Orphans and Vulnerable Children Monitoring, Evaluation, and Reporting (MER) Indicators

Facilitator's Guide

USAID
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PEPFAR

MEASURE Evaluation

Orphans and Vulnerable Children Monitoring, Evaluation, and Reporting (MER) Indicators

Facilitator's Guide

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MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

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ABBREVIATIONS

APR	annual period of reporting
ART	antiretroviral therapy
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
FAQ	frequently asked question
IP	implementing partner
MIS	management information system
MUAC	mid-upper arm circumference
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
SAPR	semi-annual period of reporting
UNC	University of North Carolina at Chapel Hill
USAID	United States Agency for International Development

INTRODUCTION

Course Overview

Module 1: Introduction to Orphans and Vulnerable Children MER Indicators (0.5 hours)

Module 2: OVC_SERV (4.0 hours)

Module 3: Graduation (2.0 hours)

Module 4: OVC_HIVSTAT (2.5 hours)

Module 5: Data Use (3.5 hours)

Teaching Methods

Course delivery is based on adult learning principles. A range of teaching methods, such as lectures, discussions, case studies, exercises, and group work, will be used to address the varying learning styles of course participants. Teaching methods are further detailed under each module.

Course Materials

The course materials are digital versions of the workshop agenda, PowerPoint presentations, review questions, worksheets, OVC MER guidance, a review quiz, and additional reference materials. Course materials are detailed here in the section for each module. All materials are available here: https://www.measureevaluation.org/our-work/ovc/routine-monitoring-of-pepfar-orphans-and-vulnerable-children-programs. They may be adapted or translated as needed, such as for step-down trainings. Slides showing United States President's Emergency Plan for AIDS Relief (PEPFAR) data (such as Slides 8 and 9 in Module 1) may also be updated with more recent data, as these become available.

Module 1

1. INTRODUCTION

Module Duration: 45 minutes

Module Learning Objectives

By the end of this module, participants will be able to:

- Understand the aims, context, and rationale of orphan and vulnerable children (OVC) programming under PEPFAR
- Understand the four domains of OVC services under PEPFAR
- Describe what they will learn in the OVC MER indicators implementing partner (IP) training

Materials Needed

- PowerPoint presentation: Module 1, "Introduction"
- Printed materials (organized in a folder for each participant, see Section 6.1 for list of materials to print)
- Participant list (pre-populated with each participant's name, position, and email address, see Section 6.2 for template)
- Name tags (optional)

Session Plan

Time	Title and Description	Methods and Materials
15 minutes	Welcome of Participants and Registration Welcome and register all participants. Have a representative of the hosting organization and/or United States Agency for International Development (USAID) Mission give a few brief remarks, if appropriate.	Materials: Participant list
15 minutes	Introduction to OVC Programming Present and discuss: • The aims, context, and rationale of PEPFAR OVC programming • The four domains of eligible OVC services under PEPFAR (healthy, stable, safe, and schooled) • The relationship of PEPFAR OVC programming to UNAIDS global targets • Data on children living with HIV globally and in PEPFAR countries, including percentage of children who know their HIV status and receive antiretroviral therapy (ART)	Lecture with PowerPoint
5 minutes	Overview of Training Present general and specific objectives of training and overview of training agenda. Briefly introduce participants to the materials in their folders and have them review the agenda.	Lecture with PowerPoint
10 minutes	Introduction of Participants Ask each participant to introduce himself or herself, including name, position or title, and other information (as appropriate).	Large group discussion

Welcome of Participants and Registration

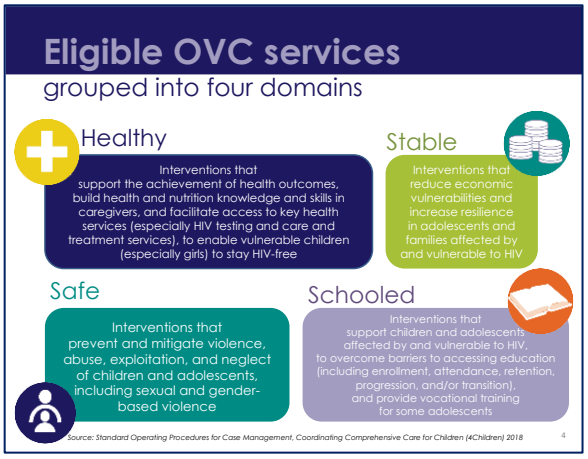
Before participants arrive, the facilitator should ensure that the room is arranged so that chairs and tables are in a U-shape and close enough to each other and to the front of the room to allow participants to easily converse with each other and with the facilitator.

Upon arrival, each participant signs in on the participant list and checks that his or her name, position, and email address are correct. Each participant also receives a folder containing all handouts for training and name tag (if using). When registration is complete, the facilitator welcomes all participants. A representative

of the hosting organization and/or USAID Mission may give a few brief remarks to further welcome participants.

Introduction to OVC Programming

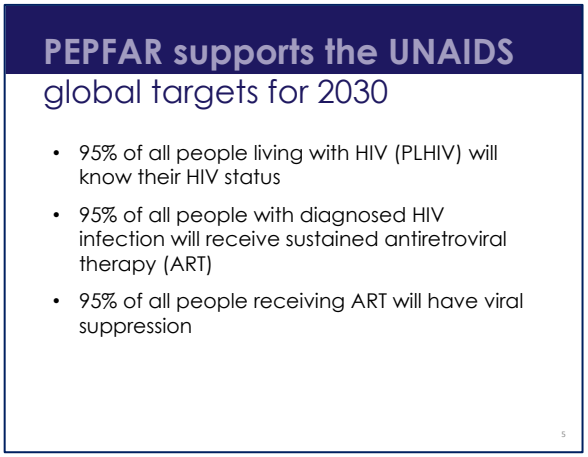
Use the following notes in presenting the slides for Module 1. Notes are given for some but not all slides.



Slide 4

Under PEPFAR, OVC services are grouped into four domains, each with specific objectives and specific eligible services. This slide is an introduction only, and we will discuss specific eligible services in more detail later in the training.

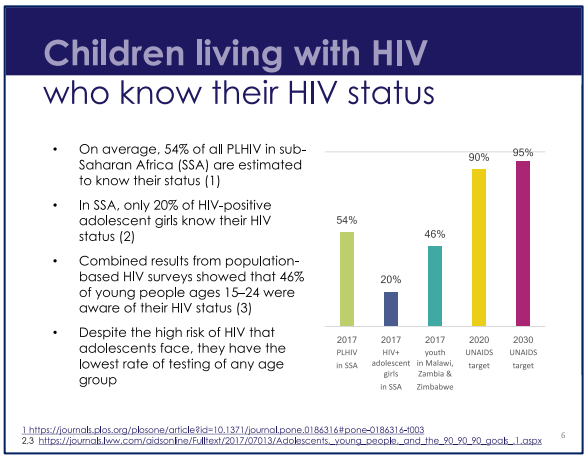
[Note to facilitator: Read the objectives of each domain from the slide.]



Slide 5

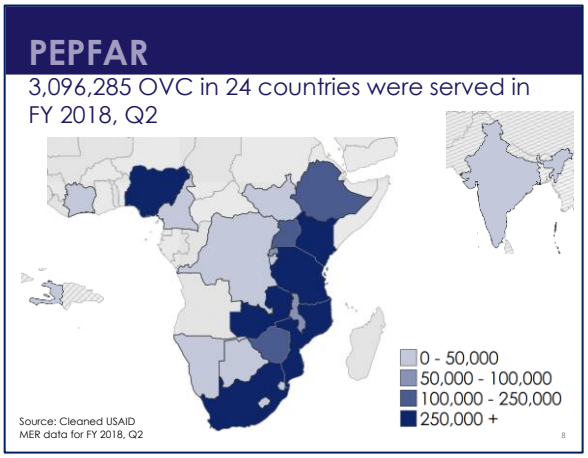
The bar has been raised since the 90-90-90 goals were set. It is important for OVC programs to evaluate how they are doing against these goals, which goal(s) are most challenging, and how they can work together with health facilities to ensure that these goals are met.

In particular, we have an important role to play in assessing children for their HIV risk and ensuring that those most at risk are referred for testing. Thus, there is a direct link between the first "95" goal and OVC_HIVSTAT, which we will cover in depth in a later module.



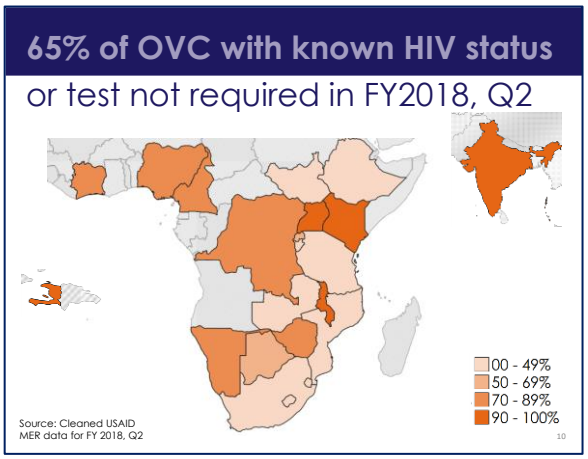
Slide 6

Multiple sources of data suggest that we are not meeting the 90-90-90 targets. Meeting the 95-95-95 targets will take even greater effort.



Slide 8

PEPFAR-funded OVC programs aim to contribute to the UNAIDS 2030 goals (95-95-95). USAID currently provides funding in 24 countries, and during Quarter 2, Fiscal Year 2018 reached a total of 3,096,285 orphans and vulnerable children under the age of 18. The countries with the highest OVC caseloads (of over 250,000) were Mozambique, Zambia, South Africa, Tanzania, Kenya, and Nigeria.



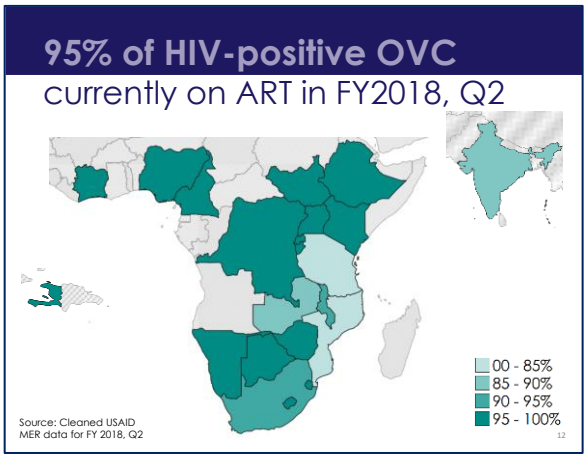
Slide 10

At present, 65 percent of OVC served by USAID know their HIV status or have been risk assessed and determined not to require testing. Meeting the target of 90 percent of children with known HIV status is a particularly important challenge because of the high rate of new infections among this group. By encouraging HIV testing of OVC, we can prevent new HIV infections during this critical period in life. Only five countries have attained the target of 90 percent of children with known HIV status: Haiti, Kenya, Uganda, Malawi, and India.

In many countries, adolescents face barriers such as laws restricting access to testing or requiring parental consent. In addition, there is a particularly strong fear of disclosure among adolescents. Additionally, laws that criminalize HIV transmission or are used to prosecute PLHIV may have a differentially high deterrent effect on adolescents. Addressing the adolescent gap in HIV testing will require increasing community-based approaches, such as approaches which rely on different types of index case finding (e.g., testing all children of an HIV-positive parent, undernourished children, or children with tuberculosis). In addition, increasing access to HIV testing services for adolescents may require revising national legal frameworks surrounding HIV and integrating HIV testing with other health services, such as reproductive health services.

OVC projects are required to conduct HIV-risk assessments to determine if a referral to HIV testing is appropriate and to accompany referred beneficiaries to the health facility, as needed. This initiative not only generates demand for HIV testing services but also ensures that those resources are used rationally.

In sum, OVC projects play an important role in diagnosing HIV-positive children with unknown HIV status.



Slide 12

At present, 95 percent of HIV-positive OVC served by USAID self-report that they are currently on antiretroviral therapy (ART). Only seven countries have attained 100 percent of HIV-positive children on ART: Botswana, Burundi, Democratic Republic of the Congo, Kenya, Namibia, South Sudan, and Swaziland.

Increasing the number of HIV-positive children on ART is a particularly important challenge because HIV-positive children who are not on treatment face high rates of mortality.

OVC projects play an important role in linking HIV-positive children to care and treatment services. By encouraging linkage to HIV treatment and accompanying newly-diagnosed HIV-positive children to the nearest health facility, OVC projects serve a critical role in linking the most vulnerable children to essential care and services. Through regular household visits, caseworkers provide household-level case management services to support sustained treatment and are able to intervene early when treatment default is suspected.

Introduction of Participants

The facilitator asks each participant to introduce himself or herself, including their name and position or title. The facilitator may also ask participants to give additional information such as country or region of origin (if appropriate).

Module 2

2. OVC_SERV

Module duration: 4.0 hours

Module Learning Objectives

By the end of this module, participants will be able to:

- Define OVC_SERV disaggregates
- Calculate the total number of beneficiaries served as of the semi-annual period of reporting (SAPR) and annual period of reporting (APR)
- Identify minimum services necessary to be considered active
- Explain the concept of graduation benchmarks
- Understand how the list of eligible OVC services is applied to children and caregivers
- Differentiate between essential case management activities and eligible OVC services
- Master how the timing of services delivered has an impact on program participation status

Materials Needed

- Module 2: OVC_SERV (PowerPoint presentation)
- Worksheet 1: Illustrative Eligible OVC Services (in participant folders, see Section 6.3)
- OVC_SERV review questions (1 copy of slides 3–14 from Module 6)
- PEPFAR official OVC MER guidance
    - OVC_SERV Indicator Reference Sheet (see Section 6.12)
    - OVC_SERV: What's Changed? (see Section 6.13)

- Illustrative Eligible Services for Active OVC Beneficiaries (Children and Caregivers) (see Section 6.16)[1]
- Questions and Answers to Possible OVC_SERV Reporting Scenarios (see Section 6.18)[2]

Session Plan

Time	Title and Description	Methods and Materials

5 minutes	**2.1. Introduction**
	Present and discuss:
	• Goals of PEPFAR OVC programming:
	  ○ Continuity of care
	  ○ Comprehensive care
	  ○ Family-centered care
	• Learning objectives of Module 1
		Lecture with PowerPoint

20 minutes	**2.2. Data Definitions** Present and discuss: • Data elements included under OVC_SERV • How to calculate OVC_SERV total • OVC_SERV disaggregates and their definitions	Lecture with PowerPoint
5 minutes	**2.3. Reporting** Explain how to report OVC_SERV at SAPR and APR	Lecture with PowerPoint
60 minutes	**2.4. Eligible OVC Services** Present and discuss: • Four domains of OVC services (healthy, stable, safe, schooled) • List of eligible of OVC services • Definition of an eligible service and how services are designated by age (all children, infants and young children, adolescents, and caregivers) • Requirements for "caregiver and child" services	Lecture with PowerPoint Handout: Illustrative Eligible OVC Services (Worksheet 1) Group work and small group discussion Large group discussion

[1] Appendix D in the *Monitoring, Evaluation, and Reporting Indicator Reference Guide Version 2.3* (PEPFAR, 2018)

[2] Appendix F in the *Monitoring, Evaluation, and Reporting Indicator Reference Guide Version 2.3* (PEPFAR, 2018)

	Activity: Illustrative Eligible OVC Services (Worksheet 1) Present Worksheet 1 and ask participants to form small groups by organization to discuss the worksheet and their organization's provision of OVC services. Reconvene all participants for large group discussion of OVC service delivery.	
15 minutes	**2.5. Essential Case Management Services** Present and discuss: • Essential case management services not considered eligible OVC services • Requirements for monitoring of beneficiaries **Activity: Discussion of Illustrative Eligible Services** Facilitate large group discussion on perceived benefits and anticipated obstacles to adopting the illustrative list of eligible services.	Lecture with PowerPoint Large group discussion using questions on PowerPoint slide
20 minutes	**Break**	
30 minutes	**2.6. Timing and Participation Status** **SAPR Reporting Examples** Present and discuss: • Criteria for beneficiaries being considered active, not reported, and exited at SAPR • Illustrative timelines showing possible reporting scenarios at SAPR **APR Reporting Examples** Present and discuss: • Criteria for beneficiaries being considered active, not reported, and exited at APR • Illustrative timelines showing possible reporting scenarios at APR	Lecture with PowerPoint
10 minutes	**2.7. Transitions** Present and discuss: • Criteria for beneficiaries becoming active and transitioning from exited to active • Illustrative timelines of such transitions	Lecture with PowerPoint
5 minutes	**2.8. Caregiver Services**	Lecture with PowerPoint

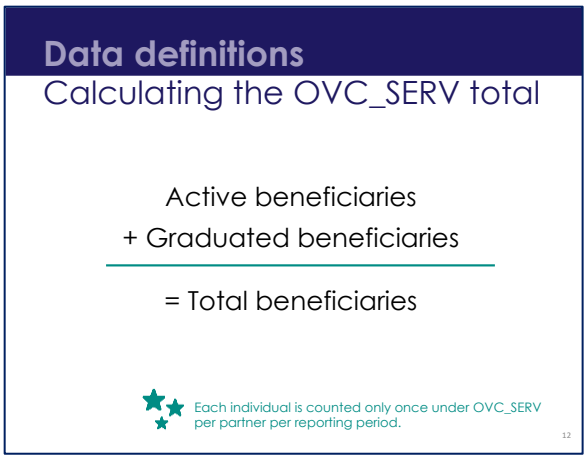
	Present and discuss criteria and illustrative timelines for: • "Caregiver and child" services • Caregiver-only services	

5 minutes	**2.9. Special Cases** Present and discuss guidelines for counting beneficiaries active in the case of: • Psychosocial support • Educational support • Beneficiaries who have participated in Peace Corps programs	Lecture with PowerPoint
15 minutes	**2.10. Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS)** Present and discuss: • Relationship of MER OVC_SERV to AGYW_PREV • Guidelines for counting as active DREAMS participants who are or are not also enrolled in an OVC program • Illustrative DREAMS reporting scenario	Lecture with PowerPoint
10 minutes	**2.11. Avoiding Double Counting** Present and discuss how to avoid double counting: • In the case of OVC caregivers under age 18 • Active and graduated beneficiaries • When beneficiaries are transferred to another PEPFAR partner	Lecture with PowerPoint
70 minutes	**2.12. Review of OVC_SERV** Distribute review questions to small groups and give 20 minutes for discussion. Reconvene large group for discussion of review questions and solutions.	Small and large group discussion Handout: OVC_SERV review questions
60 minutes	**Lunch**	

2.1. Introduction

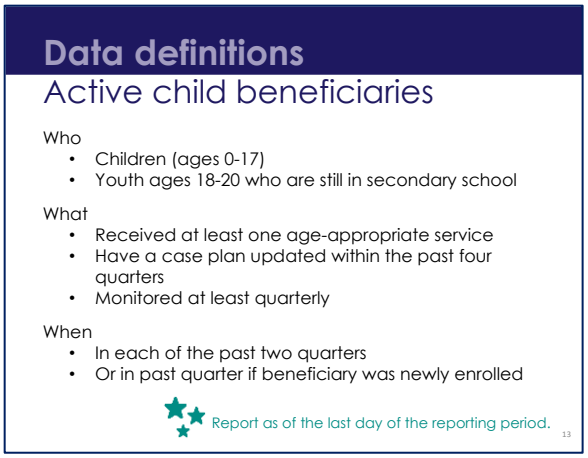
No additional instructions or notes.

2.2. Data Definitions



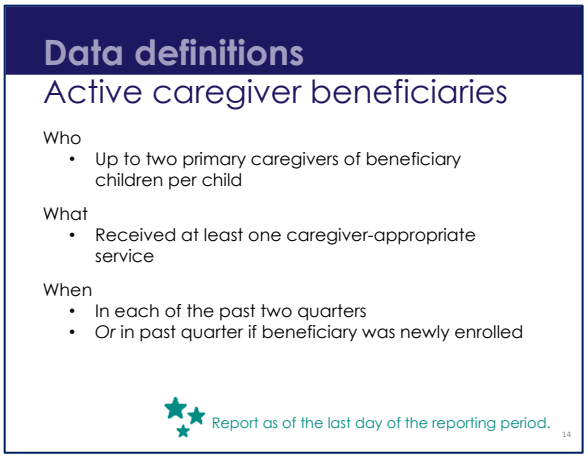
Slide 12

This definition means that some beneficiaries will be not be reported in DATIM as part of OVC_SERV total. We will discuss this issue in more depth later in this module.



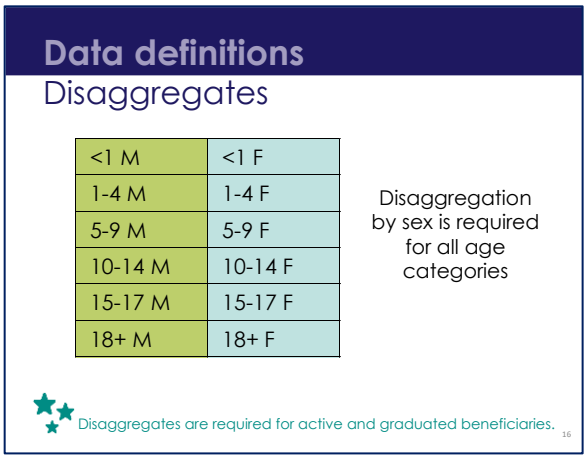
Slide 13

Youth over the age of 20 are not eligible to be counted under OVC_SERV, unless they are serving as a primary caregiver to OVC in the household. Youth ages 18–20 in vocational school cannot be counted as child beneficiaries. Only secondary school enrollment qualifies youth in this age group to be counted.



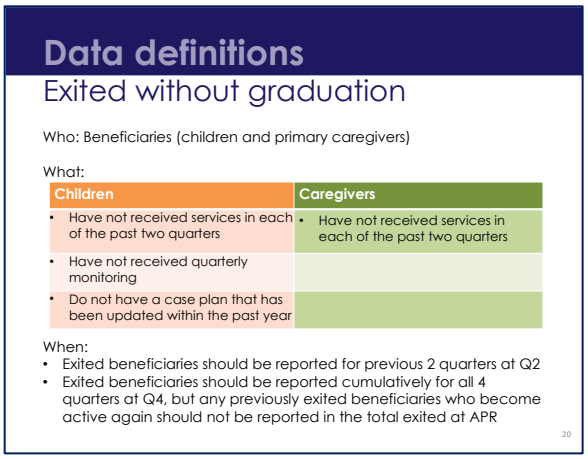
Slide 14

It is important that OVC programs only include as caregiver beneficiaries those adults who are actively fulfilling the role of parent or guardian. We will refer to these adults as "primary caregivers."



Slide 16

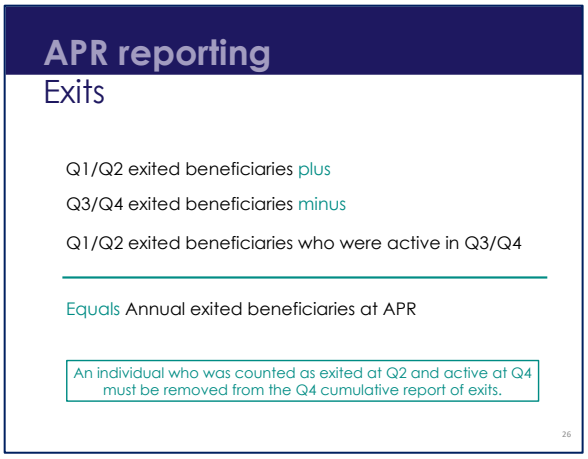
Note that disaggregation of younger children is a new requirement for all PEPFAR MER indicators.



Slide 20

[Note to facilitator: Do not engage in discussion of criteria for re-enrollment or re-entry into program. If participants raise this question, state that it is up to the country to decide how children will be re-enrolled into a program after exit.]

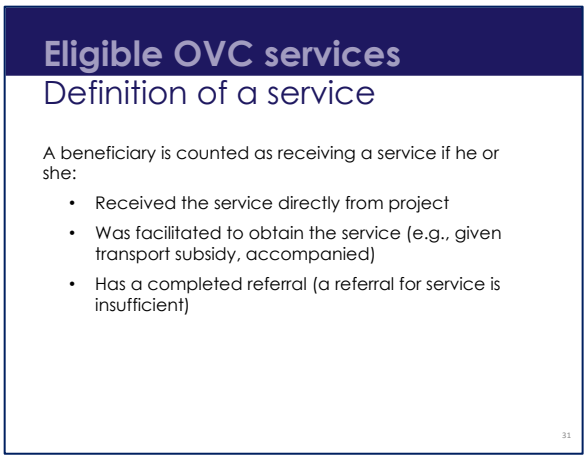
2.3. Reporting



Slide 26

These new reporting guidelines may result in declines in the number of beneficiaries reported under OVC_SERV. As this is a global change, similar trends will likely be seen across all PEPFAR countries and programs. The narrative portion of the report provides a space to explain scenarios in which beneficiaries were served but could not be reported under OVC_SERV, such as a scenario in which many beneficiaries who had been receiving services were exited without graduation.

2.4. Eligible OVC Services



Slide 31

PEPFAR does not allow purchase of commodities, but facilitating beneficiaries to obtain commodities is an eligible service. This might include public-private partnerships, such as an OVC program successfully advocating for services even if the program did not directly purchase or obtain the service.

Note that "provided a referral for" is not on this list. A referral is not considered an eligible service unless the referral is completed.

Activity: Illustrative Eligible OVC Services (Worksheet 1)

Instructions for small group discussion (20 minutes, discussion questions shown on Slide 35):

Participants form small groups by organization and spread out as much as possible in the available space. There should be one small group per organization, unless there are a large number of participants from the same organization, in which case participants may form two small groups. Ideally, each group will have two to four participants.

Participants review Worksheet 1 in small groups. Each group should review each service and discuss:

- Which services their organization is currently providing
- Which services their organization would like to provide
- Which services are not applicable to their OVC program

Instructions for large group discussion (30 minutes, discussion questions shown on Slides 36, 37):

After 20 minutes of small group discussion, participants reconvene in a large group. The facilitator moderates a discussion of the following questions, ensuring that each small group has a chance to speak:

- What are your general impressions of the list of OVC services?
- Are your organizations already providing services from each of the four domains?
- What proportion of the services are you already providing, versus those you would like to provide?
- What immediate actions will you take to better align with the published list of eligible OVC services?
- What services are you providing that are not captured in the list?

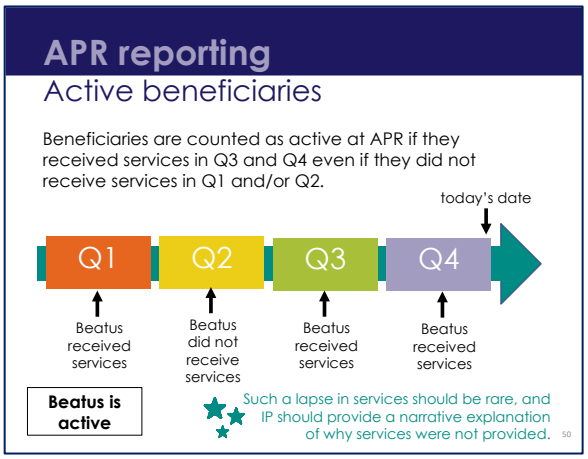
2.5. Essential Case Management Activities

Activity: Discussion of Illustrative Eligible Services

Facilitator moderates a large group discussion on perceived benefits and anticipated obstacles to adopting the illustrative list of eligible services, using the questions on slide 41:

- How will the introduction of the "Illustrative Eligible Services List" affect your organization?
- What are the perceived benefits?
- What are the anticipated obstacles?

2.6. Timing and Participation Status



Slide 50

At APR, Beatus should be removed from APR exits. He would have been reported as exited at SAPR, as he did not receive services in Q2. Although exited beneficiaries should be reported cumulatively for all four quarters at Q4, any previously exited beneficiaries who become active again should not be reported in the total exited at APR (see guidance on slide 20).

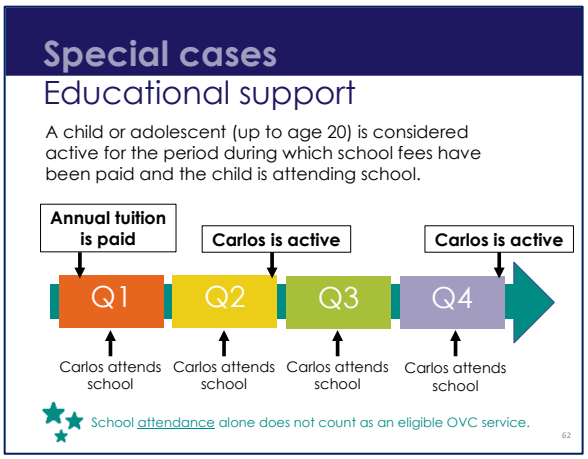
2.7. Transitions

No additional instructions or notes.

2.8. Caregiver Services

No additional instructions or notes.

