity setting 4. 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 5. 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 If services are integrated, for example EID as part of the Treatment services, then as long as EID is captured in the treatment services EMR or a separate EMR for EID is available within these services, then this would be counted as an EID EMR as well.
DREAMS SNU Specific Guidance	None

<table>
<tr><th colspan="3">LAB_PTCQI (Lab)</th></tr>
<tr><td>Description:</td><td colspan="2">Number of laboratories and blood centers/banks:

A. Engaged in Continuous Quality Improvement (CQI) activities
B. Audited and achieved accreditation
C. Performing an HIV-related test and participating in and passing Proficiency Testing (PT)</td></tr>
<tr><td>Numerator</td><td>Number of laboratories and blood centers/banks:

A. Engaged in Continuous Quality Improvement (CQI) activities
B. Audited and achieved accreditation
C. Performing an HIV-related test and participating in and passing Proficiency Testing (PT).</td><td>A. Number of PEPFAR-supported laboratories and blood centers/banks either participating in/and not participating in a CQI program to achieve accreditation.

B. Number of PEPFAR-supported laboratories and blood centers/banks which have been externally audited but do not meet full accreditation standards, and the number which are fully accredited.

C. Number of laboratories and blood centers/banks performing any of following tests: HIV Diagnosis, Early Infant Diagnosis (EID), HIV viral load, TB Xpert, TB Acid-fast bacillus (AFB) smear, or TB culture. If performing the analyte-specific test, the number of laboratories and blood centers/banks participating in and passing PT test for the analyte-specific test.</td></tr>
<tr><td>Denominator</td><td colspan="2">N/A</td></tr>
<tr><td>MER 1.0 to 2.0 Change</td><td colspan="2">This indicator is a combination of LAB_PT and LAB_CQI.</td></tr>
<tr><td>How to use:</td><td colspan="2">This indicator identifies which PEPFAR-supported laboratories and blood centers/banks are, or are not, actively engaged in an international, national, or regionally-recognized process for CQI and demonstrating measured improvement towards accreditation.

A PEPFAR-supported laboratory or blood center/bank is defined as:

<u>A laboratory is defined as:</u>
A) Having dedicated physical laboratory infrastructure
B) Having dedicated trained laboratory professionals performing testing.</td></tr>
</table>

C) Conducting laboratory testing in one or more of the following areas:
    a. Diagnosis of HIV infection with EIA or molecular methods
    b. HIV care and treatment monitoring with CD4 testing or HIV viral load
    c. Early Infant Diagnosis (EID)
    d. Hematology
    e. Clinical chemistry
    f. Serology
    g. Microbiology
    h. Blood banking
    i. TB diagnostics
    j. Malaria infection diagnostics
    k. STI diagnostics
    l. OI (Opportunistic Infection) diagnostics, including *Cryptococcal* antigen

Note: A laboratory, as define above, that uses POCT type assays (such as the Pima or rapid diagnostic tests) are to be counted as a laboratory.

<u>Blood centers/banks:</u>

A) Performs any service involved in blood donor recruitment, blood and plasma collection, testing, processing, storage, and distribution of blood and blood products.
B) Blood banks/centers may exist within a laboratory and should be counted as a laboratory.

A laboratory or blood center/bank should be counted for engaged activities supported by a recognized external CQI or accreditation preparedness program which is a national or regionally-recognized continuous quality improvement process towards meeting international standards. For laboratories, accreditation program may be a stepwise laboratory quality improvement approach 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). For blood centers/banks this may be participation in an internationally-recognized accreditation program such as the African Society for Blood Transfusion (AfSBT).

Laboratories enrolled and have achieved the minimum level of recognition (audit score) in a nationally or regionally-recognized continuous quality improvement program using the country or region's equivalent to the WHO AFRO SLIPTA Checklist (i.e., a laboratory with at least one star on the WHO AFRO SLIPTA checklist or at least tier one level of the CDC/PAHO LQMS-SIP checklist) by a qualified external auditor. Similar organizations or bodies in other regions or countries may issue this recognition under their respective continuous quality improvement program. While enrollment in a CQI program is critical, all laboratories are not expected to be accredited.

Full accreditation is achieved when the laboratory or Blood bank/center is recognized by an accrediting organization as to meeting the standards to achieve full

	accreditation. Accreditation must be maintained and not expired to be counted. Countries are encouraged to monitor the number of laboratories and testing sites performing HIV-related testing as well as the capacity of these sites. This effort seeks to evaluate PEPFAR support for laboratory capacity that will provide access to high quality, rapid, affordable diagnostic tests for care, treatment, prevention, and surveillance for HIV/AIDS. Participation in PT programs can help monitor and improve the quality of HIV-related testing at the testing sites. This indicator will encourage countries to implement a PT program if none exists, expand the PT program to cover all HIV testing sites, and will help improve quality of diagnostic and monitoring testing at all sites. The PT program is not intended to be punitive; the PT data is used for targeted technical assistance and improving overall quality of testing. The purpose is to determine the following: 1. Laboratories and blood centers/banks that are doing the HIV-related testing 2. Laboratories and blood centers/banks that are participating in a PT program specific for each test. 3. Laboratories and blood centers/banks achieving successful passing criteria on the most recent PT panel. This will be specific to each test, as specified in the disaggregation.
How to report indicator:	A PEPFAR-supported site should be allocated as either a **Laboratory or Blood Bank/Center or Point-of-Care Testing site or both.** Note: A laboratory and POCT may both be present at a facility site. Note: A laboratory, as defined above, that uses POCT type assays (such as the Pima or rapid diagnostic tests) are to be counted as a laboratory.
How to collect:	Site level data for all laboratories and blood centers/banks to indicate enrollment and recognition in a CQI program are obtained from program records of the PEPFAR-funded partners. Site level documentation of being audited by an external auditing agency and scores to indicate if quality standards are met and accreditation achieved. Site level information from test directory for HIV-related tests perform plus site level documentation of participation in a PT program and passing (satisfactory or successful) scores on the latest PT panel.
How often to report:	Q4 only
How to review for data quality:	See how to report indicator
How to calculate annual total:	Q4 only.

