USAID PEPFAR Central Custom Indicators Reference Guide
Version 1: January 15, 2021

Custom Indicators

Indicator Reference Sheets (IRS) are included for all custom indicators to be collected centrally through USAID's PEPFAR Custom Indicators process. Each IRS provides a definition of the indicator, description of reporting components (numerator, denominator, disaggregates), frequency of reporting, and information on how to collect and review for data quality.

DREAMS_GEND_NORM

Description:	Number of people in DREAMS SNUs completing an intervention pertaining to gender norms, that meets minimum criteria
Numerator:	Number of people in DREAMS SNUs completing an intervention pertaining to gender norms, that meets minimum criteria
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	This indicator will enable headquarters to: ● Gain a basic but essential understanding of the reach and scale-up of programs that address gender-related interventions within and across PEPFAR countries. ● Provide important information to key stakeholders about PEPFAR programs that reduce vulnerability to HIV/AIDS and increase access to treatment and care services through gender-related interventions. ● Demonstrate the United States' global leadership in reducing vulnerability to HIV/AIDS by addressing important issues pertaining to gender that are known to contribute to HIV risk and limit needed treatment and care. At the country level, this indicator will enable PEPFAR country teams, governments, implementing partners, and other in-country counterparts to: ● Help assess whether gender-related activities are being implemented within the country, based on the epidemiologic data, the national strategy, and social, political, economic, and cultural context. ● When possible, support efforts to assess the impact of gender-related activities and services by correlating the scale-up of these activities over time and by geographic area with outcomes related to gender (and HIV/AIDS), as described through other data collection efforts such as the Demographic and Health Survey (DHS).

	• Identify programmatic gaps by analyzing the number and types of people (male/female, age group) being reached by gender-related activities. • Contribute to building an enabling environment to prevent gender-based violence and violence against children, under PEPFAR as well as other United States Government (USG) programs. • Advocate for greater resources and technical assistance for gender-related programming.
How to collect:	Data should be collected continuously at the health facility level and/or community level, including in a variety of venues such as schools, workplace, and community organizations. Only data from facilities and venues within DREAMS SNUs that are implementing DREAMS interventions should be counted. Standard program monitoring tools, such as forms, logbooks, spreadsheets, and databases that partners develop or already use. The numerator can be generated by counting the number of adults and children who completed a PEPFAR-supported DREAMS intervention pertaining to gender norms that meets the minimum criteria during the reporting period. **Minimum Criteria** The minimum criteria required to be counted under this indicator need to include: 1. <u>A component that supports participants to understand and question existing gender norms and reflect on the impact of those norms on their lives and communities</u>. Existing evidence indicates that interventions using non-participatory methods, such as lectures and dissemination of written materials, do not have significant impact on changing gender norms. Conversely, there is evidence that participatory interventions, such as open dialogues, do have an impact on norms. Therefore, to count under this indicator the intervention MUST use a participatory methodology. 2. <u>A clear link between the gender norms being discussed and HIV prevention, treatment, care, or support</u>. A variety of gender norms have direct links to HIV. Examples include: • Norms that discourage control over sexual decision making for women and girls

	• Norms around masculinity that encourage multiple partners, violence, and limit seeking of health care services • Norms that discourage girls' access to education and economic resources • Norms that encourage violence and stigma against men who have sex with men (MSM) and transgender (TG) populations To count under this indicator, the intervention must, at some point, address norms that in one way or another are linked to HIV outcomes. 3. Minimum of 10 hours. The same person must participate in a minimum of 10 hours of total intervention time (in either an individual, small group, or community setting) to count under this indicator.[1] One-off interventions cannot be counted under this indicator. All three minimum criteria must be met for the individual to count under this indicator. The following are examples of interventions to change gender norms that meet all three criteria and have been rigorously evaluated. They all showed a significant impact on changing gender norms and related HIV risk behaviors. Teams should build off these existing and other evidence-informed interventions as much as possible. • Stepping Stones[i] • Yaari Dosti[ii] • Program H[iii] • One Man Can[iv] • Men As Partners[v] These activities are crosscutting and contribute to results across a range of PEPFAR program areas. Individuals counted under this indicator may also be captured under other relevant prevention indicators. In other words, an individual counted here might also receive other kinds of PEPFAR services, such as HIV testing, voluntary medical male circumcision (VMMC), or prevention of mother-to-child transmission (PMTCT) of HIV. Individuals reached by mass media activities, e.g., radio and TV spots, or billboards for the general population, are not counted under this indicator. **Gender** is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements, and obligations associated

	with being female and male, as well as the power relations between and among women and men, boys and girls. The definition of and expectations for what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age, and sexual orientation. All individuals, independent of gender identity, are subject to the same set of expectations and sanctions (*Interagency Gender Working Group, IGWG*). Gender is not interchangeable with women or sex. **Harmful gender norms related to HIV/AIDS** include those that govern the following behaviors: cross generational and transactional sex; multiple concurrent partnerships; alcohol/substance misuse/abuse; inequitable control of household resources; poor use of health care services; lack of support for partner's health care concerns; stigma, discrimination and violence related to sexual orientation and gender identity; and limited involvement in HIV/AIDS caregiving. **Activities that address harmful gender norms related to HIV/AIDS** seek to change traditional, cultural, and social gender norms that contribute to behaviors that increase HIV/AIDS risk in both men and women, and that impede access to care and treatment services for those who need them. These activities are crosscutting and contribute to results across a range of PEPFAR program areas, including prevention, care, and treatment. **Number of adults and children reached** is the number of individuals who are provided with the intended activity as defined in the program description and as prescribed in the activity. **Individual-level activities** are provided to one individual at a time, e.g., individual counseling, mentoring, etc. **Small group-leve**l activities are those delivered in small group settings (less than 25 people), e.g., workplace programs, men's support groups, etc. **Community-level activities** are those delivered in community-wide settings (25 or greater people), e.g., town hall meetings, community-wide education campaigns, etc. **PEPFAR direct support:** Only direct service delivery (DSD) targets and results should be reported to HQ. **Direct Service Delivery (DSD)**

	The number of adults and children reached by an individual, small group, or community-level activity that addresses gender norms can be counted as directly supported by PEPFAR when the service receives support that: **1**. Is critical to the delivery of the gender norms within the context of HIV/AIDS intervention. Examples include the provision of: ● Partial or full salary support for those developing activity-related curricula, educational materials, etc.; and/or ● Partial or full salary support for those actively delivering the individual, small group, or community-level activity (e.g., providing one-on-one counseling or information exchange; facilitating small group discussions, meetings, or debates; providing community engagement activities; facilitating town hall meetings; leading community sensitization or awareness forums, etc.) AND **2.** Requires established presence and/or frequent presence (at least one visit per quarter) at the facilities or sites (or within the communities) by the PEPFAR IP, where the activities are being delivered. Both conditions must be met to count individuals as directly supported by PEPFAR under this indicator. **Note:** Mass media activities cannot be counted as "direct" under this indicator.
How to review for data quality:	When disaggregating by age, it is important to focus on the target audience for the activity and the expected normative change. If a parent participates with his or her child, both can be counted if the activity specifically targets both. However, if the activity only targets the parent/adult, the child should not be counted, even if a logical link can be made between normative change for the parent/adult and future positive outcomes for the child. Care should be taken to not count an individual more than once within the reporting quarter.
How to calculate annual total:	Annual total can be calculated by summing the quarterly reported numbers and, as necessary, adjusting the count for individuals that were counted in more than one quarter, i.e., an individual should be counted only once for the year.

<table>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td><18 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown age F/M

OR

<18 F/M, 18-44 F/M, 45+ F/M, Unknown age F/M</td></tr>
<tr><td>Type of Activity
[Required]</td><td>Individual, small group, community-level</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>N/A</td><td>N/A</td></tr>
<tr><td>Additional Resources</td><td colspan="2">What Works for Women and Girls: Evidence for HIV/AIDS Interventions. This is a helpful tool in this process. The purpose of this PEPFAR-supported website is to provide the evidence necessary to inform country-level programming. What Works is a comprehensive review, spanning 2,500 articles and reports with data from nearly 100 countries. What Works has uncovered a number of interventions for which there is substantial evidence of success—from prevention, treatment, care, and support to strengthening the enabling environment for policies and programming. What Works also highlights a number of remaining gaps in programming. (www.whatworksforwomen.org)

Compendium of Gender Equality and HIV Indicators. The compendium of indicators (available in English and French) covers programmatic areas vital to the intersection of gender and HIV. Each of these programmatic areas includes indicators that may be used at national, regional, or programmatic levels. (https://www.measureevaluation.org/resources/publications/ms-13-82)

Program Guide for Integrating Gender-based Violence (GBV) Prevention and Response in PEPFAR Programs.</td></tr>
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	(http://ovcsupport.org/wp-content/uploads/Documents/GenderBased_Violence_and_HIV_A_Program_Guide_for_Integrating_GenderBased_Violence_Prevention_and_Response_in_PEPFAR_Programs_1.pdf) **Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.** (http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/) **Violence against Women and Girls: A Compendium of Monitoring and Evaluation Indicators.** This compendium provides a number of monitoring and evaluation indicators for GBV services. Some of the indicators measure reach and quality of services, and might be helpful as country teams and individual programs develop more detailed monitoring and evaluation plans to more fully understand implementation processes and program outcomes. (http://www.cpc.unc.edu/measure/publications/pdf/ms-08-30.pdf) [i] **Stepping Stones:** An evaluation of the Stepping Stones program for young people in the Eastern Cape Province of **South Africa** found that the program was effective in reducing sexual risk-taking and violence perpetration among young, rural African men. Jewkes et al., 2006b (http://www.steppingstonesfeedback.org/index.php/page/Home/gb) [ii] **Yaari Dosti:** This program in India replicated aspects of Program H in **Brazil.** Nearly 1,150 young men in Mumbai and rural Uttar Pradesh were exposed under the Yaari Dosti program to either peer-led group education activities alone, or those activities combined with a community-based behavior change communication or a delayed intervention which promoted gender equity. The study found that in all intervention sites there was a significant increase in reports of condom use at last sex, decreased partner violence, and increased support for gender equitable norms. The sample of young men included married and unmarried young men ages 16–29 in the urban areas and ages 15–24 in the rural settings. Logistic regression showed that men in the intervention sites in Mumbai were 1.9 times more likely and in rural Uttar Pradesh 2.8 times more likely to have used condoms with all types of partners than were young men in the comparison sites in each place. Furthermore, self-reported violence against partners declined in the intervention sites. Verma et al., 2008

	(http://www.popcouncil.org/pdfs/horizons/yaaridostieng.pdf) [iii] **Program H:** An impact evaluation of Program H, undertaken by PROMUNDO, was conducted in **Brazil** to test the hypothesis that young men in slum areas of Rio de Janeiro can change their behavior and attitudes through participation in group education activities that encourage reflection on what it means to be a man. The program resulted in significantly smaller percentages of young men supporting inequitable gender norms over time. Improvements in gender norm scale scores were associated with changes in at least one key HIV/sexually transmitted infection (STI) risk outcome. In two of the three intervention sites, positive changes in attitudes toward inequitable gender norms over one year were significantly associated with decreased reports of STI symptoms. In two of the three intervention sites young men were approximately four times and eight times less likely to report STI symptoms over time, respectively. No significant change was found in condom use. Those boys who reported that they had more equitable gender norms as measured by the GEM scale also reported a decrease in STI symptoms. Program H was developed on the premise that gender norms, which are passed on by families, peers, and institutions, among others, and are interpreted and internalized by individuals, can be changed. Furthermore, reinforcing these messages on the community level will have additional positive impacts. The quasi-experimental study, which followed three groups of young men ages over time, compared the impact of different combinations of program activities, including interactive education for young men led by adult male facilitators and a community-wide social marketing campaign to promote condom use as a lifestyle that used gender-equitable messages that reinforced the messages promoted in the education sessions. Pulerwitz et al., 2006 (http://www.promundo.org.br/en/activities/activities-posts/program-h/) [iv] **One Man Can**: A campaign in **South Africa**, One Man Can, by the Sonke Gender Justice Network, found that as a result of training workshops, 25% of the men and boys had accessed voluntary counseling and testing (VCT), 61% increased condom use and 50% reported acts of gender-based violence that the men had witnessed so that appropriate action could be taken to protect women. Sonke provided training over the period of one year to engage men in gender awareness. The campaign implemented a range of communication strategies to shift social norms about men's roles

	and responsibility, engaged in advocacy and worked with local government, resulting in men's increased utilization of VCT and increased use of condoms. Phone surveys were conducted with 2000 randomly selected men and boys who had previously participated in the One Man Can Campaign workshops. Focus group discussions, in-depth interviews and key informant interviews were also conducted. Workshops included 20 to 30 participants and took place over four to five days, using interactive and experiential activities. Pre- and post-test surveys showed positive changes toward gender equitable attitudes that would assist HIV prevention: prior to the workshop, all the men thought they as men had the right to decide when to have sex with their partners; after the workshop, this decreased to 75%. Prior to the workshop, 67% of the men thought they could get HIV from kissing that involved the exchange of saliva; after the workshop this decreased to none. Prior to the workshop, 63% of the men believed that it is acceptable for men to beat their partners; after the workshop, 83% disagreed with the statement. Prior to the workshop, 96% of the men believed that they should not interfere in other people's relationships, even if there is violence; after the workshop, all believed they should interfere. Colvin, 2009 (http://genderjustice.org.za/projects/one-man-can.html) [v] **Men as Partners (MAP):** In recent years, evidence has mounted that programs such as MAP are effective in transforming attitudes and behaviors. The World Health Organization recently published an evaluation of 57 different programs showing their meaningful impact on public health. Identifying more than two-thirds of the programs as either promising or effective, the report is the first large-scale analysis showing the value of working with men and boys. EngenderHealth's contributions to the report included the success of its MAP Programs in Nepal and South Africa. The MAP Program in Nepal (led by the ACQUIRE Project, of which EngenderHealth is the managing partner) is addressing high rates of maternal mortality by training peer educators to teach other men about pregnancy complications and the need for obstetric care. As a result, communities in Nepal have shown an increase in contraceptive use, an increase in the number of men who have accompanied their wives to clinic appointments, and an improvement in men's knowledge of and attitudes toward their pregnant wives' health needs. Dramatic indications of success have also emerged from South Africa's MAP Program. A rigorous evaluation of men who

	participated in MAP workshops in Western Cape Province revealed that such interventions translate into measurable changes in their attitudes. Most MAP participants (71%) believed that women should have the same rights as men, compared with only 25% of men who did not participate in MAP activities, and 82% of the MAP participants thought that it was abnormal for men to sometimes beat their wives, compared with 38% of men who did not participate in the MAP program. Building on these accomplishments, the MAP Program continues to thrive and innovate, with plans to expand to Ethiopia, Namibia, and Tanzania. As one MAP advocate says, "We're on a forward journey from which there is no looking back. For me, this is a mission that gives me the strength to survive and a future to look forward to." (http://www.engenderhealth.org/our-work/gender/men-as-partners.php)

DREAMS_FP	
Description:	Percentage of DREAMS beneficiaries who received a family planning (FP) service at a PEPFAR-supported HIV service delivery point (SDP) in DREAMS SNUs during the reporting period. FP service delivery may consist of FP counseling only (including screening for contraceptive need); FP counseling plus facilitated referral to another SDP (PEPFAR- or non-PEPFAR-supported) to obtain a method; or FP counseling plus method provision (disaggregated by method type).
Numerator:	Number of DREAMS beneficiaries who received an FP service at a PEPFAR-supported HIV SDP in DREAMS SNU during the reporting period
Denominator:	Total number of DREAMS beneficiaries served at a PEPFAR-supported HIV SDP in DREAMS SNUs during the reporting period
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	This indicator monitors FP service delivery and provides specific information on FP service uptake among DREAMS beneficiaries at PEPFAR-supported SDPs in DREAMS SNUs. This indicator assumes that FP service delivery may consist of FP counseling only (including screening for contraceptive need); FP counseling plus facilitated referral to another SDP (PEPFAR- or non-PEPFAR-supported) to obtain a method; or FP counseling plus method provision (disaggregated by method type). DREAMS beneficiaries receiving FP method provision from non-PEPFAR supported SDPs should be counted in the numerator if they received counselling and/or referral for method provision at a PEPFAR-supported SDP. Data collection for this indicator allows for monitoring changes in FP service delivery and use of methods over time at HIV SDPs, but provides no direct information on the quality of FP/HIV service delivery integration or the quality of FP services provided
How to collect:	A DREAMS beneficiary is an adolescent girl or young woman (AGYW) who is enrolled in DREAMS and has started or completed at least one DREAMS service/intervention.