2.9. Special Cases



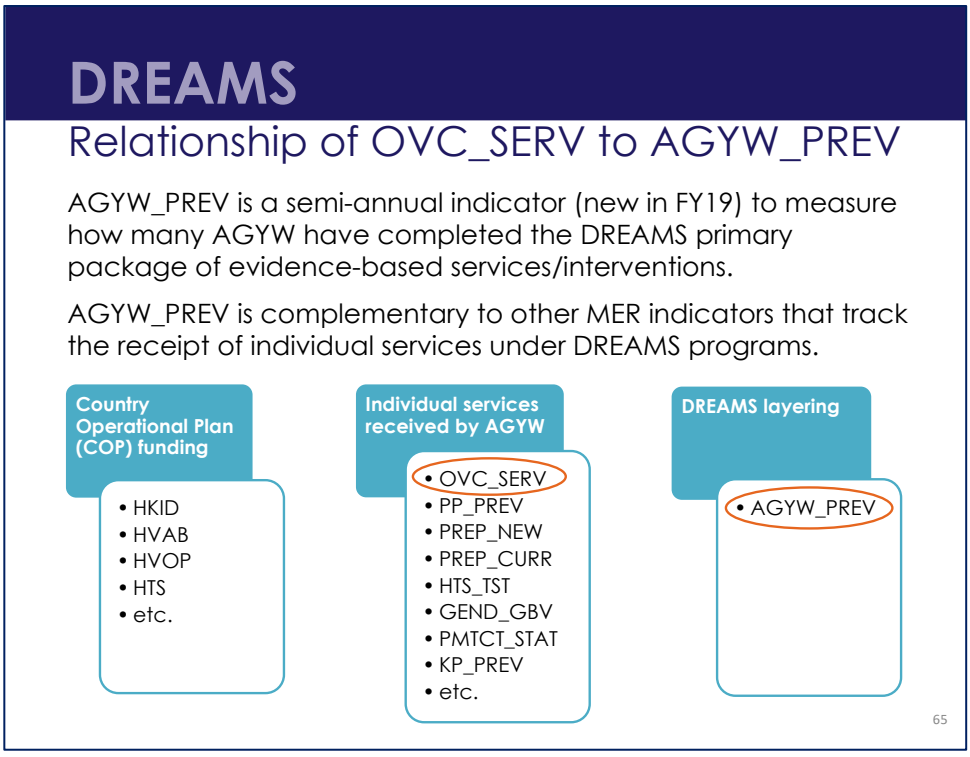
Slide 65

A child who is attending school cannot be counted as active just because he or she is attending school, unless the OVC program is also providing educational support. The program may provide support by paying school fees or through other means which facilitate the child's attendance, such as a block grant. PEPFAR guidance does not consider support to attend vocational school an eligible service.

2.10. Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS)

[Note to facilitator: Given the complexity of this content, a detailed script is provided for all slides in this section. The facilitator may read the script verbatim, as all content on the slides is also contained in the script.]

Slide 68



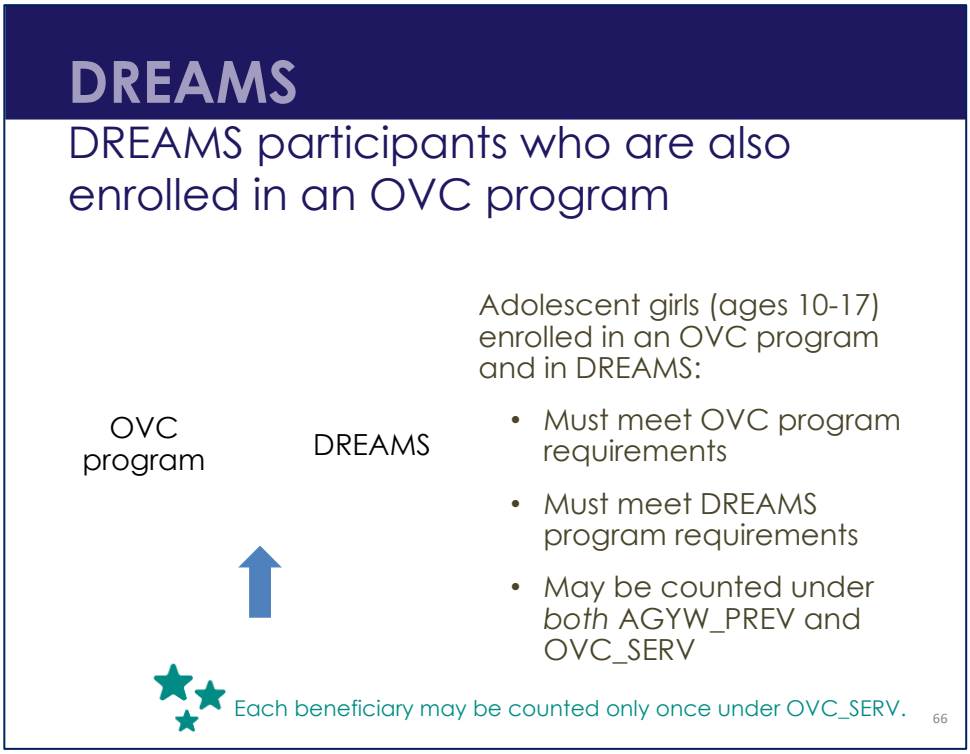
The DREAMS[i] program is offered to adolescent girls and young women (AGYW) in 14 countries in Africa, plus Haiti.[ii] DREAMS programs offer layered interventions which may include OVC services.

AGYW_PREV is a semi-annual indicator (new in fiscal year 19) that measures how many AGYW have completed the DREAMS primary package of evidence-based services and interventions. DREAMS programs are layered, which means that they provide multiple interventions and services from the DREAMS core package to each DREAMS beneficiary. The AGYW_PREV indicator measures this layering by measuring what proportion of DREAMS beneficiaries have completed at least the primary package of interventions.

AGYW_PREV is complementary to other MER indicators that track the receipt of individual services under DREAMS programs. Because of the comprehensive nature of DREAMS programs, they can also be reported using 12 other MER indicators[iii] besides AGYW_PREV. Some of these 12 indicators are listed in the middle column in the figure, and one of those indicators is OVC_SERV. These additional indicators track individual services such as HIV prevention, OVC care, and clinical interventions such as HIV treatment. These other MER indicators are complementary to AGYW_PREV.

A DREAMS program should report under OVC_SERV those beneficiaries who are receiving eligible OVC services. For example, a DREAMS beneficiary who is receiving educational support would be counted by the DREAMS program under OVC_SERV, since she is receiving an eligible OVC service.

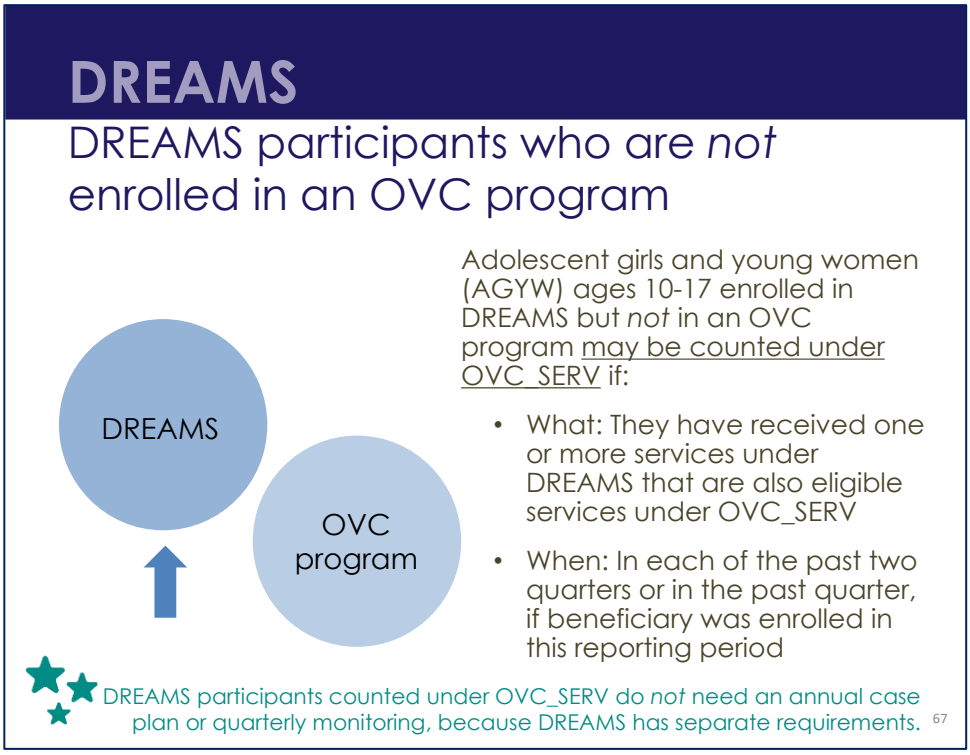
Slide 69



This slide shows a case in which a beneficiary aged 10 to 17 is enrolled in *both* an OVC program and in DREAMS. If she meets the requirements to be counted as active by the OVC program, the OVC program would report her under OVC_SERV. If she meets DREAMS program requirements, the DREAMS program would report her under the main DREAMS indicator AGYW_PREV. The DREAMS program could also report her under OVC_SERV if she had received one or more services that are eligible under OVC_SERV.

In this scenario, both programs would report her under OVC_SERV. Because each beneficiary may be counted only once per reporting period under OVC_SERV, OVC_SERV data would have to be de-duplicated at the country level so that beneficiaries who had been counted by two different programs (i.e., counted twice) are only counted once. If the same IP is providing an OVC program and a DREAMS program under different implementing mechanisms to the same beneficiary, that IP would count the beneficiary under each program and then would have to de-duplicate the data so that the beneficiary was not counted twice under OVC_SERV.

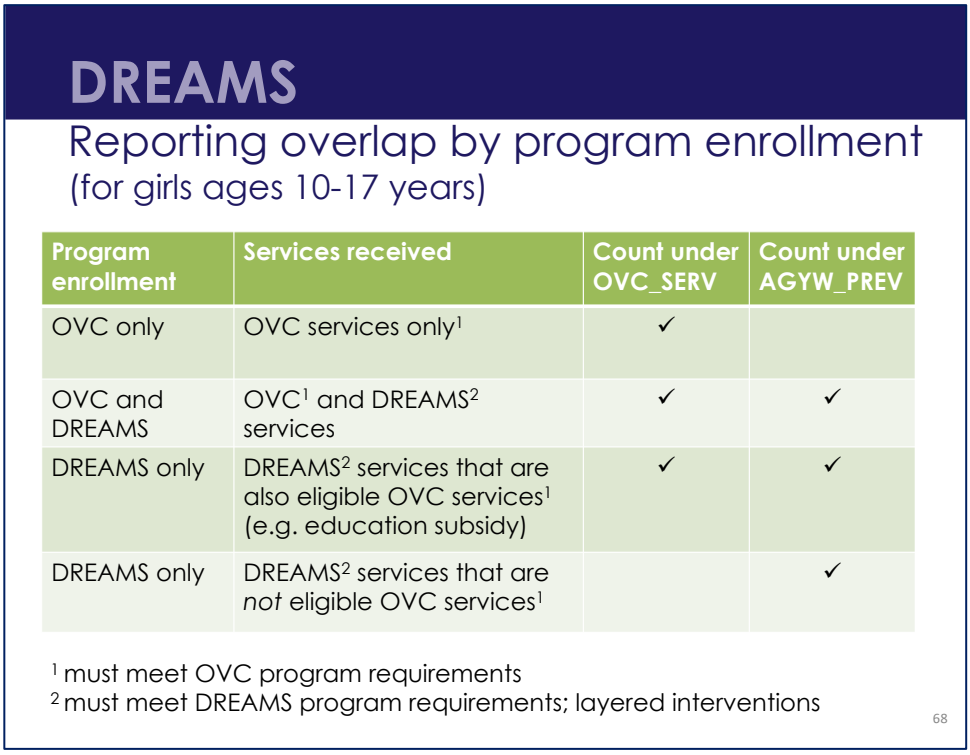
Slide 70



The other possible scenario is that a beneficiary age 10–17 is enrolled in a DREAMS program but not in an OVC program. The DREAMS program could report her under OVC_SERV if she had received one or more eligible OVC services.

In order for a DREAMS program to report a beneficiary under OVC_SERV, the girl must receive eligible OVC services which meet OVC_SERV's requirements for continuous services. Just as for other beneficiaries counted under OVC_SERV, the beneficiary must have received services in the past two quarters or in the previous quarter only if the beneficiary was newly enrolled during the reporting period. However, DREAMS beneficiaries are not required to have an annual case plan or quarterly monitoring to be counted under OVC_SERV. In other words, the requirement that OVC_SERV beneficiaries have an updated case plan and quarterly monitoring to be considered active does not apply to DREAMS beneficiaries who are counted under OVC_SERV, because the DREAMS program has separate requirements for case plan management.

Slide 71



This slide compares how beneficiaries enrolled in OVC and/or DREAMS programs would be reported under OVC_SERV and AGYW_PREV, according to different scenarios.

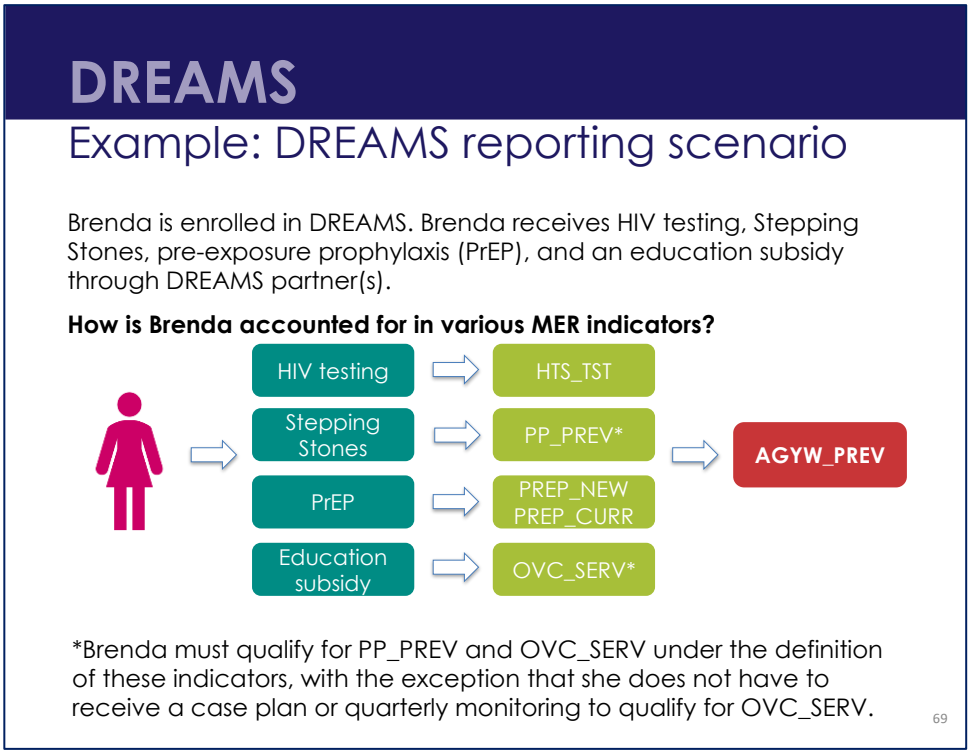
In the first row, a beneficiary is enrolled in an OVC program only and so is counted only under OVC_SERV.

In the second row, a beneficiary is enrolled in an OVC program and DREAMS. She is therefore receiving OVC services and DREAMS services, and is counted under OVC_SERV and AGYW_PREV.

In last two rows, a beneficiary is enrolled in a DREAMS program only. If she is receiving DREAMS services that are also eligible OVC services, such as an education subsidy, she would be counted under both OVC_SERV and AGYW_PREV. Remember that to be counted under OVC_SERV, she must receive services continuously (i.e., she must have received eligible OVC services in the last two quarters or in the past quarter if newly enrolled), but she does not need quarterly monitoring and an annual case plan.

If she is receiving DREAMS services that are *not* eligible OVC services, she would not be counted under OVC_SERV but would be counted under AGYW_PREV.

Slide 72



This slide shows an example reporting scenario. In this scenario, Brenda has received a variety of interventions through DREAMS, shown in dark green boxes: HIV testing, Stepping Stones (an HIV prevention intervention), pre-exposure prophylaxis, and an education subsidy. Each of these interventions can be reported under a distinct MER indicator, as can be seen in the light green boxes. In the case of PP_PREV and OVC_SERV, there are also additional requirements she must meet to be reported under those indicators. In the case of OVC_SERV, she must meet the requirement for receiving services continuously but does not have to meet the requirements for receiving an annual case plan or quarterly monitoring. Brenda is also reported under AGYW_PREV, which measures whether she has received the primary package of layered interventions.

DREAMS Frequently Asked Questions (FAQs)

[Note to facilitator: The following frequently asked questions are provided as a resource in the event that a participant raises the question. If no participant raises the question, there is no need to review these topics.

Can DREAMS beneficiaries ages 18–20 who are still in secondary school be counted under OVC_SERV if they are receiving continuous eligible OVC services?

No, DREAMS beneficiaries ages 18–20 who are still in secondary school cannot be counted under OVC_SERV unless they are also enrolled in an OVC program. Girls who are enrolled in a DREAMS program but not in an OVC program can only be counted under OVC_SERV if they are ages 10–17 and meet the requirement of receiving continuous eligible OVC services.

How should a DREAMS participant who graduates from DREAMS be counted under OVC_SERV?

DREAMS and OVC programs have different graduation requirements. A DREAMS beneficiary who meets DREAMS graduation requirements is not counted as graduated under OVC_SERV unless she and her household have also met the OVC program requirements for family-centered graduation. In the case of a DREAMS beneficiary who has been counted under OVC_SERV but is not enrolled in an OVC program, she would simply no longer be reported under OVC_SERV after she had graduated from DREAMS. She would not be reported as exited without graduation, or graduated, under OVC_SERV.

2.11. Avoiding Double Counting

No additional instructions or notes.

2.12. Review of OVC_SERV

Participants form three or four groups of approximately five people per group. Participants should mingle with participants from other organizations so that they do not end up in the same group as colleagues from their organization. One way to do this is through a creative or ice-breaker activity. For example, the facilitator can give each participant a piece of paper with an object, animal, or action written on it. Each participant is given a unique word and each word belongs to a category, with the same number of categories as there are small groups. For example, categories might be types of vehicles, types of wild animals, types of farm animals, and types of exercise. Participants then seek out the other members of their group through *non-verbal* communication, such as through silent acting. Alternatively, the facilitator can simply count off the group by threes (or fours) so that participants do not go to the same small group as the people they have been sitting next to.

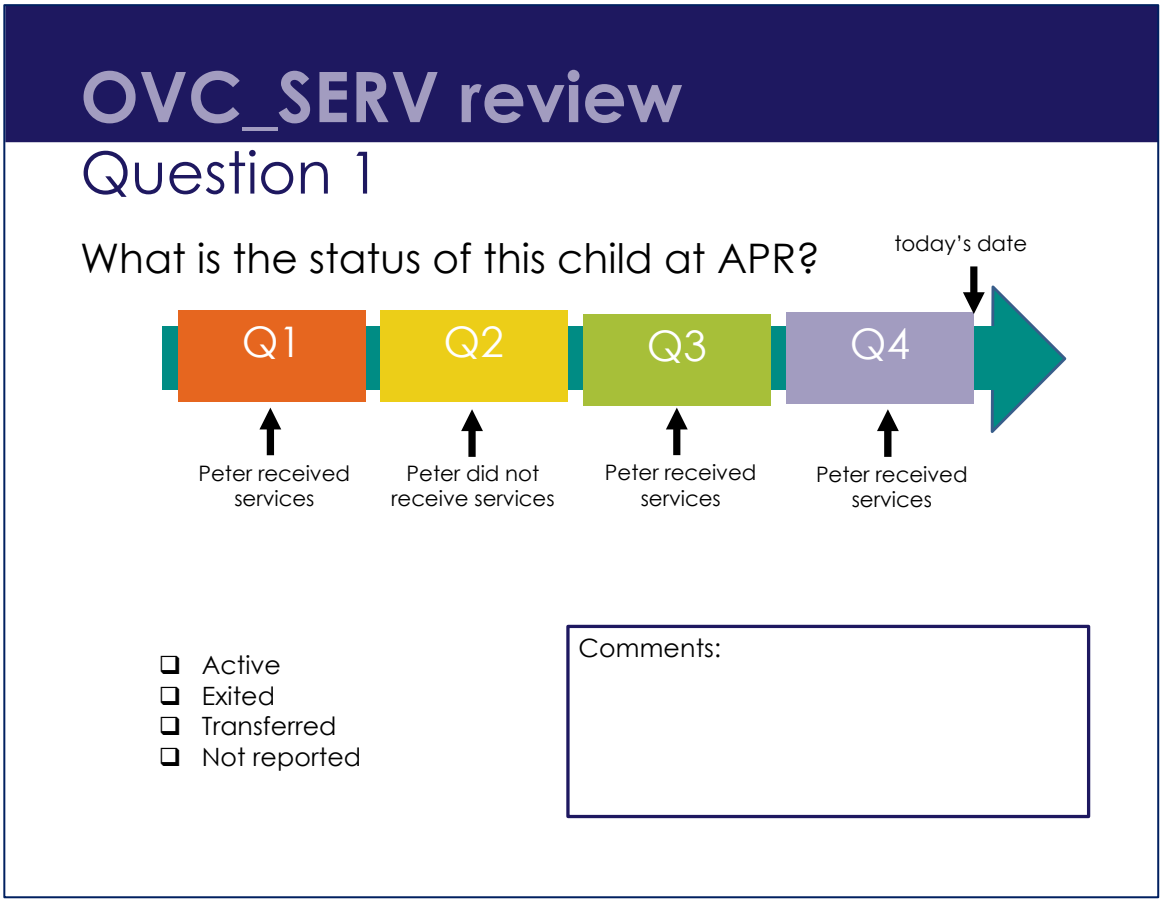
The facilitator distributes the printed review questions evenly between the small groups. There should be only one copy of each review question, and each group should be given printed copies of two to four questions (depending on the number of groups). It is fine if groups do not have exactly the same number of questions.

The small groups spread out as much as possible in the available space. Ideally, participants should not go back to their original seats and should stay away from their phones and computers during the discussion time. A more informal environment, without distractions, will enhance discussion. Small groups should discuss each question in turn and prepare to present their conclusions to the large group.

After 20 minutes of small group discussion, the facilitator reconvenes the large group. Small groups continue to sit together. Small groups present their review questions in turn, starting with the first question. The facilitator projects the slide for each question. A representative of the small group reads the question aloud and then presents the small group's answer and comments. Other participants in the large group can then ask questions or comment on the small group's conclusions and express their agreement or disagreement. The large group may express agreement or disagreement non-verbally, such as through pointing thumbs up or down, or snapping fingers to express agreement.

Once the participants have finished discussing each exercise, the facilitator should offer any additional comments or clarifications necessary. It is not necessary to read the solution found in the Facilitators Guide if the participants have already made all relevant points. The facilitator should review the written solutions as the participants share their own solutions and present any information that has not been mentioned by the participants.

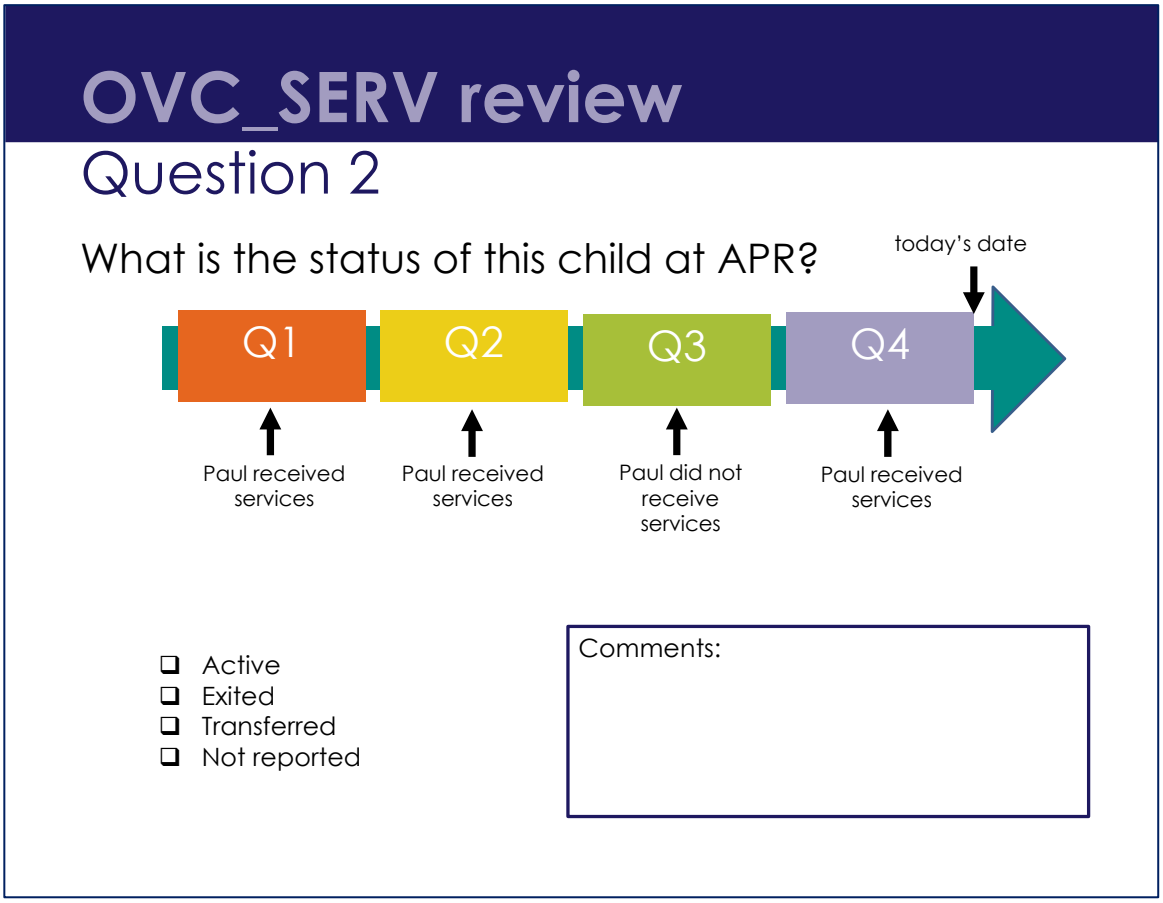
OVC_SERV Review Question 1



Solution

Peter is counted as **active** at APR (on the last day of Q4) provided he also has a case plan that has been updated within the last four quarters and has been monitored at least quarterly. He has met the requirement of receiving services in the previous two quarter (Q3 and Q4). The IP should explain any patterns of inconsistent service delivery in the narrative section of their report.

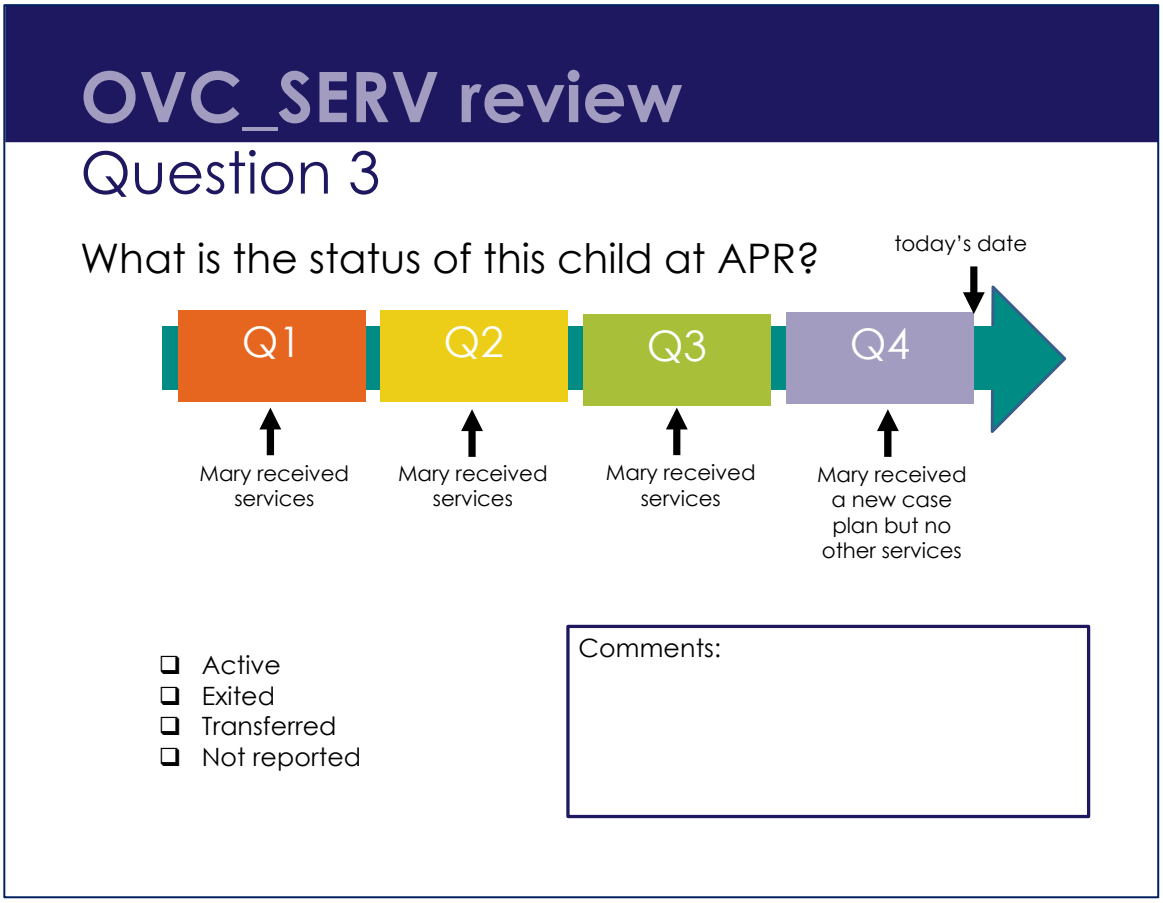
OVC_SERV Review Question 2



Solution

Paul is counted as **exited** at APR. He did not meet the requirement of receiving services in the previous two quarters, as he received services in Q4 but not Q3. Paul could be counted as active again once he had received services in the previous two quarters, had a case plan which had been updated within the last four quarters, and had been monitored at least quarterly.

