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The President's Emergency Plan for AIDS Relief

Planning and Reporting

NEXT GENERATION INDICATORS REFERENCE GUIDE

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Introduction

New PEPFAR Indicator Guidance

This document is available publicly at www.PEPFAR.gov and replaces all previous versions of PEPFAR Indicator Reference Guides. This guidance will go into effect for the FY 2013 PEPFAR planning and reporting cycle and will remain in force until a new version of the guidance is published.

This indicator reference guidance document is not PEPFAR program guidance. It is meant to be used as a companion document to the various program-related guidance documents that will be released for PEPFAR, which may include:

- COP Guidance
- Technical Considerations
- PEPFAR Reporting Guidance (SAPR and APR)
- Partnership Framework Guidance

Please refer to appropriate program guidance documents on www.PEPFAR.gov for additional information.

The indicators in this guidance meet the minimum needs of PEPFAR to demonstrate progress in the fight against HIV/AIDS. Taken together, these indicators promote responsible program monitoring across and within PEPFAR-funded technical areas. These indicators may not satisfy every country need. They are not designed to provide information on all dimensions of a program in country-specific settings. Strong program monitoring at the country level requires a broad range of indicators, which can measure quality, coverage, and other aspects of programs.

The PEPFAR Next Generation Indicators are classified in three ways:

- with respect to the relevant HIV program, as “Direct” or “National”
- with respect to PEPFAR monitoring and reporting practices, as “essential” or “recommended”
- with respect to their placement in the programmatic results cascade, as “output,” “outcome,” or “impact”

The indicators presented in this guidance document represent a comprehensive set of indicators, developed by PEPFAR interagency TWG indicator working groups (with participation of multilateral partners like WHO, PEPFAR-funded implementing partners, and civil society participants).

Background

Since the *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* (Public Law 108-25) was enacted, the President's Emergency Plan for AIDS Relief (PEPFAR) has worked to coordinate the U.S. Government's (USG) response to HIV/AIDS around the world, harmonizing the planning and reporting processes of all USG agencies working on global HIV/AIDS.

In 2008, PEPFAR's success was recognized when the *Tom Lantos and Henry J. Hyde United States Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008* (Public Law 110-293) was signed into law.

PEPFAR's success is rooted in support for country-owned strategies and national programs, with a commitment to provide resources and monitor results, achieved through partnerships with governments, multi-lateral partners, non-governmental organizations, faith- and community-based organizations, civil society, the private sector, and groups of people living with HIV/AIDS. PEPFAR is pursuing the following goals:

PEPFAR Legislative Goal	Monitoring Indicator
Treatment	
Treatment for 6 million people[1]	Number of adults and children with advanced HIV infection receiving antiretroviral therapy
Prevention	
12 million new infections averted	No routine monitoring indicator – Goal is measured through modeling at headquarters
80% coverage of testing and counseling among pregnant women	Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
85% coverage of ARV prophylaxis for HIV-positive pregnant women	Percentage of HIV-positive pregnant women who received antiretroviral therapy to reduce risk of mother-to-child-transmission
Care	
Care for 12 million people, including 5 million orphans and vulnerable children	Number of eligible adults and children provided with a minimum of one care service (disaggregated by age)
Human Resources for Health – Work Force	
Professional training for 140,000 new health care workers	Number of new health care workers who graduated from a pre-service training institution

Strategic information is a cornerstone of PEPFAR. The collection of strategic information serves multiple purposes:

- to support partner governments to plan, monitor, and manage a coordinated national response to the HIV/AIDS epidemic
- to assist PEPFAR country teams to plan, monitor, and manage USG-supported HIV/AIDS activities in support of the national plan
- to provide information to PEPFAR leadership for management of PEPFAR
- to demonstrate progress of PEPFAR to the US Congress
- to obtain continued support and resources for HIV/AIDS prevention, care, and treatment programs

[1] New treatment goal announced by the President on World AIDS Day 2011

- to coordinate efforts with the international donor community

Strategic Information is an integral part of program management and design, but the indicator guidance found in this document does not constitute program guidance. Programs should be designed to provide comprehensive, high-quality services based on international or national guidelines, best practices, and scientific evidence. Programs should not be designed around an indicator for the sole purpose of reporting on that indicator. Instead, indicators are based on programmatic guidance in order to provide information about elements of programs to stakeholders. Indicators are intended to provide an "indication" of performance based on one key or standardized element of a program. It is not the purpose of an indicator, or even a suite of indicators, to adequately capture every aspect of a comprehensive program.

PEPFAR Next Generation Indicators – Directional Shifts

The Next Generation Indicators (NGI) reflect PEPFAR's strategy to increase country ownership of HIV/AIDS efforts and ensure that countries are at the center of decision-making, leadership, and management of their HIV/AIDS programs. PEPFAR supports work towards better alignment of indicators and reporting requirements within the context of the national HIV/AIDS M&E plan of each country.

To achieve this end, the Guidance:

1. is aligned, to the extent possible, with globally harmonized indicators already reported by many nations;
2. attempts to minimize PEPFAR-specific reporting requirements to allow PEPFAR country teams more flexibility to design M&E plans in-line with countries; and,
3. strikes a balance between support for USG reporting needs and national M&E systems.

In addition, PEPFAR Next Generation Indicators seek to strengthen country programs with the inclusion of 'coverage' and 'quality' measurements. Monitoring and ensuring coverage of quality HIV services is a major focus for this next phase of PEPFAR programming.

Balance of USG reporting needs with country ownership

PEPFAR seeks to strengthen sustainable National-level monitoring and evaluation systems. The goal is to enable PEPFAR to continue to monitor program performance and to report to Congress and the American public, while supporting government ownership and development of national HIV M&E systems. Shifting emphasis to National system strengthening implies support for a national indicator set agreed upon by the government and all agencies, donors, and implementing partners working within a country as well as support for the reporting flow within a National system (site to district to regional to national offices). To support this work in country, at the headquarters level PEPFAR is working towards better alignment with indicator guidance of other international donors and organizations. In addition, PEPFAR will focus on working towards policies and guidance that support better integration of PEPFAR reporting and target-setting into national level processes as well as National M&E systems.

PEPFAR country teams may need to rely on existing parallel PEPFAR systems in the short term, but should continue working diligently to integrate these systems into the National M&E system.

Global harmonization of indicators and reporting requirements

It is widely recognized that a minimum set of indicators is needed for global reporting. The data collected through global reporting is critical for the purposes of monitoring global progress, maintaining program support, and advocating for resources and continued funding. However, these reporting demands can become burdensome in country. For these reasons, global harmonization has been a primary focus of PEPFAR.

To this end, at the headquarters level, PEPFAR has collaborated with international donors and organizations to harmonize most PEPFAR essential indicators with international standards. Specifically, PEPFAR HQ is working with multi-lateral partners to achieve a minimum core set of global reporting indicators that provide standardized data for comparison across countries and allow for aggregation at the global level.