Reporting Level:	Site level, Facility only			
Data Elements (Components of indicator)	**Numerator (required)**: Number of laboratories and blood banks/centers	**Disaggregate Groups**	**Disaggregates**	**Description of Disaggregate**
		CQI	*Is this PEPFAR-supported Laboratory or Blood Bank/Center participating in a continuous quality improvement (CQI) program to achieve accreditation*?	Yes No N/A
			What is the current status of this laboratory or Blood Bank/Center toward achievement of accreditation, select one of the following options	(**Not Audited, Externally audited but does not meet full accreditation standards, Fully Accredited)**
			Does this PEPFAR-supported laboratory or Blood Bank/Center participate in and successfully pass Proficiency Testing (PT) for either HIV diagnosis, EID, HIV VL, or TB	*HIV diagnosis* *EID* *HIV VL* *TB*:
		Test performed **(required)**	HIV Diagnostics, EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture	
		PT participation and passing score **(required)**	HIV Diagnostics, EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture	Only applicable if specific test is performed. The most recent PT panel must be scored satisfactory to be counted as a passing score.

	Denominator *N/A*	Disaggregate Groups	Disaggregates	Description of Disaggregates
PEPFAR Support definition	**DSD:** Sites will be counted as receiving direct service delivery support from PEPFAR with provision of key staff, on-site mentoring, infrastructure, information systems, maintenance service, equipment, or commodities. **TA-SDI:** Sites will be counted as supported through TA-SDI when the point of service delivery receives support from PEPFAR that meets to improve the quality of services with trainings, mentoring, and services offered at a national or sub-national level.			
DREAMS SNU Specific Guidance	None			

INVS_COMD	
Description:	Number of HIV program related commodities purchased and dollars spent in the last 12 months
Numerator (required):	PEPFAR resources used for HIV-program related commodities: number of commodities purchased and dollars spent in the last 12 months by Implementing Partner
Denominator	N/A
How to use:	To better understand PEPFAR's financial investments in commodities and overall commodities contribution to host national programs

How to collect:	The PEPFAR dollar amount spent and absolute number of commodities purchased should be completed by every implementing partner (IP) that purchases PEPFAR- funded commodities as listed below:
	• Number of HIV Rapid Diagnostic test KITS purchased;
	  ○ Dollars spent on the purchase of HIV test kits, including HIV rapid test kits, but not EID (see below)
	• HIV CD4 reagents purchased (number of tests that can be done with the reagents) Dollar spent on the purchase of CD4 reagents
	• HIV viral load reagents purchased (including EID testing); number of tests that can be done with the reagents; Dollar spent on the purchase of VL reagents.
	• First-line HIV ARVs
	  ○ Including first-line National recommendations for the treatment of pediatric and adult patients.
	  ○ Dollars spent on the purchase of first line ARVs.
	• Second-line ARVS
	  ○ Including second-line National recommendations for the treatment of pediatric and adult patients.
	  ○ Dollars spent on the purchase of second line ARVs.
	• Number of condoms purchased and dollars spent.

How often to report:	Q4 data should be collected for this indicator.
How to review for data quality:	Compare to national investment, COP document commitment and Q4 results for testing, viral load testing, patients newly and currently enrolled on ART for triangulation. Triangulate with EA data for unit expenditure investments.

<table>
<tr><td>How to calculate annual total:</td><td colspan="4">The total dollar amount spent and absolute number of select commodities purchased during the previous 12 month reporting period (regardless of whether commodities have presently been delivered to the country program).

Expenditures should be reported using the same framework as PEPFAR Expenditure Analysis. Additional details in the Alignment and relationship to PEPFAR Expenditure Analysis section.</td></tr>
<tr><td>Reporting Level</td><td colspan="4">IM OU level</td></tr>
<tr><td rowspan="5">Data Elements (Components of indicator)</td><td rowspan="3">Numerator (required):

Number of HIV program related commodities purchased and dollars spent in the last 12 months by Implementing Partner</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>USD (with current exchange rate)

(required)</td><td>Commodity Type [Dollars planned/spent HIV Rapid Diagnostic test KITS; Dollars planned/spent HIV CD4; Dollars planned/spent HIV viral load; Dollars planned/spent condoms; Dollars planned/spent HIV ARV]</td><td>HIV test KITS; HIV CD4 reagents; HIV viral load reagents (including EID testing); Condoms, First-line HIV ARVs, Second line HIV ARVs for pediatric and adults).</td></tr>
<tr><td>Number

(required)</td><td>Commodity Type [HIV Rapid Diagnostic test KITS; HIV CD4 reagents; condoms, HIV viral load reagents; First-line HIV ARVs and Second-line HIV ARVs]</td><td>Absolute number of each commodity purchased, as costs can vary by country</td></tr>
<tr><td rowspan="2">Denominator:
N/A</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>N/A</td><td></td><td></td></tr>
<tr><td>PEPFAR Support definition</td><td colspan="4">None</td></tr>
<tr><td>DREAMS SNU Specific Guidance</td><td colspan="4">None</td></tr>
</table>