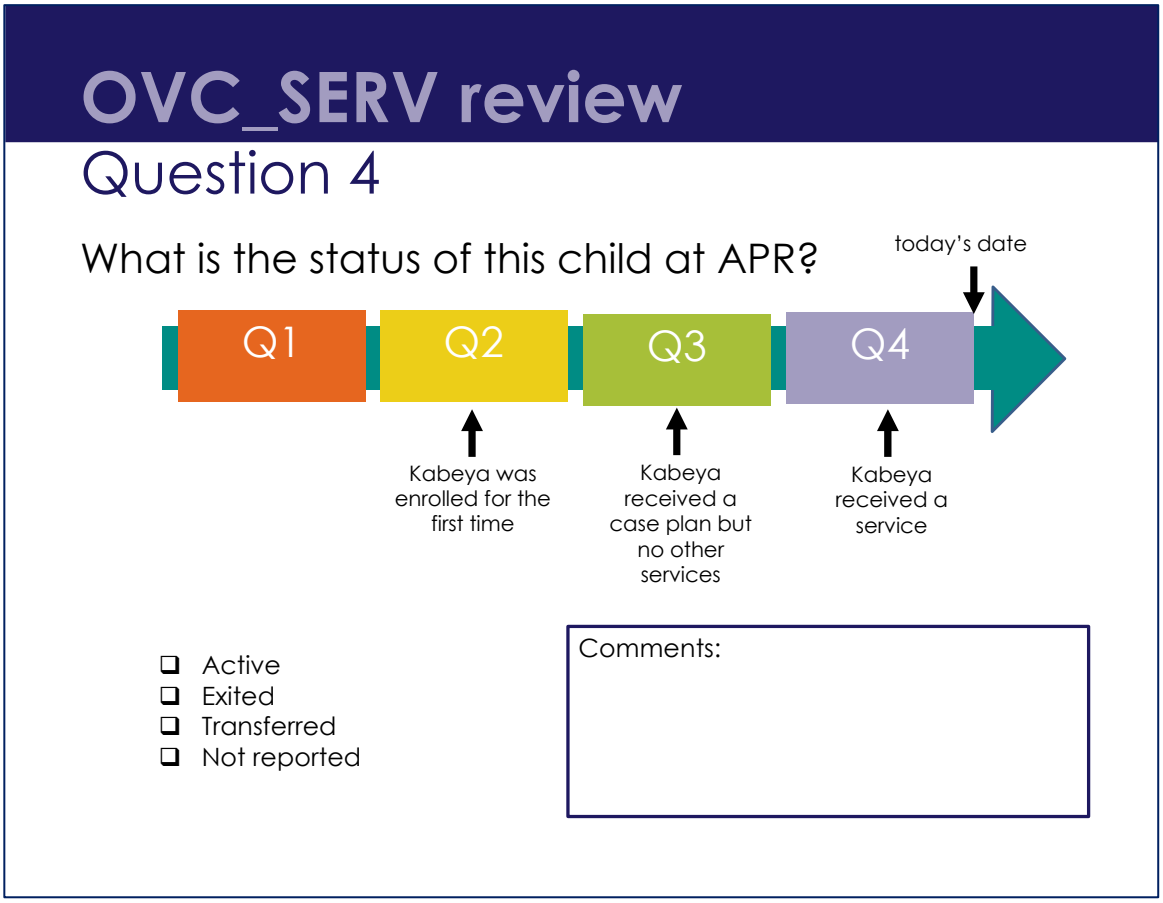
OVC_SERV Review Question 3



Solution

Mary is counted as **exited** at APR. She did not receive services in the previous two quarters, as she received services in Q3 but not Q4. Receiving a new case plan is not counted as a service, although receiving a new case plan at least once a year is a requirement for being active. Mary could be counted as active again once she had received services in the previous two quarters, had a case plan which had been updated within the last four quarters, and had been monitored at least quarterly.

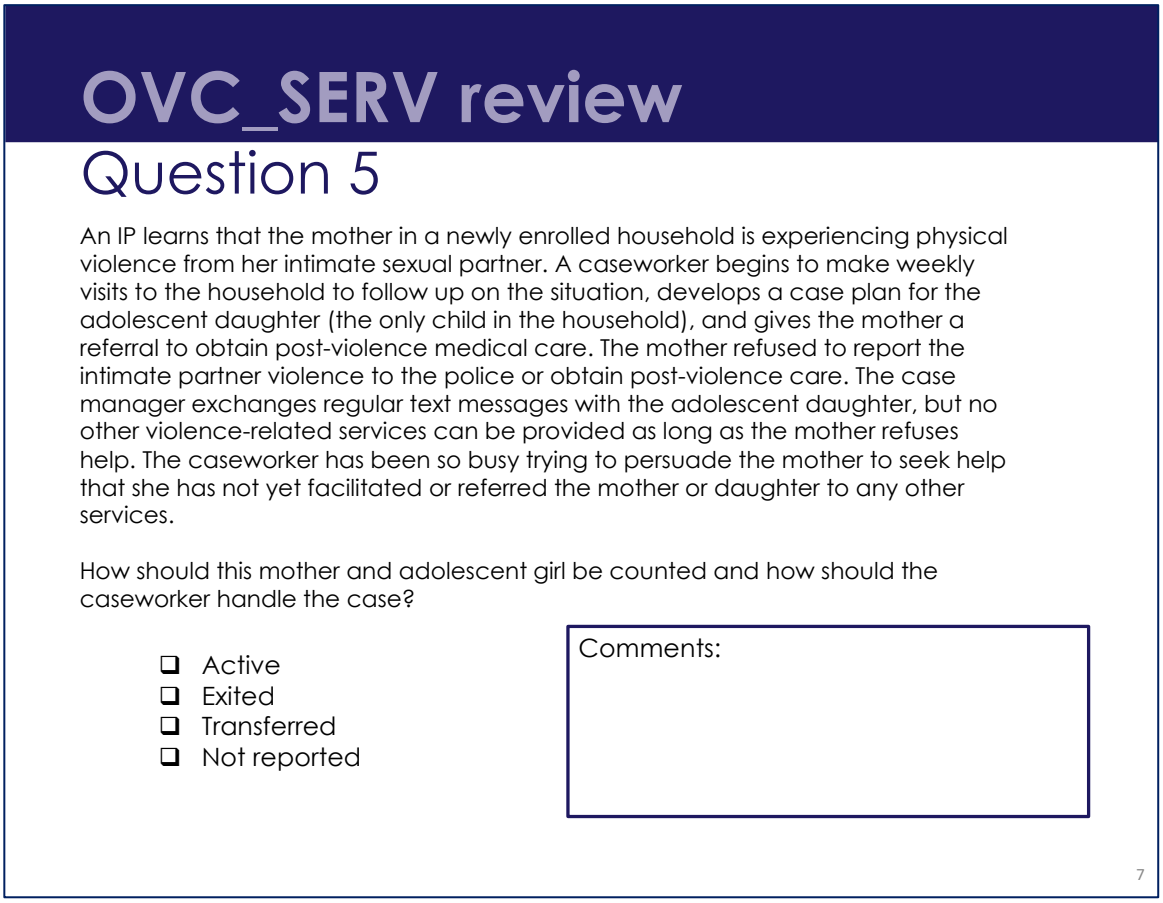
OVC_SERV Review Question 4



Solution

Kabeya is **not reported** in DATIM at APR. A newly enrolled child is not counted as active until he or she has received a service in the same reporting period when he or she was enrolled or has received services in two consecutive quarters if services did not start until the reporting period after he or she was enrolled. Because Kabeya was enrolled in Q2 and did not receive a service by the end of Q2 (the end of the reporting period), she will not become active until she receives services in two consecutive quarters. Receiving a new case plan is not counted as a service, although a case plan and quarterly monitoring are also required for Kabeya to be counted as active.

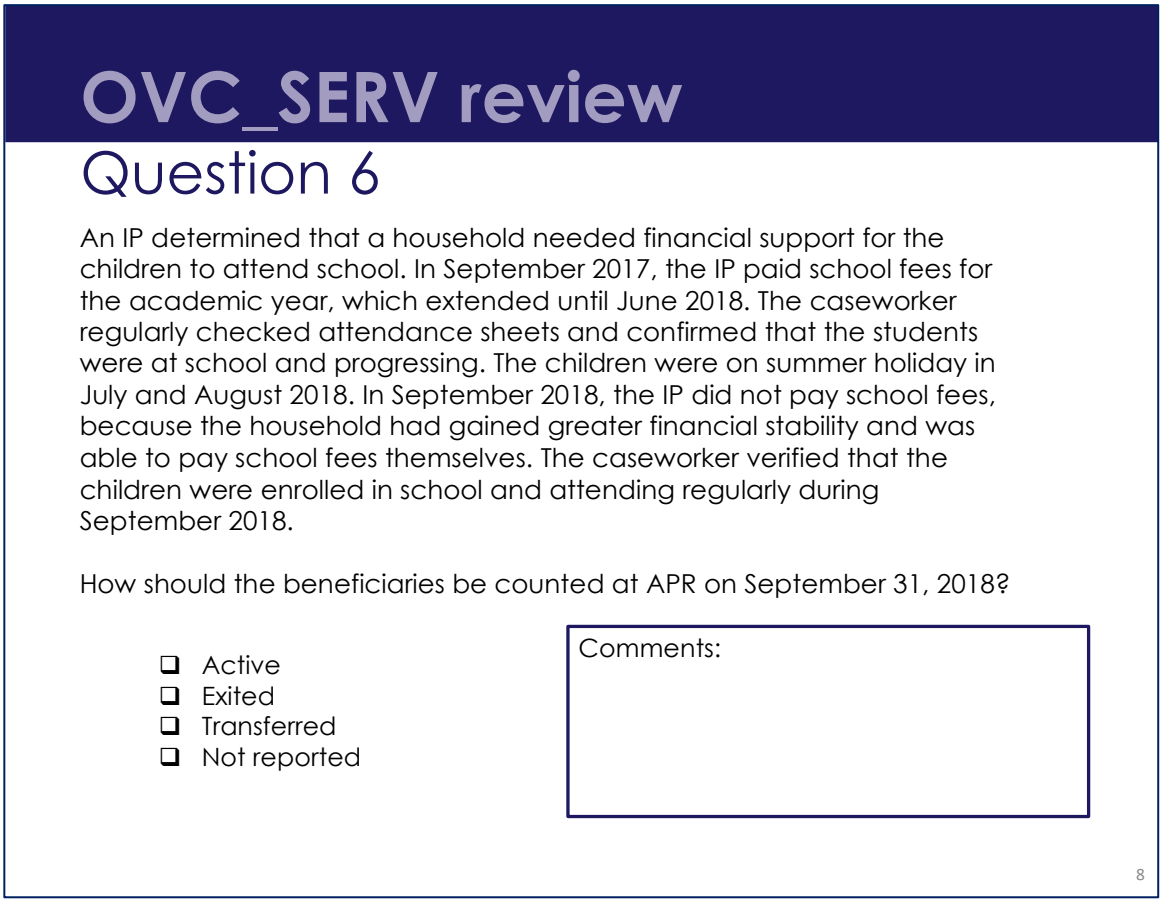
OVC_SERV Review Question 5



Solution

Psychosocial support that does not involve a specific, evidence-based psychosocial intervention does not count as a service. Although the household is receiving weekly visits, these visits to do not count as an evidence-based psychosocial intervention. The daughter has been provided with a case plan and regular monitoring, but she and her mother will **not be reported** in DATIM until they receive an eligible service. The caseworker should continue to try to persuade the mother to seek help for the violence she is experiencing, through strategies such as arranging for the mother to speak with someone with expertise in intimate partner violence. The caseworker should also ensure that the mother and daughter receive other necessary OVC services as soon as possible. In addition, the caseworker should regularly screen the daughter for violence (including sexual violence).

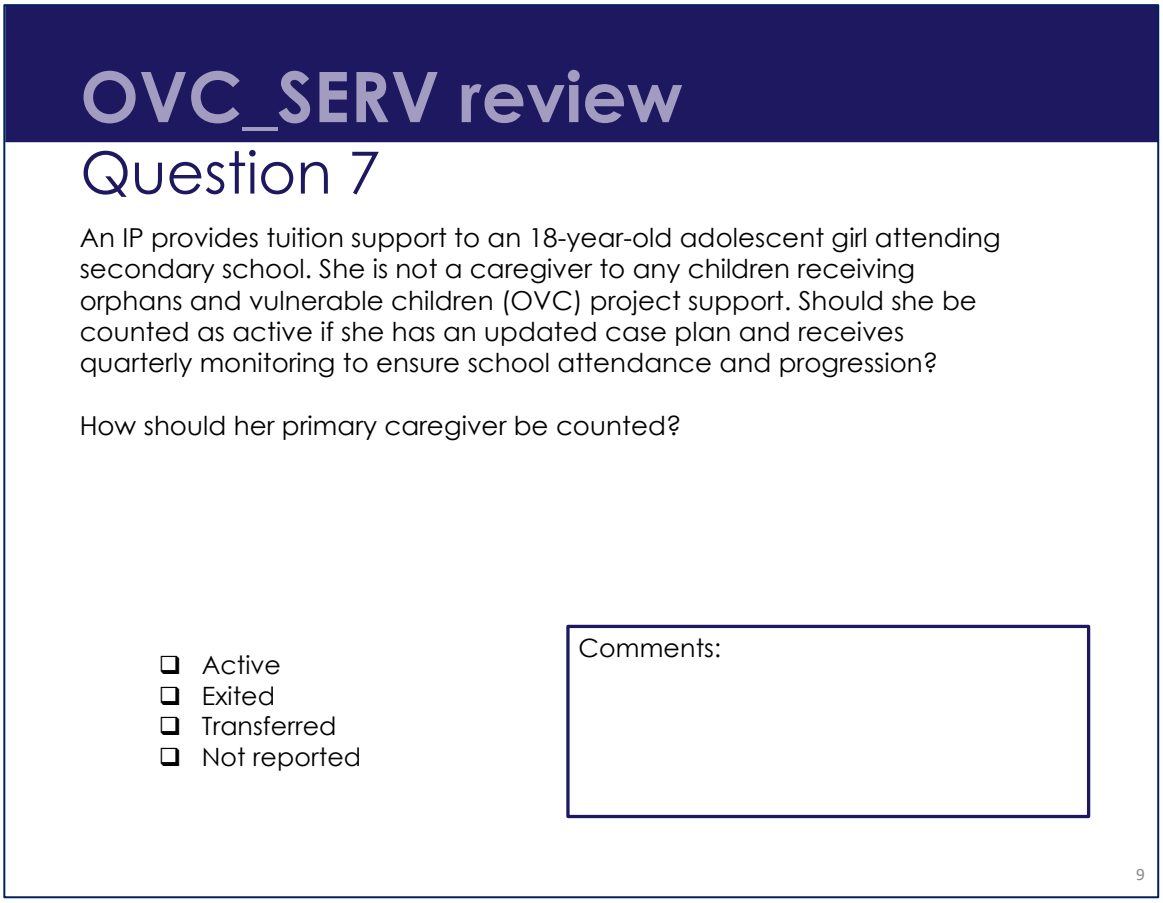
OVC_SERV Review Question 6



Solution

Children are counted active during the period for which school fees have been paid (even if they were paid in a previous quarter) and the children are attending school. In Q4 (July to September 2018), the children did not receive educational support, as the IP did not pay school fees and the children did not attend school. The children would have needed to receive another service in Q4 to be counted as active at APR. If they did not receive another service in Q4, they would be counted as **exited** at APR.

OVC_SERV Review Question 7

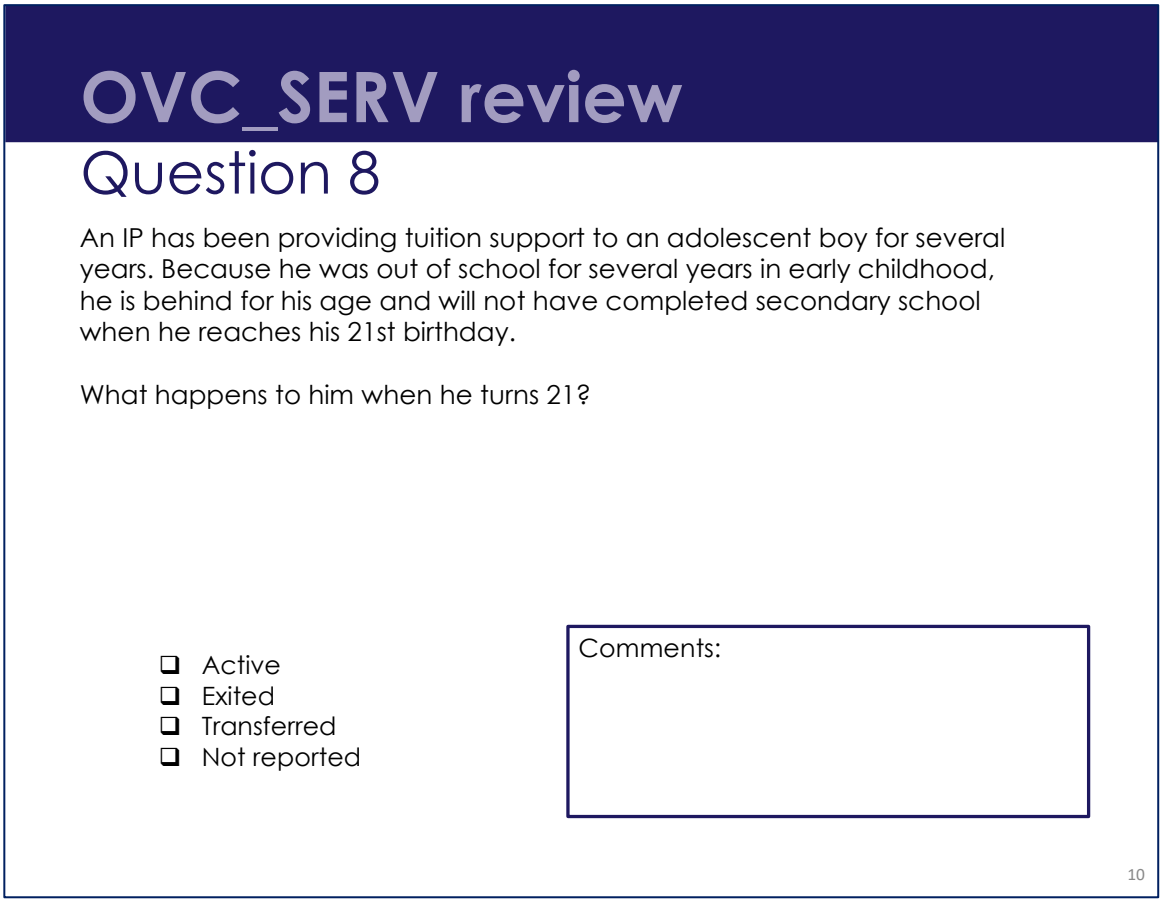


Solution

Yes, OVC beneficiaries between the ages of 18 and 20 receiving project support in both of the previous two quarters to attend secondary school and meeting the criteria for an updated case plan and quarterly monitoring may be counted as **active**.

No, her caregiver should not be counted as active unless the caregiver is also receiving OVC services.

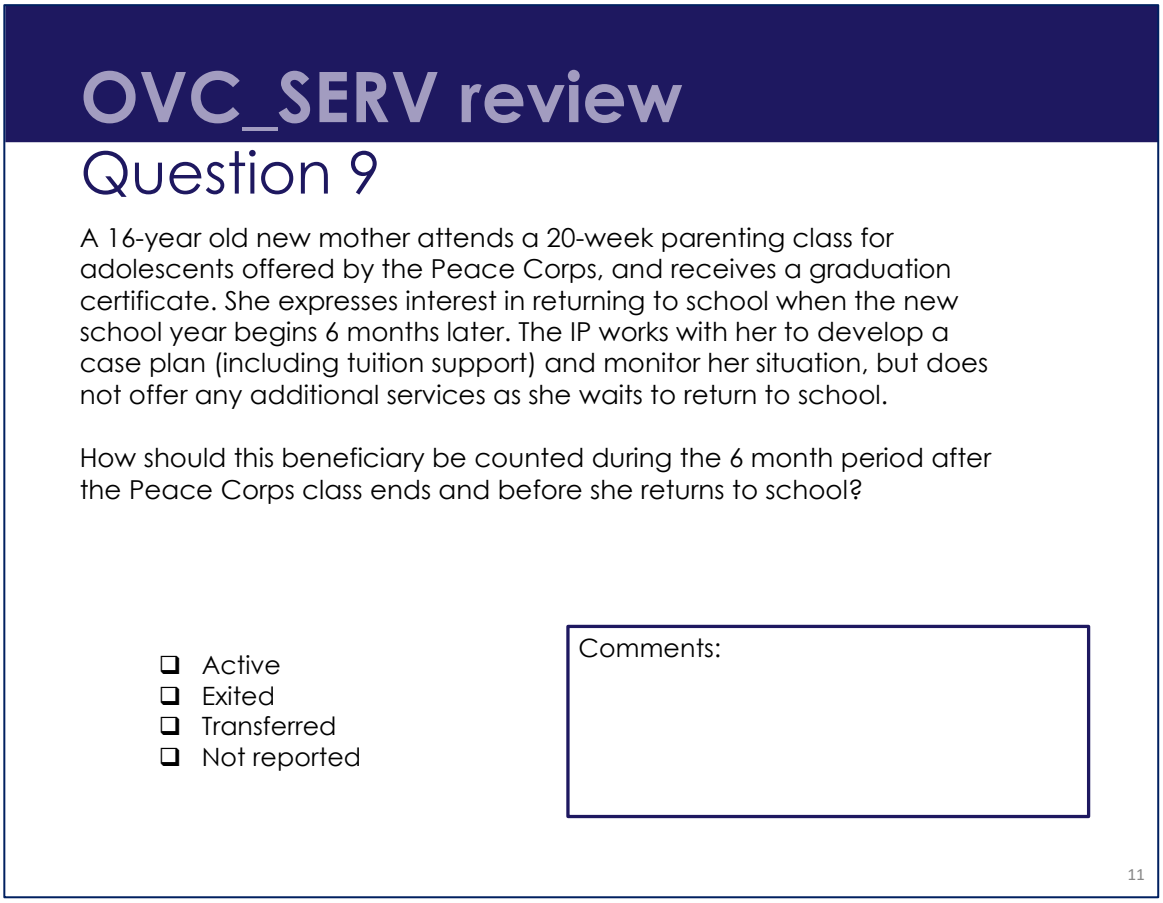
OVC_SERV Review Question 8



Solution

He may only be considered an OVC beneficiary until the age of 20 and while still in secondary school, and he can no longer be considered an OVC beneficiary after he turns 21. We recommend that the IP work to find another non-PEPFAR program capable of providing ongoing support. If all members of his household have not met all graduation benchmarks by his twenty-first birthday, he is considered **exited**.

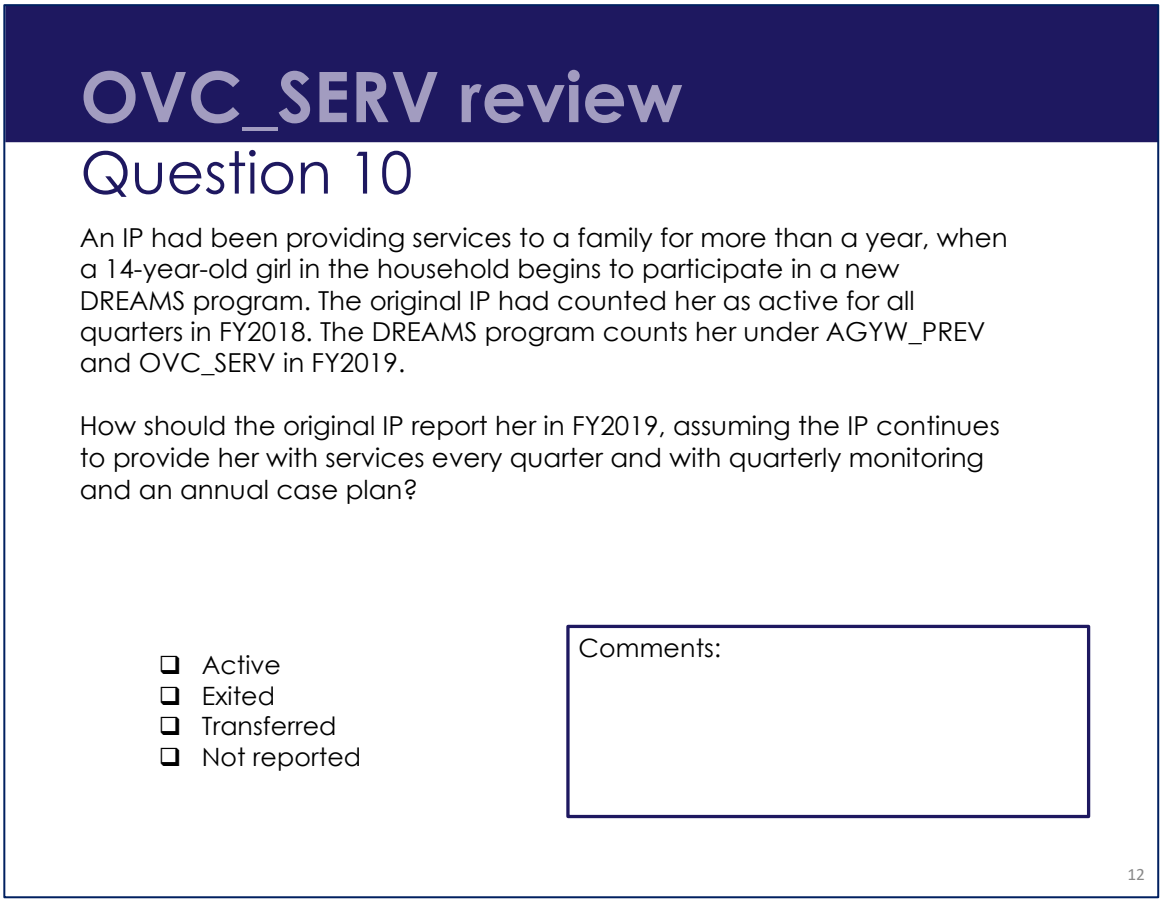
OVC_SERV Review Question 9



Solution

She becomes **exited** the quarter after the Peace Corps class ends unless she receives another eligible service. She can become active again when she resumes school or receives another service for two consecutive quarters, provided she also has a case plan that has been updated within the last four quarters and is monitored at least quarterly.

OVC_SERV Review Question 10

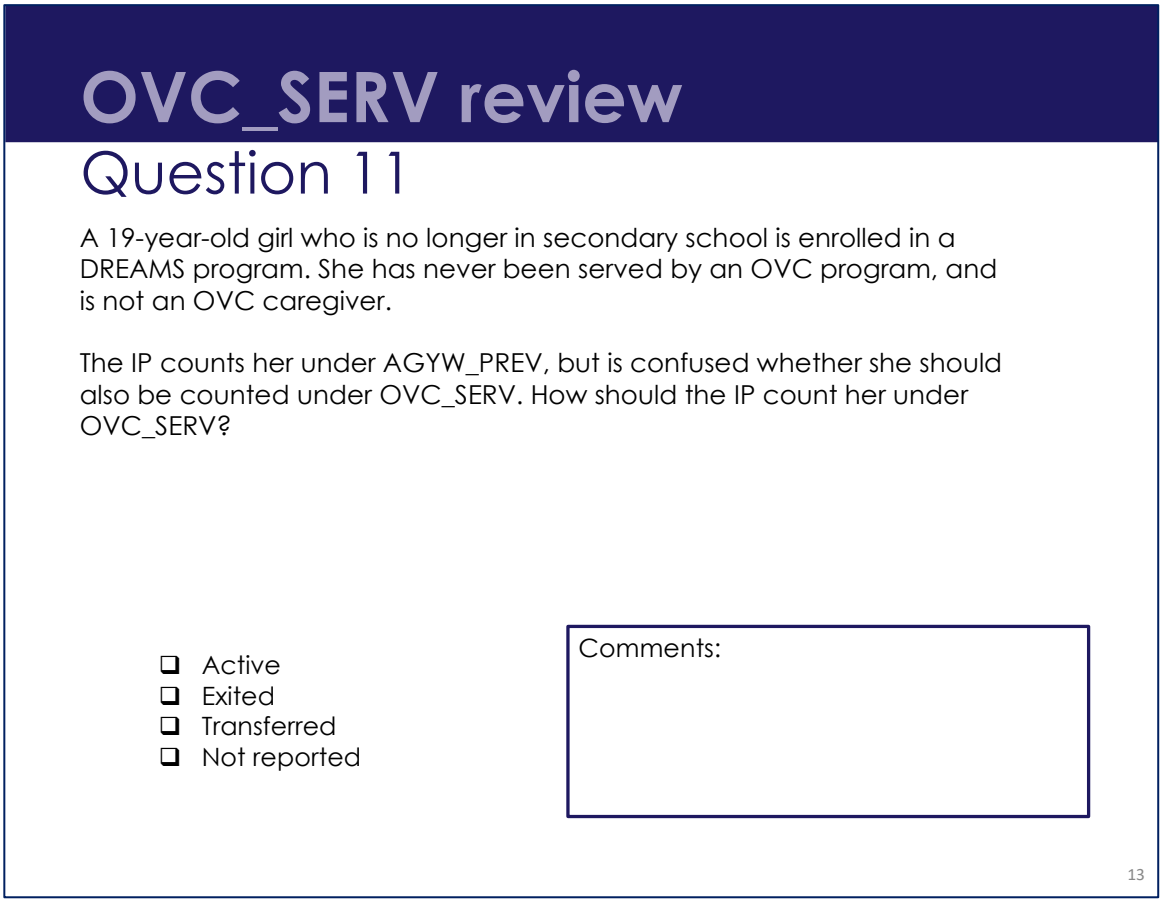


Solution

The IP should continue to count her as **active**. Each IP may count the beneficiary under OVC_SERV but should use the deduplication mechanism to ensure that the individual is only counted once, as the same beneficiary may be counted only once under OVC_SERV. However, the same beneficiary may be counted under both OVC_SERV and AGYW_PREV.

Please note that this means that it is not possible to discern the overlap between OVC_SERV and AGYW_PREV or to identify the number of individual beneficiaries who are receiving only DREAMS services, DREAMS plus OVC programming including case management and monitoring, or those receiving only traditional OVC programming including case management and monitoring. DREAMS beneficiaries enrolled only in DREAMS are not expected to be classified as graduated, nor be counted for transferred or exited without graduation.