Through the UNAIDS Monitoring and Evaluation Reference Group (MERG), PEPFAR and 18 other international multi-lateral organizations (including UNAIDS, WHO, UNICEF, GFATM, etc.) and other bilateral donors have obtained a degree of harmonization and have agreed upon a minimum set of standardized indicators. This set of Core National Indicators was released in January 2008 as an addendum to the UNGASS guidelines for 2008 reporting. The UNGASS and the Core National Set of indicators were used as the initial foundation for the PEPFAR Next Generation of Indicators. (2010 Reporting, UNGASS Core Indicators: http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf).

While the Core National Set was an enormous step forward, and the 2012 Global AIDS Response Reporting Guidelines carries the principles of harmonization forward, the UNAIDS MERG recognizes that there are important programmatic gaps that still need to be addressed (i.e. Care, Gender, Prevention, and Workforce). To fill these gaps, PEPFAR will continue to work on global harmonization through the MERG's Indicator Working Group.

Country-level harmonization of indicators

Just as there is a need to provide a standardized global picture of the response to HIV across countries; national programs require a complete picture of the breadth of HIV activities taking place in country in order to effectively manage the national response. For this reason, national programs also require a harmonized set of indicators. Ideally these indicators are supported by standardized data collection tools for use by all implementing partners, donor agencies, and other stakeholders implementing programs in country.

Nationally harmonized indicator sets are standardized within each country to allow for analysis and comparisons between partners or regions and for aggregation. However, these indicator sets may differ across countries and may not be suitable for cross-country comparisons or global aggregation.

PEPFAR country teams are encouraged to continue working with governments and other donors to achieve a harmonized set of national indicators. The national set should include harmonized global indicators wherever possible, but additional indicators are also needed to satisfy the various information needs of the country program. PEPFAR and other donor reporting requirements will need to be considered for inclusion in the national indicators sets.

Focus on Measures of Coverage and Program Quality

Coverage

Coverage indicators include measures of *program* coverage and *population* coverage.

Program coverage indicators describe coverage of a specific service within a broader program service category. Program coverage can be used to track coverage of essential key services at the partner level or at the PEPFAR program summary level, and thus can be used to describe some dimensions of quality of a program.

Example – Program Coverage

Percentage of HIV-positive persons receiving Cotrimoxizole prophylaxis
Numerator: Number of HIV-positive persons receiving Cotrimoxizole prophylaxis (Source: Program Records)
Denominator: Number of HIV-positive persons receiving a minimum of one clinical service (Source: Program Records)

Population coverage indicators generally depict national program results and describe coverage of a specific service among a population eligible for the service. Thus, indicators of population coverage often use a program output indicator over a population estimate to denote how many people in a population who need the service actually received the service. Population coverage measures can be adapted for partner use if appropriate data are available for the population denominator (e.g. eligible persons in a district or defined catchment area), but more often these measures are used at the regional or national level.

Example – Population Coverage

Percentage of individuals with advanced HIV infection receiving antiretroviral therapy (ART)
Numerator: The number of individuals with advanced HIV infection receiving antiretroviral therapy (ART) (Source: National M&E System, Program Records)
Denominator: The estimated number of individuals with advanced HIV infection (Source: Spectrum Model)

Quality

PEPFAR Next Generation Indicators seek to strengthen country programs with the inclusion of 'quality' measurements of quality.

There are many definitions of 'quality' within the health service literature and PEPFAR is employing the perspective offered by the Institute of Medicine (IOM), using three fundamental dimensions.

Structure	"the settings in which [health care] takes place and the instrumentalities of which it is the product"
Process	"whether what is known as 'good' medical care has been applied"
Outcome	"in terms of recovery, restoration of function and of survival"

PEPFAR is targeting very narrow, salient components of the quality issue, attempting to keep program monitoring effort as a low burden and of high utility to providers (i.e., support quality services). Commensurate with these objectives, this work will focus on two areas within the broader quality framework, technical performance (process) and effectiveness of care (outcome).

The ongoing work of PEPFAR to identify indicators of quality follows a similar process to that enlisted for the PEPFAR Next Generation Indicators and is built on existing indicator work. Therefore, some of the quality

indicators identified below can already be found in the PEPFAR Next Generation Indicator lists. Further guidance on quality indicators will be forthcoming upon completion of this project.

Examples – Program Quality

Process
Number of ART patients who have a documented CD4 or VL result within the last six months
Number of ART patients who have attended all of the nationally recommended number of clinical visits
Number of ART patients who have received sexual prevention counseling during their clinical visits

Outcome
Number of ART patients who are still alive and on ART at 12 months after initiating treatment
Number of patients with favorable outcomes (no OIs, good functional status, stable weight, etc.)
Number of ART patients switched from 1st to 2nd line therapy
Percentage of clients circumcised who experienced one or more moderate or severe adverse event(s)

Measures of Cost

Cost data are critically needed by PEPFAR to estimate program costs and cost-effectiveness, especially in times of budget constraints. PEPFAR country teams are encouraged to use financial data and estimates of program costs together with program performance data to fully inform decision making around program management and program scale-up. In the future PEPFAR may seek to collect cost data as part of routine monitoring and reporting.

Move from Downstream/Upstream to Direct/National

In the past, PEPFAR used the concepts of "Downstream" and "Upstream" to quantify performance of the full portfolio of PEPFAR activities in country. In the first five years of PEPFAR, "downstream" (direct service delivery) and "upstream" (indirect support) results summed to "total" PEPFAR results.

In the countries formerly referred to as "focus" countries, the PEPFAR "total result," which in some countries was the same as the national number of people receiving a service, was used to report against the PEPFAR 5-year goals. However, in countries receiving fewer resources than the focus countries the concept of "upstream" was difficult to operationalize.

Moving forward, PEPFAR is seeking to better communicate the performance of the PEPFAR program in a way that recognizes the specific PEPFAR contributions to the national HIV program. National HIV program achievements are the collective and collaborative work of country and donors, including PEPFAR.

PEPFAR thus no longer collects data on "upstream" or "indirect" targets and results.

Instead, PEPFAR now collects data at two levels: National program results and Direct PEPFAR program results.

Given that PEPFAR is one of many contributors to the national HIV program, Direct PEPFAR results should be a subset of the national program results for routine program monitoring indicators. In some higher PEPFAR-resourced countries, PEPFAR may support a large portion of the national program. In a few of these cases, it may be possible that PEPFAR supports the entire program and the Direct PEPFAR result is equal to the National, while in lower-resourced countries, PEPFAR makes a lesser contribution to the total achievements of the national HIV program. In some of these cases, especially in the handful of PEPFAR countries with programs primarily focused on a "Technical Assistance" program model, the national level results may not be sensitive enough to monitor PEPFAR's contribution. In these cases, PEPFAR countries will also be able to provide sub-national level or project-level results.

To summarize, PEPFAR will look at two levels of information:

1. The collective achievements of all contributors to a program or project (i.e. government, donors, and civil society organizations).
    - National level – all country programs will report national level data on a small core set of indicators (where applicable).
    - Some country programs may choose to also report sub-national region or a project-level defined region (i.e. four project sites).