	Data sources include service delivery statistics obtained from, for example, ministry of health FP registers and DREAMS layering tracking systems. Data requirements include counting the number of DREAMS AGYW clients served at PEPFAR-supported HIV SDPs in DREAMS SNUs during a given timeframe (e.g., quarterly) as well as confirmation of how many of them received an FP service. For FP service referrals, it is anticipated that these will be provided and tracked by DREAMS implementing partner (IP) staff/mentors through their community HIV platforms. A referral may be made to another SDP (such as a health facility) for a DREAMS AGYW to receive an FP method; confirmation of referral completion is not required as part of this indicator. For the purposes of this indicator, male and female condoms are <u>not</u> included in the list of FP methods provided in the FP service type disaggregate. ***Note:*** Per U.S. Government (USG) legal and policy requirements, 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. All referrals should include detailed information about where methods not available at the site can be accessed (e.g., facility location and operating hours). Referral occurs if a client is advised where he/she can go to find their preferred or recommended FP method not provided at the site, and the referral is documented at the referral source as proof that a referral was made.
How to review for data quality:	Although each HIV SDP should maintain a record of services provided to DREAMS AGYW clients, FP information is sometimes not well-recorded at HIV SDPs, making it difficult to accurately measure service delivery. This may lead to underreporting, overreporting (e.g., if an AGYW receives FP services more than once within the reporting period), or poor data quality. The development and implementation of a standardized reporting format, such as the national FP register and/or health management information system (HMIS) and laboratory management information system (LMIS) reporting forms that track individuals is encouraged. Over-reporting may occur if individuals outside of the specific age range (10–24) are included, so careful tracking of client biodata

<table>
<tr><td></td><td colspan="2">information is recommended. Care should also be taken to only count AGYW who are actively enrolled in DREAMS.

Standard protocols, as well as consistency in provider trainings (including adherence to national FP monitoring and reporting standards) with an aim to improve staff motivation and documentation of services, can help address data limitations.

Because this indicator is focused on individual DREAMS AGYW receipt of FP counseling, method provision, or referral provision, the DREAMS IP should aim to de-duplicate reporting of individuals. Each beneficiary who receives an FP service per the guidance below should be reported once per quarter.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Annual percentage can be calculated from sums of the quarterly reported numbers (numerator and denominator) and, as necessary, adjusting the numbers for individuals that were counted in more than one quarter, i.e., an individual should be counted only once for the year.</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>10-14 F, 15-19 F, 20-24 F, 25-29 F, Unknown Age F</td></tr>
<tr><td></td><td>Contraceptive Service/Method Type (Modern Contraception)
[Required]</td><td>• FP counseling only
• FP counseling plus referral for a method to another SDP
• FP counseling plus method provision (choose the most recent one received):
○ Oral contraceptive pills
○ Injectable
○ Implant
○ Intrauterine device (IUD)
○ Emergency contraception
○ Fertility awareness method (e.g., Cycle Beads)</td></tr>
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<table>
<tr><td rowspan="6"></td><td></td><td>○ Other (excluding condoms)</td></tr>
<tr><td>Type of PEPFAR-supported site [required]</td><td>mobile service unit, hospital, health center, school, community, other</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>10-14 F, 15-19 F, 20-24 F, 25-29 F, Unknown Age F</td></tr>
<tr><td>Type of PEPFAR-supported site [Required]</td><td>● Mobile service unit
● Hospital
● Health center
● School
● Community
● Other</td></tr>
<tr><td>Disaggregate Descriptions and Definitions</td><td colspan="2">Data sources include service delivery statistics obtained from, for example, MOH FP registers and DREAMS tracking systems.

Data requirements include counting the number of DREAMS AGYW clients served at PEPFAR-supported HIV SDPs in DREAMS SNUs during a given timeframe (e.g., quarterly) as well as confirmation of how many of them received an FP service. For FP service referrals, it is anticipated that these will be provided and tracked by DREAMS IP staff/mentors through their community HIV platforms. A referral may be made to another PEPFAR-supported or non-PEPFAR-supported SDP (such as a health facility) for a DREAMS AGYW to receive an FP method; confirmation of referral completion is not required as part of this indicator.

● For the purposes of this indicator, male and female condoms are <u>not</u> included in the list of FP methods provided in the FP service type disaggregate.
● When disaggregating by contraceptive service/method type, count the most recent experience within the reporting period. For example, if an AGYW initially receives FP counseling, but returns within the quarter and receives a method (e.g., oral contraceptives), she should be counted as</td></tr>
</table>

	receiving that method. Similarly, if she is counseled initially, but later provided with a referral, she should be counted as receiving a referral. This rule should be applied similarly for annual reporting. ***Note:*** Per U.S. Government (USG) legal and policy requirements, 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. All referrals should include detailed information about where methods not available at the site can be accessed (e.g., facility location and operating hours). Referral occurs if a client is advised where he/she can go to find their preferred or recommended FP method not provided at the site, and the referral is documented at the referral source as proof that a referral was made.
PEPFAR-Supported SDP Definition:	A PEPFAR-supported SDP 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); antiretroviral therapy (ART); screening and prophylaxis for opportunistic infections; other health services for people living with HIV (PLHIV) (e.g., positive health, dignity, and prevention [PHDP], nutrition support); and prevention activities for priority populations (key populations and AGYW). It can include fixed locations and/or mobile operations offering routine and/or regularly scheduled services. Examples include different HIV services within hospitals, health centers, dispensaries, and community-based organizations (government, private, or nongovernmental). Individual community health workers are not considered to be individual SDPs. Rather, the organization with which they are affiliated is considered the SDP.
Guiding Narrative Questions:	• When considering using the data to inform questions about access to FP services and quality of the services: Has uptake of FP methods increased over time among DREAMS AGYW in DREAMS SNUs? • When considering using the data to inform questions about access to services: Has uptake increased in certain types of SDPs in comparison with others? Has uptake increased in certain geographic locations compared to others? • When considering data disaggregations, is there evidence of increased FP uptake across a broad range of methods,

	including long-acting reversible contraceptive methods, such as implants and intrauterine devices? ● When looking at layering data, is there evidence that AGYW accepting a FP method are also accessing condoms to ensure dual protection? ● When looking at layering data, is there evidence that DREAMS AGYW accepting a FP service are also accessing PrEP? ● What is your approach to ensuring effective referral mechanisms and linkages between clinical and community-based DREAMS platforms?
Additional Considerations:	**Note on USG Legal and Policy Requirements:** HIV and FP integrated program activities must respect a client's right to make informed decisions about his or her reproductive life. The principles of voluntarism and informed choice are prerequisites to high-quality reproductive health care and form the basis of USG-supported FP programs. USG-supported HIV and FP programs are also guided by U.S. legislative and policy requirements regarding the use of foreign assistance funds. It is important to ensure that USAID-supported activities remain compliant with USG legislation and policy related to FP targets. For this purpose, a target or quota is a predetermined number that a service provider or referral agent is assigned or required to affect or achieve. While it is permissible to use quantitative estimators or indicators for planning and budgeting purposes, it is important to ensure that they do not translate into quotas or targets for individual service providers at SDPs. Service providers and referral agents cannot be subject to quotas, or other numerical targets, of total number of births, number of FP acceptors, or acceptors of a particular FP method. Indicators related to FP acceptors or couple years of protection should not be used to motivate client or service provider performance. Projections should be reviewed and revised as necessary for overall activity planning purposes.
Additional Resources:	MEASURE Evaluation: "Percent of clients at an HIV service delivery point who received a family planning method" (https://www.measureevaluation.org/prh/rh_indicators/family-planning/family-planning-and-hiv/proportion-of-people-using-any-fp-method-who)

PMTCT_EID_ELIGIBLE

Description:	Number of HIV-exposed infants eligible for EID born in the last 12 months
Numerator:	Number of infants born to women who are HIV-positive born in the last 12 months
Denominator:	N/A
Reporting level:	Facility
Reporting frequency:	Quarterly
How to use:	This indicator measures the number of infants born to clients in the last 12 months, including the reporting period, who are HIV-positive and are therefore eligible for early infant diagnostic testing. This indicator represents the number of live births of infants to women who are HIV-positive as the first indicator in the EID cascade. This indicator therefore permits a more accurate calculation of proxy EID testing coverage when used as the denominator.
How to collect:	Ideally, this data can be collected from an electronic medical record system, but a register at maternity or labor and delivery can also be used. Count the total number of live births to HIV-positive women occurring in the last 12 months, including the reporting period.
How to calculate annual total:	This is a snapshot indicator and should not be summed across reporting periods. Each quarter represents 12 months / 4 quarters of data.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Age [Required]	Infants eligible for EID • 0-12 months
Age [Optional]	Infants eligible for EID • Infant is between birth and 2 months of age (<2mo):

		Age at the end of the reporting period ● Infants is between 2 and 12 months of age: Age at the end of the reporting period
Disaggregate descriptions and definitions:	**Infant age by end of reporting period:** For the numerator to be calculated, implementing partners are required to report: ● Infant is between birth and 2 months of age (<2mo): Age at the end of the reporting period (only live births should be documented) ● Infants is between 2 and 12 months of age: Age at the end of the reporting period (only live births should be documented)	
Guiding Narrative Questions:	1. Briefly describe the HIV-exposed infant testing algorithm used in the country. 2. Specify and briefly describe the data sources used to report on this indicator (e.g., clinical records (type), laboratory records). 3. How is the facility and community partner working together to track HEI due for a test to ensure they are tested according to timing detailed in algorithm? 4. What services/support are the facility and community partners providing to HIV-positive infants to link them to ART? 5. If EID cascade is not consistent across indicators and disaggregations, please explain. 6. Describe any barriers to collecting this indicator.	
Additional Considerations:	This is a snapshot indicator and should not be summed across reporting periods. Each quarter represents 12 months / 4 quarters of data. Use as the first indicator to construct an EID cascade: ● Number of HIV-exposed infants eligible for virologic testing in the last 12 months (PMTCT_EID_ELIGIBLE) ● Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period (PMTCT_EID) ● Percentage of HIV-exposed infants with a first virologic HIV test result documented in the medical or laboratory records/laboratory information systems (LIS) who have had results reported to caregivers by 12 months of age	

	(PMTCT_EID_SAMPLE_DOCUMENTED)

PMTCT_EID_SAMPLE_DOCUMENTED

Description:	Percentage of HIV-exposed infants with a first virologic HIV test result documented in the medical or laboratory records/laboratory information systems (LIS) who have had results reported to caregivers by 12 months of age.	
Numerator:	The number of HIV-exposed infants with a first virologic HIV test result reported to caregivers during the reporting period	Age refers to age at specimen (sample) collection for virologic testing
Denominator:	Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period	The numerator is a measure of the first sample collected for virologic testing and is the same as the PMTCT_EID numerator. Age refers to age at specimen (sample) collection
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator reports the extent to which infant virologic test results are being provided to caregivers. In PMTCT programs, it is critical that virologic test results are reported rapidly to caregivers to ensure the caregiver can follow up on clinical management of HIV-exposed infants. To accomplish this goal, it is important to track health facilities reporting laboratory results to caregivers. Implementing partners should aim to reach a benchmark of >95% of infant virological test (EID) results shared with the infant's caregiver. This indicator allows programs to assess any bottlenecks in reporting of infant virological test results. The sequence of events for completing an infant virological test is as follows: ● Infant blood draw occurs at a district hospital, rural health facility, or other health location. ● Blood sample is transported to the laboratory (or run on a	

	point-of-care platform at the health facility) ● Laboratory registers the sample upon intake. ● Laboratory processes the VL test with the blood sample. ● Laboratory documents the VL results. ● Laboratory returns the VL results to the hospital/health facility. ● Hospital/health facility registers the results. ● Caregiver must return to the hospital/health facility to obtain the test results.
How to collect:	To report on this indicator, PEPFAR supported sites would ideally use electronic medical registers, however PMTCT and DBS registers can be used. The indicator is disaggregated by the age of the infant at the time of sample collection, specifically between birth and 2 months and between 2 and 12 months of age. Only results reported for the first virologic test for each HIV-exposed infant should be counted in this indicator, including tests run using conventional platforms with dried blood spots (DBS) and samples collected for POC testing (e.g., mPima or GeneXpert). Even though there is ongoing exposure of infants to HIV (through breastfeeding), this indicator only measures reporting of results from a first test, and not reporting of results to all the recommended HIV tests throughout breastfeeding. This indicator should be collected from the clinical source (i.e., HIV-exposed infant registers or patient records) to ensure unduplicated patient counting. HIV-exposed infant registers should be used to count exposed infants and results reported for virologic testing. (If available, information could come from electronic systems). If the standard report does not contain all the required information, individual patient files should be used. Additional supporting information for this indicator can be obtained from standard laboratory information systems (i.e., DNA PCR or POC/near POC log books or electronic systems) however, it will be important to ensure that repeat tests of the same sample or HIV-infected infants receiving a confirmatory virologic HIV test result are not counted twice. The numerator is divided into two groups: first sample collected between birth and 2 months of age; first sample collected between 2 and 12 months of age. The 0-2 month and