Alignment and relationship to PEPFAR Expenditure Analysis	Amount purchased and dollars spent should be reported using the same framework as PEPFAR Expenditure Analysis. Only PEPFAR expenditures should be reported. More specifically, this indicator should report any PEPFAR expenditures from eligible sources (COP funded expenditures plus those funded by central funds that support site-level targets that are not programmed through COP/ROP including TB/HIV funds, Key Population Challenge Fund, PMTCT Acceleration, Rapid Test Kit Reserves, VMMC reserves, Contraceptive fund, ACT and DREAMS). Dollars spent during the last fiscal year should be reported using a cash based of accounting and "financial expenditures" would be defined as cash disbursements from the perspective of the prime contractor or awardee. Please note: Only select commodities will be reported through MER, the total spending across MER and EA will not match (EA is comprehensive of all eligible expenditures within the last fiscal year) The total spent reported for the following disaggregates should match exactly with totals reported into the analogous EA cost categories (summed across EA program areas): HIV Test Kits, Condoms, ARVs

SC_STOCK	
Description:	Percentage of storage sites where commodities are stocked according to plan, by level in supply system
Numerator:	Number of stock status observations per tracer commodity that are between the designed minimum and maximum quantities/months of stock from storage sites at a given level (Central, Regional, etc.) of the system.
Denominator	Total number of stock status observations per tracer commodity from storage sites at a given level (Central, Regional, etc.) of the system.
MER 1.0 to 2.0 Change	Stocked According to Plan, the only change is the frequency of reporting.
How to use:	This indicator checks to see if the supply chain system is functioning as it was designed and if storage sites at all levels are able to maintain the designed quantity of stock/months of stock to treat patients and distribute to lower level facilities which treat patients. Checking this frequently can help to avoid stockouts through active supply chain management. A view of each level of the system (Central and Intermediate sites), using this metric can also help to locate bottlenecks within the system, which could prevent patients from receiving needed commodities; cause needless stock-outs, or needless expiries.
How to collect:	The country's supply chain standard operating procedures should outline the min and max levels for each level of the system. These levels were defined by the needed throughput (the amount of pharmaceuticals intended to flow through the system in a given period), the space available and the frequency of distribution. Observations of storage site and level-specific quantity of stock should be available through one or several of the following: the Procurement Planning and Monitoring Report for HIV and FP commodities (for condoms), a warehouse monitoring system, regular program monitoring reports, an existing logistics management information system, stock status reports/stock keeping records/regular physical counts, order forms from the central/regional/district/other levels, or regular supervision visits. For the required central level and at least one intermediate level, there may be numerous observations (through physical counts performed or spot checks) of stock status for the products of interest annually, or there may be monthly counts, either way, the stock status will be monitored closely and updated with each transaction. These observations should be analyzed in this fashion: · Document observations for each product of interest. · Sort observations for each product into "quantities between maximum and minimum quantities/months of stock" and quantities above or below maximum and minimum. · Number of observations where quantities are between maximum and minimum are the numerator.

<table>
<tr><td></td><td colspan="4">· Total observations available are the denominator.

Example 1: if the Central Medical Store (CMS) has monthly stock observations for RTKs, and nine of which are within max and min levels but the remaining three represent a stockout then for the CMS the resulting measurement would be 9/12 or 75%

Example 2: If there are ten regions in a country and the regional medical stores report to the CMS quarterly, then ideally there should be 40 observations. Of these observations 25 are stocked according to plan for ARVs. In this scenario the resulting measurement for ARVs at the regional level is 25/40 or 62.5%.</td></tr>
<tr><td>How often to report:</td><td colspan="4">Semi-Annual</td></tr>
<tr><td>How to review for data quality:</td><td colspan="4">Cross-reference data with shipments arriving, as shipments arrive this number should increase. Ensure the data comes from the warehouse management system. Consult with supply chain stakeholders to ensure that data is consistent.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="4">N/A</td></tr>
<tr><td>Reporting Level</td><td colspan="4">Storage sites</td></tr>
<tr><td rowspan="4">Data Elements (Components of indicator)</td><td rowspan="3">Numerator (Required): Sum the observations of stock status for tracer commodities that are between maximum and minimum quantities/months of stock from storage sites within a given level of the system during the reporting period.</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
<tr><td>System Level (Required): Central Medical Stores (CMS), Regional Medical Stores, District sites which supply commodities to lower Health Facility</td><td>NOTE: Warehouses in the PEPFAR master facility list should be entered at each system level (this does not have to be re-entered on the entry screen; however, please ensure that the site has been allocated to one of the system levels)</td><td>System Level: Central Medical Stores (CMS), Regional Medical Stores, District sites which supply commodities to lower Health Facility</td></tr>
<tr><td>Commodity (Required): Condoms, ARV drugs, second line rapid test kits, OI drugs, other</td><td></td><td>Commodity: Condoms, ARV drugs, rapid test kits, OI drugs, other</td></tr>
<tr><td>Denominator (Required):</td><td>Disaggregate Groups</td><td>Disaggregates</td><td>Description of Disaggregate</td></tr>
</table>

	Total number of observations of stock status for tracer commodities at the same level of the system during the same reporting period.	**System Level (Required):** Central Medical Stores (CMS), Regional Medical Stores, District sites which supply commodities to lower Health Facility		
		Commodity (Required): Condoms, ARV drugs, rapid test kits, OI drugs, other		
PEPFAR Support definition	**Nonstandard definition of DSD and TA-SDI:** **PEPFAR Support:** PEPFAR direct support to sites within the fiscal year is to ensure continuous access to commodities for HIV/AIDS patient diagnosis, care, and treatment. Reasons why access to commodities may be interrupted include poor infrastructure, inconsistent transportation or distribution practices, lack of equipment, poor ordering procedures, personnel and technical skills issues, or stock-outs due to any one of the above from the distribution site. PEPFAR support for supply chain sites should provide consistent access to commodities needed for care and treatment. **Direct Service Delivery (DSD)** Supply chain sites can be counted as **directly supported** by PEPFAR when the following conditions apply: 1) PEPFAR pays for **recurrent** maintenance, operations, personnel such as those who are seconded or regular provision of HIV and AIDS commodities. AND 2) There is at least annual technical support to monitor the support to the system. **Both conditions** must be met in order to count the site as directly supported (DSD) by PEPFAR. **Technical Assistance-only Support (TA-only)** Supply chain sites can be counted as directly supported through technical assistance-only when the site receives recurrent (at least quarterly) technical support.			
DREAMS SNU Specific Guidance	None			