2. The PEPFAR (Direct) achievements to HIV programs
    - This includes counts of individuals receiving prevention, care and support, and/or treatment services at a unique program or service delivery point that receives substantial USG PEPFAR support.
    - An intervention or activity that can be associated with specific achievements or deliverables that strengthen systems, build capacity, or change the legal/policy environment such as health workforce development, laboratory support, or policy development..

Indicator Classifications and Definitions

This guidance document classifies indicators in three ways:

1. By degree of importance/aggregation level:
    - Essential/Reported to HQ
    - Essential/Not Reported to HQ
    - Recommended
2. By reporting level:
    - PEPFAR Direct (Partner or Technical Area Summary)
    - National
3. By standard M&E classification:
    - Output
    - Outcome
    - Impact

Each indicator in the guidance is classified by each of these three categories.

Classification: Degree of Importance

Essential (Reported/Not Reported)

These are indicators that, where applicable, are considered to be of high importance and inherently necessary to track the progress of HIV/AIDS programs and therefore are indispensable to the basic monitoring of these programs. PEPFAR country teams determine which of the essential indicators are "applicable" to their programs and their funded partners. (See definition of applicability below.) Among the essential indicators is a subset of indicators which must be reported to PEPFAR headquarters on a semi-annual or annual basis, according to forthcoming PEPFAR Reporting Guidance.

Many essential indicators are Direct and are used to specifically monitor PEPFAR program investments, while other essential indicators are National and are used to monitor all contributions and investments to the national HIV/AIDS response. (See definitions of "direct" and "national" below). PEPFAR country teams determine how the essential indicators are to be collected from USG-funded partners and the relevant national systems and how they are to be aggregated, stored, and used for PEPFAR program monitoring in country.

Most essential indicators are based on internationally harmonized indicators and are required for global reporting by international organizations like UNAIDS or GFATM. However, there are some indicators which are not internationally harmonized but are otherwise:

- Required to report against PEPFAR goals,
- Mandated by Congress, or
- Necessary to track an emergent or high priority program area (like health system strengthening or male circumcision), or
- Otherwise of high priority to PEPFAR leadership.

Because the essential indicators are indispensable to HIV/AIDS program monitoring, if the indicators are not part of national monitoring systems, PEPFAR country teams are encouraged to negotiate with national stakeholders to include these indicators in national systems in the near future to enable basic tracking of the national HIV/AIDS response.

All Essential indicators are subject to audit at the Direct PEPFAR reporting level. At the national level, PEPFAR country teams are required to monitor and use available data on essential indicators where applicable to their programs. However, it is recognized that PEPFAR country teams can only support and encourage the collection and implementation of national data collection activities through Partnership Frameworks or other negotiation processes.

Aggregation Levels for Essential Indicators

Essential/Reported to HQ
These are the essential indicators that will be aggregated and reported to PEPFAR headquarters using standardized indicator definitions to allow data comparison across PEPFAR-supported countries. Indicator standards are defined in this guidance.

Essential/Not Reported to HQ
These essential indicators do not need to be aggregated and reported to PEPFAR Headquarters. However, partners will be required to report applicable indicators to the PEPFAR country teams. In addition, PEPFAR country teams are expected to support and encourage intermittent surveillance or surveys required to monitor those indicators not routinely captured through programs. While standardization with globally harmonized indicators is highly encouraged, the definitions of these indicators may understandably vary by country given that many national programs have core data sets in place and have adopted variations of these indicators. The intent of these essential indicators is to highlight critical program areas that country teams should be monitoring and give PEPFAR country teams increased flexibility to work within the context of the national system.

Please note that many of the indicators in the category "Essential/Not reported to HQ" are nonetheless used by PEPFAR leadership for decision-making purposes. These data are reported through other mechanisms (i.e. UNAIDS, DHS, BSS, etc.) and readily available to HQ, which is the reason that PEPFAR country teams do not need to report this information separately to HQ.

Recommended

These are additional recommended indicators for partners and program managers who need additional information for program management beyond the minimum defined in the essential set. These indicators were selected and recommended by the PEPFAR interagency TWGs as important areas for program managers to monitor, but are not considered indispensable to basic program tracking. Similar to the essential indicators, some of the recommended indicators are internationally harmonized.

Recommended indicators do not need to be aggregated and reported to PEPFAR headquarters. While standardization with globally harmonized indicators is encouraged, the definitions of these indicators may understandably vary by country given that many national programs have core data sets in place and have adopted variations of these indicators.

The intent of the recommended indicators is to encourage comprehensive monitoring of programs, provide additional recommendations on indicators beyond the PEPFAR required set, and give PEPFAR country teams increased flexibility to work within the context of the national system.

Data from many of these indicators will be available to headquarters through other sources (i.e. UNAIDS, DHS, BSS, etc.).

Classification: Reporting Level

PEPFAR Direct (Technical Area Summary and Partner Level)

Definition: Expected achievements (projections/targets) or realized achievements (results) of the PEPFAR program through its funded efforts and activities. As in the first 5 years of PEPFAR, "Direct" refers to an intervention or activity that can be associated with counts of uniquely identified individuals receiving prevention, care and support, and/or treatment services at a unique program or service delivery point that receives substantial PEPFAR support (See appendix 5 for more information on assessing PEPFAR Direct support for service delivery indicators). Direct achievements may also be captured separately in the form of an intervention or activity that can be associated with specific deliverables that strengthen systems, build capacity, or change the legal/policy environment such as health workforce development, laboratory support, or policy development.

National

Definition: Expected or realized achievements of all contributors to a country's HIV program led by the government and contributed to by all of its stakeholders, donors, civil society organizations, and the private sector.

- Most national indicators are outcome indicators, but some are output and impact indicators.
- Most national indicators are "recommended" but some are "essential," a subset of which must be reported to HQ if they are applicable to the PEPFAR program.

Classification: Standard M&E Classification

Output

Definition: Result of program activities. They relate to the direct products or deliverables of program activities, such as number of counseling sessions completed, number of people reached, and number of materials distributed.

Outcome

Definition: Effect of program activities on target audiences or populations, such as change in knowledge, beliefs, skills, behaviors, access to services, and environmental conditions.

Impact

Definition: Longer-range, cumulative effect of programs over time such as change in HIV infection, morbidity, and mortality; impacts are rarely, if ever, attributable to a single program, but a program may, with other programs, contribute to impacts on a defined population.

Definition of Applicability[2]

Applicability of an indicator will be determined by whether the PEPFAR country team is funding an activity that is expected to yield results (provision of a service or other deliverable) for the indicator in question. Applicability will apply to all indicators regardless of classification by the three categories discussed above. However, there are some differences in the definition of applicability depending on whether it is applied to either the national or direct reporting levels.

A **PEPFAR direct program** indicator should be considered **applicable** if the PEPFAR country team funds one or more partners in country to directly conduct activities that are reflected in the indicator.

- For example, if the PEPFAR country team funds one or more partners to directly provide care and treatment services, it should collect and report on the relevant indicators of people receiving those services.
- If one or more partners directly provide testing and counseling, the country team should collect and report on the number of people receiving CT services.
- If one or more partners conduct health care worker training, the country team should collect and report on the number of health workers trained.