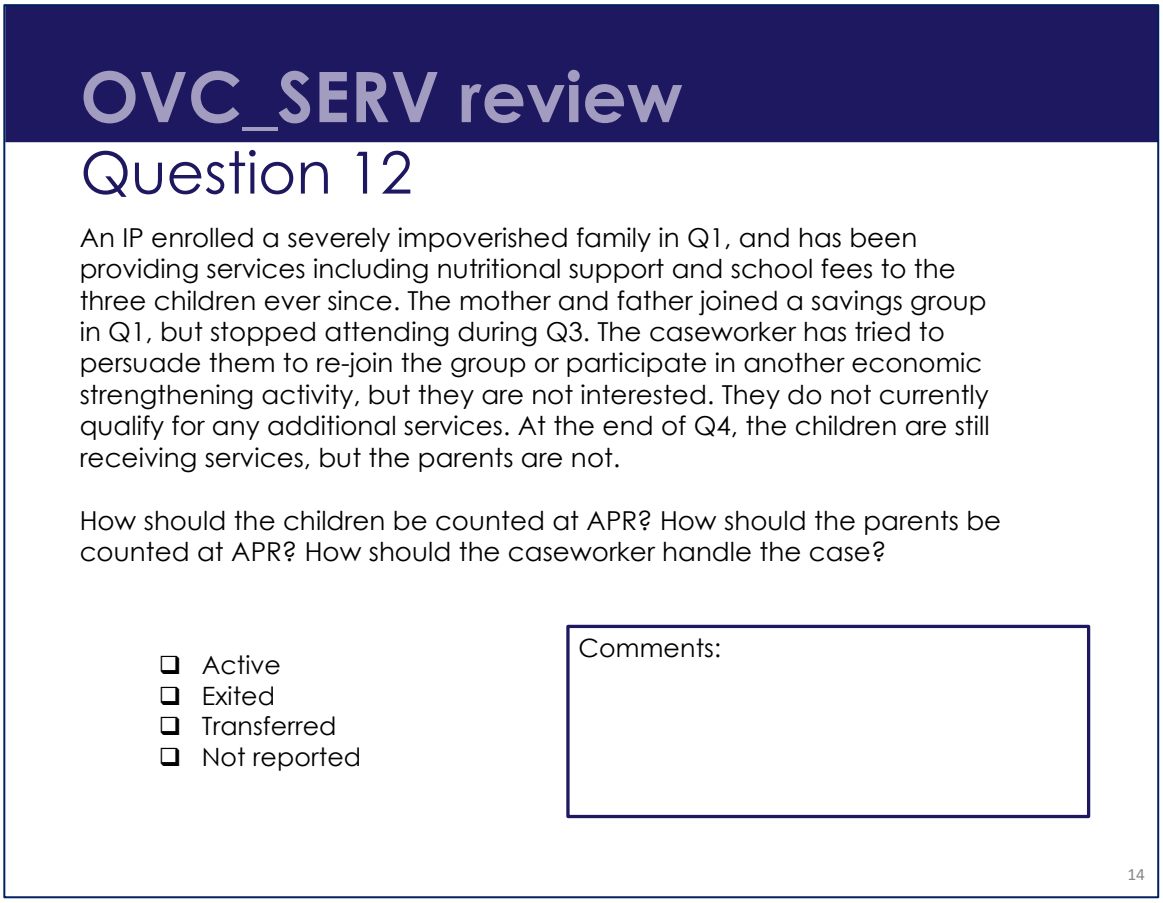
OVC_SERV Review Question 11



Solution

As she is no longer in secondary school and is not an OVC caregiver, she cannot be counted under OVC_SERV. She is **not reported.** DREAMS-only beneficiaries ages 18–24 should not be counted under OVC_SERV and instead should be counted under AGYW_PREV, PP_PREV and/or other MER indicators relevant to the services that they have received.

OVC_SERV Review Question 12



Solution

At APR, the children should be counted as **active** and the parents should be counted as **exited**. The caseworker should continue to encourage the parents to participate in economic strengthening activities and any other services for which they might be eligible. In the meantime, the program should continue to provide services to the children despite their parents' choices. Children should never be denied services because their parents have refused services or exited the program.

Module 3

3. GRADUATION

Module duration: 2.0 hours

Module Learning Objectives

By the end of this module, participants will be able to:

- Understand the eight graduation benchmarks and which benchmarks are required for different households based on household composition
- Identify which members of a household are eligible to receive OVC services
- Explain how the principle of family-centered graduation applies to individual beneficiaries

Materials Needed

- Module 3: Graduation (PowerPoint presentation)
- OVC_SERV review questions (1 copy of slides 16–30 from Module 6)
- Quiz 1: OVC_SERV and Graduation (handout, see Section 6.8)
- Evaluation of Day 1 (handout, see Section 6.10)
- Data use exercise instructions (handout, see Section 6.7)
- PEPFAR official OVC MER guidance (in participant folders)
    - Global OVC graduation benchmarks matrix (see Section 6.17)[3]

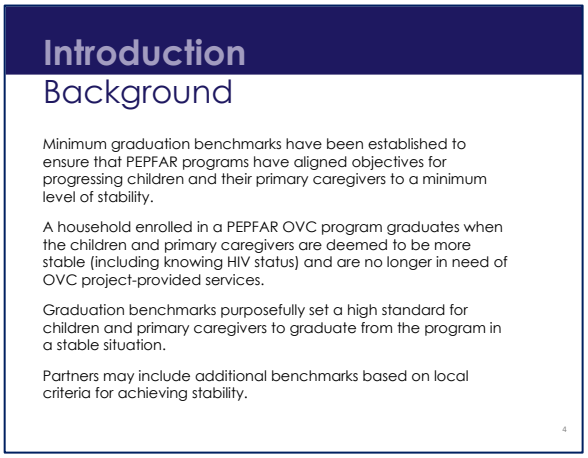
[3] Appendix E in the *Monitoring, Evaluation, and Reporting Indicator Reference Guide Version* 2.3 (PEPFAR, 2018)

Session Plan

Time	Title and Description	Methods and Materials
5 minutes	**3.1. Introduction** Present and discuss: • Rationale for minimum graduation benchmarks • Household stability as a criterion for graduation	Lecture with PowerPoint
15 minutes	**3.2. Data Definitions** Present and discuss: • Graduation as a household-level disaggregate within OVC_SERV • Eight graduation benchmarks grouped under four domains (healthy, stable, safe, schooled) • Objective and definition of each benchmark • Which household members must be assessed for each benchmark	Lecture with PowerPoint
10 minutes	**3.3. Household Composition** Present and discuss: • Who is considered to be part of the household, for purposes of OVC program graduation • Who is *not* considered to be part of the household, for purposes of OVC program graduation	Lecture with PowerPoint
10 minutes	**3.4. Household Composition Exercise** Facilitate discussion of which family members are considered eligible beneficiaries in 3 case studies.	Large group discussion using PowerPoint slides
10 minutes	**3.5. Required Benchmarks for Family-centered graduation** Present and discuss: • Minimum required benchmarks by household composition • The principle of family-centered graduation	Lecture with PowerPoint
40 minutes	**3.6. Review of Graduation** Distribute review questions to small groups and give 15 minutes for discussion. Reconvene large group for discussion of review questions and solutions.	Small and large group discussion

20 minutes	**3.7. Quiz 1 and Evaluation of Day 1** Distribute Quiz 1 and Evaluation of Day 1. Ask participants to work individually to complete the quiz and evaluation.	Individual work Handout: Quiz 1 Handout: Evaluation of Day 1
20 minutes	**3.8. Presentation of Data Use Exercise** Distribute data use exercise handout. Briefly present the instructions for the data use exercise as preparation for the exercise itself (on Day 2).	Lecture Handout: Data Use Exercise Instructions

3.1. Introduction

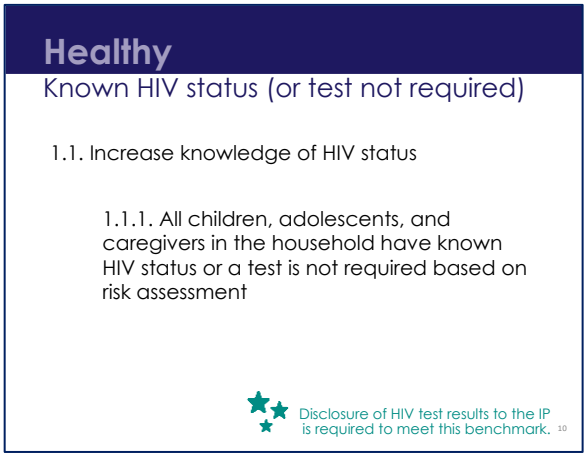


Slide 4

For some country programs, an emphasis on graduating beneficiaries may be a change, as this has not necessarily been an explicit goal in the past.

Other countries already have their own graduation criteria. Please note that PEPFAR's graduation benchmarks are a global standard to be used by all countries, although countries may also add their own additional benchmarks.

3.2. Data Definitions



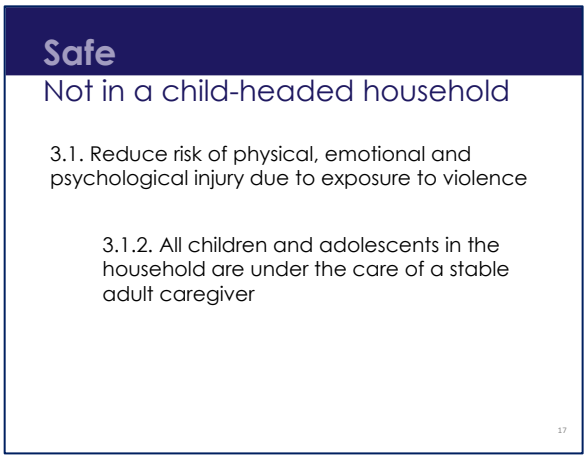
Slide 10

In this and following slides, the text at the top (in the dark blue box) refers to the domain.

Below that is the name of the benchmark (in dark blue text).

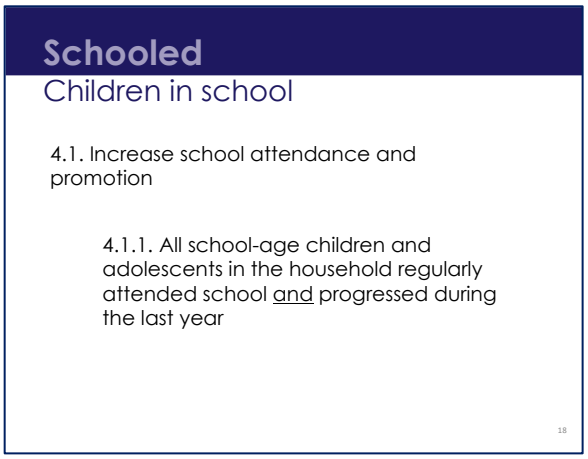
Below that is the objective of the benchmark (labeled 1.1. on this slide).

Finally comes the definition of the benchmark (labeled 1.1.1 on this slide).



Slide 17

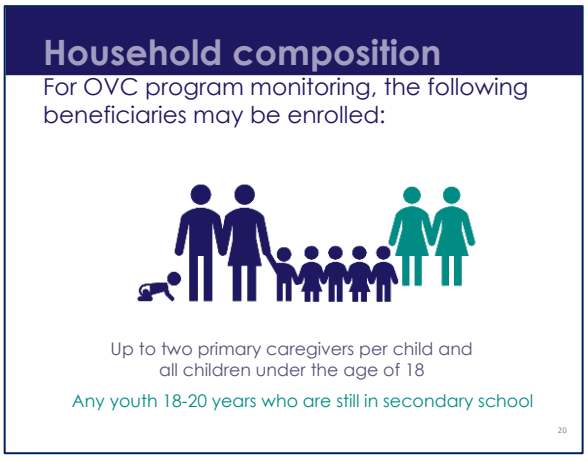
Note that this benchmark has the same objective as the previous benchmark—to reduce exposure to violence.



Slide 18

Note that adolescents ages 18 and above are *not* required to be in school. If adolescents ages 18 or older are no longer in secondary school, they are no longer considered OVC beneficiaries (unless they are primary caregivers). Therefore, if an adolescent age 18–20 dropped out of secondary school, he or she would no longer be considered part of the household for the purposes of OVC programming and graduation, and the fact that he or she was not in school would not prevent the household from graduating.

3.3. Household composition

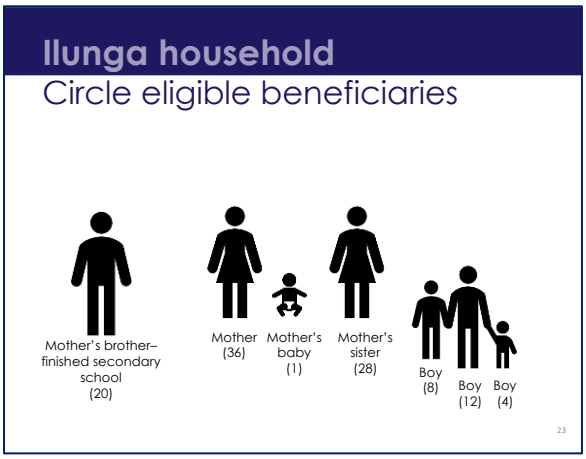


Slide 20

Adults should not be enrolled as primary caregivers unless they are playing a significant caregiver role. Although it is possible to enroll more than two primary caregivers per household, this should only be done in special cases in which there are more than two adults playing a significant caregiver role. Enrolling adults who are not primary caregivers is not in keeping with the intention of the guidance and will make it more difficult for the household to graduate, as there will be additional people who have to meet graduation benchmarks.

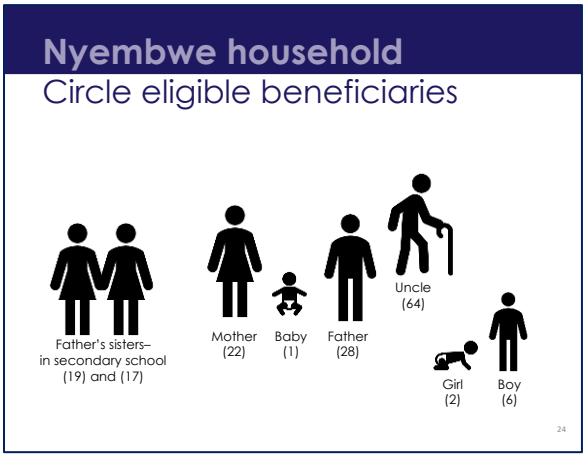
3.4. Household Composition Exercise

For each of the three slides in this exercise, the facilitator chooses a participant to come to the front and indicate which family members would be considered eligible beneficiaries and members of the household for the purpose of graduation. The participant circles the eligible beneficiaries with the pointer or his or her finger and explains why each member was chosen or not chosen as an eligible beneficiary. The facilitator then asks other participants if they agree or disagree with these conclusions. The facilitator can read any parts of the scripts below that contain points not already made by participants, or correct erroneous information. There are multiple correct solutions for each exercise, and the point is to discuss the criteria for being active.



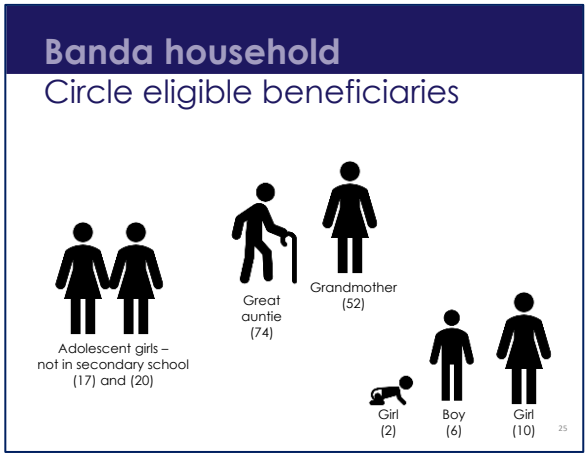
Exercise 1: Solution

If the mother and her sister are both primary caregivers, they are both beneficiaries. All children under the age of 18 are also beneficiaries. The mother's brother who is over 20 and not in secondary school is not considered a beneficiary unless he is a primary caregiver in the household.



Exercise 2: Solution

If the mother and father are both primary caregivers they are both beneficiaries. All children under the age of 18 are also beneficiaries. The 19-year-old sister who is still in secondary school is still considered a child beneficiary. The uncle is not considered a beneficiary unless he plays a significant caregiver role in the household and is enrolled as a primary caregiver.



Exercise 3: Solution

If the great auntie and grandmother are both primary caregivers they are both beneficiaries. All children under the age of 18 are also beneficiaries. The 20-year-old girl who is not still in secondary school is not considered a beneficiary unless she is a primary caregiver.

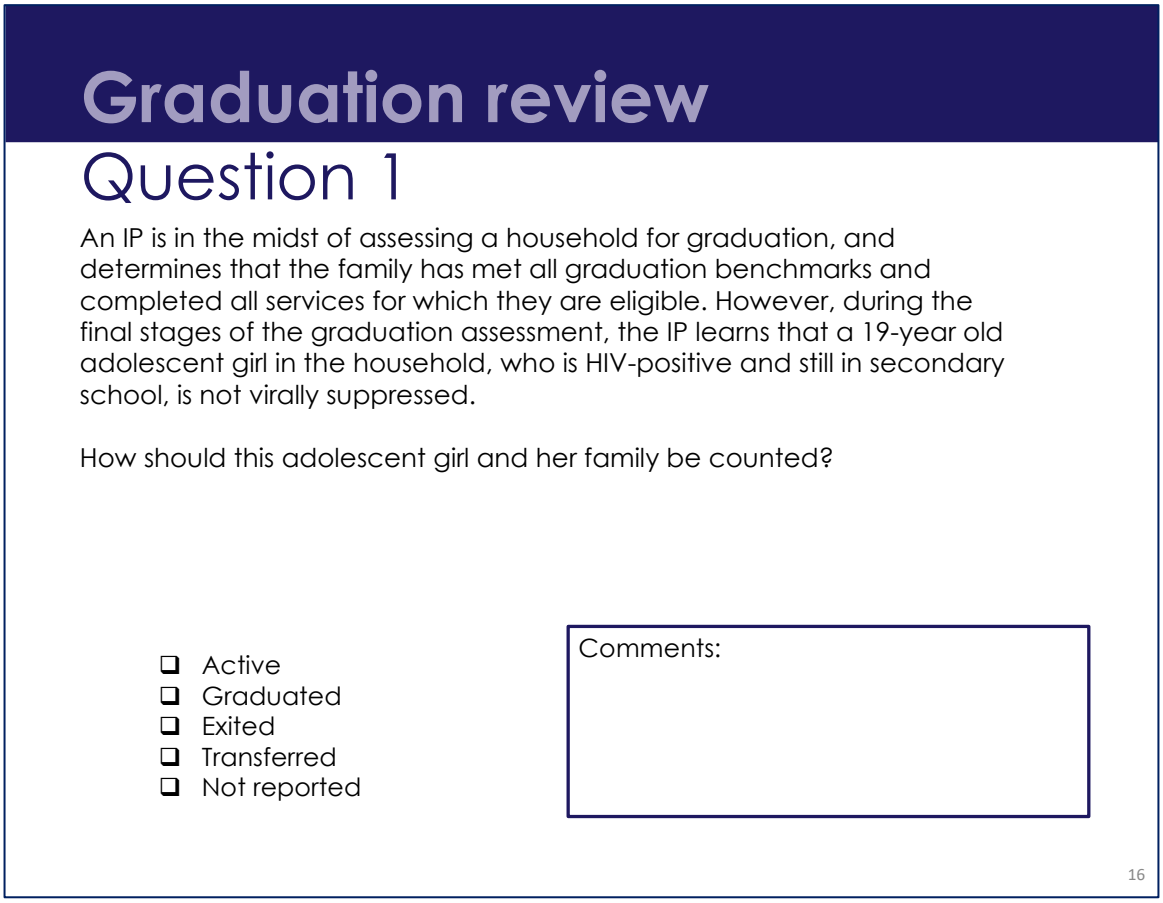
3.5. Required Benchmarks for Family-Centered Graduation

No additional instructions or notes.

3.6. Review of graduation

Follow the instructions for facilitating small and large group discussion given in Section 2.12 (Review of OVC_SERV). Give small groups only 15 minutes for discussion before starting large group discussion. For Questions 4, 5, and 6, it is very helpful if the slide showing the table of benchmarks can be projected onto a white board or other writing surface. The participants who present these questions can then write circles and checks on the table as they present their solutions.

Graduation Review Question 1

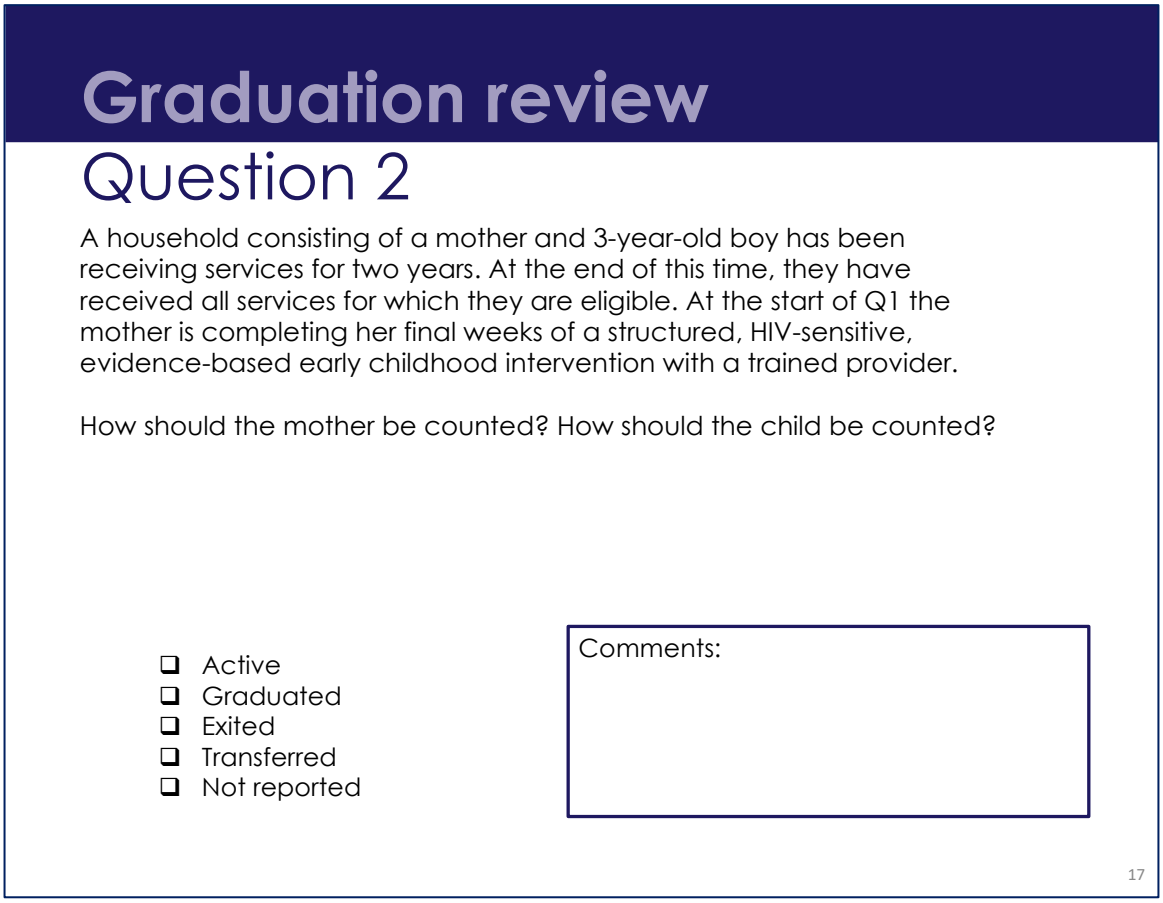


Solution

The 19-year old adolescent girl is considered a member of the household for purposes of graduation, as she is under the age of 21 and still in secondary school. Therefore, she must meet all applicable graduation benchmarks for the family to graduate, including the requirement that she be virally suppressed for at least 12 months. Given this requirement, it will be at least another year before the family can graduate.

While they are waiting to graduate, the members of the household can be counted as **active** as long as they continue to receive all services for which they are eligible and as long as children continue to be monitored by the project on at least a quarterly basis and have their case plans updated at least once a year. If the household members have completed all services for which they are eligible, but one or more members has not met graduation benchmarks, they can continue to be counted as active even if they are not receiving services, as long as children continue to receive quarterly monitoring and updated case plans.

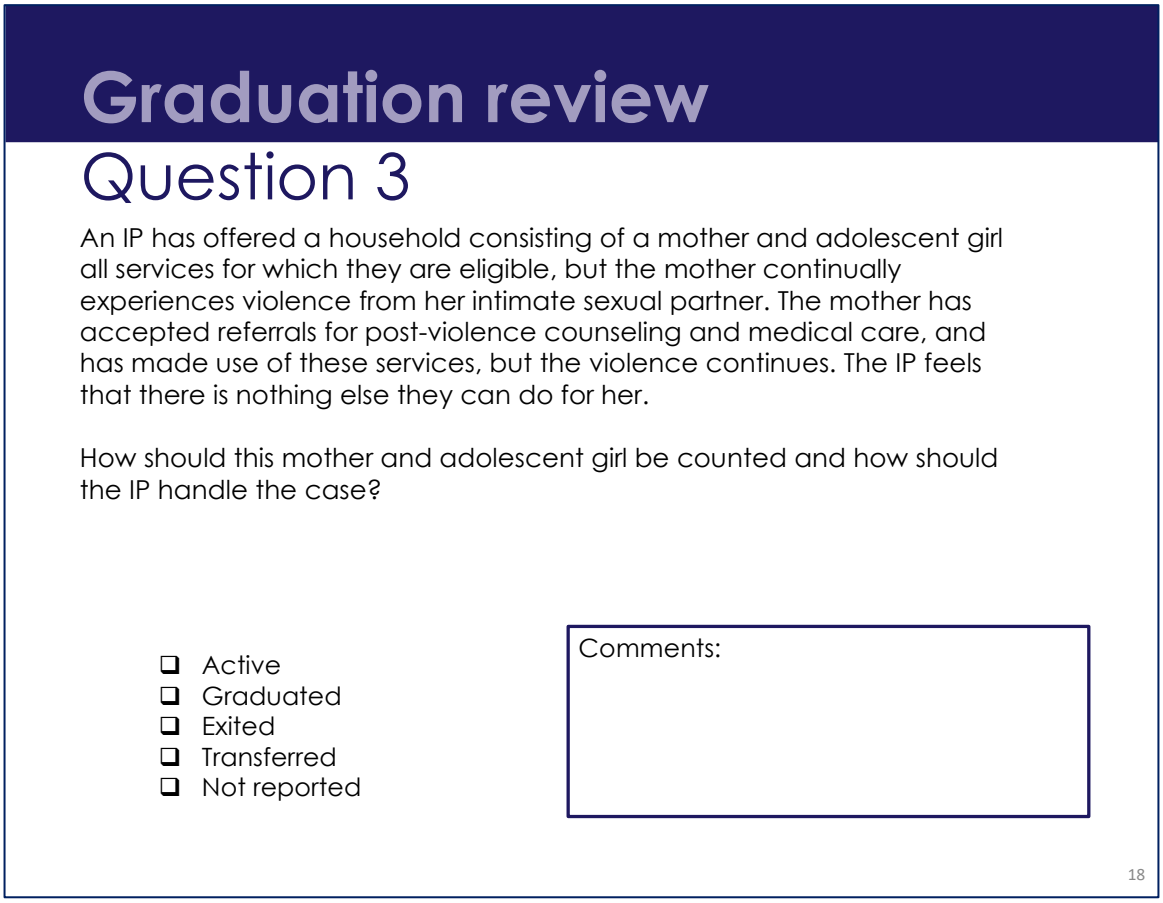
Graduation Review Question 2



Solution

If a child beneficiary has completed all eligible needed services and met the graduation benchmarks but has a caregiver who is still actively participating in a project-provided intervention with direct benefit to the child (see services marked "caregiver and child" in Figure 1), the child should be counted as **active** as long as he or she has an updated case plan and is monitored by the project on at least a quarterly basis to identify any service needs. If the mother successfully completes the intervention and all other graduation benchmarks are met at that time, the mother and child would be considered **graduated** and would be counted as graduated (not active) at SAPR.

Graduation Review Question 3



Solution

The household cannot be graduated as long as any member of the household is experiencing violence. The IP should offer services as necessary to the mother and daughter, regularly screen the adolescent girl for violence (including sexual violence), and continue to provide the girl with quarterly monitoring and a case plan updated at least once per year. If these requirements are met, the mother and daughter can continue to be counted as **active**. The family can be graduated once the mother is no longer experiencing intimate partner violence and once both the mother and daughter have met all other graduation benchmarks.

Graduation Review Question 4

The Kibiti family has four members: father (age 38), mother (age 28), adolescent girl (age 13), and a toddler boy (age 2). The mother is HIV positive and has reported HIV-negative test results for both children. The caseworker does not suspect sexual abuse or activity for either child. The mother was reported as "Currently on ART" at the last reporting period. The mother and daughter have together participated in a life skills training class and the daughter is able to answer basic questions about HIV transmission and prevention.

The mother sells fresh vegetables and cold beverages from the back of their home. With these funds, she is able to pay school fees for her 13-year-old daughter and ensure that the toddler eats well. The caseworker has not engaged much with the Kibiti father during household visits, particularly since he had a disagreement with the Kibiti mother over how to invest the money she earns. Once, the caseworker urged him to get an HIV test, but he refused.

1. Circle the boxes for all required individual and household benchmarks.
2. Check the boxes for the benchmarks that have been achieved.
3. Specify the action needed to meet the remaining required benchmarks.
4. Determine whether the household is ready to graduate.