PEPFAR

HOST COUNTRY NATIONAL INDICATORS (FY16 - Q4)

MER 2.0

KP_MAT_NAT / SUBNAT		
Description:	Percentage of people who inject drugs (PWID) on medication assisted therapy 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 headquarter 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	
Numerator:	Number of people who inject drugs (PWID) on medication assisted therapy	Explanation of Numerator: 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. Adults who initiated or transferred in during the reporting period should be counted only if they have completed a minimum of 3 months.
Denominator	Number of people who inject drugs (PWID) on MAT	
How to collect:	Data should be collected continuously at the organization level as part of service delivery and aggregated in time for national reporting cycles.	
How often to report:	Annually	

Subnational reporting:	To adequately plan the key populations medication-assisted therapy (MAT) program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical area; so that the total of the sub-National number should equal the total number of National number.
Entered by	This data should be entered by the PEPFAR USG country team at both National and subnational level.
Narratives	Narratives should include information on how National and subnational estimates have been derived for results.
Targets	N/A

Host Country National and Subnational Indicators

<table>
<tr><th colspan="3">PMTCT_ARV_NAT / SUBNAT</th></tr>
<tr><td>Description:</td><td colspan="2">Number and percentage of HIV-positive pregnant women who received antiretroviral medicine (ARV) during pregnancy to reduce the risk of mother-to-child transmission

The risk of mother-to-child transmission can be significantly reduced by providing ARVs for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretroviral medicines to the mother or child if breastfeeding, and the use of safe delivery practices and safer infant feeding. The data will be used to track progress towards global and national goals of eliminating mother-to-child transmission; to inform policy and strategic planning; for advocacy; and for leveraging resources for accelerated scale-up. It will help measure trends in coverage of antiretroviral prophylaxis and treatment, and when disaggregated by regimen type, will also assess progress in implementing more effective antiretroviral therapy regimens. As the indicator usually measures ARVs dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases.

This indicator is harmonized with GARPR indicator 3.1 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf).</td></tr>
<tr><td>Numerator:</td><td>Number of HIV-positive pregnant women who delivered and received ARV to reduce the risk of mother-to- child transmission during pregnancy and delivery.</td><td>Disaggregation: Disaggregated data is required. The numerator should be disaggregated by the three categories below for HIV- positive pregnant women for the prevention of mother-to-child transmission:
1. Newly initiated on antiretroviral therapy during the current pregnancy (New on ART, includes Maternal triple ARV prophylaxis)
2. Already on antiretroviral therapy before the current pregnancy (Already on ART)
3. Other: All other options including
• Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines)
• Single dose nevirapine (with or without tail) only
• Any other regimen not listed above</td></tr>
</table>

<table>
<tr><td>Denominator</td><td>Estimated number of HIV- positive pregnant women who delivered within the past 12 months</td><td colspan="2">The number of HIV positive pregnant women who delivered within the past 12 months is also referred to as the number of pregnant women living with HIV needing anti-retrovirals for preventing mother-to-child transmission (i.e. the number</td></tr>
<tr><td>How to collect:</td><td colspan="3">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 anti-retrovirals to reduce MTCT in the reporting period, by regimen.

Disaggregation of regimen definitions</td></tr>
<tr><td></td><td>Categories</td><td>Further Clarification</td><td>Common Examples</td></tr>
<tr><td></td><td>The first two options include women receiving lifelong antiretroviral therapy (including Option B+)

1) newly initiated on treatment during the current pregnancy (new on ART)
2) already on treatment before the pregnancy (Already on ART)</td><td>A three-drug regimen intended to provide antiretroviral therapy for life

1) Number of HIV-positive pregnant women identified in the reporting period newly initiated on antiretroviral therapy for life
2) Number of HIV-positive pregnant women identified in the reporting period who were already on antiretroviral therapy at their first antenatal clinic visit.

If a woman is initiating antiretroviral therapy for life during labour, she would be counted in category 1.

If the number of women on antiretroviral therapy is not available by the timing of when they started</td><td>Standard national treatment regimen, for example:

• TDF+3TC+EFV
• AZT+3TC+NVP</td></tr>
</table>

		antiretroviral therapy the number can be included in the cell titled total number of pregnant women on lifelong antiretroviral therapy. If a woman is initiating a three-drug regimen provided for MTCT prophylaxis started during pregnancy or as late as during labor or delivery with the intention of stopping at the end of the breastfeeding period (or stopping at delivery if not breastfeeding) (previously known as Option B), she would be counted in category 1.	
	Other	All other suboptimal regimens are counted here including: 1) Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery) 2) Single-dose nevirapine (sd- NVP) to the mother during pregnancy or delivery 3) Any other regimen that is not ART and/or one of the two options listed above	• AZT at any point before labor + intrapartum NVP • AZT at any point before labor + intrapartum NVP +7 day post-partum tail of AZT/3TC • sd-NVP for mother only at onset of labor • Sd-NVP + 7 day AZT/3TC tail ONLY • sd-NVP for mother at onset of labour and sd-NVP for baby ONLY
	For the denominator: Two methods can be used to estimate the denominator: an estimation model, such as Spectrum, using the output, number of pregnant women needing PMTCT; or, if Spectrum estimates are not available, by multiplying the number of women giving birth in the past 12 months (which can be obtained from estimates of the central statistics office, United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in ANC and appropriate adjustments related to coverage of ANC surveys).		