PEPFAR country teams decide which indicators are applicable to which partners depending upon what types of activities the partner is funded to implement; the concept of applicability presented above should be applied similarly across all partners.

- For example, if a funded partner directly provides care and treatment services, it should collect and report on the number of people receiving those services.

[2] See the section of the indicator reference sheets that is titled, "applicability" for more information on the applicability of each indicator.

The concept of applicability is broader for national program indicators. A **national program** indicator should be considered **applicable** to the PEPFAR program if the PEPFAR country team:

- Funds one or more partners in country to directly conduct activities that are reflected in the indicator (similar to above), OR
- Funds one or more partners in country to conduct or otherwise support program-related activities, or indirectly support the program area in a way that would yield a change in the activities or topic reflected in the indicator, OR
- Supports staff in country in a way that would be expected to yield a change in the activities or topic reflected in the indicator.

Utilizing the Concept of Applicability for Selecting Indicators

The concept of applicability (meaning the relevance of an indicator to the PEPFAR program) is used by PEPFAR country teams to ascertain which indicators to select for their indicator sets. PEPFAR country teams should work within the context of the national strategic plan to establish a comprehensive set of indicators for use at three levels: National, PEPFAR Direct Program (Program Summary), and Implementing Partner.

These indicators will be used to measure the annual or intermittent progress towards the national strategic goals that PEPFAR is supporting through its programs, as well as the direct activities being implemented through PEPFAR-funded partners.

National Level Indicators

At the national level, to sufficiently monitor its national response, the government's national set of indicators should include the minimum set of harmonized global indicators (Global AIDS Response Reporting) and additional indicators that represent the needs of the country's program. The PEPFAR Country team needs to negotiate with the government and other stakeholders to make sure that PEPFAR reporting requirements are taken into consideration in the country's national set.

In constructing its own comprehensive set for monitoring the USG response in support of the national program, each PEPFAR country team will review all of the PEPFAR essential national indicators for applicability to the PEPFAR activities being conducted in country.

If an indicator is deemed applicable to the PEPFAR program (i.e. PEPFAR is supporting activities that will produce a change in the results for a particular indicator as a result of technical assistance, training, direct service delivery, capacity development, or other system strengthening activity), then this indicator should be added to the PEPFAR country team's national list for monitoring.

- If the applicable indicator is categorized as essential/reported, then the PEPFAR in-country team will be required to report on this indicator to PEPFAR headquarters during the SAPR or APR reporting cycles.
- If the applicable indicator is categorized as essential/not reported, then the PEPFAR team will be expected to track these data in country in order to monitor the progress of PEPFAR support to the national HIV program.

PEPFAR country teams will also want to review the additional recommended indicators, including outcome and impact indicators, for applicability to the country program. Applicable indicators that are deemed useful by the PEPFAR country team should be monitored for country use.

PEPFAR country teams may need to increase efforts in order to support capacity building of the systems or data collection methods (i.e. surveys or surveillance) needed to collect these indicators.

Please note that indicators should address major commitments, but need not necessarily cover every program area or activity type, depending on applicability and/or prioritization and feasibility of indicators from the recommended set.

PEPFAR Direct Level Indicators (Technical Area Summary)

PEPFAR country teams should review all of the essential PEPFAR Direct program indicators for applicability to the overall PEPFAR program being conducted in country. If an indicator is deemed applicable to the PEPFAR program, meaning it is expected to directly yield results (provision of a service or other direct deliverable) in the area measured by the indicator, then the indicator should be added to the Direct Technical Area Summary list.

- If the indicator is classified as essential/reported, then the PEPFAR team routinely reports data on the indicator during the SAPR and APR reporting cycles.
- If the indicator is categorized as essential/not reported, then the PEPFAR team will be expected to track these data by partner in order to monitor the partner level progress of the PEPFAR program for country use.

The essential PEPFAR indicators are deemed the minimum information needed by country teams to monitor their programs; however, in most cases these indicators will not be sufficient for country program management. USG PEPFAR country teams are encouraged to monitor additional indicators as needed to ensure sufficient information for program management and planning. These additional indicators can be pulled either from the national set or from the PEPFAR list of "recommended" indicators. ***There are no set requirements by PEPFAR headquarters on these additional indicators. PEPFAR country teams are to determine which additional indicators might be appropriate, useful, and needed for monitoring in country.***

Please note that ideally all indicators that are being used to monitor and evaluate the PEPFAR program should come from the national set or be negotiated into the national set.

Partner Level Indicators

Once the PEPFAR country teams have selected the set of PEPFAR direct level indicators that will be used to monitor their program, they are to work with each implementing partner to determine a set of indicators that is applicable to the partner based on the scope of the funded activities. This set of indicators would constitute required reporting by implementing partners to the PEPFAR country team.

Applicability at the partner level is determined by whether or not the partner is directly supporting the service being measured by the indicator. While there is still a relationship between indicators and budget codes, the choice of budget code does not dictate which indicators should be used to track partner performance.

Partner-level indicators should, as much as possible, capture the direct accomplishments of the partner and should not attempt to indirectly connect regional or national capacity-building or system-strengthening-related activities to individuals receiving services. (See appendix 5 for more information on determining direct support).

The PEPFAR country team retains the flexibility to determine which information is critical reporting for their implementing partners. For example, the PEPFAR country team may want to require implementing partners to report on an indicator that is not on the PEPFAR essential list of indicators.

Examples of selecting partner level indicators

Selecting partner level indicators – Example 1	
Partner X provides services in a care setting. The partner's activities include provision of a comprehensive set of services to HIV-positive individuals that include clinical and supportive care, testing & counseling; prevention services (PwP), and in-service training to providers. Based on a thorough review of the partner's activities, the USG team determined that the following indicators are applicable to this partner:	
P7.1.D	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP)

	interventions
P8.1.D	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards
P11.1.D	Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results
C1.1.D	Number of eligible adults and children provided with a minimum of one care service
C2.1.D	Number of HIV-positive adults and children receiving a minimum of one clinical service
C2.2.D	Number of HIV-positive persons receiving Cotrimoxizole prophylaxis
C2.3.D	Number and proportion of HIV-positive clinically malnourished clients who received therapeutic or supplementary food
Country Defined	Number of HIV positive adults and children receiving appropriate pain management according to WHO standards
C5.6.D	Number of eligible adults and children provided with psychological, social, or spiritual support
H2.3.D	Number of health care workers who successfully completed an in-service training program

Selecting partner level indicators – Example 2	
Partner Y provides services in a PMTCT setting. The partner's activities include provision of a comprehensive set of services to pregnant women, their partners, and infants. Services include testing & counseling, ARV Prophylaxis, sexual behavior prevention services, and in-service training to providers at the PMTCT setting. Based on a thorough review of the partner's activities, the USG team determined that the following indicators are applicable to this partner:	
P1.1.D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
P1.2.D	Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission
P1.4.D	Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing in USG-supported sites
P7.1.D	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions
P8.1.D	Number of the target population (general population) reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards
P11.1.D	Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results
P1.4.D	Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing in USG-supported sites
C5.1.D	Number of eligible clients who received food and/or nutrition services in accordance with PEPFAR food and nutrition guidelines.
C4.1.D	Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth
C4.2.D	Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth
H2.3.D	Number of health care workers who successfully completed an in-service training program