<table>
<tr><td></td><td colspan="2">2-12-month age periods are based on age at collection of the sample, not on date of result return to the facility or caregiver. It is likely that at the time of reporting there will be samples that have been collected but for which no result is documented in the register or patient record.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum results across quarters</td></tr>
<tr><td rowspan="4">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Infant Test with results returned by Age at Sample Collection
[Required]</td><td>• Infants who had a first virologic test (sample collected) between birth and 2 months of age (<2mo): Age at the time the sample is collected should be reported.
• Infants who had a first virologic test (sample collected) between 2 and 12 months of age: Age at the time the sample is collected should be reported.</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Infant Test by Age at Sample Collection
[Required]</td><td>• Infants who had a first virologic test (sample collected) between birth and 2 months of age (<2mo): Age at the time the sample is collected should be reported.
• Infants who had a first virologic test (sample collected) between 2 and 12 months of age: Age at the time the sample is collected should be</td></tr>
</table>

		reported.
Disaggregate descriptions and definitions:	**Infant Test by Age at Sample Collection: For the numerator and denominator to be calculated, implementing partners are required to report:** ● Infants who had a first virologic test (sample collected) between birth and 2 months of age (<2mo): Age at the time the sample is collected should be reported. ● Infants who had a first virologic test (sample collected) between 2 and 12 months of age: Age at the time the sample is collected should be reported.	
Guiding Narrative Questions:	1. Briefly describe the HIV-exposed infant testing algorithm used in the country. 2. Specify and briefly describe the data sources used to report on this indicator (e.g., clinical records (type), laboratory records). 3. How is the facility and community partner working together to track HEI due for a test to ensure they are tested according to timing detailed in algorithm? 4. What services/support are the facility and community partners providing to HIV-positive infants to link them to ART? 5. If EID cascade is not consistent across indicators and disaggregations, please explain. 6. Describe any barriers to collecting this indicator.	
Other Considerations:	Use as the third indicator to construct an EID cascade: ● Number of HIV-exposed infants eligible for virologic testing in the last 12 minths (PMTCT_EID_ELIGIBLE) ● Number of infants who had a first virologic HIV test (sample collected) by 12 months of age during the reporting period (PMTCT_EID) ● Percentage of HIV-exposed infants with a first virologic HIV test result documented in the medical or laboratory records/laboratory information systems (LIS) who have had results reported to caregivers by 12 months of age (PMTCT_EID_SAMPLE_DOCUMENTED)	

TX_PVLS_ELIGIBLE

Description:	Number of antiretroviral therapy (ART) clients who are eligible for viral load (VL) testing within the last 12 months
Numerator:	Number of ART clients who are eligible for VL testing
Denominator:	N/A
Reporting level:	Facility
Reporting frequency:	Quarterly
How to use:	This indicator measures the number of adults and pediatric ART clients who have been initiated on ART, remained on treatment for at least three months, and need a routine VL. Viral load testing policies may differ across countries. Newer regimens of ART if taken as directed may rapidly suppress VL within three months. However, many countries have national guidelines recommending a routine VL at six months. Calculating the total number of clients eligible for VL testing can help improve client quality of care and planning for lab commodities and human resources needs at the facility and district levels. Use as the first indicator in the viral load cascade: • Number of antiretroviral therapy (ART) clients who are eligible for viral load (VL) testing within the last 12 months (TX_PVLS_ELIGIBLE) • Number of clients on ART for at least three months with a VL test sample collected within the past 12 months (benchmark >90% of eligible) (TX_PVLS_SAMPLE) • Number of VL test samples processed for clients who have been on ART for at least three months, collected within the last 12 months (TX_PVLS_SAMPLE_PROCESSED) • Number and percentage of clients on ART for at least three months with a VL test result documented in the medical or laboratory records/laboratory information systems (LIS) who have received the result within the past 12 months (TX_PVLS_SAMPLE_DOCUMENTED)

<table>
<tr><td>How to collect:</td><td colspan="2">Ideally, these data should be collected from an electronic medical record, but a register such as the ART register or ART database can be used also.
Count the total number of clients on ART for three months or more who have not yet had a VL test as well as clients with prior detectable VL test results.
Eligibility for baseline VL testing (VL tests performed prior to ART initiation) should not be included.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Numerator ≥ subtotal of each disaggregation: The total number of adults and children should be equal to the sum of all of the age/sex disaggregations.
TX_NEW Q1 + TX_NEW Q2 ≤ TX_PVLS_ELIGIBLE
TX_PVLS_ELIGIBLE ≤ TX_CURR</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">There will be no annual total. The numerator should not be summed across reporting periods due to the changing eligibility status of clients.</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td><1 M/F, 1–4 M/F, 5–9 M/F, 10–14 M/F, 15–19 M/F, 20–24 M/F, 25–29 M/F, 30–34 M/F, 35–39 M/F, 40–44 M/F, 45–49 M/F, 50+ M/F, unknown age M/F</td></tr>
<tr><td>Pregnancy/Breastfeeding status at ART initiation [Required]</td><td>• Pregnant
• Breastfeeding</td></tr>
<tr><td>Key population type
[Optional]

Note: this indicator is the same as TX_VL_ELIGIBLE in the KP Cascade Monitoring Guidance. However, KP type is required in the KP Cascade Monitoring Guidance.</td><td>• People who inject drugs (PWID)
• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People in prison and other closed settings</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
</table>

	N/A	N/A
Disaggregate descriptions & definitions:	**Indication Disaggregate Definitions:** Age/Sex: Age is defined as the age of the patient at the date of initiation on ART, not the age at the date of reporting. KP Type: Note: this indicator is the same as TX_VL_ELIGIBLE in the KP Cascade Monitoring Guidance	
Guiding Narrative:	7. Briefly describe the VL testing algorithm used in the country. Please ensure that the description includes differences in the VL monitoring algorithm for different sub-populations (e.g., key populations, pregnant women, children, etc.). 8. What proportion of those with a documented VL result are virally suppressed? 9. Specify and briefly describe the data sources used to report on this indicator (e.g., clinical records, client self-report, laboratory records). 10. How is the facility and community partner working together to track ART patients to confirm that they have a suppressed viral load within the past 12 months? 11. What services/support are the facility and community partners providing to ART patients with an unsuppressed VL result? 12. If cascade is not consistent across indicators and disaggregations, please explain. 13. Describe any barriers to collecting this indicator.	

TX_PVLS_SAMPLE

Description:	Number of clients on antiretroviral therapy (ART) for at least three months who have had a viral load (VL) test sample collected within the past 12 months
Numerator:	Number of clients on ART for at least three months who have had a VL test sample collected within the past 12 months
Denominator:	N/A
Reporting level:	Facility
Reporting frequency:	Quarterly
How to use:	This indicator measures the number of adult and pediatric ART clients on ART for at least three months who have had a VL test sample collected within the past 12 months. A client should be counted only once (i.e., this indicator does not count the number of total samples drawn during the reporting period). Within the reporting period, implementing partners should aim for a benchmark of >90% of clients eligible for a VL test to have had a VL sample collected. Use as the second indicator in the VL cascade: • Number of antiretroviral therapy (ART) clients who are eligible for viral load (VL) testing within the last 12 months (TX_PVLS_ELIGIBLE) • Number of clients on ART for at least three months with a VL test sample collected within the past 12 months (benchmark >90% of eligible) (TX_PVLS_SAMPLE) • Number of VL test samples processed for clients who have been on ART for at least three months, collected within the last 12 months (TX_PVLS_SAMPLE_PROCESSED) • Number and percentage of clients on ART for at least three months with a VL test result documented in the medical or laboratory records/laboratory information systems (LIS) who have received the result within the past 12 months (TX_PVLS_SAMPLE_DOCUMENTED)

<table>
<tr><td>How to collect:</td><td colspan="2">Ideally, these data should be collected from an electronic medical record, but a register such as the ART register, ART database, or VL register also can be used.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Numerator ≥ subtotal of each disaggregation: The total number of adults and children with time to diagnosis should be equal to the sum of all of the age/sex disaggregations.
TX_PVLS_SAMPLE ≤ TX_CURR</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">There will be no annual total. The numerator should not be summed across reporting periods due to the varying 12-month time periods for cohorts of clients.</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td><1 M/F, 1–4 M/F, 5–9 M/F, 10–14 M/F, 15–19 M/F, 20–24 M/F, 25–29 M/F, 30–34 M/F, 35–39 M/F, 40–44 M/F, 45–49 M/F, 50+ M/F, unknown age M/F</td></tr>
<tr><td>Pregnancy/Breastfeeding status at ART initiation [Required]</td><td>• Pregnant
• Breastfeeding</td></tr>
<tr><td>Key population type
[Optional]</td><td>• People who inject drugs (PWID)
• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People in prison and other closed settings</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="3">Indication Disaggregate Definitions:
Age/Sex: Age is defined as the age of the patient at the date of initiation on ART, not the age at the date of reporting.</td></tr>
</table>

Guiding narrative questions (if applicable):	1. Briefly describe the VL testing algorithm used in the country. Please ensure that the description includes differences in the VL monitoring algorithm for different sub-populations (e.g., key populations, pregnant women, children, etc.). 2. What proportion of those with a documented VL result are virally suppressed? 3. Specify and briefly describe the data sources used to report on this indicator (e.g., clinical records, client self-report, laboratory records). 4. How is the facility and community partner working together to track ART patients to confirm that they have a suppressed viral load within the past 12 months? 5. What services/support are the facility and community partners providing to ART patients with an unsuppressed VL result? 6. If cascade is not consistent across indicators and disaggregations, please explain. 7. Describe any barriers to collecting this indicator.

TX_PVLS_RESULT_DOCUMENTED

Description:	Number and percentage of clients on antiretroviral therapy (ART) for at least three months with a viral load (VL) test result documented in the medical or laboratory records/laboratory information systems (LIS) who have received the results within the past 12 months
Numerator:	Number of ART clients with documented and returned viral load test result
Denominator:	Number of VL test samples processed for clients who were on ART for at least three months
Reporting level:	Facility
Reporting frequency:	Quarterly
How to use:	This indicator measures the extent to which VL test results are being provided to clients. Implementing partners should aim to reach a benchmark of >95% of samples collected being processed, documented in the client file and shared with the client. The sequence of events for completing a VL test is as follows: ● Viral load blood draw occurs at a district hospital, rural health facility, or other health location. ● Blood sample is transported to the laboratory. ● Laboratory registers the sample upon intake. ● Laboratory processes the VL test with the blood sample. ● Laboratory documents the VL results. ● Laboratory returns the VL results to the hospital/health facility. ● Hospital/health facility registers the results. ● Client must return to the hospital/health facility to obtain the VL results. Use as the fourth indicator in the viral load cascade: ● Number of antiretroviral therapy (ART) clients who are eligible for viral load (VL) testing within the last 12 months (TX_PVLS_ELIGIBLE) ● Number of clients on ART for at least three months with a VL test sample collected within the past 12 months

<table>
<tr><td></td><td>(benchmark >90% of eligible) (TX_PVLS_SAMPLE)
• Number of VL test samples processed for clients on ART for at least three months, collected within the last 12 months (TX_PVLS_SAMPLE_PROCESSED)
• Number and percentage of clients on ART for at least three months with a VL test result documented in the medical or laboratory records/LIS who have received the result within the past 12 months (TX_PVLS_SAMPLE_DOCUMENTED) (benchmark >95% of samples collected)</td></tr>
<tr><td>How to collect:</td><td>ART database, ART register, VL register, VL database, electronic medical record

Using client records, record the number of files of clients eligible for a VL test that have a VL test result in their records. This will allow you to assess if the client VL results were returned to the facility.

There is currently no way to measure if the client received their VL test results. USAID would like partners to collect this through special information gathering exercises – targeted data collection which includes interviews with clients or physicians, for example. USAID recognizes that until there are systems in place to automatically capture if VL test results were shared (for example in client records), the quality will be low. The goal is that the data quality improves over time.</td></tr>
<tr><td>How to review for data quality:</td><td>Numerator ≥ subtotal of each disaggregation: The total number of adults and children should be equal to the sum of all of the age/sex disaggregations. TX_PVLS_SAMPLE_DOCUMENTED ≤ TX_ PVLS_SAMPLE_PROCESSED</td></tr>
<tr><td>How to calculate annual total:</td><td>There will be no annual total. The numerator should not be summed across reporting periods due to the varying 12-month time periods for cohorts of clients.</td></tr>
<tr><td>Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td></td><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>Age/Sex
[Required]</td><td><1 M/F, 1–4 M/F, 5–9 M/F, 10–14 M/F, 15–19 M/F, 20–24 M/F, 25–29 M/F, 30–34 M/F, 35–39 M/F, 40–44 M/F, 45–49 M/F, 50+ M/F, unknown age M/F</td></tr>
</table>

	Pregnancy/Breastfeeding status at ART initiation [Required]	• Pregnant • Breastfeeding
	Key population type [Required]	• People who inject drugs (PWID) • Men who have sex with men (MSM) • Transgender people (TG) • Female sex workers (FSW) • People in prison and other closed settings
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	Age/Sex [Required]	<1 M/F, 1–4 M/F, 5–9 M/F, 10–14 M/F, 15–19 M/F, 20–24 M/F, 25–29 M/F, 30–34 M/F, 35–39 M/F, 40–44 M/F, 45–49 M/F, 50+ M/F, unknown age M/F
	Pregnancy/Breastfeeding status at ART initiation [Required]	• Pregnant • Breastfeeding
	Key population type [Required]	• People who inject drugs (PWID) • Men who have sex with men (MSM) • Transgender people (TG) • Female sex workers (FSW) • People in prison and other closed settings
Disaggregate descriptions & definitions:	**Indication Disaggregate Definitions:** Age/Sex: Age is defined as the age of the patient at the date of initiation on ART, not the age at the date of reporting. KP Type: Note: this indicator is the same as TX_VL_ELIGIBLE in the KP Cascade Monitoring Guidance	
Guiding narrative questions:	1. Briefly describe the VL testing algorithm used in the country. Please ensure that the description includes differences in the VL monitoring algorithm for different sub-populations (e.g., key populations, pregnant women, children, etc.).	