Solution

The Kibiti family is **not ready to graduate**, and the following actions are required:

1. Father needs to receive HIV test and disclose the result to the caseworker
2. Caseworker needs to verify that the mother has been on ART for at least a year and is (a) virally suppressed for past 12 months or (b) ART adherent for past 12 months
3. Case or health worker needs to measure child's mid-upper arm circumference (MUAC) and check for bipedal edema
4. Caseworker needs to screen for violence, particularly given conflict between the mother and father over her earnings
5. Caseworker needs to verify that the adolescent girl progressed to the next level last year

Benchmarks	Beneficiaries				House-hold
	Father (38)	Mother (28)	Girl (13)	Toddler (2)	
Known HIV status (or test not required)	○	✓	✓	✓	
Adherent / virally suppressed		○			
Knowledgeable about HIV prevention			✓		
Not malnourished				○	
Financially stable					✓
No violence					○
Not in a child-headed household					✓
Children in school			○		

Graduation Review Question 5

The Pemba family has four members: mother (age 34), adolescent girl (age 16), adolescent boy (age 14), and young girl (age 9). The mother and teenage girl are HIV positive and have been receiving regular medical care for the past two years, thanks to the OVC program. The caseworker visits the clinic regularly to retrieve viral load results and is excited, because according to the information she has received from the clinic, both the mother and teenage girl are nearing their 12th month of viral load suppression. However, the adolescent girl and boy do not seem to understand basic facts about HIV and how it is transmitted. The adolescent boy and 9-year-old girl tested HIV negative when they entered the program three years ago.

On a recent visit, the caseworker found the younger girl (age 9) in a corner, crying and largely nonverbal. Although the caseworker was unable to discern exactly what had happened, she learned that an adult male family member had returned to live with the Pemba family.

Mother Pemba participates in a savings and loan group and was able to buy chickens. Now she is able to pay school fees; the three children attend school, and last year each progressed to the next level.

1. Circle the boxes for all required individual and household benchmarks.
2. Check the boxes for the benchmarks that have been achieved.
3. Specify action needed to meet the remaining required benchmarks.
4. Determine whether the household is ready to graduate.

Solution

The Pemba family is **not ready to graduate**, and the following actions are required:

1. Mother and daughter must reach 12 months of viral suppression and have this verified by viral load data from the clinic
2. Adolescent girl and boy must be assessed for HIV knowledge
3. The caseworker needs to screen for violence, particularly given 9-year-old girl's recent behavior
4. The caseworker should be alert to the possibility of sexual abuse, given the recent entry into the HH of the adult male relative and the 9-year-old's behavior, and should carry out a risk assessment of the 9-year-old to see if she needs an HIV test

Benchmarks	Beneficiaries				House-hold
	Mother (34)	Girl (16)	Boy (14)	Girl (9)	
1. Known HIV status (or test not required)	✓	✓	✓		
2. Virally suppressed					
3. Knowledgeable about HIV prevention					
4. Not malnourished					
5. Improved financial stability					✓
6. No violence					
7. Not in a child-headed household					✓
8. Children in school		✓	✓	✓	

Graduation Review Question 6

The Ndong family has four members: guardian grandmother (age 56), girl (age 9), boy (age 7), and boy (age 4). The grandmother took her grandchildren in when both mother and father passed away due to HIV. Luckily, the local clinic found all of the children to be HIV negative. The grandmother says that she is too old to need an HIV test. The caseworker does not have any reason to think that any of the children are experiencing sexual abuse.

The grandmother is a school teacher and is able to enroll the 9- and 7-year-olds in the local elementary school at a reduced fee. She is proud that they were both first in their classes last year. One of her brothers, who owns a taxi company, stops by regularly with generous gifts of rice and cooking oil.

The youngest child cries a lot and does not seem to be growing. Recently, he had an elevated fever and the midnight trip to the clinic for malaria treatment cost more money than the family could pay. Grandmother Ndong is considering selling her only two goats to pay off the debt at the clinic.

1. Circle the boxes for all required individual and household benchmarks.
2. Check the boxes for the benchmarks that have been achieved.
3. Specify action needed to meet the remaining required benchmarks.
4. Determine whether the household is ready to graduate.

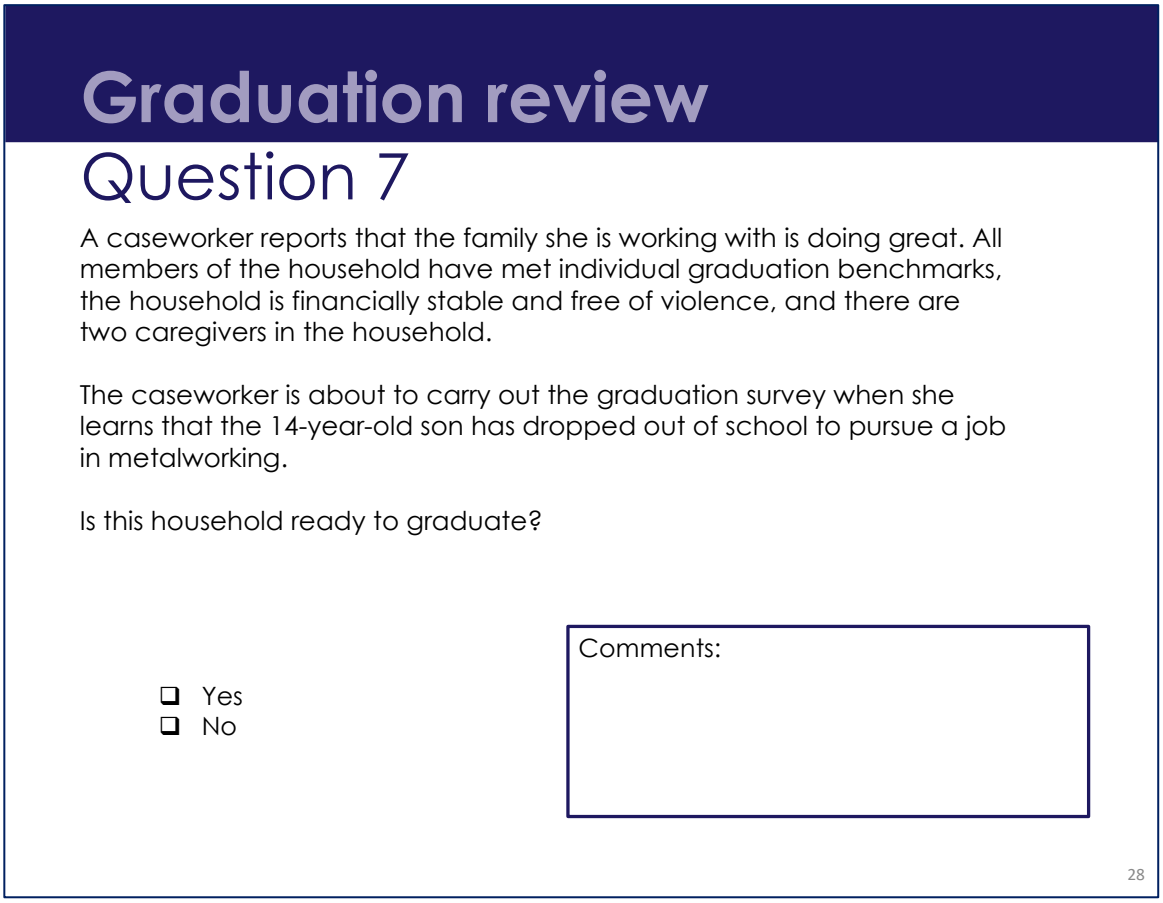
Solution

The Ndong family is **not ready to graduate**, and the following actions are required:

1. Grandmother needs an HIV test and to disclose results to caseworker
2. Case or health worker needs to measure 4-year-old child's MUAC and check for bipedal edema
3. Household should be offered interventions to increase financial stability, and will not meet this graduation benchmark until greater financial stability is achieved

Benchmarks	Beneficiaries				House-hold
	Grand-mother	Girl (9)	Boy (7)	Boy (4)	
1. Known HIV status (or test not required)	○	✓	✓	✓	
2. Virally suppressed					
3. Knowledgeable about HIV prevention					
4. Not malnourished				○	
5. Improved financial stability					○
6. No violence					✓
7. Not in a child-headed household					✓
8. Children in school		✓	✓		

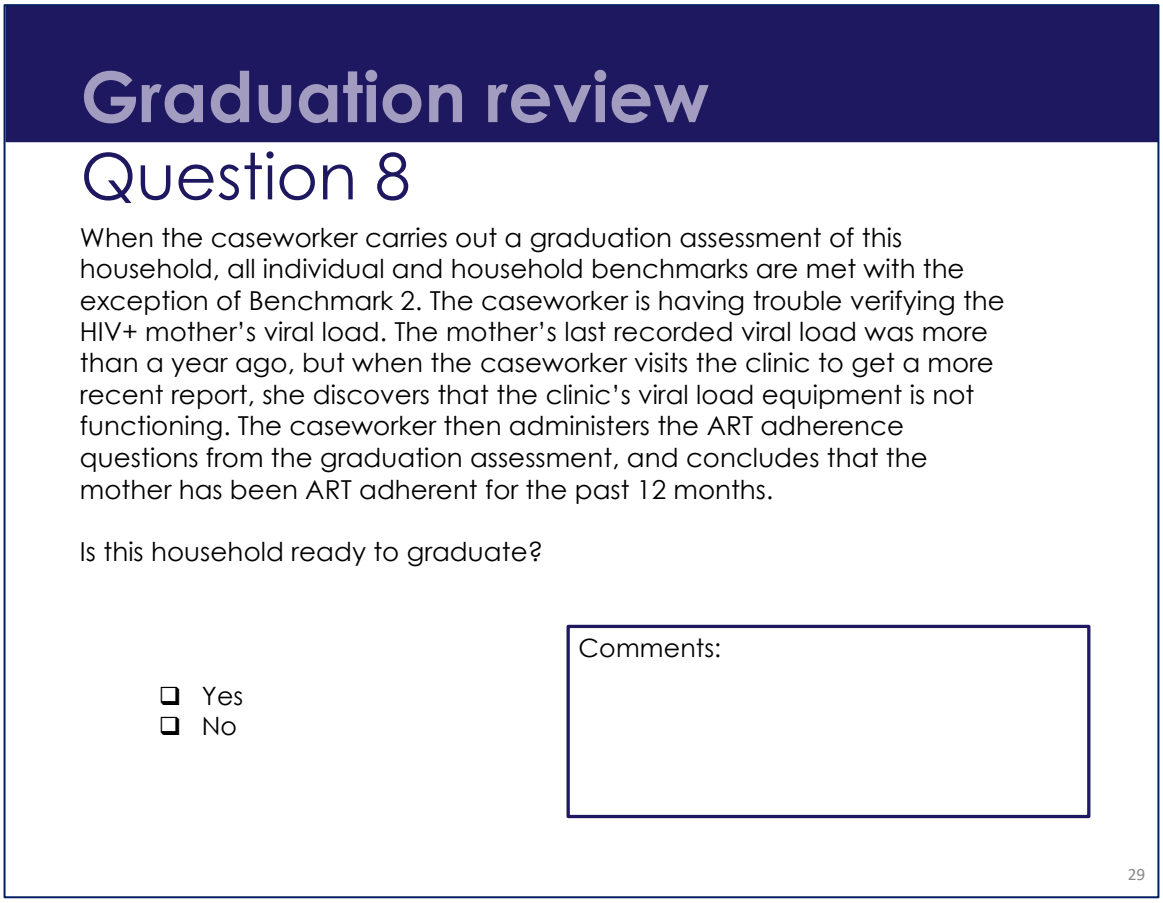
Graduation Review Question 7



Solution

This household is **not ready to graduate**. All children in the household must stay in school until they turn 18 (or reach the age at which national policy specifies that a child is no longer required to attend school). If the 16-year-old son is no longer in school, the household cannot graduate.

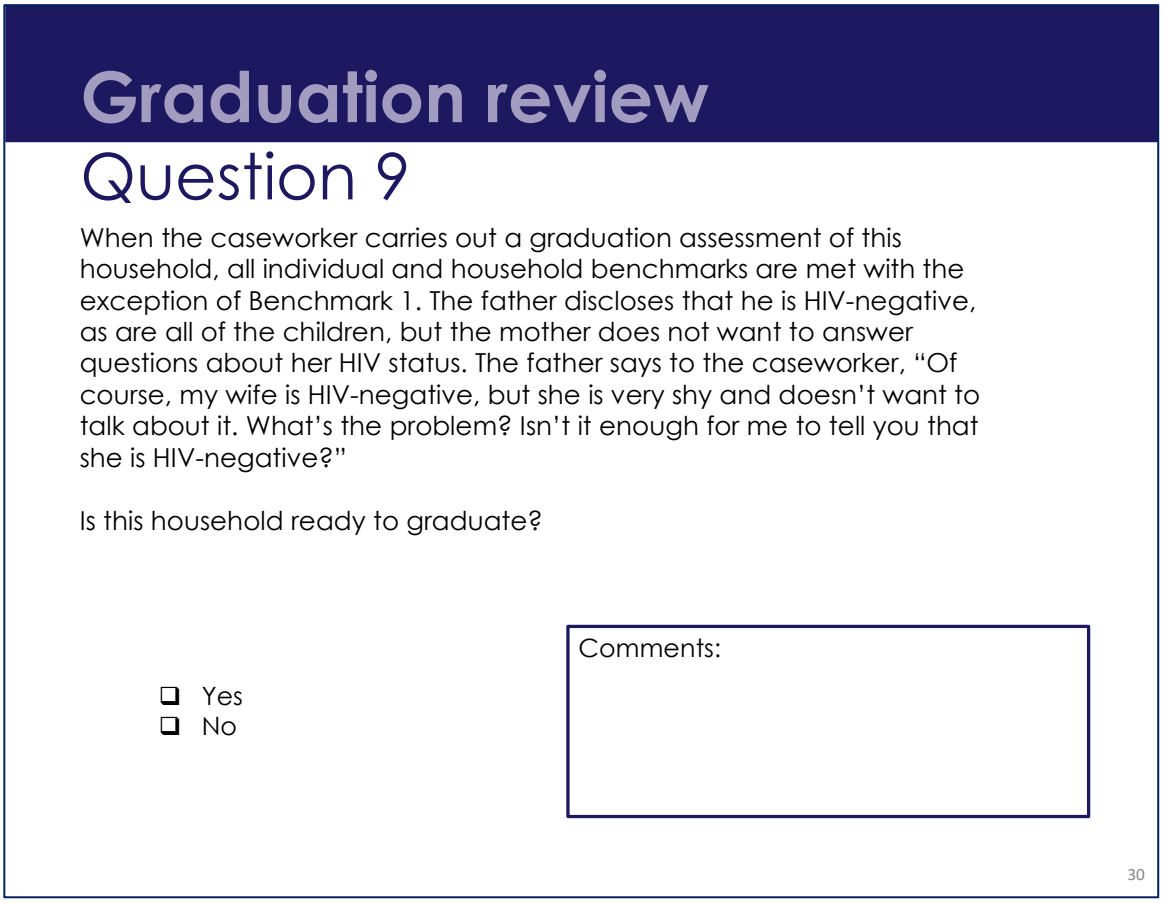
Graduation Review Question 8



Solution

The mother's ART adherence can be verified through self-report. If she is ART adherent according to Option (b) for Benchmark 2, the household **is ready to graduate**.

Graduation Review Question 9



Solution

This household is **not ready to graduate**. The mother must self-report her own HIV status to the caseworker for Benchmark 1 to be met.

3.7. Quiz 1 and Evaluation of Day 1

Participants will work individually to fill out the evaluation and complete the quiz.

Evaluation: Facilitator distributes printed copies of the evaluation and instructs participants that they do not have to put their name on the evaluation. The facilitator should review the evaluations that evening and compile feedback into brief comments that can be shared with the participants at the start of Day 2.

Quiz 1: Facilitator distributes printed copies of Quiz 1.

3.8. Presentation of Data Use Exercise

Each participant receives data use exercise instructions and the following instructions:

- We will be asking you to review the data you already have available for the most recent reporting period.
- Please make sure that you bring these data sets with you to tomorrow's session to be able to create the graphs in the handout.
- At a minimum, you will need your recent DATIM submission.
- If possible, the second exercise requires your internal program management data.
- Ideally, all data should be presented from the optic of how you would use it to improve your results. (In other words, are you able to visualize the performance of the CBOs who report to you?)
- We are not going over these visualizations now but are giving you a brief introduction and these materials to prepare you for tomorrow.
- You will have approximately one hour to complete this activity tomorrow (Day 2). If you prefer to start the activity sooner, feel free to do so between now and tomorrow morning.

Module 4

4. OVC_HIVSTAT

Module duration: 3.0 hours

Module Learning Objectives

By the end of this module, participants will be able to:

- Define OVC_HIVSTAT disaggregates
- Learn how to review data for errors before submitting in DATIM
- Consider the possibility of collecting additional data to monitor how OVC move through the HIV assessment continuum
- Understand when to conduct an HIV risk assessment
- Understand how to collect disaggregates to be reported in DATIM
- Ensure all HIV-positive OVC are assessed for ART treatment status every six months
- Know how to handle missing data

Materials Needed

- Module 4: OVC_HIVSTAT (PowerPoint presentation)
- Quiz 1 solutions (PowerPoint presentation)
- Evaluation of Day 1 (results summarized on PowerPoint presentation)
- OVC_HIVSTAT Flow Chart (in participant folders, see Section 6.5)
- HIV Risk Assessment Prototype (in participant folders, see Section 6.6)
- OVC_HIVSTAT review questions (1 copy of slides 32–36 from Module 6)
- PEPFAR official OVC MER guidance (in participant folders)
    - OVC_HIVSTAT Indicator Reference Sheet (see Section 6.14)
    - OVC_HIVSTAT: What's Changed? (see Section 6.15)

Session Plan

Time	Title and Description	Methods and Materials
15 minutes	Welcome of participants and registration Welcome and register all participants.	Materials: Participant list
10 minutes	**Evaluation of Day 1** Present and discuss one to three PowerPoint slides which summarize participant evaluation of Day 1.	Large group discussion using PowerPoint slides
10 minutes	**Discussion of Quiz 1** Present and discuss the correct answers to Quiz 1.	Large group discussion using PowerPoint slides
5 minutes	**4.1. Introduction** Present and discuss: • Goals of collecting OVC_HIVSTAT data • Rationale for regularly assessing HIV status and conducting HIV risk assessment • OVC_HIVSTAT as a self-reported measure	Present relevant PowerPoint slides
15 minutes	**4.2. Data Definitions** Present and discuss: • Data elements included under OVC_HIVSTAT • OVC_HIVSTAT disaggregates and their definitions • Possible explanations for "HIV status unknown"	Present relevant PowerPoint slides
10 minutes	**4.3. Data Quality Checks** Present and discuss equations which can be used to check data quality and identify errors.	Present relevant PowerPoint slides
10 minutes	**4.4. HIV Risk Assessment Continuum** Present and discuss the HIV risk assessment continuum and the place of "test not required" in the continuum.	Present relevant PowerPoint slides
30 minutes	**4.5. OVC_HIVSTAT Flow Chart** Present and discuss the OVC_HIVSTAT Flow Chart. Engage participants in a discussion of the chart, possible pathways through the chart, and possible outcomes (i.e., OVC_HIVSTAT disaggregates).	Lecture and large group discussion using handout and relevant PowerPoint slides Handout: OVC_HIVSTAT Flow Chart
20 minutes	**Break**	

20 minutes	**4.6. HIV Risk Assessment Prototype** Present and discuss: • Rationale for strategically targeting HIV testing to children using the HIV Risk Assessment • Best practices in adapting the prototype • Step-by-step introduction to the prototype and a data entry map showing how the prototype maps to OVC_HIVSTAT disaggregates	Present relevant PowerPoint slides Handout: HIV Risk Assessment Prototype
10 minutes	**4.7. ART Treatment Status** Present and discuss: • Importance of updating a child's ART treatment status in DATIM on quarterly basis • Examples of how a child's ART treatment status might change and be updated in DATIM • Timing of monitoring and reporting of ART treatment status versus ART adherence	Present relevant PowerPoint slides
5 minutes	**4.8. Missing Data** Present and discuss: • How to handle missing data in OVC_HIVSTAT • Programmatic implications of missing data	Present relevant PowerPoint slides
45 minutes	**4.9. Review of OVC_HIVSTAT** Distribute review questions to small groups and give 15 minutes for discussion. Reconvene large group for discussion of review questions and solutions.	Small and large group discussion
10 minutes	**4.10. Quiz 2** Distribute Quiz 2. Ask participants to work individually to complete the quiz.	Individual work Handout: Quiz 2

Evaluation of Day 1

In advance of this session, the facilitator reviews evaluation forms and notes common themes (i.e., similar feedback given by multiple people) or any particular areas of concern. The facilitator should decide on several key points to emphasize and make one to three simple PowerPoint slides to present these points. The facilitator uses these slides as a basis for a brief discussion with participants, including asking for clarification for any points of participant feedback that were not clear.

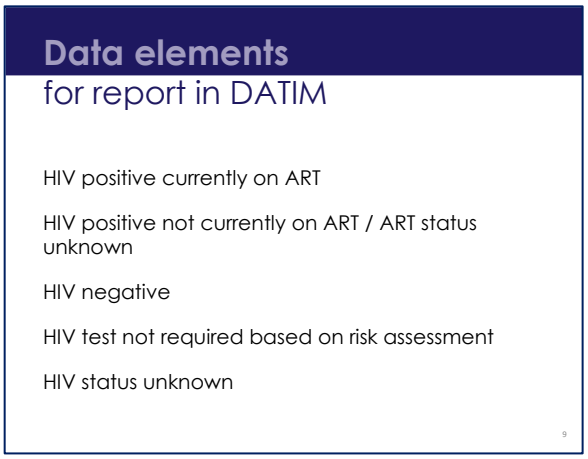
Discussion of Quiz 1

In advance of this session, facilitator scores Quiz 1 and updates the PowerPoint slides to show how many participants got each question right and wrong. Facilitator presents quiz questions (using PowerPoint slides) and discusses the right answers, giving particular attention to any questions that one or more people answered incorrectly.

4.1. Introduction

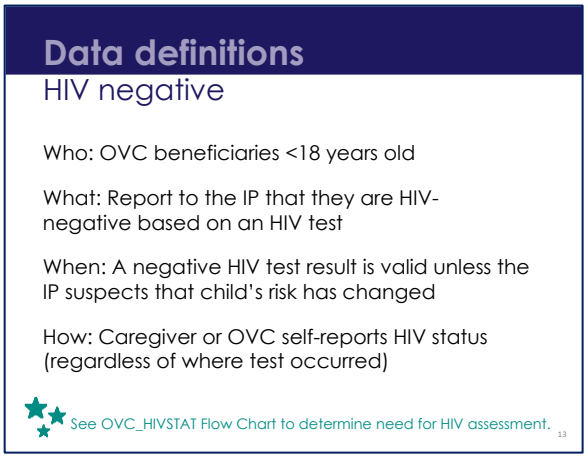
No additional instructions or notes.

4.2. Data Definitions



Slide 9

DATIM automatically calculates the number of HIV-positive beneficiaries as the sum of "HIV positive currently on ART" and "HIV positive not currently on ART."



Slide 13

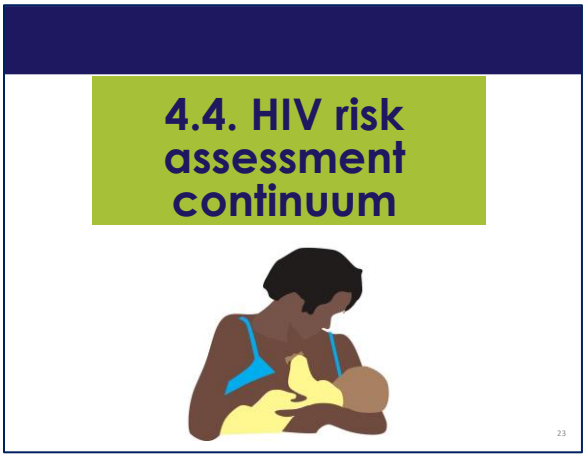
It is much more important to focus on testing children with unknown HIV status than children who have tested HIV negative. It is not necessary to re-test HIV-negative children every six months unless they are sexually active or there is reason to think their risk has changed. Programs should focus their efforts on those who have never had an HIV test.

Ideally, an HIV test should be performed in the household so that the parents can be told the result of the test. Tests done in a setting such as a school are valid but not ideal.

4.3. Data Quality Checks

No additional instructions or notes.

4.4. HIV Risk Assessment Continuum



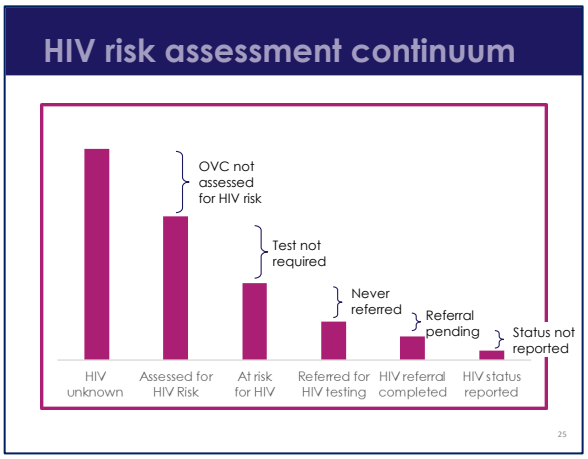
Slide 23

Pause at this slide to ask participants to answer the questions:

- What is the big change between old and new guidance?
- Why is this important and what does this mean for case management and follow-up?

Answers:

- There is now a new disaggregate of "test not required based on risk," which is distinct from the "HIV status unknown" category.
- There is no category for missing data, as all missing data are included in the "HIV status unknown" category.
- The follow-up is the same for anyone classified as "HIV status unknown," regardless of the reason for unknown status.



Slide 25

The HIV risk assessment continuum shows us the steps at which OVC are "lost." Every drop-off represents a missed opportunity, with one notable exception. We would expect to see a drop-off between columns 2 and 3 (green circle), because not all children who receive an HIV risk assessment are at risk for HIV and require HIV testing. The difference between columns 2 and 3 is the number of children who receive an HIV risk assessment but do not require HIV testing and are thus in the disaggregate "HIV test not required based on risk assessment."

Ideally, we would not see any drop-offs between other columns, because all children with unknown HIV status would receive an HIV risk assessment (column 1 to column 2), and all children who were at risk for HIV would be referred for HIV testing, receive the test, and report the result (columns 3 to 6).

By tracking the HIV risk assessment continuum, we can visualize missed opportunities in following up with OVC to determine HIV status and where we can do better. The goal is to increase the proportion of children with a known HIV status or for whom an HIV test is not required.

4.6. OVC_HIVSTAT Flow Chart

All participants place their printed copies of the flow chart in front of them so that they can refer to it during the discussion.

The facilitator explains the flow chart from top to bottom, as follows, pointing to the various elements:

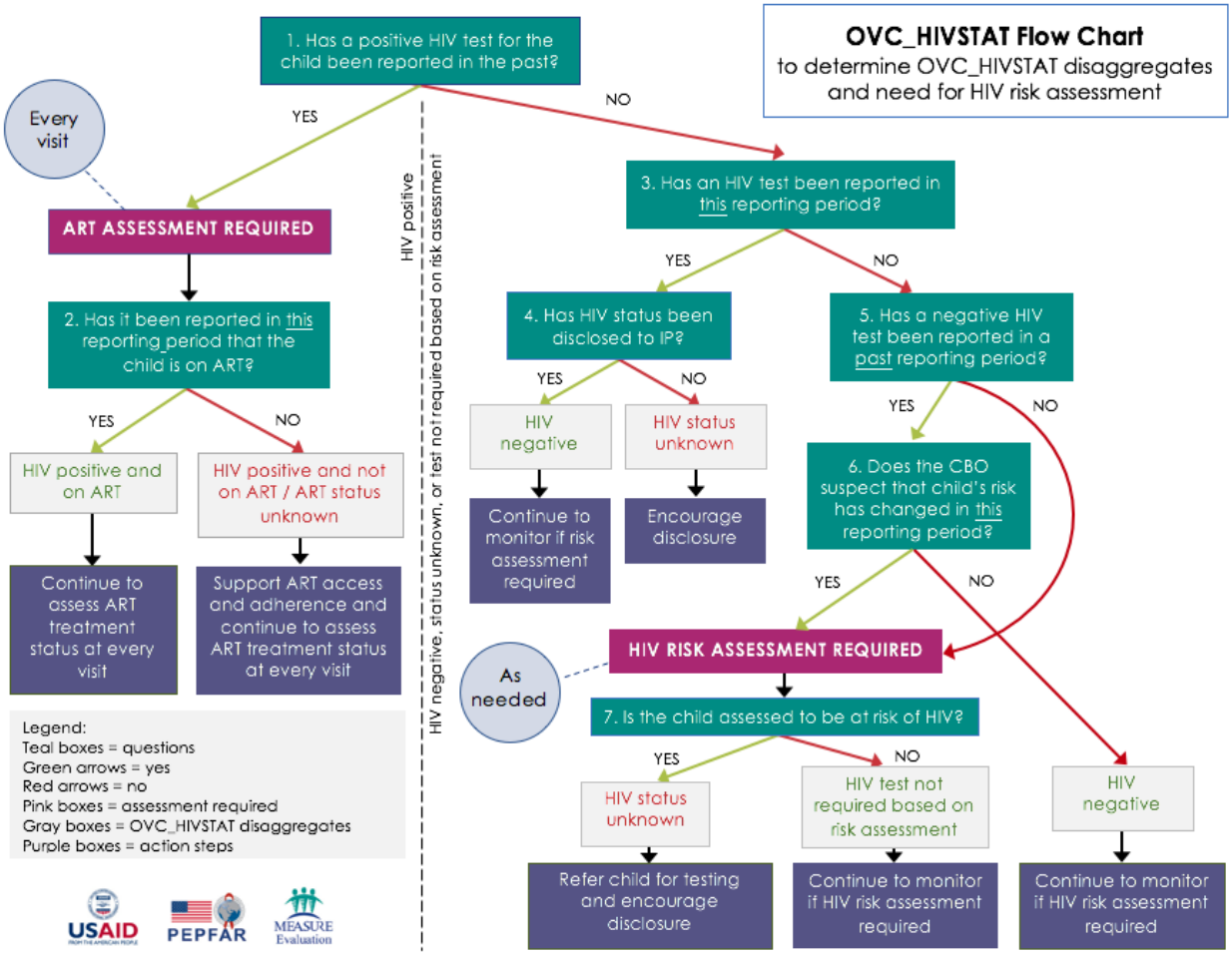
Title: The purpose of the flow chart is to show how to classify the various OVC_HIVSTAT disaggregates, and when to carry out (a) HIV risk assessments and (b) ART status assessments.