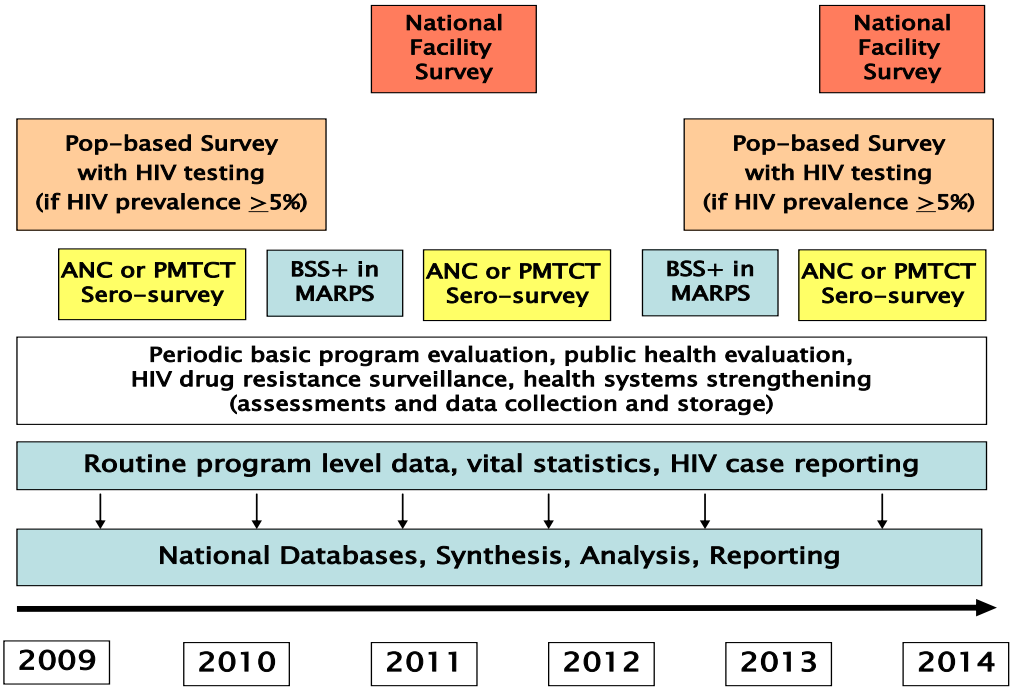
Note: In the first five years of PEPFAR, Partner X and Y may have been considered "Care" or "PMTCT" partners respectively. Now, given their span of activities, these partners will be reporting on indicators that come from multiple technical areas.

Strategies for the Collection of Outcome and Impact Indicators

In keeping with the Third One – moving toward one harmonized country-level M&E reporting system – outcome and impact indicators are aligned with international standards and measurement tools.

A variety of surveillance and survey activities are used to collect and measure national outcome and impact indicators including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. Many PEPFAR country teams collected baseline data as well as multiple data points during the first five years of PEPFAR. Country teams should continue to plan for surveillance and/or survey activities to collect and analyze baseline and multiple data points for each of their selected outcome and impact

indicators before the end of the next phase of PEPFAR (September 2013). Routine surveillance information should be collected yearly or every other year. For countries with generalized epidemics, it is recommended that national population surveys be conducted every 3-5 years. Countries with concentrated epidemics should plan for Behavioral Surveillance surveys targeted to high-risk groups.



Indicator Summary Tables

TABLE 1: PEPFAR ESSENTIAL/REPORTED INDICATORS

Essential/Reported Indicators			
Prevention			
Prevention Sub Area 1: PMTCT			
P1.1.D	PEPFAR Output	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	
P1.2.D	PEPFAR Output	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	
			By Regimen Type: Life-long ART (including Option B+); Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery); Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery); Single-dose nevirapine (with or without tail)
P1.1.N	National Outcome	Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	
P1.2.N	National Outcome	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission during pregnancy and delivery	
See “Clinical Care” for essential pediatric indicators			
Prevention Sub Area 4: Injection and Non-injection drug use			
P4.1.D	PEPFAR Output	Number of injecting drug users (IDUs) on opioid substitution therapy	
Prevention Sub Area 5: Male Circumcision			
P5.1.D	PEPFAR Output	Number of males circumcised as part of the minimum package of MC for HIV prevention services	

			by age: <1, 1-9, 10-14, 15-19, 20-24, 25-49, 50+
P5.2.D	PEPFAR Output	Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery, within the reporting period	
Prevention Sub Area 6: Post-Exposure Prophylaxis			
P6.1.D	PEPFAR Output	Number of persons provided with post-exposure prophylaxis (PEP)	
			By exposure type: Occupational, Rape/Sexual Assault Victims, or Other Non-Occupational
Prevention Sub Area 7: Prevention with People Living with HIV (PwP)			
P7.1.D	PEPFAR Output	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions	
Prevention Sub Area 8: Sexual and other Risk Prevention			
P8.1.D	PEPFAR Output	Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	
P8.2.D	PEPFAR Output		Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required
P8.3.D	PEPFAR Output	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	
			By MARP type: CSW, IDU, MSM, and Other Vulnerable Populations
Prevention Sub Area 11: Testing and Counseling			
P11.1.D	PEPFAR Output	Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results	
			By age and sex: <15 Male, 15+ Male, <15 Female, 15+ Female
			By test result: Positive, Negative
Prevention Sub Area 12: Gender-Based Violence			
P12.5.D	PEPFAR Output	Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (Gender Based Violence Initiative pilot indicator)	
P12.6.D	PEPFAR Output	Number of GBV service-encounters at a health facility (Gender Based Violence Initiative pilot indicator)	
P12.7.D	PEPFAR Output	Percentage of health facilities with Gender-Based Violence and Coercion (GBV) services available (Gender Based Violence Initiative pilot indicator)	
Care			
Care Sub Area 1: "Umbrella" Care Indicators			

C1.1.D	PEPFAR Output	Number of eligible adults and children provided with a minimum of one care service			
			By age and sex: <18 Male, 18 + Male, <18 Female, 18+ Female		
C1.1.N	National Output	Number of eligible adults and children provided with a minimum of one care service			
			By Age: <18, 18+		
Care Sub Area 2: Clinical Care					
C2.1.D	PEPFAR Output		Number of HIV-positive adults and children receiving a minimum of one clinical service		
				By age and sex: <15 Male, 15 + Male, <15 Female, 15+ Female	
C2.2.D	PEPFAR Output			Number of HIV-positive persons receiving cotrimoxazole prophylaxis	
C2.3.D	PEPFAR Output			Number and proportion of undernourished people living with HIV (PLHIV) who received therapeutic or supplementary food during the reporting period	
					By Age: <18, 18+
C2.4.D	PEPFAR Output			TB/HIV: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	
C2.5.D	PEPFAR Output			TB/HIV: Percentage of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	
OVC					
See section titled "CARE/Support Services" for OVC program indicators					
Care Sub Area 4: Clinical/Preventive Services – Additional Pediatric					
	PEPFAR Output		Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth		
				Infants who received virological testing in the first 2 months	
				Infants who were tested virologically for the first time between 2 and 12 months or who had an antibody test between 9 and 12 months	
Care Sub Area 5: Support Care					
C5.1.D	PEPFAR Output		Number of eligible clients who received food and/or other nutrition services		
				By Age: <18, 18+	
				Pregnant/lactating women	
Treatment					
Treatment Sub Area 1: ARV services					