	2. What proportion of those with a documented VL result are virally suppressed? 3. Specify and briefly describe the data sources used to report on this indicator (e.g., clinical records, client self-report, laboratory records). 4. How is the facility and community partner working together to trackART patients to confirm that they have a suppressed viral load within the past 12 months? 5. What services/support are the facility and community partners providing to ART patients with an unsuppressed VL result? 6. If cascade is not consistent across indicators and disaggregations, please explain. 7. Describe any barriers to collecting this indicator.

SC_ARVDISP

Description:	The number of adult and pediatric ARV bottles (units) dispensed by ARV drug category at the end of the reporting period	
Numerator:	Number of ARV bottles (units) dispensed within the reporting period by ARV drug category	Number of bottles of ARVs by category dispensed to patients
Denominator:	N/A	
Reporting level:	Facility	
Reporting frequency:	Quarterly	
How to use:	This indicator measures the number of ARV bottles of several types of ARVs dispensed from a facility. These data should be used to help understand uptake, transition and maintenance of patients to optimized ARV regimens, as well as the phasing out of non-optimal regimens. By reviewing trends over time by each ARV category, programs should monitor coverage of DTG-based regimens relative to other regimens down to the implementing partner and facility level. In addition, data from this indicator should prompt action to investigate any specific sites dispensing regimens which may not be supported by the WHO Standard Treatment Guidelines (STGs).	
How to collect:	This indicator should be collected from facility dispensing registers, reported at the facility level, based on data available to the facility-based implementing partner, and could include: host government-supported Logistics Management Information System (LMIS). Operating Units (OUs) should work with IPs supporting facilities and/or the supply chain partners to access the facility dispensing registers or the LMIS to consolidate dispensing data by facility and ARV category. This indicator should be reported from PEPFAR-supported facilities which provide treatment or report on treatment indicators, specifically: TX_NEW, TX_CURR, PMTCT_ART, and TB_ART. If an OU or a facility in a given OU, does not report on any of these indicators, then they are not required to report on SC_ARVDISP.	

<table>
<tr><td></td><td colspan="2"><u>ARV Dispensation Data Versus 'Issues Data'</u>

If data on ARV dispensation are not available, 'issues data' may be used for reporting. 'Issues data' is defined as bottles of ARVs provided to facilities from a distribution center. If 'issues data' are used for reporting, include the following in the narrative section: (1) an explanation for doing so and (2) what steps will be taken to provide ARV dispensation data in the future. If data on ARV dispensation are incomplete at the end of the reporting period, use EITHER 'issues data' or 'dispensed data'. If availability of dispensed data does not align with the PEPFAR reporting period, use the data available from that reporting period and include the following in the narrative: (1) rationale for the data discrepancy and (2) which months are included in the data reported.

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

Do not include any PrEP commodities in this indicator reporting.

For Drug categories: "Other" categories include medications like Abacavir or Lopinavir/Ritonavir (stronger than 40/10). These are expected to be a much smaller proportion of the total than Tenofovir-based regimens</td></tr>
<tr><td rowspan="2">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>ARV Category
[Required]</td><td>• TLD 30-count bottles
• TLD 90-count bottles
• TLD 180-count bottles
• TLE/400 30-count bottles
• TLE/400 90-count bottles
• TLE 600/TEE bottles
• LPV/r 40/10 (pediatric) bottles
• NVP (adult) bottles
• NVP (pediatric), (not including NVP 10) bottles
• Other (adult) bottles
• Other (pediatric) bottles</td></tr>
</table>

		• DTG 10 bottles (90-count) • DTG 10 bottles (180-count)
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A

SC_CURR	
Description:	The current number of ARV drug units (bottles) at the end of the reporting period by ARV drug category
Numerator:	The number of ARV drug units (bottles) at the end of the reporting period by ARV drug category
Denominator:	N/A
Reporting level:	PEPFAR-supported facilities as well as intermediate or central warehouses and/or locations where ARVs are held in inventory)
Reporting frequency:	Quarterly
How to use:	This indicator measures the number of ARV drug units available at the time of reporting. This can serve as an indication of the current stock levels at PEPFAR-supported facilities. The indicator is designed to provide insight into the 'on-the-shelf' availability of crucial products, required for HIV treatment. Data from this indicator may be coupled with SC_ARVDISP to determine how long the quantity of stock will last based on past ARV dispensation records. Similarly, data from this indicator can be used with forecasting data to illustrate that either sufficient stock are available for future or an upcoming need by ARV category exists. Data from SC_CURR can be used in many ways, such as: (1) to justify a change in the supply plan (i.e., if one ARV drug category is overstocked while another is understocked), (2) to illustrate if a ARV drug category is not being dispensed as anticipated, (3) to determine if an ARV drug category is overstocked, (4) to determine where ARVs may be overstocked, (5) to identify bottlenecks or sites where stock is available and, when coupled with SC_ARVDISP, not dispensed. Data can also be used to examine the relationship between facilities dispensing to patients and sites providing ARVs to dispensing sites (i.e., warehouses) to determine if quantities held at any site are reasonable.

<table>
<tr><td>How to collect:</td><td colspan="2">This indicator should be collected from facility dispensing registers or stock records, reported at the site level, based on data available to the facility-based implementing partner, but could include host government-supported Warehouse or Logistics Management Information System(s) (LMIS) as well. Operational Units (OUs) should work with IPs supporting facilities and/or the supply chain IPs to access facility dispensing registers or the LMIS to consolidate dispensing data by site and ARV category for reporting.

This indicator should be used to describe any anticipated stock-outs, ARV gaps, or are unable to extend their treatment coverage due to supply constraints. In addition, programs should utilize monthly data on each ARV drug category, when available, especially if those data are collected for donor organization and collaboration (such as the PPMR-HIV or SC- FACT).
● If any OU does not support one of the drugs in the disaggregate list, report zero and note it in your narrative.

Do not include PrEP commodities in this indicator.

For drug categories:The “Other” categories include medications like single molecule Abacavir or Lopinavir/Ritonavir (stronger than 40/10) which are expected to be a much smaller proportion of the total than Tenofovir-based regimens.</td></tr>
<tr><td rowspan="2">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>ARV Category
[Required]</td><td>● TLD 30-count bottles
● TLD 90-count bottles
● TLD 180-count bottles
● TLE/400 30-count bottles
● TLE/400 90-count bottles
● TLE 600/TEE bottles
● LPV/r 40/10 (pediatric) bottles
● NVP (adult) bottles
● NVP (pediatric), (not including NVP 10) bottles
● Other (adult) bottles</td></tr>
</table>

		• Other (pediatric) bottles • DTG 10 bottles (90-count) • DTG 10 bottles (180-count)
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A

SC_LMIS

Description:	LMIS reporting rate by country
Numerator:	Number of facilities which reported into the LMIS during the reporting period
Denominator:	Number of facilities that should have reported into the LMIS during the reporting period
Reporting level:	SNU
Reporting frequency:	Quarterly
How to use:	If one has an understanding of how many facilities reported during the reporting period one can answer questions regarding completeness as well as determine a relative confidence that the data describe the situation on the ground. Likewise, it is also possible to determine from the LMIS data if a specific geographic area is not reporting or if reporting is less common at a certain level of the system.
How to collect:	1. Determine the total number of PEPFAR sites in the lowest SNU either from a national site list or a PEPFAR site list. This number will serve as the SNU numerator. 2. Refer to the most recent version of the country's Logistics Management Information system (LMIS). This may be electronic or it may be in excel. Regions, Provinces, States, Zones, or the Central level should have a copy of this information. **Look at the LMIS data and filter by the lowest SNU and PEPFAR support**. 3. Count the number of PEPFAR supported sites that reported into the LMIS in the most recent reporting period. That number will serve as the SNU denominator. 4. Calculate the results by SNU.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Group	Disaggregates
Number of sites [Required]	Total number of PEPFAR Supported site reporting into LMIS

Denominator Disaggregations:

Disaggregate Group	Disaggregates

	Number of sites [Required]	Total number of PEPFAR Supported sites

GEND_GBV		
Description:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package	
Numerator:	Number of people receiving post-gender based violence (GBV) clinical care based on the minimum package	This indicator DOES NOT include GBV prevention activities or non-clinical community-based GBV response.
Denominator:	N/A	
Indicator changes (MER 2.0 v2.4 to v2.5):	Reporting frequency changed from annual to semi-annual	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This is the PEPFAR MER GEND_GBV indicator, but reported quarterly rather than semiannually. This indicator measures delivery of a basic package of post-GBV clinical services (including PEP and EC) as a result of any GBV i.e. not limited to GBV associated with any HIV service delivery activities. NOTE: This indicator DOES NOT include GBV Prevention activities or non-clinical community-based GBV response (e.g., shelter programs, case management). This indicator will enable PEPFAR to: ● To determine the number of individuals that are suffering from GBV and reporting to clinical partners. ● To assess whether post-GBV clinical services are being used. ● Gain an understanding of the uptake of post-GBV clinical services offered across PEPFAR countries. ● Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. • Support efforts to assess the impact of post-GBV clinical services by correlating the reach (i.e., number of people served) of these services over time with outcomes related	

	to GBV (and HIV/AIDS), as described through other data collection efforts such as survey data (DHS/PHIA/VACS). ● Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.
How to collect:	Data sources are standard program monitoring tools, such as forms, log books, spreadsheets and databases that national programs and /or partners develop or already use. Data should be collected continuously at the point of service delivery (i.e., ANC, PMTCT, ART, etc.) and aggregated in time for PEPFAR reporting cycles. The indicator can be generated by counting the number of persons receiving post-GBV clinical care, disaggregated by the age group and sex of the client receiving the service, as well as the type of service (sexual violence or emotional/physical violence) and PEP completion (see below for disaggregation information). To adequately capture the provision of these services, logs and monitoring forms will need to be used wherever the services are offered. These forms will need to track both the outcome of the initial assessment and the provision of referrals or services. For PEP specifically, registries should collect both the administration of the PEP as well as its completion and the patient's adherence. **Special considerations:** As outlined in the Program Guide for Integrating GBV Prevention and Response in PEPFAR Programs all programs seeking to address GBV must first and foremost protect the dignity, rights, and well-being of those at risk for, and survivors of, GBV. There are four fundamental principles for integrating a GBV response into existing programs and specific actions for putting these principles into practice. These principles are as follows: ● Do no harm ● Privacy, confidentiality, and informed consent ● Meaningful engagement of people living with HIV (PLHIV) and GBV survivors + Accountability and M&E

<table>
<tr><td>How to review for data quality:</td><td colspan="2">Numerator ≥ subtotal of each of the disaggregations: The number of people receiving post GBV clinical care should be greater or equal to the sum of each individual disaggregate group.

Total sexual violence numerator ≥ PEP age/sex disaggregates for the same reporting period.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum across both reporting periods; de-duplicating unique individuals already reached and reported in Q1-Q2 of the same fiscal year in Q4 reporting.</td></tr>
<tr><td rowspan="3">Disaggregations</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Violence Service Type by Age/Sex
[Required]</td><td>Sexual Violence by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M

Physical and/or Emotional Violence by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35- 39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Number of People Completing Post-Exposure Prophylaxis (PEP) Services by Age/Sex (Disaggregate of the Sexual Violence Service Type)
[Required]</td><td>Completed PEP by: <10 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">Violence Service Type Disaggregate Definitions:
Sexual violence (post-rape care): Although guidelines for post-rape care will vary from country to country, in addition to treatment of serious or life-threatening medical issues (e.g., lacerations, broken bones) and the necessary forensic interviews</td></tr>
</table>

	and examinations, the minimum package of post-rape care services should always begin with an assessment of the client's specific needs. The following represents the Minimum Package for post-rape care services that must be in place to count under this indicator: ● Provision of Clinical Services: (all of the following must be in place, including relevant commodities, and ability to count individuals—independent of whether individuals use the specific service) ● Rapid HIV testing with referral to care and treatment as appropriate ● Post exposure prophylaxis (PEP) for HIV -- if person reached within the first 72 hours • STI screening/testing and treatment ● Emergency contraception, if person is reached in the first 120 hours. PEPFAR funds cannot be used to procure EC. EC is legal in all PEPFAR countries except Honduras, so should be available in all countries except for Honduras ● Counseling (other than counseling for testing, PEP, STI and EC) **Physical and/or emotional violence (other Post-GBV care):** GBV can take many forms and includes physical and emotional violence. **The following services should be available for persons who have experienced GBV that is not sexual. If a client experiences both sexual and physical and/or emotional violence, the client should be counted under the sexual violence disaggregate-only. However, the client should receive the appropriate services as defined under both packages. Services** should always begin with an assessment of the client's specific needs and include, as appropriate. The following represents the Minimum Package for other post-GBV care services that must be in place to count under this indicator: ● Provision of Clinical Services: (all the following must be in place and available to count persons—independent of whether people use the specific service) ● Rapid HIV testing with referral to care and treatment as appropriate (Please note that individuals should also be counted under the MER HIV testing and counseling indicator (i.e., # of individuals who received HIV testing and counseling services and received their results).

	• STI screening/testing and treatment • Counseling (other than for HIV counseling and testing) **For both Sexual violence and Physical and/or emotional violence: These** cannot be counted for the indicator alone, however where applicable should be offered: • Longer-term psycho-social support (e.g., peer support groups) • Legal counsel • Police • Child protection services • Economic empowerment **Number of People Completing Post-exposure prophylaxis (PEP) Services Description:** PEP service provision should only be counted under this indicator if the individual receives PEP treatment (i.e., drugs) in accordance with international and/or national protocols, guidelines, etc., and if the individual **completes** the full course of treatment. If an individual is provided with PEP, completes the full course of treatment (and meets the other criteria detailed within this indicator reference sheet) the individual should be counted under this GBV care indicator. The individual should not be additionally counted under other MER treatment indicators (e.g., # of individuals new on ART; # of individuals ever on ART, etc.) PEP is intended to prevent HIV infection, while other MER treatment indicators monitor ARV provision to those who are HIV positive.
PEPFAR support definition:	Standard definition of DSD and TA-SDI used. Provision of key staff or commodities for GEND_GBV includes: ongoing procurement of commodities (e.g., ARVs, rapid HIV test kits, STI testing or treatment commodities) or funding of salaries (partial or full) for HCW actively delivering the components of GBV care in accordance with international or national protocols or guidelines [i.e., physicians, nurses, and other health care workers who can assess GBV and provide treatment and appropriate referrals. Ongoing support for GEND_GBV service delivery improvement includes: mentoring and supportive supervision, training, guidance development, site level QA/QI, regular assistance with monitoring and evaluation functions and data quality assessments, or commodity consumption forecasting and supply management.