How often to report:	Annually
Subnational reporting:	To adequately plan the PMTCT program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc.). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical area; so that the total of the subnational number should equal the total number of National number.
Entered by	This data should be entered by the PEPFAR country team at both National and subnational level.
Narratives	Narratives should include information on how National and SNU estimates have been derived for both results and targets.
Targets	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). Targets should aligned with the START free, STAY free, AIDS-free super-FAST TRACK initiative. If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting with the PEPFAR planned targets (at the least) should constitute the host country targets.

PMTCT_STAT_NAT / SUBNAT

Description:	Percentage of pregnant women with known HIV status The risk of mother-to-child transmission (MTCT) can be significantly reduced by providing ARVs to the mother during pregnancy, delivery and (if applicable) breastfeeding. This indicator provides information on coverage of the first step in the prevention of mother-to-child transmission (PMTCT) cascade. High coverage enables early initiation of care and treatment for HIV-positive mothers. The total number of identified HIV-positive women provides the facility-specific number of pregnant women with HIV to start a facility-based PMTCT cascade. This indicator is harmonized with GARPR indicators 3.4 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf).	

Numerator:	Number of pregnant women attending antenatal clinics (ANC) and/or had a facility-based delivery and were tested for HIV during pregnancy, or already knew they were HIV positive	*Disaggregation*: Disaggregated data is required. This indicator should be disaggregated by:
		• HIV status/test results:
		  ○ known HIV infection at antenatal clinic entry (Known Positive)
		  ○ tested HIV positive at ANC during current pregnancy (Newly tested positive)
		  ○ tested HIV negative at ANC during current pregnancy (Newly tested negative)

Denominator	Number of pregnant women who attended ANC or had a facility-based delivery in the past 12 months	
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. Denominator: Count all women who were enrolled in ANC during the 12-month reporting period OR delivered at the facility (recorded in the L&D register), reconciling the latter with the former using the ANC No. to avoid double counting. As per global guidance (see GARPR indicator 3.4, link above), it is expected that the national program can reconcile information collected from ANC with L&D records. However in MER 2.0 the PEPFAR indicator for PMTCT_ART has been simplified to collect information only at antenatal care (ANC) sites to better align with 2016 WHO Consolidated ARV guidelines, reduce burden on data collection, and improve data quality. Therefore in reporting this indicator PEPFAR operating units should 1) utilize the national system whether it is able avoid double counting or not and are not expected to collect or report this information through a separate system 2) if it this is not possible to report individuals from both ANC and L&D, please include an explanation in the narrative whether the data is from ANC, L&D and/or both. Pregnant women's HIV status should be counted only once per pregnancy. This may be difficult if national guidelines recommend testing a pregnant woman more than once during a pregnancy or if a woman seroconverts during her pregnancy and has multiple tests.
How often to report:	Annually

Subnational reporting:	To adequately plan the PMTCT program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical area; so that the total of the subnational number should equal the total number of National number.
Entered by	This data should be entered by the country team at both National and subnational level. Narratives should include the methodology used for National and subnational data.
Narratives	Narratives should include information on how National and SNU estimates have been derived for both results and targets.
Targets	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). Targets should aligned with the START free, STAY free, AIDS-free super-FAST TRACK initiative. If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting with the PEPFAR planned targets (at the least) should constitute the host country targets.

VMMC_CIRC_NAT / SUBNAT

Description:	Number of males circumcised during the reporting period according National standards There is compelling evidence that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions in which heterosexual activity plays a significant role in HIV transmission. This indicator is harmonized with GARPR indicator 1.23 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). Males should be provided with circumcision as part of the VMMC for HIV prevention program and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia, or other WHO normative guidance (in the case of device-based VMMC), and per national standards by funded programs/sites in the reporting period meet the definition for the numerator. Males who are provided with circumcision using a medical device by funded programs/sites in the reporting period also meet the definition for the numerator as long as the device used is recognized or pre- qualified by WHO.	
Number: (required)	Number of males circumcised during the reporting period according National standards	Disaggregation: Disaggregated data is required. Enter data disaggregated by age. • Age (<15, 15-29, 30+)
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.	
Subnational reporting:	To adequately plan the VMMC program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU; District, province etc.). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical areas; so that the total of the sub-National number should equal the total number of National number.	

Entered by	This data should be entered by the country team at both National and Sub-National level.
Narratives	Narratives should include information on how SNU estimates have been derived for both results and targets.
Targets	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting with the PEPFAR planned targets (at the least) should constitute the host country targets.

VMMC_TOTALCIRC NAT / SUBNAT

Description:	Total number of men ever circumcised There is compelling evidence that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of heterosexually acquired HIV infection in men by approximately 60%. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions in which heterosexual activity plays a significant role in HIV transmission. This indicator is harmonized with GARPR indicator 1.22 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). The denominator for this indicator is the number of male populations estimates, disaggregated by age (<15, 15-29, 30+). This information is collected under the population estimates indicator in the IMPATTS (Implementation and Planning Attributes).	
Numerator: (optional)	Total number of men ever circumcised	Disaggregation: Disaggregated data is optional. If data is available enter by age. • Age (<15, 15-29, 30+)
How to collect:	This indicator is harmonized with GARPR indicator 1.22 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf). A guide to indicators for male circumcision programs in the formal health care system. Geneva, World Health Organization/UNAIDS, 2009. http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf Estimates derived from Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Surveys or other representative survey); 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.	
How often to report:	Annually	

Subnational reporting:	To adequately plan the VMMC program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU). This data should be entered for all subnational units, regardless of PEPFAR funding supporting these geographical areas; so that the total of the subnational number should equal the total number of National number.
Entered by	This data should be entered by the country team at both National and subnational level.
Narratives	Narratives should include information on how subnational estimates have been derived for both results and targets.
Targets	Host country teams often set targets by OU, and subnational level to plan their programs (please describe the target setting process that the host country employs in the narratives). If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting with the PEPFAR planned targets (at the least) should constitute the host country targets.