T1.1.D	PEPFAR Output	Number of adults and children with advanced HIV infection newly enrolled on ART	
			By age and sex: <1, <15 Male, 15+ Male, <15 Female, 15+ Female
			Pregnant women
T1.2.D	PEPFAR Output	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	
			By age and sex: <1, <15 Male, 15+ Male, <15 Female, 15+ Female
T1.3.D	PEPFAR Outcome	Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	
T1.2.N	National Outcome	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	
			By Age: <15, 15+
			By Sex: Male and Female
Health System Strengthening			
Health System Strengthening Sub Area 1: Laboratory			
H1.1.D	PEPFAR Output	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	
H1.2.D	PEPFAR Output	Number of testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation	
Health System Strengthening Sub Area 2: Human Resources for Health			
H2.1.D	PEPFAR Output	Number of new health workers who graduated from a pre-service training institution	
			By Specific Types: Doctors, Nurses, Midwives
H2.2.D	PEPFAR Output	Number of community health and para-social workers who successfully completed a pre-service training program	
H2.3.D	PEPFAR Output	Number of health care workers who successfully completed an in-service training program	
			By Specific Types: Male Circumcision, Pediatric Treatment
H2.1.N	National Output	Number of new health workers who graduated from a pre-service training institution	
Health System Strengthening Sub Area 6: Health Systems Governance			
H6.1.D	PEPFAR Outcome	Monitoring policy reform and development of PEPFAR supported activities (Policy Tracking Table - Required for Partnership Framework Countries)	

			Human Resources for Health (HRH)
			Gender
			Orphans and other Vulnerable Children
			Counseling and Testing
			Access to high-quality, low-cost medications
			Stigma and Discrimination
			Strengthening a multi-sectoral response and linkages with other health and development programs
			Pain Management for PLWHA
*PEPFAR countries with Partnership Frameworks may have Headquarter reporting requirements associated with these policy areas. See Appendix 3 of guidance for more information on monitoring policy reform.			

TABLE 2: PEPFAR OUTPUT, OUTCOME, AND IMPACT INDICATORS

Indicator No.	Type	Data Source	Reporting Requirements*	Indicator	Reference
Prevention					
Prevention Sub Area 1: PMTCT					
P1.1.D	**PEPFAR Output**	**Routine Program**	1	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Numerator: UNAIDS additional #7; GF HIV-P10
			2	Known positives at entry; Number of new positives identified	
P1.2.D	**PEPFAR Output**	**Routine Program**	1	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	GARPR #3.1; UNGASS #5; GF HIV-P13
			1	By Regimen Type: • Life-long ART (including Option B+); - Newly initiated on treatment during the current pregnancy - Already on treatment at the beginning of the current pregnancy • Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery); • Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery); • Single-dose nevirapine (with or without tail)	
P1.3.D	**PEPFAR Output**	**Routine Program**	3	Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	PMTCT Guide Core # 2

P1.4.D	**PEPFAR Output**	**Routine Program**	**3**	Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing		PMTCT Guide Core # 4; GF HIV-P12
P1.5.D	**PEPFAR Output**	**Routine Program**	**3**	Number of HIV-positive pregnant women newly enrolled into HIV care and support services		PMTCT TWG
P1.6.D	**PEPFAR Output**	**Routine Program**	**3**	Percentage of Infants by feeding type		PMTCT Guide Core # 9
			3		By Type of feeding (Exclusive breastfeeding, exclusive formula feeding, mixed feeding)	
P1.1.N	**National Outcome**	**Routine Program**	**1**	Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)		UNAIDS additional #7; GF HIV-P10
			2		Known positives at entry; Number of new positives identified	
P1.2.N	**National Outcome**	**Routine Program**	**1**	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission during pregnancy and delivery		GARPR #3.1; UNGASS #5; GF HIV-P13
			2		By Regimen Type: • Life-long ART (including Option B+); - Newly initiated on treatment during the current pregnancy - Already on treatment at the beginning of the current pregnancy • Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery); • Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery); • Single-dose nevirapine (with or without tail)	
P1.7.N	**National Impact**	**Intermittent: Modeling, survey, special study**	**2**	Percentage of infants born to HIV-infected mothers who are infected		UNGASS #25, PMTCT Guide Core # 11
See "Clinical Care" for essential pediatric indicators						
Prevention Sub Area 2: Blood Safety						
P2.1.N	**National Outcome**	**Routine NBTS**	**2**	Percentage of donated blood units screened for HIV in a quality assured manner		UNGASS #3; GF HIV-P19
P2.2.N	**National Outcome**	**Routine NBTS**	**3**	Number of units of whole blood collected by the NBTS network and screened for transfusion-transmissible infections per 1,000 population per year		WHO

P2.3.N	**National Outcome**	**Routine NBTS**	**3**	Proportion of health facilities receiving at least 80% of the blood units used for transfusions from the National Blood Transfusion Service network	WHO
P2.4.N	**National Outcome**	**Routine NBTS**	**3**	Percent of blood units collected and screened by the NBTS network which are identified as reactive for HIV by an NBTS network laboratory	WHO
Prevention Sub Area 3: Injection Safety and Waste Disposal					
P3.1.N	**National Outcome**	**Intermittent: Survey (population or facility) or assessment**	**3**	Percentage of health facilities with no stock outs of new sterile syringes (standard or safety) in the prior 6 months	WHO/SIGN
P3.2.N	**National Outcome**		**3**	Percentage of health facilities with no stock outs of safety boxes in the prior 6 months	WHO/SIGN
P3.3.N	**National Outcome**		**3**	Percentage of health facilities with final disposal method for health care waste	WHO/SIGN
P3.4.N	**National Outcome**		**3**	Average number of medical injections per person per year	WHO/SIGN
P3.5.N	**National Outcome**		**3**	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package	WHO/SIGN
See Appendix for additional Injection Safety Indicators					
Prevention Sub Area 4: Injection and Non-injection drug use					
P4.1.D	**PEPFAR Output**	**Routine Program**	**1**	Number of injecting drug users (IDUs) on opioid substitution therapy	PEPFAR MARP Sexual Prevention TWG
P4.1.N	**National Outcome**	**Intermittent: Survey, special study**	**3**	Percentage of injecting drug users (IDUs) on opioid substitution therapy	GF HIV-P6; PEPFAR MARP Sexual Prevention TWG
Prevention Sub Area 5: Male Circumcision					
P5.1.D	**PEPFAR Output**	**Routine Program**	**1**	Number of males circumcised as part of the minimum package of MC for HIV prevention services	GF HIV-P9; WHO/UNAIDS Manual for Male Circumcision Under Local Anesthesia
			1	By age: <1, 1-9, 10-14, 15-19, 20-24, 25-49, 50+	
			3	By HIV status	
			3	By service delivery location	
P5.2.D	**PEPFAR Output**	**Routine Program**	**1**	Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery, within the reporting period	Draft WHO Guide C4.1