Guiding narrative questions:	1. How are GBV cases identified in the community and/or at the facility? If cases are identified in the community, how are they referred to a facility for post-GBV clinical care? 2. Of those coming in for services who are screened and disclose sexual violence, what proportion receive PEP? What proportion of those who disclose sexual violence refuse PEP? 3. Is site level data on the type of violence disclosed collected? If so, please provide available data in the narratives on the proportion that disclose physical and/or emotional violence, and of those choose to receive services. 4. What proportion of clients experienced both sexual and physical/emotional violence? a. Note: If clients experience both sexual and physical/emotional violence, they should only be counted under sexual violence to ensure that there is no duplication.

VMMC_AE

Description:	Number of moderate and severe adverse events (AEs) reported during the reporting period
Numerator:	Number of AEs reported during the reporting period
Denominator:	Number of VMMCs performed
Reporting level:	Facility
Reporting Frequency	Quarterly
How to use:	This indicator will be used to monitor safety and quality of VMMC services. Data will be collected at the site level and will be compared across IPs and OUs to identify AE clusters in order to promptly intervene and course correct. The indicator will be linked with the follow up rate obtained from the VMMC_CIRC indicator (i.e. AE information is obtained from MCs for which follow up is performed). Ideally, we expect the follow up rate to be 100%. Threshold for AE rate is <2.0% per reporting period.
How to collect:	The numerator (#AEs) can be generated by counting the number of moderate and severe AEs, which should be a component of VMMC program monitoring. The denominator 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 Registers, or client medical records maintained by each program/site/service provider.
How to review for data quality:	Total numerator for VMMC_AE = SUM of age disaggregates = SUM AE type disaggregates= SUM of circumcision method disaggregates= SUM of site type disaggregates
Disaggregations:	**Numerator Disaggregations**

Disaggregate Groups	Disaggregates
Age [Required]	10-14 M, 15-19 M, 20- 24 M, 25-29 M, 30-34 M, 35-39 M, 40-44 M, 45-49 M, 50+ M, Unknown Age M

	AE Type [Required]	• Moderate • Severe • Unknown
	Circumcision Method [Required]	**Surgical method:** • Dorsal Slit • Forceps-guided • Sleeve Resection • Other • Unknown **Device**: • Shang Ring
	Site Type [Required]	• Static • Outreach • Mobile • Unknown

TX_NEW_VERIFY

Description:	Number of HIV-positive KPs verified as newly enrolled on antiretroviral therapy (ART)
Numerator:	Number of HIV-positive KPs verified as newly enrolled on antiretroviral therapy (ART)
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	The indicator measures the coverage of case management-type services provided by non-treatment partners for supporting and ensuring new ART enrollment of HIV-positive KP clients identified through KP programs. This KP-funded assistance specifically refers to active KP peer-navigation or case-management for ART initiation. Reporting of TX_NEW_VERIFY will help foster accountability and coordination between KP non-treatment partners and partners that provide clinical care by measuring new enrollment in treatment of HIV-positive KP clients identified through the KP program. This indicator will form part of a KP monitoring activity to ensure the treatment cascade, which will help demonstrate the impact of KP programs. Disaggregations by KP type will help show the ability of KP programs to reach target groups and the relative effectiveness of ART enrollment efforts. This indicator represents a new method to record the full cascade of services provided to KP who are often lost in TX_NEW documentation at ART sites that do not collect data on KP status. The MER Indicator Reference Guide 2.5 provides instructions on the collection and use of TX_NEW, which apply to TX_NEW_VERIFY, except when indicated. KP members who are newly initiated on treatment directly by the KP partner will be reported through the analogous MER indicator, TX_NEW. From MER Indicator Reference Guide 2.5 on TX_NEW: 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. Please refer to the Key Population Cascade Monitoring Guide for additional details. As relevant, all partners should report on these indicators. Those reporting for KPIF should continue reporting per established processes, but any partners not currently reporting should use the central custom indicators reporting template and process.
How to collect:	This indicator can be generated by counting the number of newly diagnosed individuals successfully navigated to an ART facility and verified to have been newly initiated on ART. This indicator should be reported by all KP partners who do not offer treatment to KP clients but are funded to provide KP case management-type activities. KP clinical partners who provide ART to their KP beneficiaries are expected to record and report TX_NEW with KP disaggregates into DATIM and should NOT be reporting on this TX_NEW VERIFY indicator. In some cases, a KP clinical provider will also use case managers to verify that KP clients who elect to access outside ART facilities are actually being initiated on ART elsewhere. Verification of ART initiation requires visual confirmation from clinical data sources and documentation of key enrollment dates. Clinical data sources can include 1) treatment registers or patient files, 2) national or clinic program data systems, or 3) ART patient card or ARV pickup card that clearly documents the confirmation of patient being newly initiated on ART in the reporting period. In order to count individuals under TX_NEW_VERIFY, KP partners must document date of ART initiation and the data source used for confirmation.

<table>
<tr><td></td><td>Key factors to consider for both TX_NEW_VERIFY and TX_CURR_VERIFY are:
KP programs often have a dual approach consisting of ART initiation and/or ART referral
Peer navigators in community settings and ART clinic “coordinators” may have a role in both models
Collaboration is needed between outreach teams and clinic teams to refer and document new enrollment on ART
KP status not mandatory in the ART clinical record but validation that a KP individual from HTS was successfully linked to an ART site is needed to show successful KP services cascades
Further evolution in streamlined systems may match KP outreach UICs with ART number in electronic systems
From MER Indicator Reference Guide 2.5 on TX_NEW: Facility ART registers/databases, program monitoring tools, or drug supply management systems. The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards). Patients who known to transfer in from another facility, or who temporarily stopped therapy and have started again should not be counted as new patients. Patients who have been off treatment from >28 days and restart ART should be not be counted in TX_NEW_VERIFY. • 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.</td></tr>
<tr><td>How to review for data quality:</td><td>This indicator forms part of a cascade that includes HTS_TST, HTS_TST_POS (and KP_PREV on a semi-annual basis) and the counts reported for all KP disaggregates should be consistent across the cascade. Numerator ≥ subtotal of each disaggregation. Confirm that TX_CURR_VERIFY ≥ TX_NEW_VERIFY and TX_NEW_VERIFY ≤ HTS_TST_POS for a particular partner.</td></tr>
<tr><td>How to calculate annual total:</td><td>Sum results across quarters</td></tr>
<tr><td rowspan="2">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
</table>

<table>
<tr><td rowspan="5"></td><td>Type of clinical site and by Key population
[Required]</td><td>Verified at PEPFAR-supported Site, by Key Populations:
Men who have sex with men (MSM)
Transgender people (TG)
Female sex workers (FSW)
People who inject drugs (PWID)
People in prison and other closed settings *
Non-KP (Gen Pop)**
Verified at non-PEPFAR supported Site, by Key Populations:
Men who have sex with men (MSM)
Transgender people (TG)
Female sex workers (FSW)
People who inject drugs (PWID)
People in prison and other closed settings*
Non-KP (Gen Pop)**</td></tr>
<tr><td>Age/Sex
[Optional]</td><td><20F, <20M, 20-24F, 20-24M, 25-29F, 25-29M, 30-34F, 30-34M, 35-39F, 35-39M, 40-44F, 40-44M, 45-49F, 45-49M, 50+F, 50+M</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td colspan="2">*This is likely rare but retaining for consistency with other KP disaggregations.
**Example: partner of KP index client contacted and tested negative for HIV through KP index testing.</td></tr>
</table>

	Key population disaggregate values are: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); and, People in prison and other closed settings. As stated in the MER guidance, reporting of key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which s/he is most identified to avoid double-counting.
Guiding narrative questions (if applicable):	1. What services/support does the outreach worker/peer navigator/case manager provide to ensure that a newly diagnosed individual is successfully linked to treatment? 2. What proportion of those newly diagnosed are successfully linked to a treatment site? 3. How is the facility and community partner tracking newly diagnosed individuals to ensure they attend scheduled appointments and, if absent, are quickly contacted and supported to attend his/her next appointment? 4. Can comparisons be made between those receiving community support vs. those not receiving community support and TX_NEW? 5. If cascade is not consistent across indicators and KP disaggregations, please explain. 6. Describe any barriers to collecting this indicator

TX_CURR_VERIFY

Description:	Number of HIV-positive KP clients that have been reached by KP programs and are verified as currently enrolled on ART at the end of the reporting period
Numerator:	Number of HIV-positive KP clients that have been reached by KP programs and are verified as currently enrolled on ART at the end of the reporting period
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	The indicator measures the coverage of case management-type services provided by non-treatment partners for ensuring and confirming ART retention of HIV-positive KP clients supported through KP activities. Reporting of TX_CURR_VERIFY will help foster accountability and coordination between KP non-treatment partners and partners that provide clinical care by measuring current enrollment and retention in treatment of HIV-positive KP clients identified through KP programs. This indicator will form part of a KP-specific treatment cascade, which will help demonstrate the impact of KP programs. Disaggregations by KP type will help show the ability of KP programs to reach target groups and the relative effectiveness of ART enrollment efforts. KP members who are provided treatment directly by the KP partner will be reported through the analogous MER indicator, TX_CURR. This indicator represents a new method to record the full cascade of services provided to KP who are often lost in TX_CURR documentation at ART sites that do not collect data on KP status. The MER Indicator Reference Guide 2.5 provides instructions on the collection and use of TX_CURR, which apply to TX_CURR_VERIFY, except when indicated. KP members who are newly initiated on treatment directly by the KP partner will be reported through the analogous MER indicator, TX_CURR. Based on some PEPFAR countries' work, the following programmatic activities can assist in a) documenting/verifying a KP client is started on ART and b) remains on ART:

	• Consider a model for treatment initiation by collaborating MOH partners at the outreach event, i.e., with same-day enrollment (as in the FIKIA model in Tanzania) • Engage service providers in all ART sites to improve patient education and empowerment on knowledge of treatment and viral suppression, especially for KP clients who may find more barriers to accessing MOH facilities • Ensure adherence and retention for KPs with emphasis on U=U messages at multiple levels (community, provider, and regional/national) • Implement treatment optimization – e.g., DTG for KPs, including FSWs • Implement Differentiated Service Delivery models for KPs with 6 months prescription and dispensing using a patient-centered approach once patient is stable • Implement 100% viral load access and at least 95% suppression for KPs This indicator represents a new method to record the full cascade of services provided to KP who are often lost in TX_CURR documentation at non-KP-focused ART sites. The MER Indicator Reference Guide 2.5 provides instructions on the collection and use of TX_CURR which apply to TX_CURR_VERIFY, except when indicated. Multi-Month Dispensing (MDD) seeks to address retention and adherence support. This method of differentiated ART delivery supports countries by decreasing the burden on health facilities and patients by reducing the number of visits for refills and preventing overcrowding at facilities. It also increases treatment initiation, patient retention, and viral load suppression. Countries in low-resource settings may have challenges with regards to providing patients with longer refills. The main purpose of MMD or differentiating ART delivery is to better provide for the patient's specific needs at a particular point along their continuum of care. Treatment outcomes may be improved by reducing the frequency of clinical review visits and facilitating ART refill collection within key population communities or at community sites where key population members feel comfortable. Task shifting ART refill visits to key population peers

	can increase involvement of key population communities and organizations and support improved outcomes. From MER Indicator Reference Guide 2.5 on TX_CURR: *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.* Please refer to the Key Population Cascade Monitoring Guide for additional details. As relevant, all partners should report on this indicator. Those reporting for KPIF should continue reporting per established processes, but any partners not currently reporting should use the central custom indicators reporting template and process.
How to collect:	This indicator should be reported by all KP partners who do not provide ART services but rather provide case management services to KP clients who are established and retained on ART. KP clinical partners who provide ART to their KP beneficiaries are expected to record and report TX_CURR with KP disaggregates into DATIM and should NOT be reporting on this TX_CURR_VERIFY indicator. As mentioned under TX_NEW_VERIFY, some KP clinical partners may record TX_CURR_VERIFY if KP clients access other facilities not supported by PEPFAR and the KP partner implements case management activities to ensure that all KP clients are retained on ART at non-PEPFAR-funded or non-KP specific sites. Verification of ART retention requires visual confirmation from clinical data sources and documentation of key ART dates (see excerpt from MER 2.5 below). Clinical data sources can include 1) treatment registers or patient files, or 2) national or clinic program data systems, or 3) ART patient card (i.e. last schedule visit was completed and ART dispensed) or ARV pickup card. In order to count individuals under TX_CURR_VERIFY, KP partners must document either 1) the drug pick-up date and number of days pills were dispensed; or 2) next drug pick-up date (proxy for when ART pills will run out) based on data source aforementioned.