TX_CURR_NAT / SUBNAT		
Description:	Percentage of adults and children receiving antiretroviral therapy ART coverage is the second 90 of the global target, and an important step in ending the AIDS epidemic. Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among those living with HIV, and onward HIV transmission. Studies have also shown that early initiation, regardless of an individual's CD4 cell count, can enhance treatment benefits and save lives, and WHO currently recommends treatment for all. The percentage of adults and children receiving antiretroviral therapy among all adults and children living with HIV provides a benchmark for monitoring global targets over time, and comparing progress across countries. It is one of the 10 global indicators in WHO's 2015 *Consolidated strategic information guidelines for HIV in the health sector*. This indicator is harmonized with GARPR indicator 4.1 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf).	
Numerator:	The number of adults and children on ART at the end of the reporting period.	Disaggregation: Disaggregated data is required. If data is available use the Age/ex disaggregates, if not available use the Sex disaggregate. Do not enter both. • Sex: Male, Female • Coarse Age/Sex Disag: Female<15, Male <15, Female 15+, Male 15+
Denominator	The estimated number of adults and children living with HIV (PLHIV Estimate).	*Denominator is not collected as part of indicator, but rather is calculated from PLHIV_NAT numerator* (see PLHIV_NAT/SUBNAT for more details)

How to collect:	This indicator measures the progress towards providing antiretroviral therapy to all people living with HIV. The data source for this indicator is ART program monitoring tools, such as ART patient registers, pharmacy dispensing records, and summary reporting forms. The number of adults and children receiving treatment can be obtained through data from facility- based antiretroviral therapy registers or drug supply management systems. Data should be collected continuously and aggregated on a monthly or quarterly basis to obtain subnational and national totals. The most recent full year of data should be used for annual reporting. Data should be collected from health facility recording and reporting forms, program data, health information system. This indicator can be generated by counting the number of adults and children receiving antiretroviral therapy at the end of the reporting period. This value should equal the number of adults and children who have ever started antiretroviral therapy minus those not currently on treatment prior to the end of the reporting period. This will exclude those who died, stopped treatment or were lost to follow-up during the year. Some people pick up several months of antiretroviral medicines (ARVs) at one visit, which could cover the last months of the reporting period. Efforts should be made to include these people in the numerator as receiving anti-retrovirals even if they do not attend the clinic in the last month of the reporting period. When disaggregating the numerator by age, people receiving antiretroviral therapy should be reported in the relevant age category based on their age at the end of the reporting year. HIV- positive pregnant women who are on antiretroviral therapy should be included in the numerator. People receiving antiretroviral therapy in the private and public sectors should be included where data are available.
How often to report:	Annually
Subnational reporting:	To adequately plan the ART program, these numbers are needed from both the National and subnational level. The subnational level is considered that in which the country team has prioritized their program (PSNU). This data should be entered for all SNUs, regardless of PEPFAR funding supporting these geographical areas; so that the total of the sub-National number should equal the total number of National number.
Entered by	This data should be entered by the country team at both National and Sub-National level by the USG PEPFAR team.
Narratives	Narratives should include information on how National and subnational have been derived for both results and targets.

Targets	Host country teams often set targets by OU, and SNU level to plan their programs (please describe the target setting process that the host country employs in the narratives). Targets should aligned with the 90-90-90 UNAIDS HIV response initiative. If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting with the PEPFAR planned targets (at the least) should constitute the host country targets.

DIAGNOSED_NAT		
Description:	The percentage of adults and children living with HIV who know their status (have been diagnosed) Diagnosed is the first 90 of the global targets. To ensure people living with HIV receive the care and treatment required to live healthy, productive lives, and to reduce the chance of transmitting HIV, it is critical that they know their status. In many countries, targeting testing and counselling at locations and populations with the highest HIV burden will be the most efficient way to reach people living with HIV and ensure they are aware of their status. This indicator captures the efficacy and coverage of HIV testing interventions. This indicator is harmonized with GARPR indicator 1.5 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf).	
Numerator:	Among people living with HIV, the number who know their HIV status	Disaggregation: Disaggregated data is required. If data is available use the Age/ex disaggregates, if not available use the Sex disaggregate. Do not enter both. • Sex: Male, Female • Coarse Age/Sex Disag: Female<15, Male <15, Female 15+, Male 15+
Denominator	The estimated number of adults and children living with HIV (PLHIV Estimate). Denominator is not collected as part of indicator, but rather is calculated as PLHIV_NAT numerator	(see PLHIV_NAT/SUBNAT for more details)

How to collect:	*Numerator*: There are multiple methods to estimate the number of people living with HIV who know their status. • Case-based surveillance In countries with well-functioning HIV reporting systems, the number of people diagnosed can be estimated from national case-based data. The number of deaths among PLHIV must be subtracted from the cumulative number diagnosed to calculate the number of people living with HIV who know their status. • Survey-based reporting o 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. o 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: o 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. o Because household surveys are typically only done every five years, data from non-recent surveys may not reflect current levels of testing coverage.
Subnational reporting:	Subnational data will be collected for FY17 data collection.
Entered by	This data should be entered by the country team at the National level. Narratives should include the methodology used for determining sub-National data
Narratives	Narratives should include information on how the National estimates have been derived for both results and targets.
Targets	N/A