			2		by severity	
P5.3.D	PEPFAR Output	Routine Program	3	Number of locations providing MC surgery as part of the minimum package of MC for HIV prevention services within the reporting period		MC TWG
P5.4.D	PEPFAR Output	Routine Program	3	Number of males circumcised within the reporting period who return at least once for post-operative follow-up care (routine or emergent) within 14 days of surgery		MC TWG
P5.1.N	National Output	Routine Program	3	Number of male circumcisions performed according to national or international standards, within the reporting period		Draft WHO Guide P2
P5.5.N	National Outcome	Intermittent: pop survey, special study	3	Proportion of males circumcised in the intended population		Draft WHO Guide P1
Prevention Sub Area 6: Post-Exposure Prophylaxis						
P6.1.D	PEPFAR Output	Routine Program	1	Number of persons provided with post-exposure prophylaxis (PEP)		PEPFAR Gender and Injection Safety TWGs; GF HIV-P18
			1		By exposure type: Occupational, Rape/Sexual Assault Victims, or Other Non-Occupational	
P6.2.N	National Outcome	Intermittent: Facility survey, special study	2	Percentage of health facilities with HIV post-exposure prophylaxis (PEP) available		UNAIDS Additional #1; GF Prevention #HIV-P15
			2		By exposure type: Occupational and Non-Occupational	
Prevention Sub Area 7: Prevention with People Living with HIV (PwP)						
P7.1.D	PEPFAR Output	Routine Program	1	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions		PwP TWG
			3		By setting where reached: in a clinic/facility-based and in a community/home-based	
Prevention Sub Area 8: Sexual and other Behavioral Risk Prevention						
P8.1.D	PEPFAR Output	Routine Program	1	Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required		Prevention TWG
			3		By sex: Male and Female	
			3		By age: (10-14, 15+)	
P8.2.D	PEPFAR Output	Routine Program	1		Number of the targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	Prevention TWG

P8.3.D	PEPFAR Output	Routine Program	1	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required		Partially UNGASS #9, GF HIV-P4
			1		By MARP type: CSW, IDU, MSM, Other Vulnerable Populations	
			2		By sex: Male and Female	
P8.4.D	PEPFAR Output	Routine Program	3	Number of targeted condom service outlets		Prevention TWG
P8.5.D	PEPFAR Output	Routine Program	3	Number of individuals from target audience who participated in community-wide event		Partially GF prevention #HIV-P3
P8.6.D	PEPFAR Output	Intermittent: Survey, special study	3	Exposure: % of target population reached: # of people estimated to have been reached, by channel (radio or TV) divided by the estimated size of the target population *(In Development)*		PEPFAR, In Development
P8.7.D	PEPFAR Output		3	Exposure: % of population who recall hearing or seeing a specific message *(In Development)*		PEPFAR, In Development
P8.8.N	National Outcome		2	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		GARPR #1.1; UNGASS #13; GF HIV-C-P1
P8.9.N	National Outcome		2	Percent of never-married young people aged 15–24 who have never had sex		Additional UNAIDS #12; GF prevention #HIV-02
P8.10.N	National Outcome		2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.		UNGASS #15; GF HIV-O1; GARPR #1.2
P8.11.N	National Outcome		2	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months		GARPR #1.3; UNGASS #16; GF HIV-O2
P8.12.N	National Outcome		2	Percent of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom their last sexual intercourse.		GARPR #1.4; UNGASS #17; GF HIV-O3
P8.13.N	National Outcome		3	The percentage of women and men aged 15-49 with more than one ongoing sexual partnership at the point in time six months before the interview		UNAIDS Reference Group on Estimates, Modelling and Projections
P8.14.N	National Outcome		3	Percent of men and women aged 15-49, who have two or more concurrent partners within the past twelve months		UNAIDS Reference Group on Estimates, Modelling and Projections
P8.15.N	National Outcome		3	Cross-generational sex: Percentage of women respondents aged 15-19 who have had non-marital sex with a man 10 years or more older than themselves in the last 12 months, of all those who have had non-marital sex in the last 12 months		UNAIDS 2000 Young People #7

P8.16.N	National Outcome		3	Sexually active in past year: Percentage of young never married people (aged 15-24) who have had sex in the last 12 months	2000 UNAIDS Youth #2
P8.17.N	National Outcome		3	Percentage of youth who have ever had sexual intercourse	Prevention TWG
P8.18.N	National Outcome		3	Percentage of young people (aged 15-24) who used a condom the first time they ever had sex, of those who have ever had sex, disaggregated by age group (15-19, 20-24) and gender	2000 UNAIDS Youth #6
P8.19.N	National Outcome		2	Percentage of young women and men aged 15-24 who report they could get condoms on their own	UNAIDS additional #11
P8.20.N	National Outcome		3	Condom use at last premarital sex, last sex: Percentage of young never married people (aged 15-24) who used a condom at last sex, of all young single sexually active people surveyed	2000 UNAIDS Youth #3
P8.21.N	National Outcome		3	Percentage of adults who are in favour of young people being educated about the use of condoms in order to prevent HIV/AIDS	Youth Guidance Determinant #7
P8.22.N	National Outcome		2	STIGMA: Percentage of the general population with accepting attitudes toward PLHA (UNAIDS)	UNAIDS additional #14
P8.23.N	National Impact		2	Percentage of young women and men aged 15–24 who are HIV infected	UNGASS #22; GF HIV-I2; GARPR #1.6
Prevention Sub Area 9: Concentrated Epidemics					
P9.1.N	National Outcome	Intermittent: Survey, special study	2	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	UNGASS #14/UNAIDS MARPS Guide#3
P9.2.N	National Outcome		2	Percentage of female and male sex workers reporting the use of a condom with their most recent client	UNGASS #18/UNAIDS MARPS Guide#4; GF HIV-O4; GARPR #1.8; #1.12; #2.2
P9.3.N	National Outcome		2	Percent of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse	UNAIDS Additional #13
P9.4.N	National Outcome		2	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	UNGASS #19/UNAIDS MARPS Guide#5; GF HIV-O5
P9.5.N	National Outcome		2	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	UNGASS #20/UNAIDS MARPS Guide#6; GF HIV-O6
P9.6.N	National Outcome		3	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	UNGASS #21//UNAIDS MARPS Guide#7; GF HIV-O7; GARPR #2.3
P9.7.N	National Outcome		3	Percentage of male respondents aged 15-49 reporting sex with a sex worker	UNAIDS 2000 Sexual Behavior #3
P9.8.N	National Outcome		3	Percentage of female and male sex workers reporting the use of a condom with every client in the last month	Prevention TWG
P9.9.N	National Outcome		3	Percentage of men who have had anal sex with more than one male partner in the last 6 months of all men surveyed who have sex with a male partner	UNAIDS 2000 Sexual Behavior #6