	Key factors to consider for both TX_NEW_VERIFY and TX_CURR_VERIFY are: ● KP programs often have a dual approach consisting of ART initiation and/or ART referral ● Peer navigators in community settings and ART clinic "coordinators" have a role in both models ● Collaboration is needed between outreach teams and clinic teams to refer and document new enrollment on ART ● KP status not mandatory in the ART clinical record but validation that a KP individual from HTS was successfully linked to an ART site is needed to show successful KP services cascades ● Further evolution in streamlined systems may match KP outreach UICs with ART number in electronic systems Adapted from MER Indicator Reference Guide 2.5 on TX_CURR: *This indicator should be collected from facility ART registers/databases, program monitoring tools, and drug supply management systems. Importantly, patients who have not received ARVs within four weeks (i.e., 28 days) of their last missed drug pick-up should not be counted.* *The following should also be considered: (1) Patients on ART who initiated or transferred-in during the reporting period should be counted. (2) Patients that pick up 3 or more months of ARV drugs at one visit (i.e., MMD) should also be counted as long as they have received enough ARVs to last to the end of the reporting period at a minimum. However, if it is determined that a patient has died, they should immediately be removed from the TX_CURR_VERIFY results.* *Patients excluded from the current on ART count are patients who died, stopped treatment, transferred out, or are lost to follow-up. Patients who have not received ARVs within four weeks (i.e. 28 days) of their last missed drug pick-up should not be counted. Patients do not need to qualify as lost to follow-up before tracing efforts commence. Efforts to trace patients that have missed a clinical visit or drug pick-up should begin immediately following a missed clinical contact. TX_ML describes the PEPFAR-recommended patient tracing process in more detail.*
How to review for data quality:	This indicator forms part of a cascade that includes TX_PVLS_VERIFY and the counts reported for all KP disaggregates should be consistent across the cascade (i.e., the number of MSM verified as currently on ART should be greater than the number of

<table>
<tr><td></td><td colspan="2">MSM with verified viral load results within the last 12 months (TX_PVLS or TX_PVLS_VERIFY). Confirm that TX_CURR_VERIFY ≥ TX_NEW_VERIFY for a particular partner. Periodic DQAs are recommended for KP program indicators that require coordination and communication across partners.</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Type of clinical site and by Key population
[Required]</td><td>Verified at PEPFAR-supported Site, by Key Populations:
Men who have sex with men (MSM)
Transgender people (TG)
Female sex workers (FSW)
People who inject drugs (PWID)
People in prison and other closed settings *
Non-KP (Gen Pop)**
Verified at non-PEPFAR supported Site, by Key Populations:
Men who have sex with men (MSM)
Transgender people (TG)
Female sex workers (FSW)
People who inject drugs (PWID)
People in prison and other closed settings*
Non-KP (Gen Pop)**</td></tr>
<tr><td>Multi-month dispensing
[Optional]</td><td><3 months
3-5 months
6+ months</td></tr>
</table>

	Age/Sex [Optional]	<20F, <20M, 20-24F, 20-24M, 25-29F, 25-29M, 30-34F, 30-34M, 35-39F, 35-39M, 40-44F, 40-44M, 45-49F, 45-49M, 50+F, 50+M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	*This is likely rare but retaining for consistency with other KP disaggregations. **Example: partner of KP index client contacted and tested negative for HIV through KP index testing. Key population disaggregate values are: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); and, People in prison and other closed settings. As stated in the MER guidance, reporting of key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which s/he is most identified in order to avoid double-counting.	
Guiding narrative questions (if applicable):	1. What services/support does the community-based program provide to ensure that a PLHIV on treatment successfully adheres in the long-term? 2. What proportion of those supported through community-based services are successfully in TX_CURR from one quarter to the next? 3. What proportion of those supported through community-based services are successfully in TX_CURR from one quarter to the next vs those NOT supported through community-based services? 4. How is the facility and community partner tracking PLHIV on treatment to ensure they attend scheduled appointments and, if absent, are quickly contacted and supported to attend his/her next appointment?	

	5. If cascade is not consistent across indicators and KP disaggregations, please explain. 6. Describe any barriers to collecting this indicator.

TX_PVLS_VERIFY

Description:	Percentage of KP ART patients that have been reached by KP programs, have a confirmed VL measurement within the past 12 months, and are confirmed as having a suppressed VL result (<1,000 copies/ml) documented in the medical or laboratory records/LIS	
Numerator:	Number of KP ART patients that are confirmed as having a suppressed VL result (<1,000 copies/ml) documented in the medical or laboratory records/LIS within the past 12 months.	Per MER Indicator Reference Guide, if there is more than one VL result for a patient during the past 12 months, report the most recent result. Only patients who have been on ART for at least 3 months should be considered.
Denominator:	Number of KP ART patients that have been reached by KP programs and are confirmed as having a VL result (<1,000 copies/mL) documented in the medical or laboratory records/LIS within the past 12 months.	
Reporting level:	Facility & Community	
Reporting frequency:	Quarterly	
How to use:	This indicator monitors the proportion of documented viral load results from KP program beneficiaries who have been on ART for at least 3 months (or according to national guidelines) with a suppressed result (<1,000 copies/mL). This indicator will provide data on patients who have a viral load (VL) test in the past 12 months and the percentage who were virally suppressed at the most recent test. The indicator requires that non-treatment KP partners follow and verify VL testing and VL suppression within the past 12 months for HIV-positive KP clients identified through KP activities who are on ART. It will help foster accountability at the KP partner level for ensuring proper clinical management for HIV-positive KP clients. This indicator will form part of a KP-specific treatment cascade, which will help ensure accurate measurement of the impact of KP programs. Disaggregations by KP type will help demonstrate the ability of KP programs to reach target groups and the relative effectiveness of efforts to enroll KP in care. VL suppression for KP members who are provided treatment directly by the KP partner	

	will be reported through the analogous MER indicator, TX_PVLS, with appropriate disaggregates. Considerations to improve viral load monitoring to document success: ● ART is a prevention commodity for KP especially in the era of U=U ● Key Populations are migratory and dynamic ● Monitoring treatment outcomes is key for overall program success ● Even in settings with one-stop shops and standalone KP clinics, some proportion of KP clients may choose to access ART in other public and private facilities ● Tracking ART initiation and viral load results for KP clients who opt to access care at other health facilities is critical for KP service providers From MER Indicator Reference Guide 2.5 for TX_PVLS:: *VL SUPPRESSION OUTCOMES: This indicator allows ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression. VL TESTING COVERAGE: Comparison of the denominator for this indicator with the result for TX_CURR from 6 months earlier (i.e., two quarters prior) can be used to crudely estimate VL testing coverage supported by PEPFAR. For example, a comparison may be made between the FY20 Q1 denominator for TX_PVLS and FY19 Q3 TX_CURR, given that patients newly initiating ART and included in TX_CURR in FY19 Q4 and FY20 Q1 may not be eligible for a viral load test. In calculating this estimate, it is important to ensure that individuals, not tests are being reported for TX_PVLS. Analyzing both VL testing coverage and suppression rates by geography, sub-population, and implementing mechanisms is essential for program management and quality of care. Real-time review of VL results should trigger an immediate response to follow-up on patients who are not suppressed (i.e., VL ≥1000).* Please refer to the Key Population Cascade Monitoring Guide for additional details. As relevant, all partners should report on this indicator. Those reporting for KPIF should continue reporting per established processes, but any partners not currently reporting should use the central custom indicators reporting template and process.

How to collect:	This indicator should be reported by all KP partners who do not offer treatment with viral load testing to their KP beneficiaries. KP clinical partners who provide viral load testing to their beneficiaries are expected to record TX_PVLS and should NOT be reporting on the TX_PVLS_VERIFY indicator. As mentioned under TX_NEW_VERIFY, some KP clinical partners may record TX_PVLS_VERIFY if KP clients access non-PEPFAR funded facilities and the KP partner implements case management activities to ensure that all KP clients are obtaining viral loads and are virally suppressed. Verification of viral load suppression requires follow-up and visual confirmation from clinical data sources and extraction of key viral load dates and results. Clinical data sources can include 1) treatment registers or patient files, 2) national or clinic program data systems, or 3) ART patient card with verified laboratory result. In order to count individuals under TX_PVLS_VERIFY, KP partners must document the VL measurement date and the clinical data source used for confirmation. In cases where the case manager cannot verify viral load results from clinical records or databases, case managers can verify VL results directly with patients only if the patient possesses documentation of the date of last viral load test and the viral results (e.g., health passport, client held booklet). Some PEPFAR country implementing partners have used the following to collect VL results: ● Client self-report: Empowering client to collect & bring their own results ● HCW/Laboratory services: Collect the correct clinic number from KP client; Log onto a national VL website, if available, and record the VL results ● Health Care provider: Collect the correct clinic number from the KP client; Contact the ART clinic and request the ART outcome records including VL From MER Indicator Reference Guide 2.5 for TX_PVLS: *This indicator should be collected from clinical sources (e.g., electronic or paper patient records), where possible, to ensure de-duplicated patient counting and receipt of results to inform patient care. Ideally, data for this indicator should be collected from an electronic medical records system (EMR) to minimize data collection errors and ensure that results are informing patient care. If data collection from an EMR is not possible, indicator data may be collected from paper-based registers or reports that reflect the VL results. If*

	standard patient registers do not contain all the required information, individual patient records should be reviewed. If a clinical source does not exist or does not contain the desired information, data may be extracted from an electronic laboratory information system (LIS). VL results from an LIS must be linked back to the individual patients and their record at sites. *NOTE: If patient-linked VL results from LIS is used for reporting, it is incumbent that the implementing partner ensure this information is transcribed into the patient record for timely VL results utilization/patient management. The data source used for reporting on this indicator should be specified and data reported should be de-duplicated and used to inform patient care at sites. If the LIS is used, please explain why clinical sources could not be used to report on this indicator in the narrative (see guiding narrative question section below).* *Both only VL tests with recorded results and VL results that are linked back to patients should be included in the numerator and denominator of this indicator. VL results should be reported for patients who have been on ART for at least 3 months (or according to national guidelines). It is important to ensure that the data sources used to collect and aggregate data are updated to be able to report VL results data for patients who have been on ART for at least 3 months.*
How to review for data quality:	This indicator forms part of a cascade that includes TX_CURR or TX_CURR_VERIFY and the counts reported for all KP disaggregates should be consistent with across the cascade (i.e., the number of MSM currently verified on ART (TX_CURR_VERIFY) should be greater than the number of MSM on ART who have verified VL results (TX_PVLS_VERIFY denominator for a particular partner: TX_CURR_VERIFY ≥ TX_PVLS_VERIFY (D)). Periodic DQAs are recommended for KP program indicators that require coordination and communication across partners. TX_PVLS_VERIFY Denominator ≥ TX_PVLS Numerator: The number of VL results from KP on ART must be greater than or equal to the number of VL results from ART patients with a VL <1,000 copies/ml. TX_PVLS Numerator ≥ subtotal of each disaggregation: The total number of VL results with a VL <1,000 copies/ml should be greater than or equal to the sum of all of the results disaggregated by type of clinical site/KP.

<table>
<tr><td>How to calculate annual total:</td><td colspan="2">This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Type of clinical site and by Key population
[Required]</td><td>Verified at PEPFAR-supported Site, by Key Populations:
Men who have sex with men (MSM)
Transgender people (TG)
Female sex workers (FSW)
People who inject drugs (PWID)
People in prison and other closed settings *
Non-KP (Gen Pop)**
Verified at non-PEPFAR supported Site, by Key Populations:
Men who have sex with men (MSM)
Transgender people (TG)
Female sex workers (FSW)
People who inject drugs (PWID)
People in prison and other closed settings*
Non-KP (Gen Pop)**</td></tr>
<tr><td>Age/Sex
[Optional]</td><td><20F, <20M, 20-24F, 20-24M, 25-29F, 25-29M, 30-34F, 30-34M, 35-39F, 35-39M, 40-44F, 40-44M, 45-49F, 45-49M, 50+F, 50+M</td></tr>
<tr><td colspan="2">Denominator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
</table>

	Type of clinical site and by KP [Required]	**Verified at PEPFAR-supported Site,** by Key Populations: ● Men who have sex with men (MSM) ● Transgender people (TG) ● Female sex workers (FSW) ● People who inject drugs (PWID) ● People in prison and other closed settings * ● Non-KP (Gen Pop)** **Verified at non-PEPFAR supported Site**, by Key Populations: ● Men who have sex with men (MSM) ● Transgender people (TG) ● Female sex workers (FSW) ● People who inject drugs (PWID) ● People in prison and other closed settings* ● Non-KP (Gen Pop)**
	Age/Sex [Optional]	<20F, <20M, 20-24F, 20-24M, 25-29F, 25-29M, 30-34F, 30-34M, 35-39F, 35-39M, 40-44F, 40-44M, 45-49F, 45-49M, 50+F, 50+M

Disaggregate descriptions & definitions:	*This is likely rare but retaining for consistency with other KP disaggregations. **Example: partner of KP index client contacted and tested negative for HIV through KP index testing. Key population disaggregate values are: People who inject drugs (PWID); Men who have sex with men (MSM); Transgender people (TG); Female sex workers (FSW); and, People in prison and other closed settings. As stated in the MER guidance, reporting of key population disaggregation should be consistent with what is described under the KP_PREV "How to review for data quality" section on mutual exclusivity of an individual who falls under multiple KP categories (e.g., FSW who injects drugs). In such instances, the individual should only be reported in ONE KP disaggregation category with which s/he is most identified in order to avoid double-counting.
Guiding narrative questions (if applicable):	7. Briefly describe the VL testing algorithm used in the country. Please ensure that the description includes differences in the VL monitoring algorithm for different sub-populations (e.g., key populations, pregnant women, children, etc.). 8. What proportion of those with a documented VL result are virally suppressed? 9. Specify and briefly describe the data sources used to report on this indicator (e.g., clinical records, client self-report, laboratory records). 10. How is the facility and community partner working together to track KP ART patients to confirm that they have a suppressed viral load within the past 12 months? 11. What services/support are the facility and community partners providing to KP ART patients with an unsuppressed VL result? 12. If cascade is not consistent across indicators and KP disaggregations, please explain. 13. Describe any barriers to collecting this indicator.

TX_RTT_VERIFY

Description:	Number of HIV positive, treatment-experienced KPs with no clinical contact (or ARV drug pick-up) for greater than 28 days since their last expected contact who are successfully navigated by the KP partner to a service delivery point and verified as re-enrolled into treatment
Numerator:	Number of HIV positive, treatment-experienced KPs who experienced an interruption in treatment (IIT), during any previous reporting period, i.e. were off treatment for >= 28 days, who are successfully navigated by the KP partner to a service delivery point and verified as re-enrolled into treatment and remained on treatment until the end of the reporting period.
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	This indicator provides a count of the number of known HIV positive treatment-experienced KPs who are assisted into/re-enrolled into treatment through the KP partner after experiencing an interruption in treatment in a previous reporting period. Interruption in treatment (ITT) refers to those KPs with no clinical contact or ARV pick-up in the past 28 days after their last expected contact. To be counted under TX_RTT_VERIFY, KP must have remained current on ART at the end of the reporting period, and therefore also counted under TX_CURR_VERIFY. Please consult the TX_RTT indicator in the PEPFAR MER 2.0 Version 2.5 guidance. This indicator only includes HIV positive KPs who were previously started on ART but were not in treatment as they had either stopped ART or had no clinical contact for >=28 days in the last reporting period. It is extremely useful for those projects that do not directly support or provide ART services but conduct outreach activities through which HIV- positive KPs are identified and then referred to a treatment site that is operated either by the government or another implementing partner. The agencies that operate the facility that provide ART will report these persons. This custom indicator is intended to capture data that reflects the role of

<table>
<tr><td></td><td colspan="2">the KP partner in the identification or HIV positive persons who have interrupted their treatment and ensuring that they are linked back to treatment.