Legend: Green arrows always go to the left and mean "yes," red arrows always go to the right and mean "no," and the colored boxes have the meanings indicated.

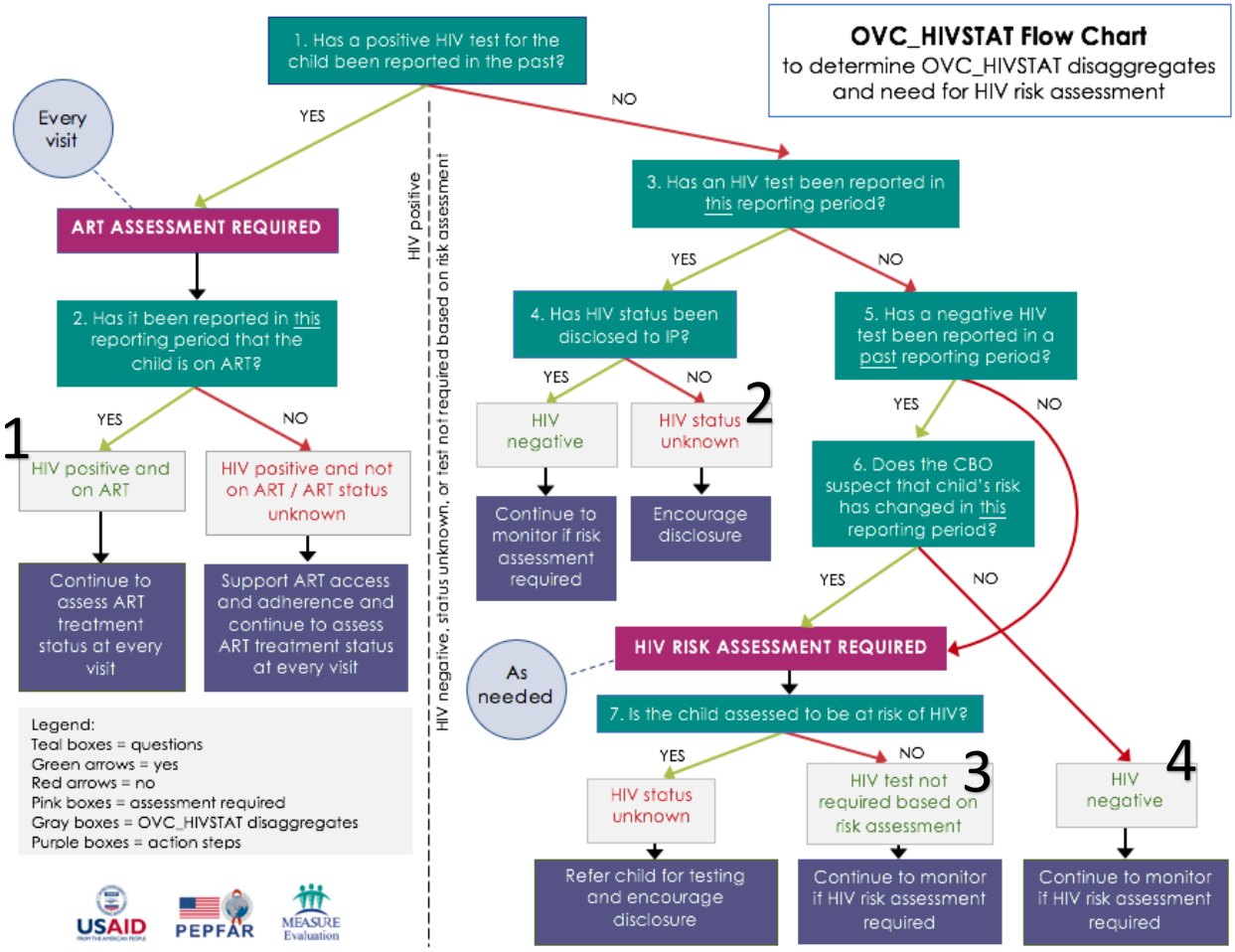
Teal boxes: The teal boxes show the seven questions that are needed to classify beneficiaries into the various OVC_HIVSTAT disaggregates.

Dotted line: All HIV-positive children are to the left of the dotted line in the diagram, and all other children are to the right of the dotted line (HIV negative, "test not required based on risk assessment," and HIV status unknown).

If a child on the right side of the diagram "drops out" at any point along the pathway and does not "arrive" at one of the gray boxes, he or she is considered "HIV status unknown."



Next, the facilitator chooses a participant to explain how a beneficiary might move down the Flow Chart, starting at Question 1, to arrive in one of the OVC_HIVSTAT disaggregates (gray boxes). The facilitator continues to select participants to explain the pathways to the disaggregates, one by one. The large black numbers give a recommended order.



Finally, the facilitator selects other participants to answer the following questions:

When should a caseworker re-assess someone who has a documented HIV-negative result?

The caseworker should carry out a risk assessment any time he or she suspects that the child's risk has changed, such as if sexual abuse or sexual activity is suspected. If an HIV risk assessment indicates that the child is at risk of HIV, the caseworker should refer the child for HIV testing.

How should an IP classify a child who has tested HIV-negative in the past, is suspected to have had a change in risk profile, but has not yet received an HIV risk assessment?

The child is considered "HIV status unknown" until an HIV risk assessment has been carried out.

How should an IP classify a child who has tested HIV-negative in the past, has received an HIV risk assessment, has received an HIV test, but has not disclosed his or her HIV status to the IP?

The child is considered "HIV status unknown" until an HIV status has been disclosed.

4.7. HIV Risk Assessment Prototype

No additional instructions or notes.

4.8. ART Treatment Status

No additional instructions or notes.

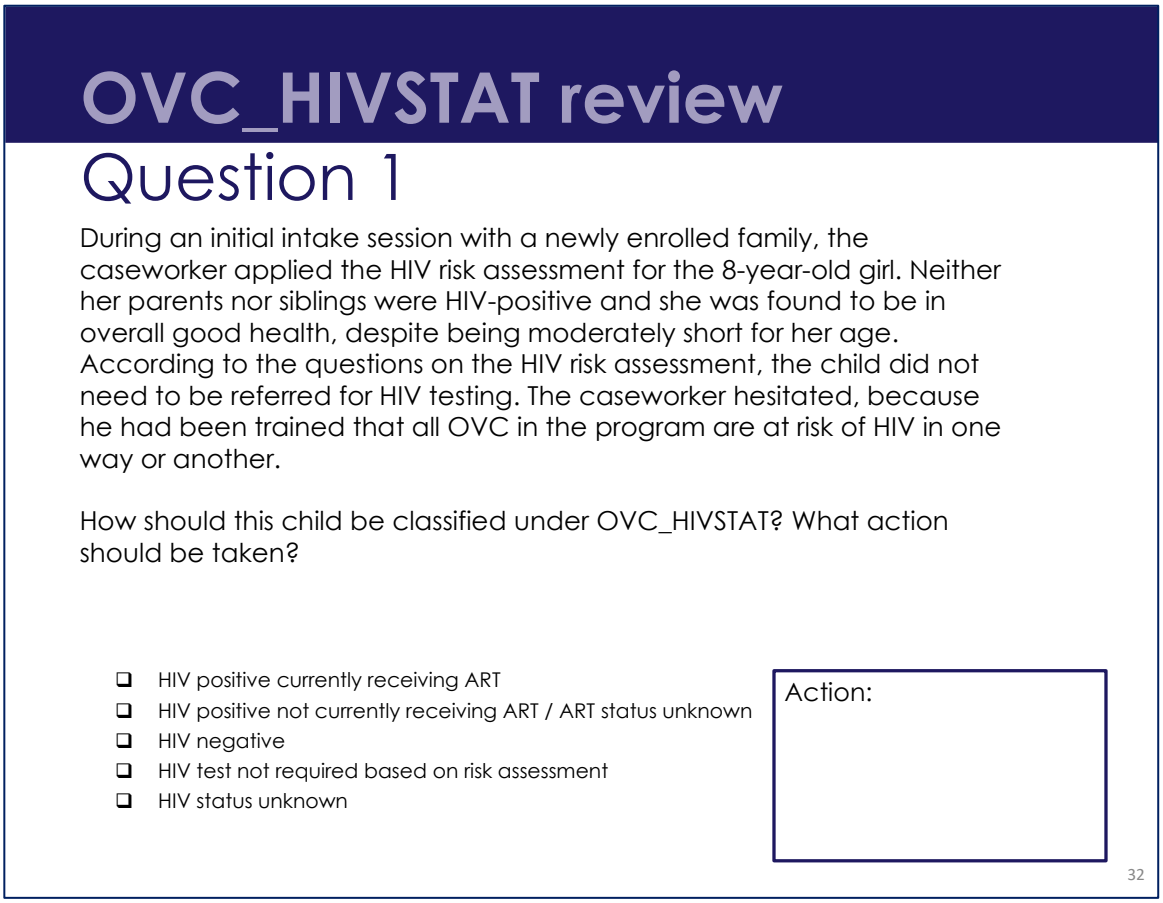
4.9. Missing Data

No additional instructions or notes.

4.10. Review of OVC_HIVSTAT

Follow the instructions for facilitating small and large group discussion given in Section 2.12 (Review of OVC_SERV). Give small groups only 15 minutes for discussion before starting large group discussion.

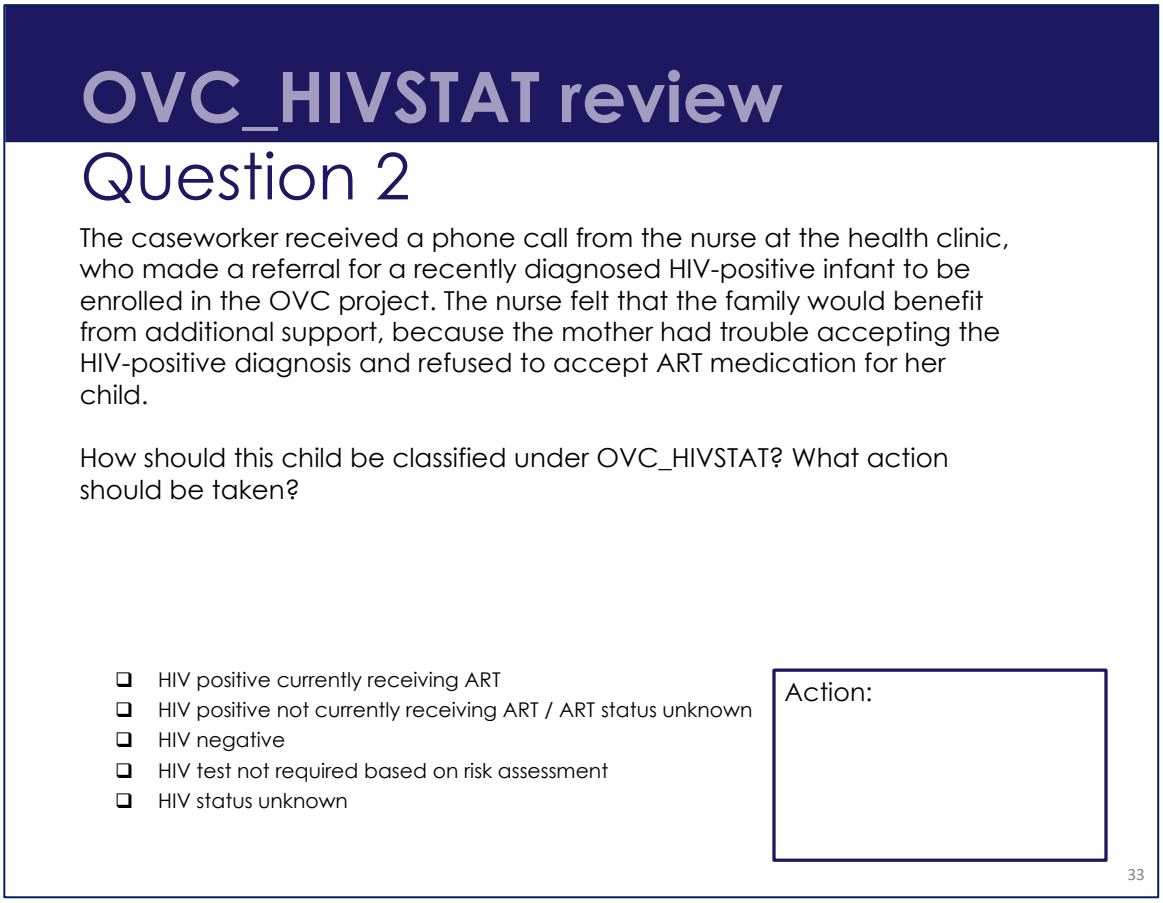
OVC_HIVSTAT Review Question 1



Solution

The child is classified as **HIV test not required based on risk assessment.** The caseworker should monitor the child and carry out an HIV risk assessment any time he suspects her risk has changed.

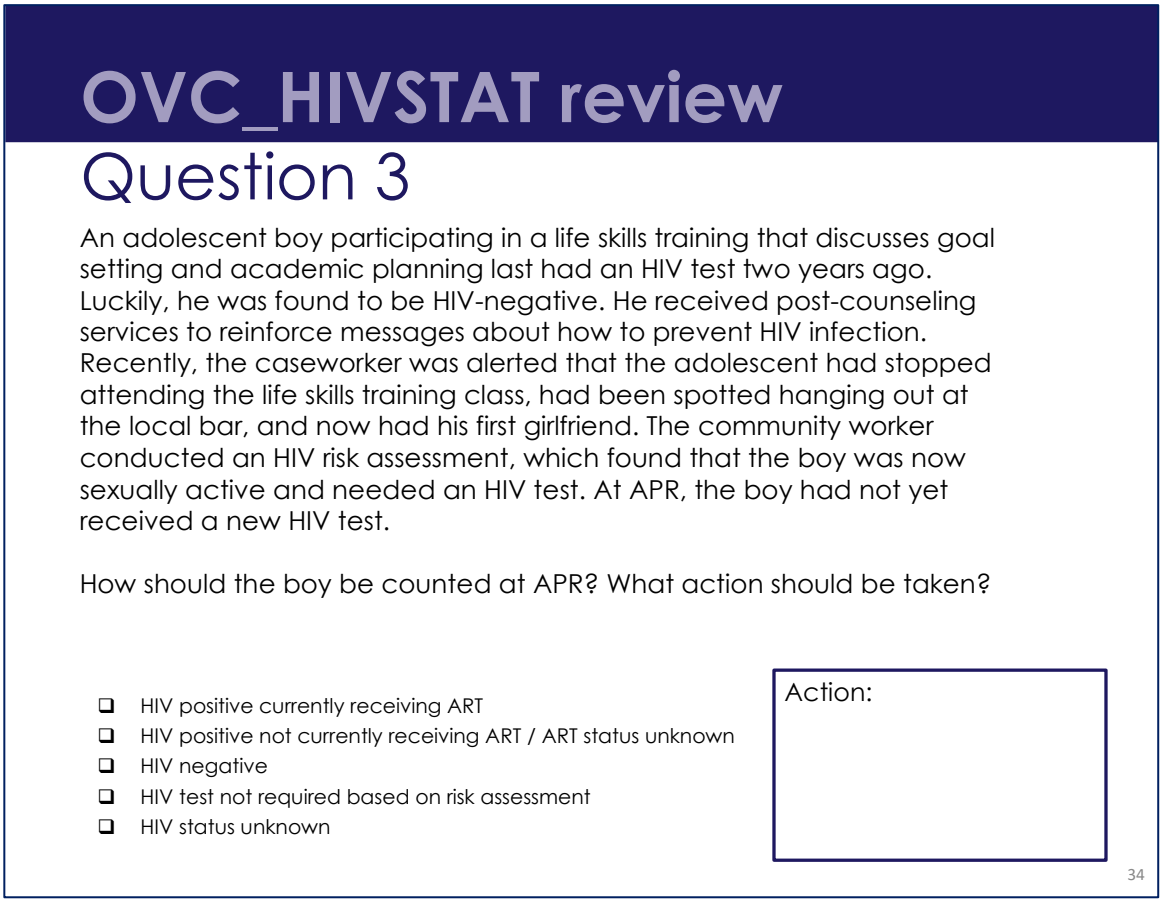
OVC_HIVSTAT Review Question 2



Solution

The child is classified as **HIV positive not currently receiving ART/ART status unknown**. The caseworker should support the child's ART access and adherence and continue to assess ART treatment status at every visit and report in DATIM every six months. The caseworker should also encourage the mother to get an HIV test and support her ART access and adherence if she tests HIV positive.

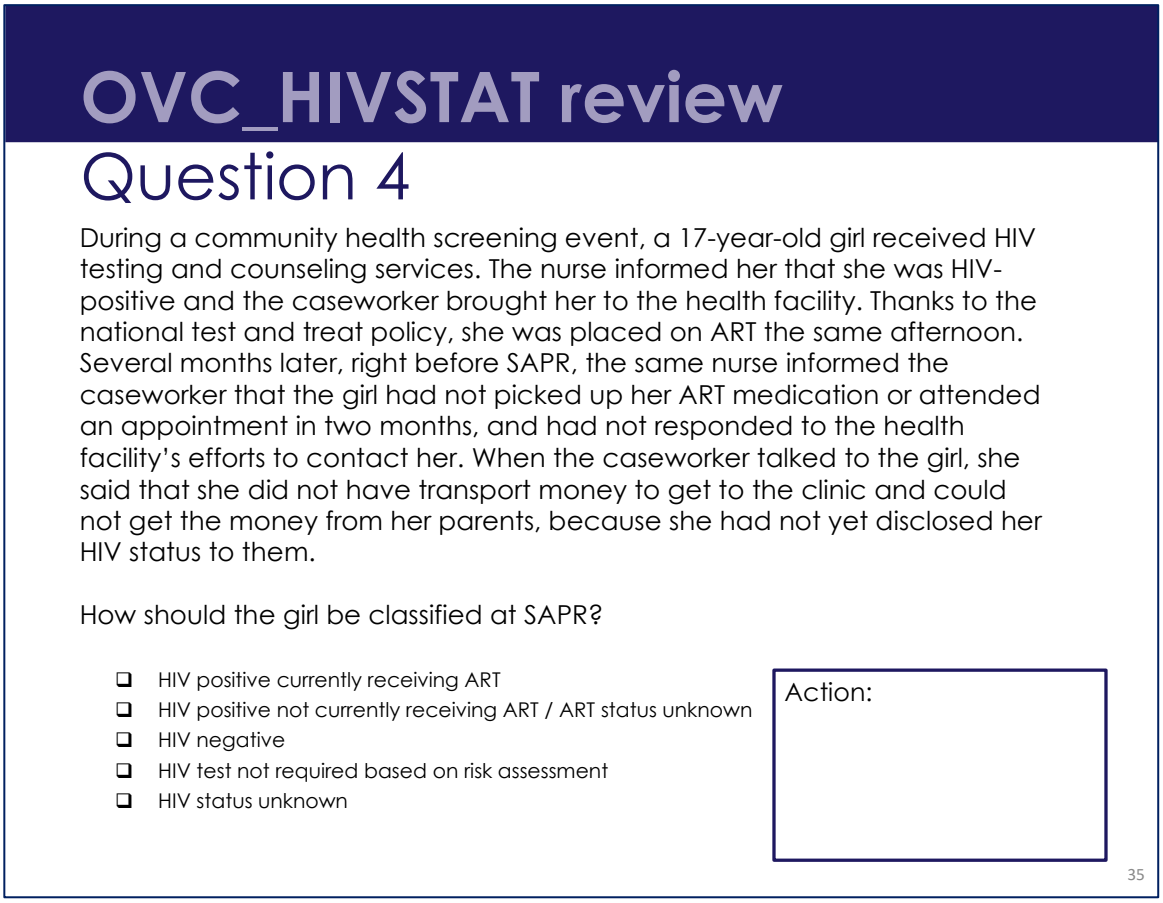
OVC_HIVSTAT Review Question 3



Solution

The boy is classified as **HIV status unknown**. Although he has tested HIV-negative in the past, his HIV risk has changed given the fact that he has become sexually active and started drinking. The boy should be classified as "HIV status unknown" until he receives another HIV test and discloses his HIV status to the caseworker.

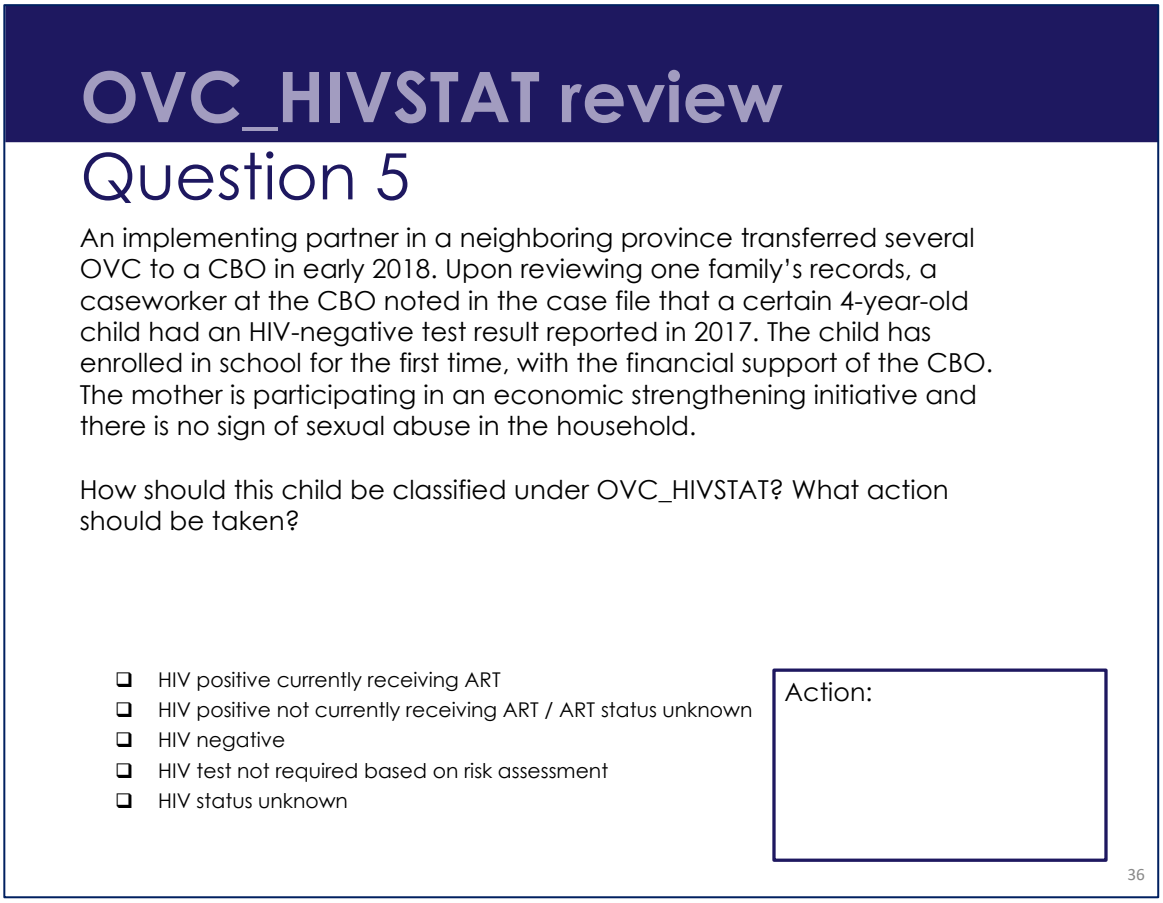
OVC_HIVSTAT Review Question 4



Solution

The child is classified as **HIV positive not currently receiving ART/ART status unknown**, given the fact that she has not been retained in ART treatment. The caseworker should encourage her to disclose her HIV status to her parents if it is safe for her to do so. If it is not, they should ask her about other trusted adults that she could talk to. The IP should also provide necessary support for her to attend clinic appointments, such as through providing transportation subsidies.

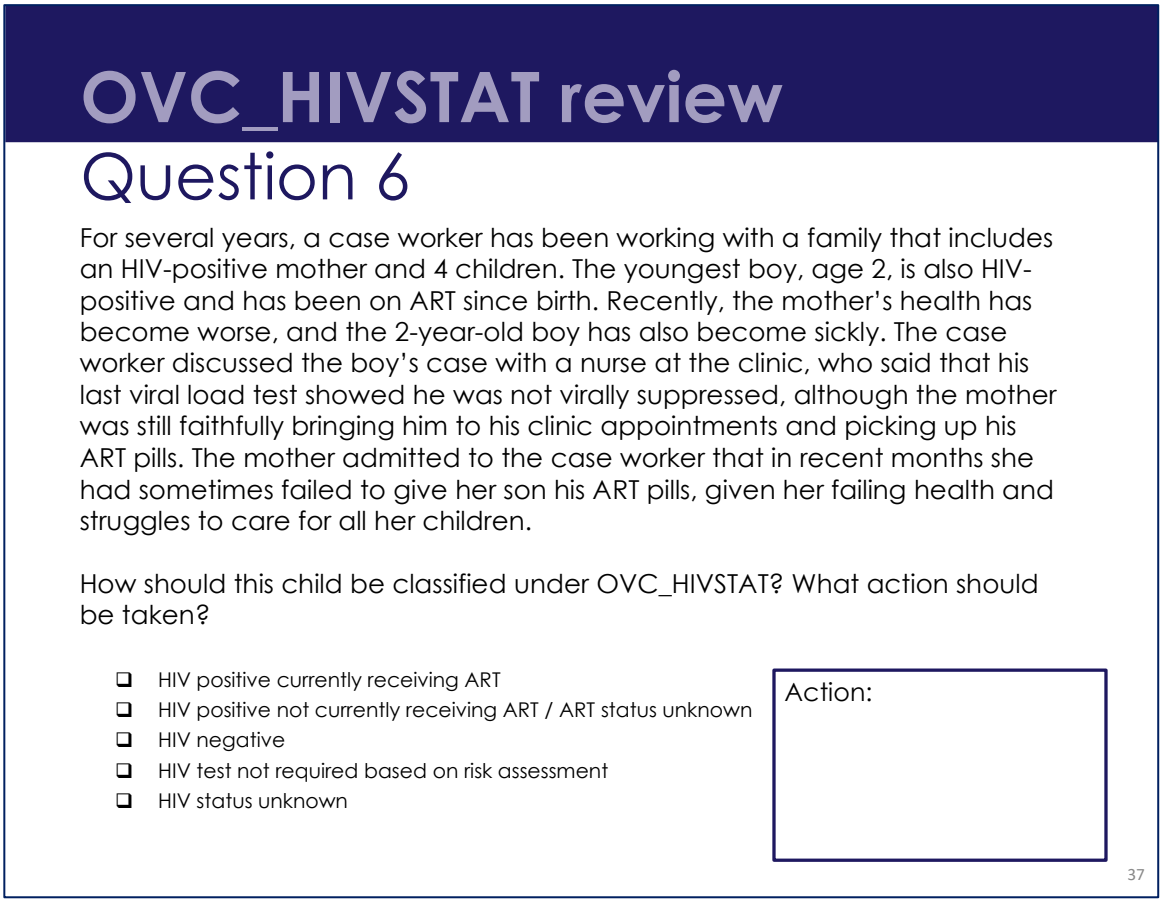
OVC_HIVSTAT Review Question 5



Solution

The child is classified as **HIV negative**. Based on the child's past HIV negative test result and the fact that the caseworker has no reason to think the child's risk has changed since that HIV test, the child can continue to be counted as HIV negative. The child does not need an HIV test unless the caseworker has reason to think that the child's risk has changed, at which time the caseworker should carry out an HIV risk assessment to determine if an HIV test is needed.

OVC_HIVSTAT Review Question 6



Solution

The child is classified as **HIV positive, currently receiving ART**. He is still being retained in care and so is counted as receiving ART despite evidence of poor adherence. The caseworker should provide support to the mother in improving her child's adherence and also support her in her own HIV adherence and care seeking.

4.11. Quiz 2: OVC_HIVSTAT

Participants complete Quiz 2, following instructions for Quiz 1 (Session 3.7). Facilitator reviews quiz results during lunch or while participants are doing the small group work portion of the data use exercise. Facilitator can then present quiz results during the last session of the day.