VL_SUPPRESSION_NAT		
Description:	Percentage of people living with HIV on ART with a suppressed viral load Viral suppression is the third and last 90 of the global target, and the ultimate goal of the HIV treatment cascade. Patients on ART who achieve and maintain viral suppression minimize their risk of disease progression and HIV transmission. Viral suppression is a critical quality of service quality; unsuppressed viral load can be indicative of suboptimal treatment adherence, and can lead to the development and spread of drug resistance. This indicator is harmonized with GARPR indicator 4.6 (https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf)	
Numerator:	Number of people living with HIV and on ART [in the reporting period] who have a suppressed viral load (<1000 copies/mL)	Disaggregation: Disaggregated data is required. If data is available use the Age/Sex disaggregate, if not available use the Sex disaggregate. Do not enter both. • Sex: Male, Female • Coarse Age/Sex Disag: Female<15, Male <15, Female 15+, Male 15+
Denominator	TX_CURR_NAT	(see TX_CURR_NAT/SUBNAT for more details) *TX_CURR_NAT Denominator is not collected as part of indicator, but rather is calculated as TX_CURR_NAT Numerator.*

How to collect:	*Numerator:* The numerator can be generated by counting the number of adults and children receiving antiretroviral therapy at the end of the reporting period. Count the patient if, during the reporting months, viral load has been recorded and is <1000 copies/mL. For countries with other thresholds (e.g. undetectable <50 copies/ml or <400 copies/ml), preliminary evidence from several studies suggests the proportion of those with 50 copies/ml or above and less than 1000 copies/ml is small, so no adjustment is required. The testing threshold value should be reported in the narrative for countries with thresholds other than <1000 copies/ml. Viral-load testing should be routine rather than episodic; for example, when treatment failure is suspected. If multiple viral-load tests are done annually for a person, only the last routine test result should be reported. Results from episodic viral loads should not be reported. If viral-load testing coverage is less than 75% of those receiving antiretroviral therapy in the reporting year, results should be interpreted with caution. Tools for measuring viral load may vary across countries. Routine viral-load suppression tests from clinical and program data should be reported where available. In countries where such data are not available, results from HIV population-based surveys or drug-resistance surveys based on a random sample of people on antiretroviral therapy may be reported. Countries should report the source of the numerator and denominator data, and data from both sources should be reported if available, although clinical and program data are preferred. If results from a survey are used, that should be included when reporting.
	Where clinical and program data are available from routine monitoring systems, results will be recorded in patient files or in a laboratory system. Data should be de-duplicated where patients receive multiple viral-load tests in a year. If an HIV population-based or drug-resistance survey is used in place of routine program monitoring data, measurement of viral load should be done for the entire population of HIV- positive individuals where ARV is detected in specimens. Self-reported treatment status has been shown to be of limited quality. Therefore, viral-load estimates among those who report receiving antiretroviral therapy should not be used.
How often to report:	Annually.
Subnational reporting:	Subnational data will be collected for FY17 data collection.
Entered by	USG PEPFAR team
Narratives	Narratives should include information on how the National estimates have been derived for both results and targets.

Targets	Host country teams often set targets by OU level. Targets should aligned with the 90-90-90 UNAIDS HIV response initiative. If the host country does not develop targets for this indicator, then for planning purposes, data should be entered that includes MOH results from the previous reporting with the PEPFAR planned targets (at the least).

MER 2.0 Guidance Appendices

Appendix 1: Key population classification document

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

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

Appendix 2: MER 1.0 & EA 2016 Alignment

EA Program Area	EA Expenditure Disaggregation		Unit Expenditure Calculated	EA Indicator Description (UE Denominator)	MER1.0 Indicator Used
FBCTS*	Pre-ART		None		
		Pediatric Pre-ART	None		
		Adult Pre-ART	None		
	ART		All-Age ART*	Number of ART patient years	[TX_CURR - PMTCT_ARV]
		Pediatric ART	Pediatric ART* (only calculated as appropriate)	Number of Pediatric ART patient years	[TX_CURR (<15 years old)]
		Adult ART	Adult ART* (only calculated as appropriate)	Number of Adult ART patient years	[TX_CURR (>15 years old) - PMTCT_ARV]
CBCTS	CBCTS		None		
		Linkage	None		
		Adherence and Retention	None		
		Non-Facility Based Medical Care	None		
		Other Essential Community-Based Care and Support	None		
PMTCT	Pregnant Women Tested		Pregnant Women Tested	Number of pregnant women tested	PMTCT_STAT - PMTCT_STAT Known Pos
			Pregnant Women Tested Positive	Number of pregnant women tested positive	PMTCT_ARV denominator – PMTCT STAT Known Pos
	Pregnant Women on Treatment		Pregnant Women on Treatment	Number of pregnant women on treatment	PMTCT_ARV
	Infants Tested		Infants Tested	Number of infants tested	PMTCT_EID Numerator