Please refer to the Key Population Cascade Monitoring Guide for additional details. As relevant, all partners should report on this indicator. Those reporting for KPIF should continue reporting per established processes, but any partners not currently reporting should use the central custom indicators reporting template and process.</td></tr>
<tr><td>How to collect:</td><td colspan="2">This indicator can be generated by counting the number of unique KP members who were re-enrolled on ART after experiencing an interruption in treatment in a previous reporting period. Verification of ART re-enrollment requires visual confirmation from clinical data sources and documentation. Clinical data sources can include 1) treatment registers or patient files, 2) national or clinic program data systems, or 3) ART patient card or ARV pickup card that clearly documents the confirmation of patient currently on ART at the end of the reporting period.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">The number of HIV positive KP members who experience an interruption in treatment in a previous reporting period but are successfully navigated by the KP partner to a service delivery point and verified as re-enrolled into treatment should be less than those currently on treatment (TX_CURR_VERIFY).</td></tr>
<tr><td>How to calculate annual total:</td><td colspan="2">Sum results across quarters</td></tr>
<tr><td rowspan="3">Disaggregations:</td><td colspan="2">Numerator Disaggregations:</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Key population
[Required]</td><td>• Men who have sex with men (MSM)
• Transgender people (TG)
• Female sex workers (FSW)
• People who inject drugs (PWID)
• People in prison and other closed settings *
• Non-KP (Gen Pop)**</td></tr>
</table>

	Age/Sex [Optional]	<20F, <20M, 20-24F, 20-24M, 25-29F, 25-29M, 30-34F, 30-34M, 35-39F, 35-39M, 40-44F, 40-44M, 45-49F, 45-49M, 50+F, 50+M
	Denominator Disaggregations:	
	Disaggregate Groups	**Disaggregates**
	N/A	N/A
Disaggregate descriptions & definitions:	*This is likely rare but retaining for consistency with other KP disaggregations. **Example: partner of KP index client contacted and tested negative for HIV through KP index testing.	
Guiding narrative questions (if applicable):	1. What community support services and/or activities, and to what frequency, are they provided to those who experienced a treatment interruption? 2. How does the community based PLHIV support program partner with the treatment clinical site to determine which PLHIV need to be supported back into treatment? 3. How is the facility and community partner tracking PLHIV individuals currently enrolled in treatment to ensure they attend scheduled appointments and, if absent, are quickly contacted and supported to attend his/her next appointment? 4. What proportion of those who experienced an interruption in treatment in a previous reporting period are re-enrolled into treatment? 5. Can comparisons be made between those receiving community support vs. those not receiving community support and TX_CURR, TX_ML, and/or TX_PVLS?	

PrEP_SCREEN

Description:	Number of individuals who have been screened for eligibility for PrEP during the reporting period
Numerator:	Number of individuals who have been screened for eligibility for PrEP during the reporting period
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency	Quarterly
How to use:	This indicator counts the number of individuals screened for PrEP and provides a key step of the PrEP cascade that can be used to monitor the numbers of individuals who test HIV negative, are screened, determined eligible, and are initiated on PrEP (HTS_TST_NEG, PrEP_SCREEN, PrEP_ELIGIBLE, and PrEP_NEW). This indicator measures the number of HIV-negative individuals who were screened for PrEP eligibility. A screening tool will be used to determine if an individual is eligible for PrEP in a given setting. The WHO PrEP Implementation Tool (Module 1: Clinical) provides an exhaustive list of suggested screener questions (https://apps.who.int/iris/bitstream/handle/10665/255889/WHO-HIV-2017.17-eng.pdf?sequence=1). If no national PrEP screener has been developed, consider using the ICAP PrEP Screener (https://icap.columbia.edu/wp-content/uploads/1_PrEP_Screening_for_Substantial_Risk_and_Eligibility_final_3.4.2019.pdf).
How to collect:	Data may be obtained from PrEP registers, client record forms, or other instruments/databases used to track PrEP services. This indicator can be generated by counting the number of unique HIV-negative individuals who are screened for PrEP eligibility.
How to review for data quality:	The total numerator should be equal to: • the sum of all of the age/sex disaggregations • the sum of all of the population type disaggregations PrEP_SCREEN ≥ PrEP_ELIGIBLE by age/sex and population type
Disaggregations:	**Numerator Disaggregations**

	Disaggregate Groups	Disaggregates
	Age/Sex[1] [Required]	10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F
	Pregnant/Breastfeeding [Required]	• Pregnant • Breastfeeding
	Population Type [Required]	• Female sex workers (FSW) • Men who have sex with men (MSM) • People in prison and other closed settings • People who inject drugs (PWID) • Transgender people (TG) • Non-KP (seronegative persons in serodifferent partnerships) • Non-KP (general population)[2]

[1] KP programming supported through the Key Population Investment Fund (KPIF) are permitted to report the following age/sex disaggregates: <20 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F. These disaggregates are in concordance with reporting guidance found in the KP Cascade Monitoring Guide.
[2] Clients who do not fit into one of the other population types should be reported under this disaggregate. Example: non-KP partner of KP index client contacted and tested negative for HIV through KP index testing.

PrEP_ELIGIBLE

Description:	Number of individuals who are eligible for **and** were offered PrEP during the reporting period
Numerator:	Number of individuals who are eligible for **and** were offered PrEP during the reporting period
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	This indicator measures the number of HIV negative individuals who tested negative for HIV, screened for PrEP eligibility, determined to be eligible for PrEP, and offered PrEP. Eligibility may differ among countries based on local context and program focus. This indicator provides a key step of the PrEP cascade that can be used to monitor the numbers of individuals who test HIV negative, are screened, determined eligible, and are initiated on PrEP (HTS_TST_NEG, PrEP_SCREEN, PrEP_ELIGIBLE, and PrEP_NEW). There are four criteria that are universally essential before offering an individual PrEP: 1. Confirmed HIV-negative status 2. No signs or symptoms of acute HIV infection 3. Determined to be eligible as defined by national guidelines (countries may define this differently) 4. Creatinine clearance (eGFR) >60ml/min PrEP screening tools should not be used to deny PrEP services, especially if an individual considers themselves at risk and wants to take PrEP. Having clear guidance on eligibility requirements, with tools to support and harmonize eligibility assessments and documentation, is important for implementing PrEP at scale. Additionally, each person who meets these initial criteria must consider what taking PrEP requires of them. Before potential PrEP users decide if they are willing to use PrEP, healthcare providers need to explain the

<table>
<tr><td></td><td colspan="2">requirements for adherence and quarterly HTS that are needed for PrEP.</td></tr>
<tr><td>How to collect:</td><td colspan="2">Data may be obtained from PrEP registers, client record forms, or other instruments/databases used to track PrEP services. This indicator can be generated by counting the number of unique HIV-negative individuals who meet the criteria for PrEP eligibility.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">The total numerator should be equal to:
● the sum of all of the age/sex disaggregations
● the sum of all of the population type disaggregations.

By age/sex and population type:
PrEP_SCREEN ≥ PrEP_ELIGIBLE ≥ PrEP_NEW</td></tr>
<tr><td rowspan="4">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex[3]
[Required]</td><td>10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F</td></tr>
<tr><td>Pregnant/Breastfeeding
[Required]</td><td>● Pregnant
● Breastfeeding</td></tr>
<tr><td>Population Type
[Required]</td><td>● Female sex workers (FSW)
● Men who have sex with men (MSM)
● People in prison and other closed settings
● People who inject drugs (PWID)
● Transgender people (TG)
● Non-KP (seronegative persons in serodifferent partnerships)
● Non-KP (general population)[4]</td></tr>
</table>

[3] KP programming supported through the Key Population Investment Fund (KPIF) are permitted to report the following age/sex disaggregates: <20 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F. These disaggregates are in concordance with reporting guidance found in the KP Cascade Monitoring Guide.
[4]Clients who do not fit into one of the other population types should be reported under this disaggregate. Example: non-KP partner of KP index client contacted and tested negative for HIV through KP index testing.

PrEP_1MONTH	
Description:	Number of pre-exposure prophylaxis (PrEP) clients who returned on-time* for their one-month follow-up visit after initiating PrEP
Numerator:	Number of pre-exposure prophylaxis (PrEP) clients who returned on-time* for their one-month follow-up visit after initiating PrEP
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	PrEP_1MONTH[5] counts the number of PrEP clients within the reporting period who returned on-time* for their one-month follow-up visit after initiating medication. It reflects the number of clients returning on time for post-initiation refill prescriptions at one month and only measures continuity of use after the first/initial PrEP visit. Clients returning after restart should not be counted. ***On time:** The number of days may be different based on local definitions but typically clients are considered on time if they return within 14 days of scheduled one-month visit.; The **month** disaggregates allow programs to calculate a proxy indicator that measures the proportion of new PrEP clients who returned on-time for their one-month follow-up visit after initiating PrEP. This continuation indicator is calculated as: PrEP_NEW as reported through HFR from previous month / PrEP_1MONTH disaggregated by month
How to collect:	Data may be obtained from PrEP registers, client record forms, or other instruments/databases used to track PrEP services
How to review for data quality:	Data should be reviewed monthly. PREP_1MONTH for a month should be ≤ PREP_NEW from the previous month as reported in HFR.

[5] This is a USAID/PEPFAR PrEP Custom Indicator.

	The total numerator should be equal to the sum of all of the months by age/sex disaggregations.	
Disaggregations:	**Numerator Disaggregations**	
	Disaggregate Groups	**Disaggregates**
	Month by Age/Sex[6] [Required]	• Month 1 of reporting quarter (number of clients who returned during month 1 of the reporting quarter for a follow-up visit within one month of initiating PrEP) by: 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F • Month 2 of reporting quarter (number of clients who returned during month 2 of the reporting quarter for a follow-up visit within one month of initiating PrEP) by: 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F • Month 3 of reporting quarter (number of clients who returned during month 3 of the reporting quarter for a follow-up visit within one month of initiating PrEP) by: 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49

[6] KP programming supported through the Key Population Investment Fund (KPIF) are permitted to report the following age/sex disaggregates: <20 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F. These disaggregates are in concordance with reporting guidance found in the KP Cascade Monitoring Guide.

		M/F, 50+ M/F, Unknown Age M/F

PrEP_NEW_VERIFY

Description:	Number of individuals successfully referred for and confirmed to be newly initiated on pre-exposure prophylaxis (PrEP) at a facility or community site during the reporting period
Numerator:	Number of individuals successfully referred for and confirmed to be newly initiated on pre-exposure prophylaxis (PrEP) at a facility or community site during the reporting period
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	This indicator measures the number of HIV-negative individuals who receive program assistance for starting PrEP, but initiate PrEP at facility or community sites supported by other organizations or institutions. This program assistance specifically refers to active HIV prevention services navigation up to the point of PrEP dispensation. This indicator allows programs to attribute program-specific, PrEP-supportive activities that do not directly provide PrEP, but that conduct HIV testing and/or actively link HIV-negative clients to government or community facilities that prescribe and dispense PrEP. In settings where PrEP is available, all partners that conduct HIV testing activities should screen HIV-negative clients to determine if they are eligible for PrEP according to national guidelines and screening tools. This indicator only includes those persons initiating PrEP for the first time (i.e., PrEP naïve). Clinical partners providing PrEP to their program beneficiaries must report PrEP_NEW with numerator disaggregates (e.g., Age/Sex and Key Pop type) and should NOT report on this PrEP_NEW_VERIFY indicator. As such, this custom indicator captures PrEP-related activities provided under community programs but are NOT counted as PrEP_NEW.
How to collect:	This indicator can be generated by counting the number of HIV-negative individuals successfully navigated to a PrEP prescribing/dispensing facility and verified to have been initiated on PrEP. This indicator should be

<table>
<tr><td></td><td>reported by all partners who do not offer PrEP to clients directly but are funded to provide prevention, outreach and HTS activities.

Verification of PrEP initiation requires visual confirmation of official clinical data sources and documentation of date of first PrEP drug pick up. Clinical data sources can include 1) PrEP registers or patient files, 2) national or clinic program data systems, or 3) patient card. In order to count individuals under PrEP_NEW_VERIFY, partners must document the date that the patient initiates PrEP, the date of verification, and the clinical data source used for confirmation.

Data Source would be Individual Tracking Sheet with PrEP initiation verified through clinical data as described above, or through the standard referral process.</td></tr>
<tr><td>How to review for data quality:</td><td>The total should be less than PrEP_SCREEN and PrEP_ELIGIBLE by age/sex and population type.

The total numerator should be equal to:
• the sum of all of the age/sex disaggregations
• the sum of all of the population disaggregations.</td></tr>
<tr><td>Disaggregations:</td><td>Numerator Disaggregations
<table><tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr><tr><td>Age/Sex[7]
[Required]</td><td>10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F</td></tr><tr><td>Pregnant/Breastfeeding
[Required]</td><td>• Pregnant
• Breastfeeding</td></tr><tr><td>Population Type
[Required]</td><td>• Female sex workers (FSW)
• Men who have sex with men (MSM)
• People in prison and other closed settings
• People who inject drugs (PWID)
• Transgender people (TG)</td></tr></table></td></tr>
</table>

[7] KP programming supported through the Key Population Investment Fund (KPIF) are permitted to report the following age/sex disaggregates: <20 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F. These disaggregates are in concordance with reporting guidance found in the KP Cascade Monitoring Guide.

		• Non-KP (seronegative persons in serodifferent partnerships) • Non-KP (general population)[8]

[8] Clients who do not fit into one of the other population types should be reported under this disaggregate. Example: non-KP partner of KP index client contacted and tested negative for HIV through KP index testing.

PrEP_CURR_VERIFY

Description:	Number of individuals confirmed to be currently on pre-exposure prophylaxis (PrEP) at a facility or community site during the reporting period
Numerator:	Number of individuals confirmed to be currently on pre-exposure prophylaxis (PrEP) at a facility or community site during the reporting period
Denominator:	N/A
Reporting level:	Facility & Community
Reporting frequency:	Quarterly
How to use:	This indicator provides a count of the number of HIV negative individuals with the assistance of program staff at facility or community sites supported by other organizations. This indicator should be reported by all partners who do not directly provide PrEP services but rather provide case management services to clients who are established and currently on PrEP. Clinical partners who provide PrEP to their program beneficiaries are expected to record PrEP_CURR with the numerator disaggregates and should NOT be reporting on this PrEP_CURR_VERIFY indicator.
How to collect:	This indicator should be reported by all partners who may not offer PrEP to clients directly but are funded to provide case management-type activities. Count the number of unique HIV-negative individuals who were successfully navigated into a site providing PrEP that is not operated by the partner where they are verified to be on PrEP during the reporting period. Please note that PrEP_CURR_VERIFY counts the number of individuals that received PrEP at ANY point during the reporting period, so the client does not have to be active on PrEP on the last day of the reporting period. Data Source would be Individual Tracking Sheet/Peer Calendar in Program Monitoring Toolkit with active PrEP enrollment verified through clinical data, or through the standard referral process.

<table>
<tr><td>How to review for data quality:</td><td colspan="2">The total should be less than PrEP_SCREEN and PrEP_ELIGIBLE by age/sex and population type, and is complementary to PrEP_CURR.