Module 5

5. DATA USE

Module duration: 3.0 hours

Module Learning Objectives

By the end of this module, participants will be able to:

- Visualize OVC_SERV and OVC_HIVSTAT data submitted in DATIM
- Display process indicators created with HIV status data potentially collected in the management information system (MIS) database
- Identify best practices for data visualization
- Reflect on how to leverage available data to improve resource allocation and strengthen performance

Materials Needed

- Module 5: Data Use (PowerPoint presentation)
- Worksheet 2: Narrative Questions (in participant folders, see Section 6.4)
- Quiz 2 solutions (PowerPoint presentation)
- Evaluation of Day 2 (handout, see Section 6.11)

Session Plan

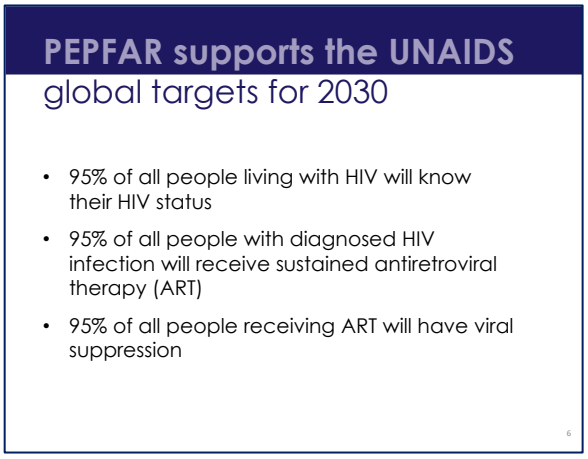
Time	Title and Description	Methods
5 minutes	**5.1. Introduction** Present and discuss: • Barriers to effective use of data for decision making • UNAIDS global "95-95-95" targets for 2030	Lecture with PowerPoint
10 minutes	**5.2. Meeting Targets for OVC Receiving Services** Present and discuss: • Global overview of OVC receiving services • Assessing program performance using OVC_SERV data	Lecture with PowerPoint

10 minutes	**5.3. Increasing the Proportion of Children Who Know Their HIV Status** Present and discuss: • Global progress towards the first "95" target • Assessing program performance against this target using OVC_HIVSTAT data	Lecture with PowerPoint, large group discussion
10 minutes	**5.4. Increasing the Proportion of HIV-Positive Children Who Receive Sustained ART** Present and discuss: • Global progress towards the second "95" target • Assessing program performance against this target using OVC_HIVSTAT data	Lecture with PowerPoint, large group discussion
5 minutes	**5.5. Process Indicators** Present and discuss: • OVC_HIVSTAT logic model • HIV risk assessment continuum and process indicators	Lecture with PowerPoint
60 minutes	**5.6. Data Use Exercise** Present and discuss: • Instructions for Exercises 1 and 2 • Tips for improving data visualizations Ask representatives of IPs to form small groups by IP, and work together to produce the data visualizations in the handout with data use exercise instructions (distributed at end of Day 1).	Lecture with PowerPoint, small group work
60 minutes	Lunch	
60 minutes	**Data Presentations by IPs** Ask IPs to present their data visualizations.	Large group presentation
5 minutes	**5.7. Conclusion** Present and discuss: • Strategies for improving evidence-based decision making • Comments or observations based on data presentations	Lecture with PowerPoint Handout: Worksheet 2 (Narrative Questions)

10 minutes	**Evaluation of Day 2** Distribute evaluation of Day 2. Ask participants to work individually to complete the evaluation.	Individual work
10 minutes	**Discussion of Quiz 2** Present and discuss the correct answers to Quiz 2.	Large group discussion
25 minutes	**Discussion of Next Steps** Facilitate large group discussion of next steps, such as step-down trainings or coordinating the development and dissemination of tools.	Large group discussion
10 minutes	**Closing Ceremony** Present certificates of completion to all participants, and offer concluding remarks as appropriate.	Award of certificates

Session Activities

5.1. Introduction



Slide 6

All the data we collect should be helping inform programmatic decisions that move us in the direction of the UNAIDS 95-95-95 goals.

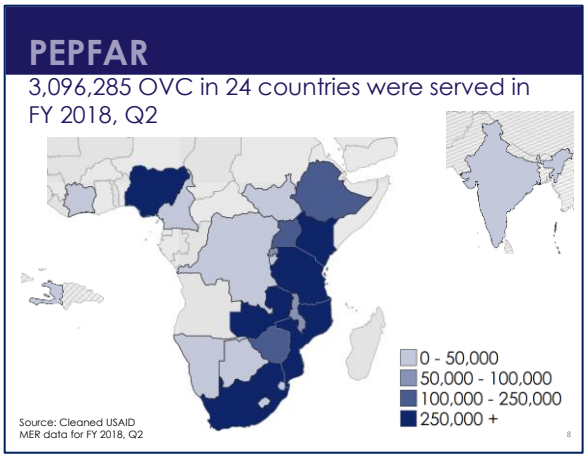
1. Do we have sufficient coverage to make an impact?
2. Are we encouraging HIV testing for OVC populations when appropriate?
3. Are we ensuring that HIV-positive children in OVC programs are receiving necessary treatment in a sustained and effective way?

This presentation aims to take the data we are currently collecting and show how it can be used to track performance.

5.2. Meeting Targets for OVC Receiving Services

Slide 7

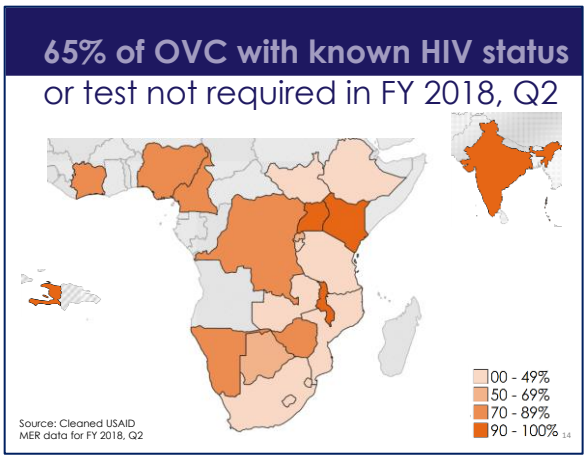
Pause on this slide to ask IPs to state how many CBO partners they have. This information can guide the suggestions made in the data use exercise. For example, an IP with only a few CBO partners could present data by CBO in the data visualizations. An IP with a large number of CBOs should disaggregate data in a different way, such as by region.



Slide 8

To review data that we saw in the first presentation, USAID is currently providing support to over 3 million orphans and vulnerable children.

5.3. Increasing the Proportion of Children Who Know Their HIV Status

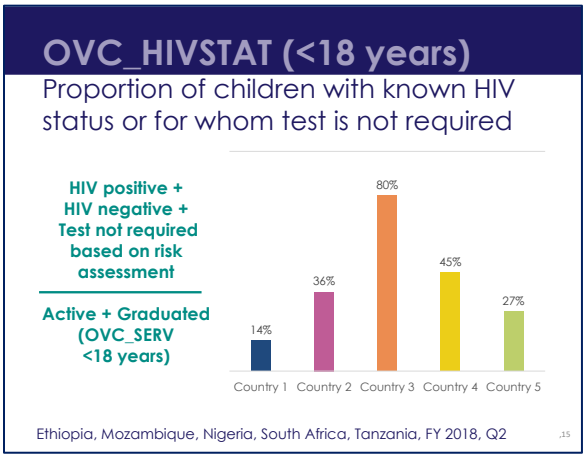


Slide 14

Ask participants who is included in the numerator and denominator of the 65 percent figure. Choose a participant to answer if no one volunteers.

Choose a participant (ideally, the participant who seems to have had the most trouble understanding the concept) to define "test not required based on risk assessment." Ensure that all participants clearly understand this concept before proceeding.

Emphasize that only a handful of countries have met PEPFAR's target of 90 percent.



Slide 15

Explain that of these five countries, most are not coming close to meeting the 90 percent target.

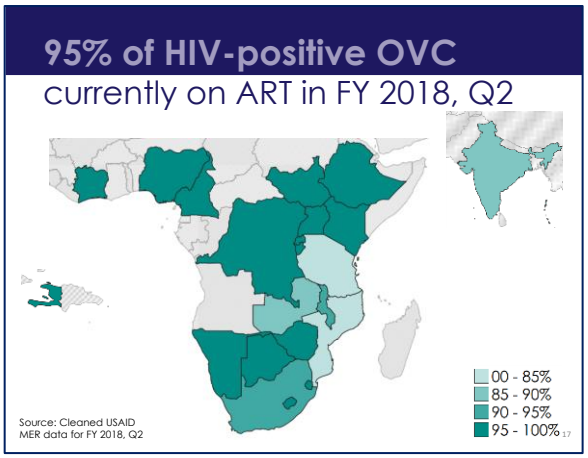
Ask participants to generate questions that would help them understand performance against the target. After participants have given their answers, discuss any questions below which have not already been mentioned.

- Are all beneficiaries being risk assessed? Why or why not?
- Are all beneficiaries who are at risk being referred for HIV testing? Why or why not?
- Are all of those who are referred completing their HIV test? Why or why not?
- Are those who complete their HIV test self-reporting results to the IP? Why or why not?
- Are some IPs performing better than others?
- Are some CBOs performing better than others?
- Are some caseworkers performing better than others?

Discussion points for each question:

- Is a universal target of 90 percent feasible?
- What programmatic changes need to be put in place to achieve this target?
- Should the emphasis be on assessing all children once or re-assessing high-risk populations?
- What is the benefit of conducting risk assessments vs. universally testing all orphans and vulnerable children?

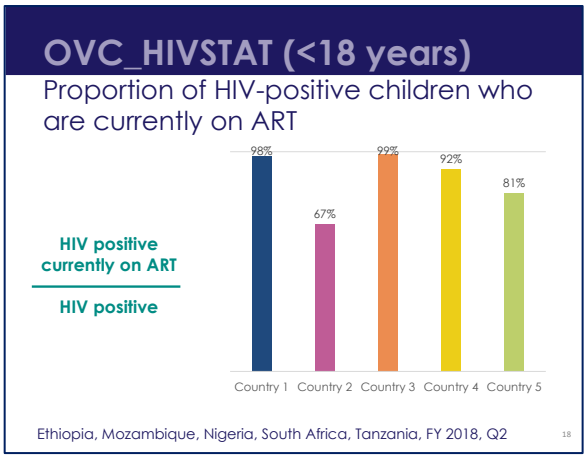
5.4. Increasing the Proportion of HIV-Positive Children Who Receive Sustained ART



Slide 17

PEPFAR OVC programs are doing much better at meeting the second "95" target – that 5 percent of all people with diagnosed HIV infection will receive sustained ART. Most countries have met this target.

Ask participants if this figure is capturing linkage to ART treatment or maintenance on ART treatment? (The answer is both.)

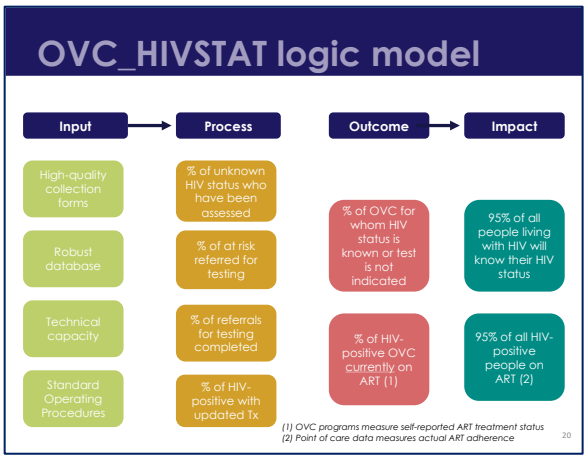


Slide 18

Ask participants to generate questions that would help them understand performance against the target. After participants have given their answers, discuss any questions below which have not already been mentioned.

- What are the mechanisms in place for caseworkers to regularly verify self-reported ART treatment?
- Do those mechanisms allow for reporting of self-declared defaulters to the MIS system and subsequently to DATIM?
- Is there a way for CBOs to verify that ART treatment status is regularly being verified?

5.5. Process Indicators



Slide 20

On this slide, we propose an OVC_HIVSTAT logic model to link inputs with processes, outcomes, and desired impact.

Input

Inputs include high-quality data collection forms; robust databases able to track OVC individually; technical capacity to assess HIV risk and perform pre- and post-test counseling; and the standard operating procedures that guide both monitoring and evaluation processes and case management.

Process

We encourage IPs to collect data on process indicators in their MIS databases so that they can provide feedback to subrecipients in the field. These process indicators capture performance related to discrete activities we expect subrecipients to do: conduct HIV risk assessments on all OVC with status unknown, ensure that those OVC determined to be at risk are subsequently referred for testing, and then ensure that those referrals are completed. At the same time, it is necessary that all MIS databases regularly capture the ART treatment status of HIV-positive OVC. This includes both children linked to treatment when enrolled and at regular intervals (at least every three months).

Outcome

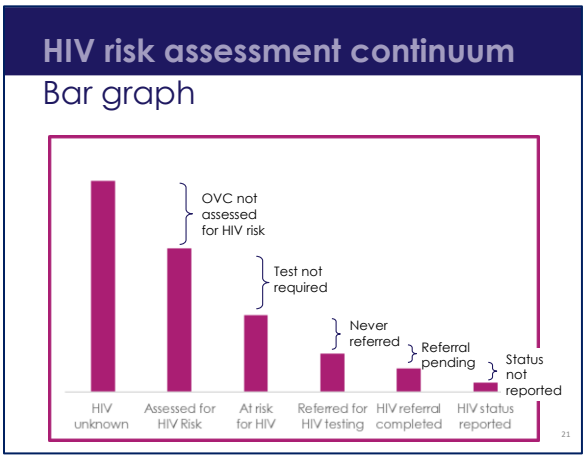
If IPs successfully do all those activities, we will observe a commensurate improvement in the outcome indicator.

IPs are required to report "percentage of OVC for whom HIV status is known or test is not required." This indicator measures the proportion of children who have either been tested or who do not need a test at present. This proportion will increase as the proportion of "HIV status unknown" (for any reason) decreases.

"Percent of HIV positive OVC currently on ART" can be calculated from disaggregates reported in DATIM. This indicator measures the proportion of children who are on ART, according to self-report.

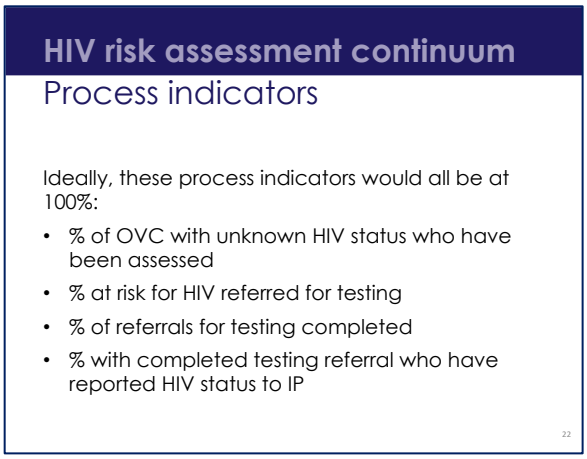
Impact

By regularly assessing OVC for HIV risk and following up to refer to testing as necessary, we will contribute to the overall UNAIDS goal that 95 percent of people living with HIV will know their status. By regularly verifying ART treatment status, we will detect defaulters early and support their return to treatment and care services, thus contributing to the overall UNAIDs goal of 95 percent of HIV-positive people on ART.



Slide 21

To review, the HIV risk assessment continuum is also a useful tool in assessing program performance in meeting the target towards 90 percent of OVC knowing their HIV status. At what stages are programs seeing "drop-offs"? Remember that ideally, the only "drop-off" we want to see is "test not required based on HIV risk assessment." We would expect to see this drop off because not all children who receive an HIV risk assessment are at risk for HIV and require HIV testing.



Slide 22

We would hope to see all of these process indicators at 100 percent—i.e., to not see any drop-offs in the HIV risk assessment continuum, except for the category of "test not required based on HIV risk assessment."

5.6. Data Use Exercise

IP participants form small groups with other members of their organization to work on the data use exercise. Participants not from IPs (e.g., representatives of USAID) can serve as a resource or answer questions during this time, if they wish.

The facilitator briefly reviews the instructions for the data use exercise, including the slide giving tips for improving data visualizations. Participants should refer to the data use exercise handouts for guidance as they carry out the exercise. The facilitator circulates among small groups during the exercise, to serve as a resource, answer questions, and make sure that participants are staying focused and are aware of the amount of time left for the exercise.

5.7. Data Presentations by IPs

At the beginning of the session, the facilitator asks each IP to save their presentation onto a USB drive, so that they cannot continue to work on the presentation while other groups are presenting.

Facilitator invites IPs to present their data, one at a time. The facilitator should give each IP 5 to 10 minutes and attempt to manage the time so that all IPs are able to present. If there are many IPs, this may not be possible.

At the close of each presentation, the facilitator invites comments from the large group.

- Complements? Criticisms? Questions?
- Are the graphs clearly understood?

Finally, the facilitator provides closing comments, which may include the following points (based on the partners present and the data presentations):

- Data should be presented in a way that is actionable and clearly identifies gaps in programming and opportunities for improvement.
- Data should be disaggregated to the level where program management occurs. For example, it is not useful to present data for a large geographic region with multiple programs. Data need to be disaggregated to the level of program or specific region, so that it is usable by the partner responsible for program results at that level.
- IPs should direct feedback to persons or partners that can actually be responsible for improving performance.
- Are IPs presenting feedback to CBOs? If so, what has been the impact of providing this feedback? In particular, focus on MIS database data—would it be possible to provide feedback based on MIS data?

5.8. Conclusion

After all the IPs have presented, the facilitator refers participants to Worksheet 2 (in their folders), and emphasizes that they are to answer these questions each time they report via DATIM.

The facilitator then asks participants to generate ideas for how to enhance data use in their organization. After participants have given their suggestions, the facilitator presents the final slide in the slide deck ("Strategies for improving evidence-based decision making").

Evaluation of Day 2

Have participants fill out the evaluation for Day 2, as for Day 1 (Section 3.7).

Discussion of Quiz 2

Facilitator presents quiz questions (using PowerPoint slides) and discusses the right answers, giving particular attention to any questions that one or more people answered incorrectly.

Closing Ceremony

Facilitator presents certificates of completion to participants, assisted by a representative of USAID or another partner, as appropriate. The facilitator and/or representative of another organization may offer concluding remarks thanking the participants for their participation.

6. MATERIALS FOR TRAINING

6.1. List of Materials

Section	Title	Number to Print
	Module 6: Review Questions (PowerPoint presentation)	1 total
6.2	Participant list (template)	1 total
6.3	Worksheet 1: Illustrative Eligible OVC Services	1 per participant
6.4	Worksheet 2: Narrative Questions	1 per participant
6.5	OVC_HIVSTAT Flow Chart	1 per participant
6.6	HIV Risk Assessment Prototype	1 per participant
6.7	Data Use Exercise Instructions	1 per participant
6.8	Quiz 1: OVC_SERV and Graduation	1 per participant
6.9	Quiz 2: OVC_HIVSTAT	1 per participant
6.10	Evaluation of Day 1	1 per participant
6.11	Evaluation of Day 2	1 per participant
6.12	OVC_SERV Indicator Reference Sheet[4]	1 per participant (optional)
6.13	OVC_SERV: What's Changed?	1 per participant (optional)
6.14	OVC_HIVSTAT Indicator Reference Sheet[4]	1 per participant (optional)
6.15	OVC_HIVSTAT: What's Changed?	1 per participant (optional)
6.16	Illustrative Eligible Services for Active OVC Beneficiaries (Children and Caregivers)[4]	1 per participant (optional)
6.17	Global OVC Graduation Benchmarks Matrix[4]	1 per participant (optional)
6.18	Questions and Answers to Possible OVC_SERV Reporting Scenarios[4]	1 per participant (optional)

[4] Excerpted from Monitoring, Evaluation and Reporting Indicator Reference Guide MER 2.0 (Version 2.3)

Available at https://ovcsupport.org/wp-content/uploads/2018/10/MER-Indicator-Reference-Guide-Version-2.3-FY19.pdf

6.2. Participant List

Participant List for OVC MER Training

[Location] • [Dates]

Participant Name	Title and Organization	Email Address	Signature – Day 1	Signature – Day 2
1.				
2.				
3.				
4.				
5.				

6.3. Worksheet 1: Illustrative Eligible OVC Services

Illustrative eligible OVC services

Worksheet 1

Overview

- The list of eligible OVC services defines minimum services that beneficiaries (children and caregivers) may receive to be considered active.
- These services will move beneficiaries towards graduation which will be attained when the entire household can be deemed healthy, safe, schooled and stable.
- Minimum graduation benchmarks are described elsewhere.

Definition of a service

- The beneficiary is counted as receiving a service if he or she:
  - Received the service directly from project;
  - Was facilitated to obtain the service (e.g. transport subsidy, accompaniment); or
  - Has a completed referral (a referral for service is insufficient).

Illustrative nature of the list of eligible OVC services

- This list while comprehensive is not exhaustive.
- For services that are not captured in the list, local USG funding agency approval must be received in order to count these services towards active OVC status.

OVC beneficiaries under the age of 18

- Age-appropriate services for child beneficiaries are designated with a check mark in the columns "All children", "Infants and young children", or "Adolescents".
- A child beneficiary is considered active when he/she:
  - Receives at least one service in the preceding two quarters;
  - Has a case plan updated within the last 12 months; and
  - Is monitored at least quarterly.

OVC caregivers

- Caregiver services are designated with a check mark in the columns "Caregiver" or "Caregiver and child".
- A caregiver beneficiary is considered active when he/she:
  - Receives at least one service in the preceding two quarters.

Special relationship between caregiver services and benefits to the child

- A caregiver service designated with a check mark in the column for "Caregiver and child" may be counted toward both the child and caregiver as it provides direct benefit to the child.
- A caregiver service designated with a check mark in the column for "Caregiver" alone may not be counted toward both the child and caregiver as it provides direct benefit primarily to the caregiver.

Worksheet instructions

- For the purpose of discussion, review the list and identify services:
  - Currently providing
  - Would like to provide
  - Not applicable to the program

Illustrative eligible OVC services

Worksheet 1

	Type of Beneficiary					Worksheet		
	All children	Infants and young children	Adolescents	Caregivers	Caregiver and child[1]	Currently providing	Would like to provide	Not applicable to program
HEALTHY								
1. Individual health insurance coverage or health access card	✓							
2. Family health insurance coverage or health access card					✓			
3. Insecticide Treated Mosquito net (ITN)	✓							
4. Age-appropriate HIV treatment literacy (for CLHIV)	✓							
5. Age-appropriate counseling and HIV disclosure support[2]	✓			✓				
6. HIV adherence support	✓			✓				
7. Completed a referral for or was facilitated to obtain HIV-related testing (HTS, EID, TB, CD4 VL)	✓			✓				
8. Completed a referral for or was facilitated to obtain HIV (or related opportunistic infection) treatment and care	✓			✓				
9. Completed a referral for or was facilitated to obtain STI treatment	✓			✓				
10. Completed a referral for or was facilitated to obtain routine healthcare	✓							
11. Completed a referral for or was facilitated to obtain emergency health care	✓			✓				
12. Structured PLHA support group	✓			✓				
13. Completed a referral for or was facilitated to obtain Early Infant Diagnosis (EID)		✓						
14. Supplementary or therapeutic foods based on moderate or severe acute malnutrition status (per assessment, e.g. MUAC)		✓						
15. Completed a referral for or was facilitated to obtain immunization appropriate to age-based national protocol		✓						
16. Regularly[3] tracked developmental milestones in HIV affected, HEU and infected infants and young children		✓						
17. Completed referrals for developmental support for HEU and HIV infected children		✓						
18. Completed a referral for or was facilitated to obtain age-appropriate HIV prevention support, including PrEP, condoms and/or VMMC			✓	✓				
19. Completed a referral for or was facilitated to obtain age-appropriate women's health counseling and/or products, including condoms			✓	✓				
20. Completed a referral for or was facilitated to obtain substance abuse support by a trained provider			✓	✓				
21. Completed a referral for or was facilitated to obtain perinatal care including PMTCT				✓				
22. Household hygiene counseling and WASH messaging					✓			

[redacted]

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

Illustrative eligible OVC services

Worksheet 1

	Type of Beneficiary					Worksheet		
	All children	Infants and young children	Adolescents	Caregivers	Caregiver and child[4]	Currently providing	Would like to provide	Not applicable to program
SAFE								
23. Safety plan	✓							
24. Structured family group conferencing to prevent occurrence/ reoccurrence of child abuse, exploitation or neglect	✓							
25. Structured psycho-social support related to family conflict mitigation and family relationships					✓			
26. Post-violence trauma-informed counseling from a trained provider	✓			✓				
27. Completed a referral for or was facilitated to obtain post-violence medical care	✓			✓				
28. Session with child protection officer, police, or other local child protection authority	✓							
29. Project-filed report of suspected abuse to child protection office, police or other local authority	✓							
30. Emergency shelter/care facility or kinship care placement and monitoring for children	✓							
31. Emergency shelter/care facility					✓			
32. Legal assistance related to maltreatment, GBV, trafficking, exploitation	✓			✓				
33. Structured safe spaces intervention			✓					
34. Evidenced-based intervention on preventing HIV and violence, and in reducing and avoiding sexual risk			✓					
35. Caregiver participated in a structured, HIV-sensitive, evidence-based early childhood intervention with a trained provider					✓			
36. Caregiver participated in an evidence-based parenting intervention to prevent and reduce violence and/or sexual risk of their children					✓			
SCHOOLED								
37. Received regular assistance/ support with homework (e.g. homework club participation)	✓							
38. Received school uniform, books, or other materials	✓							
39. Received bursary, tuition, school fees or fee exemption	✓							
40. Received assistance for re-enrollment (i.e. for drop-outs or teen mothers)	✓							
STABLE								
41. Legal & other administrative fees related to guardianship, civil registration, or inheritance					✓			
42. Succession plan					✓			
43. Cash transfer or another social grant					✓			
44. Short-term emergency cash support					✓			
45. Evidenced-based food security intervention					✓			

[4] Activity completed by the caregiver may be counted toward both the child and caregiver as it provides direct benefit to the child.

Illustrative eligible OVC services

Worksheet 1

	Type of Beneficiary					Worksheet		
	All children	Infants and young children	Adolescents	Caregivers	Caregiver and child[5]	Currently providing	Would like to provide	Not applicable to program
STABLE (continued)								
46. Caregiver or adolescent regularly participated in a market-linked economic strengthening activity such as: a. financial literacy training b. business skills training c. entrepreneurship training and support d. agribusiness training e. women's economic empowerment f. savings groups g. linkages to formal financial institutions (banks, credit unions, MFIS, etc.) h. numeracy training i. soft skills training (job readiness, borrower training, career planning, etc.) j. small business support (business planning, market linkages, etc.)			✓		✓			
47. Safe shelter-related repair or construction					✓			

[redacted]

[redacted]

[redacted]

[5] Activity completed by the caregiver may be counted toward both the child and caregiver as it provides direct benefit to the child.

6.4. Worksheet 2: Narrative Questions

Narrative questions

Worksheet 2

Overview

The list of OVC_SERV and OVC_HIVSTAT narrative questions is found in the indicator reference sheets and should be addressed during each reporting period in DATIM.

OVC_SERV

1) Please explain reasons and context for highest/lowest performing partners' performance (i.e. results/target) for OVC_SERV total numerator and OVC_SERV <18, including any programmatic shifts or monitoring updates that were made as a result of the change in indicator guidance for MER v2.3.

2) Please explain results by Program Participation Status:

   a) For active beneficiaries, were there any interventions that were provided and approved by local USG funding agency that were not included in the illustrative examples (Figure 1)?

   b) For graduation, were any of the benchmarks especially challenging to achieve or monitor? If so, which?

   c) Of those who are reported to be active, what percentage are newly enrolled in the reporting period? Any re-enrollments of those LTFU (i.e. exited without graduation)? If yes, how many? Are any partners especially good at finding and re-enrolling those LTFU? Are these pieces of information tracked by MIS systems? How many active beneficiaries <18 were counted as active because they had received all eligible services but they or other household members did not meet the criteria for graduation?

3) Please explain results by exited/transferred:

   a) How many beneficiaries exited without graduation? Please explain the reasons for exiting without graduation and try to quantify with percentages if possible. Are there certain partners with higher rates of exiting without graduation? How are you managing this with the partner(s)?

   b) How many beneficiaries were transferred? To whom (e.g., other NGOs, government support, etc.). Where were beneficiaries transferred? Please provide disaggregates for beneficiaries transferred to specific sources of support.

4) How many of those counted as active under OVC_SERV were DREAMS adolescent girls or young women enrollees who were not also enrolled in an OVC program?

Narrative questions

Worksheet 2

OVC_HIVSTAT

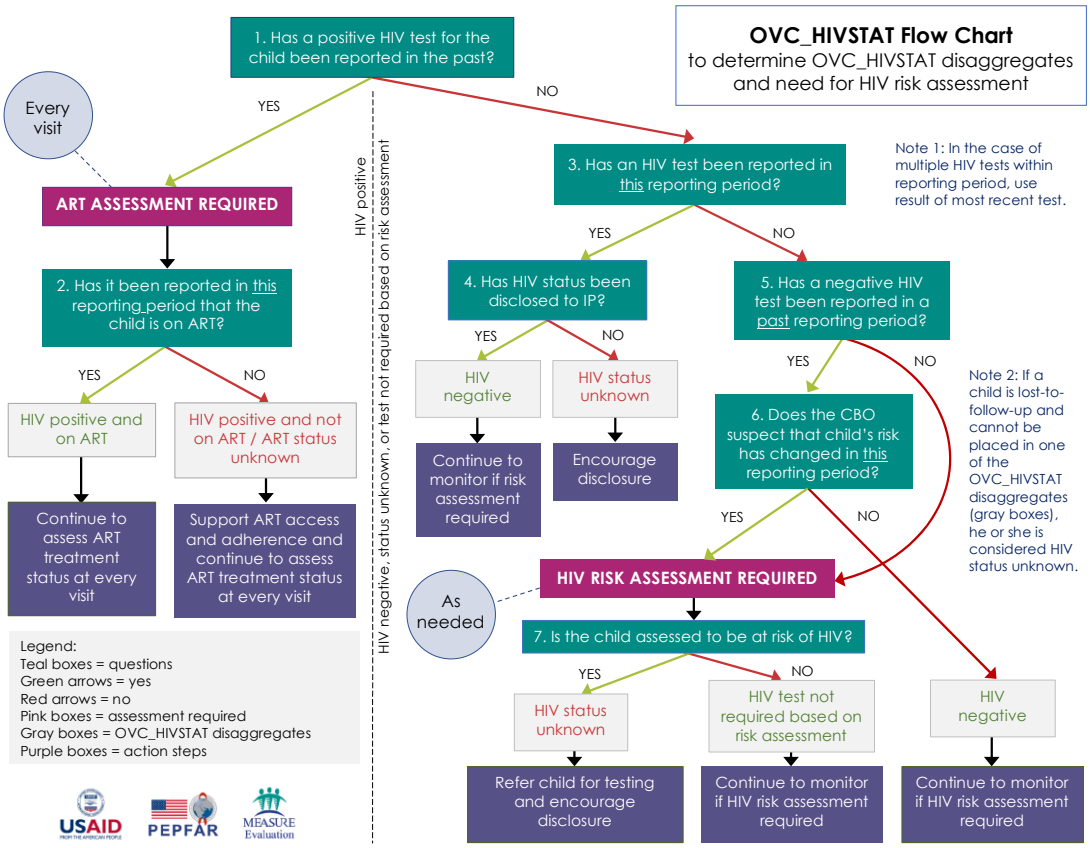
1. If the sum of reported HIV negative + reported HIV positive + Test not required based on risk assessment is less than 90% of OVC_SERV <18, please explain why such a high proportion are being reported in the category of "HIV Status Unknown" (i.e. the performance metric described in the "how to use" section). Are there certain partners that are struggling with reporting or understanding the disaggregates? How is the Mission responding?