			Infants Tested Positive	Number of infants tested positive	PMTCT_EID disaggregate
	Infants on Care		Infants on Care	Number of infants on care	TBD
VMMC	VMMC		VMMC	Number of males medically circumcised	VMMC_CIRC
HTS	HTS		HTS Tested	Number of persons tested and counseled	[HTS_TST - (PMTCT_STAT + PMTCT_EID numerator + VMMC_CIRC tested)]
			HTS Positive	Number of persons tested and counseled who were found positive	[HTS_TSTPOS - (PMTCT_ARV denominator + PMTCT_EID disaggregate + VMMC_CIRC positive)]
		PITC	HTS PITC Tested	Number of persons receiving provider initiated testing and counseling (PITC)	HTS_TST Disaggregation (Sum of TB, STI, Outpatient, Inpatient, HIV care and treatment clinic)
			HTS PITC Positive	Number of persons who were found positive via PITC	HTS_TST Disaggregation (Sum of TB, STI, Outpatient, Inpatient, HIV care and treatment clinic) POS
		VCT	HTS VCT Tested	Number of persons receiving voluntary testing & counseling (VCT)	HTS_TST Disaggregation (Sum of VCT co-located, VCT standalone)
			HTS VCT Positive	Number of persons who were found positive via VCT	HTS_TST Disaggregation (Sum of VCT co-located, VCT standalone) POS
		CBTC	HTS CBTC Tested	Number of persons receiving community-based testing & counseling (CBTC)	HTS_TST Disaggregation (Sum of Mobile, Home-based)
			HTS CBTC Positive	Number of persons who were found positive via CBTC	HTS_TST Disaggregation (Sum of Mobile, Home-based) POS
PEP	PEP		None		
Blood Safety	Blood Safety		None		
Lab	Lab		None (Relevant lab expenditures are added to appropriate FBCTS &		

			PMTCT UEs)		
Infection Control	Infection Control		None		
OVC	OVC		OVC All Care	Number of orphan and vulnerable children beneficiaries	OVC_SERV
		Health access and health promotion	None		
		ECD	None		
		Primary Educational Support	None		
		Secondary Educational Support	None		
		Economic Strengthening	None		
		Psychosocial Support	None		
		Nutrition/Food Security	None		
		Child Protection	None		
		Case Management	None		
PP-PREV	Prevention-Priority Population		PP-Prev	Number of PP-PREV prevention beneficiaries	PP_PREV
Prevention-PWID	Prevention-PWID		KP-PWID	Number of KP-PWID prevention beneficiaries	KP_PREV disaggregation of PWID
Prevention-FSW	Prevention-FSW		KP-FSW	Number of KP-FSW prevention beneficiaries	KP_PREV disaggregation of FSW
Prevention-MSMTG	Prevention-MSMTG		KP-MSMTG	Number of KP-MSMTG prevention beneficiaries	KP_PREV disaggregation of MSMTG
MAT	MAT		KP-MAT	Number of beneficiaries receiving medication assisted therapy	KP_MAT

Appendix 3: DREAMS SNU indicators

Table 2: DREAMS-related indicator and disaggregation requirements for reporting

Indicator	Required Disaggregations for DREAMS	Who should report?
PMTCT_STAT	Females Known at Entry Positive: 10-14, 15-19, 20-24, 25-49 Newly Identified Positive: 10-14, 15-19, 20-24, 25-49 Newly Identified Negative: 10-14, 15-19, 20-24, 25-49	All partners in DREAMS SNUs delivering PMTCT services
PrEP_NEW	Females: 15-19, 20-24	All partners in DREAMS SNUs delivering PrEP
HTC_TST	Females By Service Delivery Point/Test Result Positive: 10-14, 15-19, 20-24, 25-49 Negative: 10-14, 15-19, 20-24, 25-49 Males By Service Delivery Point/Test Result Positive: 10-14, 15-19, 20-24, 25-49 Negative: 10-14, 15-19, 20-24, 25-49	All partners delivering HTS
KP_PREV	Key population type (DREAMS Disaggregation): Female Sex Worker (FSW)	All partners delivering KP prevention services
PP_PREV	Females: 10-14, 15-19, 20-24, 25-49 Males: 10-14, 15-19, 20-24, 25-49	All partners delivering prevention services
GEND_GBV	Females: 10-14, 15-17, 18-19, 20-24	All partners providing post violence care
VMMC_CIRC	Males: 15-19, 20-24, 25-29, 30-49	All partners delivering male circumcision services
OVC_SERV	Education Support Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Parenting/Caregiver program Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Social Protection Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Economic Strengthening Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+ Other Females: 10-14, 15-17, 18-24, 25+ Males: 10-14, 15-17, 18-24, 25+	All partners in DREAMS SNUs serving OVC
TX_NEW	Males: 15-19, 20-24, 25-49	All partners providing treatment services
TX_CURR	Males: 15-19, 20-24, 25-49	All partners providing treatment services
TX_RET	Males: 15-19, 20-24, 25-49	All partners providing treatment services

Appendix 4: Frequency of Reporting Table

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

Frequency of Reporting Table

MER INDICATOR GROUPINGS	PREVENTION	90: Knowing your HIV Status	90-90: On ART	90-90-90: Viral Suppression	Health Systems
	PREP_NEW	FPINT_SITE	TX_NEW	TX_RET	HRH_PRE
	VMMC_CIRC	HTS_TST*	TX_CURR	TX_PLVS	HRH_CURR
	KP_PREV	PMTCT_STAT*	PMTCT_ART		HRH_STAFF
	PP_PREV	PMTCT_EID*	TB_ART		EMR_SITE
	TB_PREV	TB_STAT*	TX_TB		LAB_PTCQI
	OVC_SERV	OVC_HIVSTAT			INVS_COMD
	KP_MAT	PMTCT_FO			SC_STOCK
	GEND_GBV				

*Includes Positive disaggregate (POS)

Quarterly	Report 3 months of results for these indicators at each reporting cycle Q1, Q2, Q3, and Q4.
Semiannual	Report 6 months of results for these indicators at each reporting cycle Q2 and Q4.
Annual	Report results for the entire 12 month reporting period for these indicators at the Q4 reporting cycle.