The total numerator should be equal to:
● the sum of all of the age/sex disaggregations
● the sum of all of the population disaggregations.</td></tr>
<tr><td rowspan="4">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex[9]
[Required]</td><td>10-14 M/F, 15-19 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F, Unknown Age M/F</td></tr>
<tr><td>Pregnant/Breastfeeding
[Required]</td><td>● Pregnant
● Breastfeeding</td></tr>
<tr><td>Population Type
[Required]</td><td>● Female sex workers (FSW)
● Men who have sex with men (MSM)
● People in prison and other closed settings
● People who inject drugs (PWID)
● Transgender people (TG)
● Non-KP (seronegative persons in serodifferent partnerships)
● Non-KP (general population)[10]</td></tr>
</table>

[9] KP programming supported through the Key Population Investment Fund (KPIF) are permitted to report the following age/sex disaggregates: <20 M/F, 20-24 M/F, 25-29 M/F, 30-34 M/F, 35-39 M/F, 40-44 M/F, 45-49 M/F, 50+ M/F. These disaggregates are in concordance with reporting guidance found in the KP Cascade Monitoring Guide.
[10] Clients who do not fit into one of the other population types should be reported under this disaggregate. Example: non-KP partner of KP index client contacted and tested negative for HIV through KP index testing.

OVC_OFFER

Description:	Percentage of children and adolescents on ART in PEPFAR clinical settings offered enrollment in the OVC program, as counted through family-based enrollment as the number of children and adolescents on ART who are in enrolled households
Numerator:	Number of children and adolescents on ART in PEPFAR clinical settings whose households are offered enrollment in the OVC program PLUS the number of children and adolescents already in the OVC Program who are HIV+ and on ART.
Denominator:	(TX_CURR <20)
Reporting level:	Facility & Community
Reporting frequency:	Semi-annual
How to use:	This indicator is a measure of the number and percentage of children and adolescents who are on ART in a PEPFAR clinical setting whose households are offered enrollment in a PEPFAR OVC program. This measures the process of offering facility-based client enrollment in community-based OVC programs, which can be monitored over time and across age and sex of beneficiaries through this indicator. Through a memorandum of understanding (MOU, or equivalent), PEPFAR OVC implementing partners should monitor clinical clients for enrollment in the OVC program. Giving HIV-positive clients support through OVC programs provides critical support to families for ART adherence, psychosocial support, economic strengthening, and prevention of HIV transmission.
How to collect:	The data for the numerator should be collected by PEPFAR OVC implementing partners. Data sources for this indicator include facility patient records, referral forms, or other facility monitoring tools that track those in treatment and care. OVC implementing partners who do not have a MOU (or equivalent) with PEPFAR-supported facilities that allows the OVC partner to monitor patients on ART will not be able to report under this indicator. In other words, OVC implementing partners should only report under this indicator if they are engaged in the identification and screening of prospective OVC beneficiaries at the facility.

<table>
<tr><td>How to review for data quality:</td><td colspan="2">Through routine data quality audits or assessments conducted by the program or externally. The denominator should be greater than or equal to the numerator</td></tr>
<tr><td>How to calculate annual totals</td><td colspan="2">This is a cumulative indicator that calculates all prospective beneficiaries whose households were offered enrollment during the fiscal year. For example, during both Q2 and Q4 reporting, calculate and sum all beneficiaries offered enrollment at any point during that fiscal year-to-date. All beneficiaries offered enrollment should be counted only once, regardless of the number of times they were offered enrollment during a reporting period.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>By <1 F/M, 1–4 F/M, 5–9 F/M, 10–14 F/M, 15–17 F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

OVC_ENROLL	
Description:	Percentage of HIV-positive children and adolescents on ART at a PEPFAR clinical setting whose households are enrolled in the OVC comprehensive program after having been offered enrollment. This is counted through family based enrollment as the number of children and adolescents on ART who are in households enrolled in the OVC comprehensive program.
Numerator:	Number of HIV-positive children and adolescents on ART at a PEPFAR clinical setting whose households are enrolled in the OVC comprehensive program after having been offered enrollment
Denominator:	Number of children and adolescents on ART in PEPFAR clinical settings whose households are offered enrollment in the OVC program (OVC_OFFER)
Reporting level:	Facility & Community
Reporting frequency:	Semi-annual
How to use:	This indicator is a measure of the process of enrolling HIV-positive children and adolescents in an OVC program through PEPFAR-funded health facilities/clinics. This measures whether the process of offering enrollment to ART clients is effectively resulting in enrollment in an OVC program. This indicator assumes that prospective beneficiaries are screened for eligibility before being offered enrollment so that everyone offered enrollment can be enrolled in the program, if they consent/agree. Giving HIV-positive clients support through OVC programs provides critical services to families for ART adherence, psychosocial support, economic strengthening, and prevention of HIV transmission.
How to collect:	These data should be collected by PEPFAR OVC implementing partners. Data sources for this indicator include facility patient records, OVC referral forms, or other monitoring tools that track those in treatment and care. OVC implementing partners who do not have a MOU (or equivalent) with PEPFARsupported facilities that allows the OVC partner to monitor patients on ART 13 will not be able to report under this indicator. In other words, OVC implementing partners should only report under this indicator if they are engaged in the identification and screening of prospective OVC beneficiaries at the

<table>
<tr><td></td><td colspan="2">facility (e.g., through an OVC staff member enrolling new beneficiaries at the facility, or equivalent). On the other hand, if facility staff are identifying, screening, and referring OVC beneficiaries, these referrals should not be counted under this indicator</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Through routine data quality audits or assessments conducted by the program or externally.</td></tr>
<tr><td>How to calculate annual totals</td><td colspan="2">This is a cumulative indicator that calculates all children and adolescents on ART in a PEPFAR clinical setting whose households were enrolled in the OVC comprehensive program during the fiscal year. For example, during both Q2 and Q4 reporting, calculate and sum all such prospective beneficiaries offered enrollment and then enrolled at any point during that fiscal year at the time of reporting. All beneficiaries enrolled should be counted only once, regardless of the number of times they were offered enrollment during a reporting period.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex
[Required]</td><td>By <1 F/M, 1–4 F/M, 5–9 F/M, 10–14 F/M, 15–17 F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

OVC_VL_ELIGIBLE

Description:	Percentage of HIV-positive OVC (required) and caregivers (optional) on ART, active or graduated, who are served by an OVC comprehensive program, who are eligible for viral load testing. (Eligible means consistently on ART for a minimum of three months or whatever the standard established in the country.)
Numerator:	Number of HIV-positive children and caregivers on ART (active or graduated) who are served by an OVC comprehensive program who are eligible to have a viral load test
Denominator:	Number of HIV-positive children and caregivers on ART (active or graduated) who are served by an OVC comprehensive program
Reporting level:	Facility & Community
Reporting frequency:	Semi-annual
How to use:	CD4+ T-cell counts are used, together with the viral load test, to get a complete picture on how the immune system is fighting the virus. As HIV reproduces in the body, the viral load increases, HIV destroys the CD4+ Tcells, and lowers the number of T-cells present. Generally, the higher the HIV 14 viral load, the more CD4+ T-cells are being destroyed. The goals are to keep CD4+ T-cell count high and viral load low.2 OVC implementing partners should refer beneficiaries who are on ART and eligible for viral load testing. Eligibility for viral load testing should be based on in-country criteria and guidance. This indicator continues along the HIV continuum of care from OVC_HIVSTAT to ensure that HIV-positive beneficiaries are receiving appropriate treatment to reach viral suppression. Implementing partners should refer to definitions of "on ART" provided under OVC_HIVSTAT in the MER 2.4 guidance
How to collect:	Viral load testing is conducted by clinical providers, not directly by OVC programs. Viral load testing eligibility should be monitored primarily by clinical partners; however, OVC implementing partners should confirm beneficiary reported viral load test eligibility with facility-based partners. This requires a data sharing agreement that should be articulated in a MOU (or equivalent) between the facility partner and OVC partner. Data sources for this indicator include client records or other confidential CM and program monitoring tools that track those in treatment and care. All beneficiaries should be counted

<table>
<tr><td></td><td colspan="2">only once. OVC_VL_ELIGIBLE is applicable to all HIV-positive OVC_SERV beneficiaries (active or graduated) who are served by an OVC comprehensive program, who are on ART.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Disaggregates should add up to 100 percent of the numerator.</td></tr>
<tr><td>How to calculate annual totals:</td><td colspan="2">Calculate by counting all OVC_SERV who are on ART, then calculate the number who are eligible for viral load testing.</td></tr>
<tr><td rowspan="6">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/ Sex
[Required]</td><td>By <1 F/M, 1–4 F/M, 5–9 F/M, 10–14 F/M, 15–17 F/M</td></tr>
<tr><td>Age/Sex
[Optional]</td><td>18+ F/M caregivers</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

OVC_VLR	
Description:	Percentage of HIV-positive OVC (required) and caregivers (suggested) on ART, active or graduated, who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months
Numerator:	Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months
Denominator:	Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program who were eligible to have a viral load test in the previous 12 months
Reporting level:	Facility & Community
Reporting Frequency	Semi-annual
How to use:	CD4+ T-cell counts are used, together with the viral load test, to get a complete picture on how the immune system is fighting the virus. As HIV reproduces in the body, the viral load increases, HIV destroys the CD4+ Tcells, and lowers the amount of T-cells present. Generally, the higher the HIV viral load, the more CD4+ T-cells are being destroyed. The goals are to keep CD4+ T-cell count high and viral load low.3 OVC implementing partners should monitor beneficiaries' eligibility, the frequency of viral load testing, and refer beneficiaries who are eligible for viral load testing but have not had the test, as needed. When the implementing partner does not know the last viral load test status, the program should discuss and provide any relevant counseling support with the beneficiary/caregiver. This indicator continues along the HIV continuum of care from OVC_HIVSTAT to ensure that HIV-positive beneficiaries are receiving appropriate treatment to reach viral suppression. Implementing partners should refer to definitions of "on ART" provided under OVC_HIVSTAT in the MER 2.4 guidance.
How to collect:	Viral load testing is conducted by clinical providers, not directly by OVC programs. Viral load testing should be monitored primarily by clinical partners; however, OVC implementing partners should confirm beneficiary reported viral load test results with facility-based partners. This requires a data sharing agreement that should be articulated in a MOU (or equivalent) between the facility partner and OVC partner.

<table>
<tr><td></td><td colspan="2">Data sources for this indicator include client records or other confidential CM and program monitoring tools that track those in treatment and care. In the absence of an MOU, OVC partners can collect self-reported viral load test results from beneficiaries. This should be a temporary method of reporting on this indicator, while MOUs are being established. Viral load results that are self-reported should be counted as “self-report” under the disaggregates provided. All beneficiaries should be counted only once, regardless of the number of times they were tested and reported during a reporting period. OVC_VLR is applicable to all OVC_SERV who are served by an OVC comprehensive program.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Disaggregates should add up to 100 percent of the numerator.</td></tr>
<tr><td>How to calculate annual totals</td><td colspan="2">Calculate by counting all OVC_SERV who are on ART, then calculate the number who are eligible for a viral load test, then calculate the number who have a documented viral load test result in the last 12 months.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Confirmed with facility (as applicable), by age and sex</td><td>• Confirmed <1 F/M, 1–4 F/M, 5–9 F/M, 10–14 F/M, 15–17 F/M, 18–20 F/M youth
• Confirmed 18+ F/M caregivers (optional)</td></tr>
<tr><td>Self-reported (as applicable), by age and sex</td><td>• Self-reported <1 F/M, 5–6 F/M, 10–14 F/M, 15– 17 F/M, 18–20 F/M youth
• Self-reported 18+ F/M caregivers (optional)</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

OVC_VLS	
Description:	Percentage of HIV-positive OVC (required) and caregivers (optional) on ART, active or graduated, who are served by an OVC comprehensive program who are virally suppressed (<1000 copies/ml)
Numerator:	Number of HIV-positive OVC (required) and caregivers (optional) on ART (active or graduated) who are served by an OVC comprehensive program and whose most recent viral load test result in the last 12 months was virally suppressed (<1000 copies/ml).
Denominator:	Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months (OVC_VLR numerator)
Reporting level:	Facility & Community
Reporting Frequency	Semi-annual
How to use:	If taken as prescribed, ART reduces the amount of HIV in the body—otherwise known as the viral load, to a very low level. This keeps the body's immune system working and prevents illness. Suppressing the viral load to this point is called viral suppression and is measured as having <1000 copies/ml. OVC implementing partners should monitor beneficiaries' viral suppression and refer beneficiaries who are due for a viral load test or showing signs of worsening illness. When the implementing partner does not know the last viral load test status, the program should discuss and provide any relevant counseling support with the beneficiary/caregiver. This indicator continues along the HIV continuum of care from OVC_HIVSTAT to ensure that HIV-positive beneficiaries are receiving appropriate treatment to reach viral suppression. Implementing partners should refer to definitions of "on ART" provided under OVC_HIVSTAT in the MER 2.4 guidance.
How to collect:	Viral load testing is conducted by clinical providers, not directly by OVC programs. Viral load suppression should be monitored primarily by clinical partners; however, OVC implementing partners should confirm beneficiary reported viral load test results with facility-based partners. This requires a data sharing agreement that should be articulated in a MOU (or equivalent) between the facility partner and OVC partner. Data sources for this indicator include client records or other

<table>
<tr><td></td><td colspan="2">confidential CM and program monitoring tools that track those in treatment and care. In the absence of an MOU, OVC partners can collect self-reported viral suppression from beneficiaries. This should be a temporary method of reporting on this indicator, while MOUs are being established. Viral suppression instances that are self-reported should be counted as “self-report” under the disaggregates provided. OVC_VLR is applicable to all OVC_SERV who are served by an OVC comprehensive program.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Disaggregates should add up to 100 percent of the numerator.</td></tr>
<tr><td>How to calculate annual totals</td><td colspan="2">Calculate by counting all OVC_SERV who are on ART, then calculate the number with a known documented viral load test result in the last 12 months, then calculate the number who are virally suppressed.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Confirmed with facility (as applicable), by age and sex</td><td>• Confirmed <1 F/M, 1–4 F/M, 5–9 F/M, 10–14 F/M, 15–17 F/M, 18–20 F/M youth
• Confirmed 18+ F/M caregivers (optional)</td></tr>
<tr><td>Self-reported (as applicable), by age and sex</td><td>• Self-reported <1 F/M, 5–6 F/M, 10–14 F/M, 15– 17 F/M, 18–20 F/M youth
• Self-reported 18+ F/M caregivers (optional)</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>