2. Please explain the breakdown of those reported under "HIV Status Unknown". What percentage of caregivers refused to disclose a child's HIV status? What percentage represents those who have been referred for testing but do not yet have results? What percentage represents missing data where an implementing partner failed to document the child's HIV status?

3. For children reported as "Reported HIV Positive - not currently on ART or ART Status Unknown", what efforts are being undertaken in response? Are there certain partners with low ART coverage, why? Is this an issue related to community case management? Or are partners having a hard time collecting timely confirmation of treatment status (i.e. missing)?

4. How many of those reported on for OVC_HIVSTAT were adolescent girls aged 10-17 enrolled in DREAMS who are not also enrolled in an OVC program? If you are a partner implementing DREAMS, please explain any challenges you have in reporting on OVC_HIVSTAT for these DREAMS beneficiaries.

6.5. OVC_HIVSTAT Flow Chart



6.6. HIV Risk Assessment Prototype

HIV RISK ASSESSMENT

For assessing orphan & vulnerable children less than 18 years

Today's Date: _____ *Case Worker Name:* _____ *Geographic ID:* _____

Child Name/ID: _____ *Child Age:* _____ *Caregiver Name:* _____

CURRENT HIV STATUS

Does the caregiver know the status of the child?	**No**, the caregiver doesn't know the status.	Assess for HIV Risk, **go to Q1**
	Yes, the child is HIV positive. Use the **ART Treatment Assessment.**	HIV positive ☐
	Yes, the child is HIV negative, go to the next question.	
Was the HIV test done less than 6 months ago?	**Yes**, the test was done less than 6 months ago. **STOP**	HIV negative ☐
	No, the test was more than 6 months ago. Assess for HIV Risk, **go to Q1**	

HIV RISK ASSESSMENT

Q1		Yes ☐	No ☐	
Q2		Yes ☐	No ☐	
Q3		Yes ☐	No ☐	
Q4		Yes ☐	No ☐	
Q5		Yes ☐	No ☐	
Q6		Yes ☐	No ☐	
Q7		Yes ☐	No ☐	
Q8		Yes ☐	No ☐	

Did the child have a **YES to at least one** of the above questions?

YES, the child is at risk, HIV TEST REQUIRED ☐ **CONTINUE**

NO, the child is not at risk, HIV TEST NOT REQUIRED ☐ **STOP**

PROGRESS MONITORING / UPDATING HIV STATUS

This section is used to track progress of children who are at risk and require an HIV test.

Date: _____	Does the caregiver accept HIV testing for the child?	Yes ☐ No ☐
Date: _____	Was a formal referral made for HIV testing?	Yes ☐ No ☐
Date: _____	Was the referral to HIV testing completed?	Yes ☐ No ☐

If no, report why not: _____

If yes, elicit the HIV test result of the child from the caregiver.

HIV Positive ☐ Date: _____

HIV Negative ☐ Date: _____

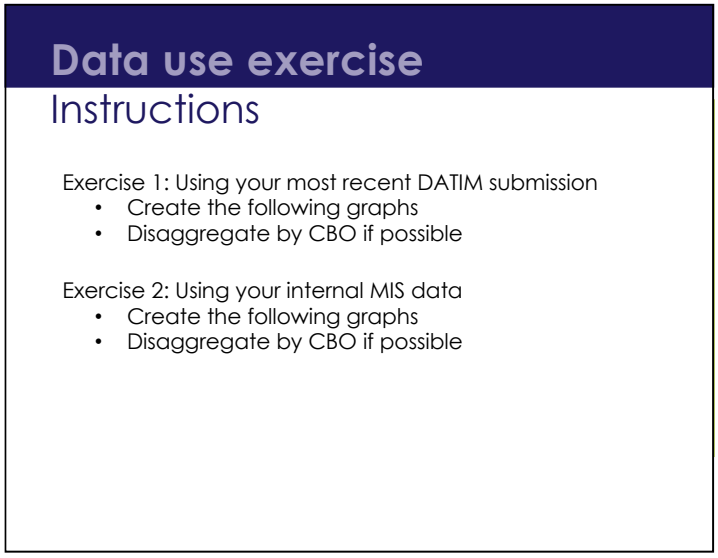
Unknown/undisclosed ☐ Date: _____

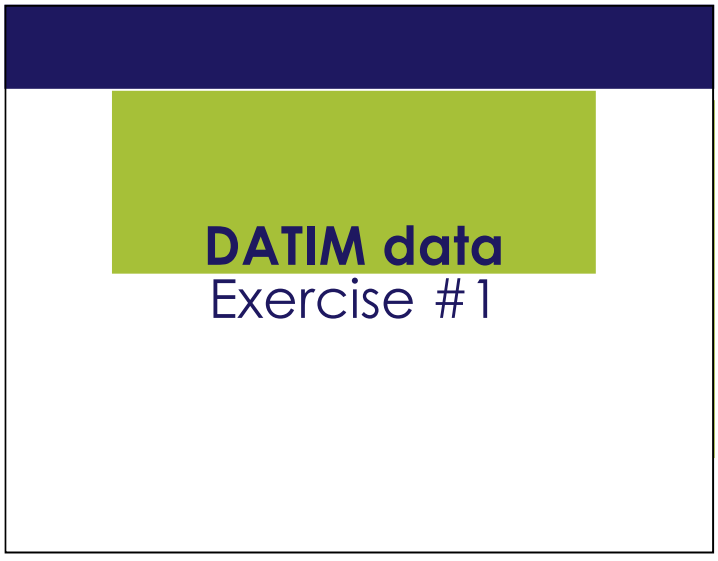
Date: _____	If HIV positive, was the child referred for ART?	Yes ☐ No ☐
Date: _____	If HIV positive, was the ART referral completed?	Yes ☐ No ☐

(If applicable) Record facility of child's enrollment: _____

6.7. Data Use Exercise Instructions

11/16/18

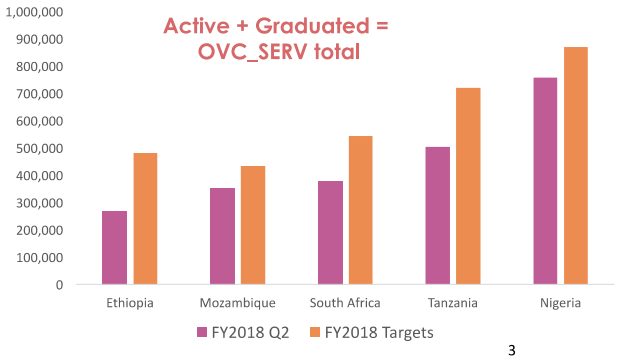




1

OVC_SERV (<18 years)

Interpret performance against targets

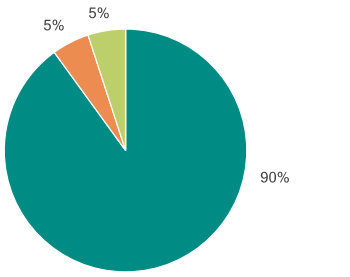


3

OVC_SERV

Active
+
Graduated
+
Exited without graduation
+
Transferred

Total



Ethiopia, Mozambique, Nigeria, South Africa, Tanzania, FY18 Q2

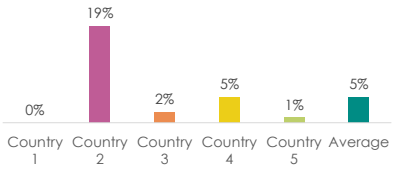
4

OVC_SERV

Proportion of beneficiaries exited by country

Exited

Active + Graduated + Exited + Transferred



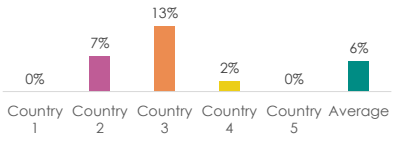
Ethiopia, Mozambique, Nigeria, South Africa, Tanzania, FY 2018, Q2

OVC_SERV

Proportion of beneficiaries graduated by country

Graduated

Active + Graduated + Exited + Transferred



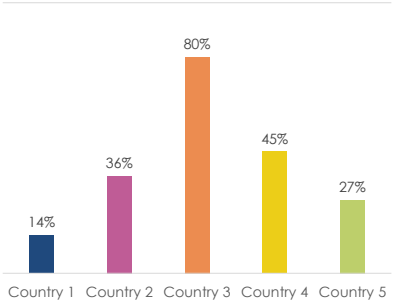
Ethiopia, Mozambique, Nigeria, South Africa, Tanzania, FY 2018, Q2

OVC_HIVSTAT (<18 years)

Proportion of children with known HIV status or for whom test is not required

HIV positive + HIV negative + Test not required based on risk assessment

Active + Graduated (OVC_SERV)



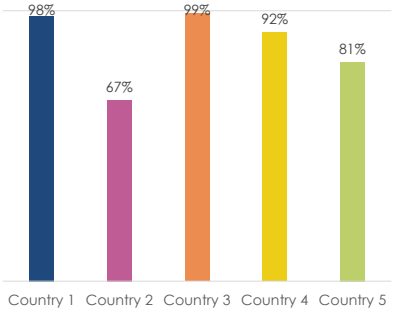
Ethiopia, Mozambique, Nigeria, South Africa, Tanzania, FY 2018, Q2

OVC_HIVSTAT (<18 years)

Proportion of HIV-positive children who are currently on ART

HIV positive currently on ART

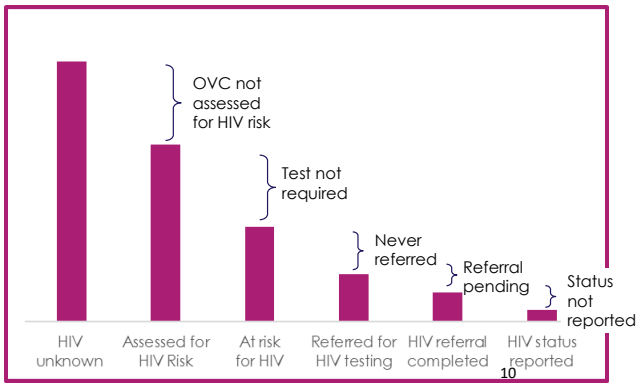
HIV positive



Ethiopia, Mozambique, Nigeria, South Africa, Tanzania, FY 2018, Q2

MIS data
Exercise #2

HIV risk assessment continuum
Bar graph



10

Tips for improving data visualizations

1. Make sure you're using the appropriate denominator. For example:
   - OVC_SERV (Active + Graduated)
   - Active + Graduated + Exited + Transferred
   - HIV-positive
2. Give the chart a meaningful title, including year(s) of data collection.
3. Consider disaggregating data by sex and/or age.

Simple, clean presentations allow your data to speak for themselves.

25

Tips for improving data visualizations

1. Make sure you're using the appropriate denominator. For example:
   - OVC_SERV (Active + Graduated)
   - Active + Graduated + Exited + Transferred
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2. Give the chart a meaningful title, including year(s) of data collection.
3. Consider disaggregating data by sex and/or age.

Simple, clean presentations allow your data to speak for themselves.

25

6.8. Quiz 1: OVC_SERV and Graduation

Note: The correct answer is shown in bold type, and the "takeaway point" in italic type.

1. Amaka is eight years old. She receives a service from the list of eligible OVC services and a quarterly monitoring visit in both Q3 and Q4. However, her case plan was developed more than 12 months ago and has not been updated. At APR, Amaka is:
    a. Active
    b. Exited

    All three aspects are required for someone to be active (services, visit, and case plan).

2. Joseph is five years old. He is enrolled in Q2, receives a case plan and a quarterly monitoring visit in Q3, and a service from the list of eligible OVC services in Q4. At APR, Joseph is:
    a. Active
    b. Exited

    The IP must provide services in the reporting period in which beneficiary was enrolled.

3. Although Camille is reported as exited at SAPR, she received necessary interventions to be counted as active at Q4. At APR, Camille is:
    a. Counted as active and exited for the year
    b. Counted as active and removed from exited for the year

    Beneficiaries may only be reported in one program participation disaggregate at APR (active, graduated, exited or transferred).

4. The eight minimum graduation benchmarks:
    a. Provide useful global guidance to inform national dialogue and may be adapted to fit local context
    b. Must be used by PEPFAR programs; additional benchmarks may be added, if necessary

    The eight minimum graduation benchmarks are mandatory.

5. Which statement about the eight minimum graduation benchmarks is true?
    a. These benchmarks apply to all members of the household. When all members have met the applicable eight minimum graduation benchmarks, the household may graduate.
    b. In exceptional cases, the members of the household who are ready to graduate may do so while the IP continues to provide services to those requiring additional support to become healthy, stable, safe, and schooled.

    All members of the household must graduate at the same time.

6.9. Quiz 2: OVC_HIVSTAT

Note: The correct answer is shown in bold type, and the "takeaway point" in italic type.

1. Gregoire is 14 years old and HIV positive. He is linked to ART treatment and care upon enrollment in the OVC program. The caseworker visits his home and provides adherence support. Gregoire is regularly attending appointments at the clinic and receiving medication.
    a. There is no need to update Gregoire's ART treatment status since he has been linked to ART treatment.
    b. Gregoire's retention in ART treatment and care should be updated at each reporting period.

    HIV-positive OVC require semi-annual reports of ART retention.

2. The correct calculation of the OVC_HIVSTAT performance indicator is:
    a. (HIV positive + HIV negative + HIV test not required) divided by (all active + graduated OVC under the age of 18 years)
    b. (HIV positive + HIV negative + HIV test not required + HIV unknown) divided by (all active + graduated OVC under the age of 18 years)

3. In addition to OVC_HIVSTAT data reported via DATIM, we recommend collecting internal program management data on the HIV risk assessment continuum: OVC with unknown HIV status, OVC who have received risk assessments, OVC determined to be at risk, OVC referred for testing, and OVC referrals completed. Which statement about the HIV risk assessment continuum is true?
    a. Collecting data on the HIV risk assessment continuum is useful in further understanding disaggregates of OVC with unknown HIV status.
    b. Collecting data on the HIV risk assessment continuum will help us calculate the yield of HIV testing.

4. OVC may be affected by HIV in a multitude of ways, and therefore we recommend:
    a. Routinely testing all children
    b. Applying an HIV risk assessment before referring for HIV testing to identify those children at greatest risk

    Not all OVC require HIV testing.

5. For OVC who reported an HIV-negative test result more than six months ago, we recommend:
    a. Applying an HIV risk assessment as soon as a change in risk profile is suspected
    b. Routinely re-testing all previously reported HIV-negative OVC every six months

    Not all OVC previously reported as HIV negative require re-assessment of HIV risk.

6.10. Evaluation of Day 1

Evaluation Form

OVC MER Training • Day 1

1. What was the most useful part of today's training?

2. Was anything in today's training not useful? If so, please describe.

3. Was anything in today's training not clear? If so, please describe.

4. What do you wish had been given more time in the training?

5. What do you wish had been given less time in the training?

6.11. Evaluation of Day 2

Evaluation Form

OVC MER Training • Day 2

1. What was the most useful part of today's training?

2. Was anything in today's training not useful? If so, please describe.

3. Was anything in today's training not clear? If so, please describe.

4. What do you wish had been given more time in the training?

5. What do you wish had been given less time in the training?

6.12. OVC_SERV Indicator Reference Sheet

PREVENTION

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

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

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

	Active OVC_SERV beneficiaries include several, potentially overlapping, categories of recipients with the following requirements: 1. Child beneficiary ("OVC") aged 0-17 (note: children aged 18 to 20 and still completing secondary education may be included per the PEPFAR OVC 2012 Guidance): a. Has a case plan developed (or updated) in last 12 months b. Continues to be monitored at least quarterly, but as often as is necessary according to the child's safety, schooling, stability, and health status. Monitoring includes establishing contact in person, or virtually where needed, to ensure that the case plan is progressing, and documentation of this contact is recorded in the case plan. c. Has received directly from the project, was facilitated to obtain, or has a completed referral for at least one intervention in each of the preceding two quarters (see Appendix D for illustrative eligible interventions for children ages 0-17; if a service is not included on this list seek approval from local USG funding agency). Intake assessment, enrollment, subsequent assessments including HIV risk assessment, case plan development, and case plan monitoring are considered critical administrative processes rather than services but remain critical to ensuring provision of needs-based services in a timely manner. 2. Caregiver beneficiary (primarily aged 18+) of an OVC (child/adolescent aged 0-17 or 18-20 still enrolled in secondary education) who has met the following criteria: a. Has received directly from the project, was facilitated to obtain, or has a completed referral for at least one caregiver intervention in each of the preceding two quarters (see Appendix D for illustrative examples). b. In addition, select services, including parenting, household economic strengthening, and food security interventions (specified in Appendix D in the caregiver and child column), qualify both the caregiver and OVC to be counted as active. 3. DREAMS participant aged 10-17 a. A DREAMS participant who is not otherwise actively enrolled in an OVC program must receive a DREAMS service/intervention that is also included in the list of OVC_SERV illustrative services (Appendix D). However, they are not required to have an OVC case plan. □ **"Graduation"** is defined as when a household enrolled in a PEPFAR OVC program is deemed to have become more stable and is no longer in need of project-provided services. For caregivers and children 17 or under (or aged 18- 20 and completing secondary education for OVC program beneficiaries) to be counted as an individual graduated in DATIM, all child and all caregiver beneficiaries in a household must meet all applicable (age and HIV status specific) graduation benchmarks established by PEPFAR for improving stability in the household. For the purposes of graduation, a household is defined as all children in the household less than age 18 years and their caregiver(s) (not to exceed two people fulfilling the role of parent or guardian). PEPFAR guidance for graduation from an OVC project includes the following eight benchmarks (see Appendix E for additional details and definitions), which align with the illustrative services in Appendix D. **Graduation Benchmarks:** **DOMAIN: HEALTHY** ○ BENCHMARK: All children, adolescents, and caregivers in the household have known HIV status or test not required based on risk assessment ○ 1.2.1. (a) BENCHMARK: All HIV+ children, adolescents and caregivers in the household with a viral load result documented in the medical record and/or laboratory information systems (LIS) have been virally suppressed for the last 12 months. *OR If viral load testing or viral load testing results are unavailable at clinic treating HIV+ beneficiaries, then:*

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

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

6.13. OVC_SERV: What's Changed?

OVC_SERV: What's Changed?

Change	Programmatic Rationale for Change
Minimum graduation benchmarks added	Provide OVC programs, OVC caregivers, and vulnerable children definitions for success which the OVC program, caregivers and OVC can agree to work towards
Beneficiaries must have received at least one service in each of the preceding two quarters from a list of illustrative eligible services	Assure that beneficiaries are reached promptly and regularly with specific services
Active status requirements updated for <18 to include at least quarterly monitoring, an updated case plan, and receipt of at least one service in each of the preceding two quarters	Assure that children and adolescents receive substantive, timely, and regular support based on a needs assessment after enrollment
Age bands revised for additional disaggregations <10 and removed 18-24	Alignment with PEPFAR standard disaggregates for <10; DREAMS beneficiaries 18-24 will not be included in OVC_SERV so caregivers captured with 18+
Active and graduated disaggregates will be collected by age/sex	Programs collect these data by age/sex and will improve ease of data entry with autocalculation
DREAMS disaggregates removed (OVC_SERV age/sex/service)	New AGYW_PREV indicator added to MER to capture DREAMS layering
Timing of data submitted for Q4 graduation, exit/transfer disaggs clarified	Beneficiaries should only be counted once, with graduated and active status taking priority at Q4
Definitions and expectations for caregivers and households added	To align with graduation benchmarks and right-size portfolio proportions of OVC <18 versus caregivers

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6.14. OVC_HIVSTAT Indicator Reference Sheet

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

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

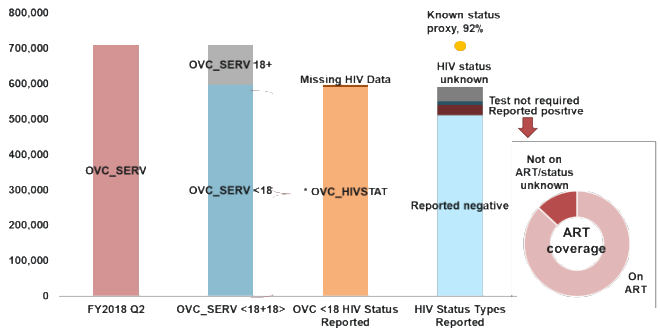
	A2. Because the CHW thinks that Elizabeth may be at risk of HIV infection, the CHW would conduct the risk assessment and she is no longer reported as "Reported HIV Negative". If found at risk (e.g., GBV exposure) then she should be referred for testing. If determined to be Test Not Required Based on Risk Assessment Elizabeth would be captured as "Test Not Required Based on Risk Assessment". If she completes the testing within the reporting period and the caregiver is willing to disclose the result of the test, her response would be captured accordingly. If she is risk assessed and referred for testing but her caregiver is not able/willing to complete the test or disclose the status within the reporting period it is captured as "No HIV Status". Hopefully by the following reporting period, the caregiver will have completed the referral and disclosed the child's status so it can be captured as positive or negative. It is understandable that the whole process from risk assessment to referral completion and disclosure may not be completed within 6 months and there be movement from "No HIV Status" to "Reported HIV positive" or "Reported HIV Negative" in future reporting periods. **Q3.** What do we do when a caregiver refuses to disclose their status and the status of their child or refuses to complete an HIV test – even when the HIV risk screening tool indicates that their child is at high risk of HIV infection? **A3.** A caregiver should never be forced to disclose their or their child's status, the results of an HIV test, or to complete an HIV test. HIV status and completion of an HIV test are not required for enrollment in an OVC program. If a child is believed to be at high risk of HIV and the caregiver is reluctant to disclose results or complete a test, OVC programs should attempt to facilitate a meeting with the caregiver, and persons specially trained on HIV disclosure. OVC programs may also consider enlisting the support of community members with whom the caregiver has greater trust. Until the client chooses to disclose test results, status under OVC_HIVSTAT should be recorded as "No HIV Status." **Q4.** How do we report on HIV exposed infants who are still too young to have had their final HIV status testing? **A4.** Because HIV-exposed infants may be tested at multiple points prior to receiving a final HIV status, we recommend that they be counted as "no status" until such time that the clinic determines their final status as positive (infected) or negative (not infected). A note can be entered in DATIM in the narrative section indicating the number of children entered as "no status" that are HIV-exposed (i.e., infants during the reporting period who were of undetermined status). It is important for all HIV-exposed infants and their caregivers to be facilitated to make appointments deemed necessary by the clinic.
How to review for data quality:	The OVC_HIVSTAT total numerator should equal OVC_SERV<18 results total numerator, including active and graduated. Review any site with the following reporting issues: 1) numerator greater than 100% of OVC_SERV <age 18, and 2) very low coverage of OVC_HIVSTAT (defined as OVC_HIVSTAT numerator divided by OVC_SERV <18) which provides data on reporting of status. Missing data should be documented under "HIV status unknown" or "Reported HIV positive-Not currently receiving ART or ART status unknown." Potential reasons for missing data may include: 1) IP was not able to collect information from all caregivers of OVC_SERV<18 within the reporting period, 2) IP was not able to locate all the caregivers of OVC_SERV<18 (e.g., relocated, migrant work).
How to calculate annual total:	This is a snapshot indicator. Results are cumulative at each reporting period.
Disaggregations:	**Numerator Disaggregations:**

Disaggregate Groups	Disaggregates
Status Type [Required]	☐ Reported HIV positive to implementing partner o Currently receiving ART o Not currently receiving ART or ART status unknown ☐ Reported HIV negative to implementing partner

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

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

Data Visualization & Use Examples:	OVC_HIVSTAT Cascade:



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6.15. OVC_HIVSTAT: What's Changed?

OVC_HIVSTAT: What's Changed?

Change	Programmatic Rationale for Change
"Test not indicated" disaggregate renamed to "Test not required based on risk assessment"	Simplify language for clarity
"No HIV status reported to the implementing partner (HIV status unknown)" will no longer have sub-disaggregates: "test not required based on risk assessment" will be its own disaggregate and "other reasons" will be removed	Disaggregate categories caused confusion; Review performance by creating a category of known status/risk (by combining those reported HIV-positive, HIV-negative, and those for whom a test is not required based on risk assessment) and compare this with OVC_SERV <18
HIV positive OVC for whom ART status is not documented will be reported under "Reported HIV Positive -- Not currently receiving ART or ART status unknown"	Children not on ART and for whom ART status is unknown require similar follow up for partner; provides clear instruction for data entry on where to include missing data
OVC for whom HIV status is missing will be reported under "No HIV status reported to the implementing partner (HIV status unknown)"	Simplifies indicator to make it clear where missing data should be included, and narrative will collect additional information on reasons for HIV status unknown
HIV positive category will be auto-calcuated from the disaggregates "Reported HIV Positive -- currently receiving ART" and "Reported HIV Positive -- Not currently receiving ART or ART status unknown"	Reduce data entry burden since data entry clerks only enter data in one place instead of in two places and ensure data quality and consistency to eliminate completeness issues
Clarifications made to highlight risk assessment	Risk assessment programmatically important to find those who do not know their status and need to be tested

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6.16. IAppendix D: Illustrative Eligible Services for Active OVC Beneficiaries

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

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

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

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

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

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

6.17. Global OVC Graduation Benchmarks Matrix

APPENDIX E: GLOBAL OVC GRADUATION BENCHMARKS MATRIX

GLOBAL ORPHANS AND VULNERABLE CHILDREN GRADUATION BENCHMARKS MATRIX Updated 7-06-2018
This document provides information on the minimum global benchmarks for OVC graduation. Benchmarks are organized by domain (healthy, stable, safe, and schooled) and key objective. "Graduation" occurs when a child and caregiver enrolled in a PEPFAR OVC program are deemed to have become more stable and no longer in need of OVC project-provided services. For caregivers and children 17 or under[4] to be counted as graduated, all child and all caregiver beneficiaries in a household must meet ALL applicable (age and HIV status specific) graduation benchmarks established by PEPFAR for improving stability. Additional guidance and tools to facilitate implementation of these global minimum benchmarks is forthcoming.
1. DOMAIN - HEALTHY
1.1. KEY OBJECTIVE - INCREASE DIAGNOSIS OF HIV INFECTION
1.1.1. BENCHMARK: All children, adolescents, and caregivers in the household have known HIV status or a test is not required based on risk assessment
DATA SOURCES AND DEFINITIONS: • Caregivers self-reported HIV positive or negative test results for children (0-9 years)/adolescents (10-17 years) • For children without HIV status reported by caregivers, case manager has completed a PEPFAR approved HIV risk assessment for children/adolescent showing HIV test not indicated • Caregivers self-reported HIV test results for HIV-Exposed Infants (HEI) at 18 months of age or at least one week after cessation of breastfeeding, whichever comes later • Caregivers self-reported HIV positive or negative test results • For caregivers without HIV status reported, the case manager has completed the PEPFAR HIV risk assessment showing HIV test not indicated
1.2. KEY OBJECTIVE - INCREASE HIV TREATMENT ADHERENCE, RETENTION AND VIRAL SUPPRESSION
1.2.1. (a) BENCHMARK: All HIV+ children, adolescents and caregivers in the household with a viral load result documented in the medical record and/or laboratory information systems (LIS) have been virally suppressed for the last 12 months.[5] *OR If viral load testing or viral load testing results are unavailable at clinic treating HIV+ beneficiaries, then:* 1.2.1. (b) BENCHMARK: All HIV+ children, adolescents, and caregivers in the household have adhered to treatment for 12 months after initiation of antiretroviral therapy[6]
DATA SOURCES AND DEFINITIONS: • ART clinicians confirmed that HIV+ caregivers/children/adolescents are virally suppressed or if viral load testing is unavailable, regularly attending appointments and picking up medications over the past 12 months; or • HIV+ caregivers and caregivers of HIV children/adolescents self-report that they are regularly attending appointments and picking up medications over the past 12 months • HIV+ caregivers and HIV+ adolescents 12 years and older self-reported that they have regularly taken medication without missing doses for the past 12 months. • Caregivers for HIV+ children and adolescents younger than 12 years self-reported that children have regularly taken medication without missing doses for the past 12 months
1.3. KEY OBJECTIVE - REDUCE RISK OF HIV INFECTION
1.3.1. BENCHMARK: All adolescents 10-17 years of age in the household have key knowledge about preventing HIV infection

[4] OVC may be aged 20 or under if they are completing secondary education
[5] Beneficiaries whose earliest viral load test result was <12 months ago are ineligible to meet this benchmark.
[6] Beneficiaries who initiated ART <12 months ago, and those with a break in adherence during the 12-month period, are ineligible to meet this benchmark.

DATA SOURCES AND DEFINITIONS:

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

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

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

DATA SOURCES AND DEFINITIONS:

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

2. DOMAIN – STABLE

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

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

DATA SOURCES AND DEFINITIONS:

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

3. DOMAIN – SAFE

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

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

DATA SOURCES AND DEFINITIONS:

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

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

DATA SOURCES AND DEFINITIONS:

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

4. DOMAIN – SCHOOLED

4.1. KEY OBJECTIVE - INCREASE SCHOOL ATTENDANCE AND PROMOTION

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

DATA SOURCES AND DEFINITIONS:

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

6.18. Appendix F: Questions and Answers to Possible OVC_SERV Reporting Scenarios

APPENDIX F: QUESTIONS AND ANSWERS TO POSSIBLE OVC_SERV REPORTING SCENARIOS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

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