P9.10.N	National Outcome		3	Percentage of most-at-risk populations (IDU, MSM, SW) who received an HIV test in the last 12 months and who know the results	UNAIDS MARPS Guide#2/UNGASS 2005; GF HIV C-P5; GF HIV C-P6; GF HIV C-P7; GARPR #1.9; #1.13; #2.4
P9.11.N	National Outcome		3	Percentage of IDU active in the last month who report sharing injecting equipment the last time they injected drugs	UNAIDS 2000 IDU Indicator #1
P9.12.N	National Outcome		3	Percentage IDU who sought treatment for STI, of those reporting symptoms	Prevention TWG
P9.13.N	National Outcome		3	Percentage of IDUs surveyed who used a condom the last time they had sex with a regular partner	UNAIDS 2000 Injecting drug #3
P9.14.N	National Outcome		3	Percentage of IDUs surveyed who used a condom the last time they had sex with a non-regular partner	UNAIDS 2000 Injecting drug #3
P9.15.N	National Outcome		3	Percentage of military personnel reporting more than one sexual partner in the past 12 months	Prevention TWG
P9.16.N	National Outcome		3	Percentage of military personnel who received HIV test in the past 12 months and know their results	Prevention TWG
P9.17.N	National Impact		2	Percentage of most-at-risk populations (IDU, MSM, SW) who are HIV-infected	UNGASS #23;Partially GF HIV-I3; GF HIV-I4, GF HIV-I5; GARPR #1.10; #1.14; #2.5
Prevention Sub Area 10: Work Place Programs					
P10.1.D	PEPFAR Output	Routine Program	3	Number of enterprises implementing an HIV/AIDS workplace program, providing at least one of the 4 critical components	Partially GF supportive environment #HIV-SE2
P10.2.D	PEPFAR Output	Routine Program	3	Estimated number of people reached through work place programs	PEPFAR
			3	By sex: Male and Female	
P10.3.N	National Outcome	Intermittent: Survey, special study	3	Percent of large enterprises/companies that have HIV/AIDS workplace policies and programs	Partially GF supportive environment #HIV-SE2
Prevention Sub Area 11: Testing and Counseling					
P11.1.D	PEPFAR Output	Routine Program	1	Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results	Partially UNGASS #7 and GF HIV-P7
			1	By age and sex: <15 Male, 15+ Male, <15 Female, 15+ Female	
			1	By test result: Positive, Negative	
			3	By type of counseling/test: Individual, Couple	
			3	In concentrated epidemics by MARP type (CSW, IDU, MSM)	
P11.2.N	National Outcome	Intermittent: Program, survey, special study	2	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	UNGASS #7

P11.3.N	**National Outcome**		**3**	Percentage of health facilities that provide HIV testing and counseling services		WHO, UNICEF, UNAIDS (Ind #2.3)
P11.4.N	**National Outcome**		**3**	Percentage of districts that provide HIV Testing and Counseling services		WHO, UNICEF, UNAIDS (Ind #2.4)
P11.5.N	**National Outcome**		**3**	Percentage of HIV Testing and Counseling sites with Quality Assurance (QA) systems for HIV counseling service delivery (non-test elements).		WHO, UNICEF, UNAIDS (Ind #3.2)
P11.6.N	**National Outcome**		**3**	Percentage of the patient population aged 15 and older who received HIV T&C and received their results through provider-initiated services in the past 12 months		WHO, UNICEF, UNAIDS (Ind #5.1)
P11.7.N	**National Outcome**		**3**	Population of people with a sexually transmitted infection (STI) aged 15 and older who received HIV T&C and received their results through provider-initiated services in the past 12 months		WHO, UNICEF, UNAIDS (Ind #5.3)
P11.8.N	**National Outcome**		**3**	Percentage of HIV positive individuals who know their status		WHO, UNICEF, UNAIDS (Ind #7.2)
Prevention Sub Area 12: Gender						
P12.1.D	**PEPFAR Output**	**Routine Program**	**3**	Male Norms and Behaviors: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS		PEPFAR Gender TWG
			3		By sex: Male and Female	
			3		By Age (0-15, 15-24, 25+)	
P12.2.D	**PEPFAR Output**	**Routine Program**	**3**	Gender Based Violence and Coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence		PEPFAR Gender TWG
			3		By sex: Male and Female	
			3		By Age (0-15, 15-24, 25+)	
P12.3.D	**PEPFAR Output**	**Routine Program**	**3**	Women's Legal Rights and Protection: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS		PEPFAR Gender TWG
			3		By sex: Male and Female	
			3		By Age (0-15, 15-24, 25+)	
P12.4.D	**PEPFAR Output**	**Routine Program**	**3**	Number of people reached by an individual, small group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS		PEPFAR Gender TWG
			3		By sex: Male and Female	
			3		By age (0-15, 15-24, 25+)	

Care

Care Sub Area 1: "Umbrella" Care Indicators

C1.1.D	PEPFAR Output	Routine Program	1	Number of eligible adults and children provided with a minimum of one care service			Partially GF HIV-CS3
			1		By sex and age: <18 Male, 18 + Male, <18 Female, 18+ Female		
C1.1.N	National Output	Routine Program	1	Number of eligible adults and children provided with a minimum of one care service			Partially GF care & support #HIV-CS2
			1		By age: <18, 18+		

Care Sub Area 2: Clinical Care

C2.1.D	PEPFAR Output	Routine Program	1		Number of HIV-positive adults and children receiving a minimum of one clinical service		Care and Support TWG
			1			By sex and age: <15 Male, 15+ Male, <15 Female, 15+ Female	
C2.2.D	PEPFAR Output	Routine Program	1			Number of HIV-positive persons receiving cotrimoxazole prophylaxis	GF HIV-CS1
			2			By Age: <15, 15 +	
C2.3.D	PEPFAR Output	Routine Program				Number and proportion of undernourished people living with HIV (PLHIV) who received therapeutic or supplementary food during the reporting period	Harmonized Nutrition and HIV indicator; Global HIV/AIDS Indicator Registry; GF HIV-CS2
			1			By Age: <18, 18+	
			3			By sex, age < 24 months, 24-59 months, 5-14 years, 15+, and pregnancy status/postpartum status	
C2.4.D	PEPFAR Output	Routine Program	1			TB/HIV: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	Partially GF TB/HIV-1
C2.5.D	PEPFAR Output	Routine Program	1			TB/HIV: Percentage of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	Partially UNGASS #6; Partially GF TB/HIV-2; Partially GARPR #5.1
C2.6.D	PEPFAR Output	Routine Program	3			TB/HIV: Number of eligible HIV positive patients starting Isoniazid Preventive Therapy (IPT)	Partially GF TB/HIV-4
C2.7.N	National Outcome	Routine Program	3	Percentage of ART sites that have pain management programs			Care and Support TWG
C2.8.N	National Outcome	Intermittent: Facility survey, special study	3	Percentage of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART			WHO/UNAIDS Care & Support Guide (2004) Indicator CS7
C2.9.N	National Outcome		3	Percentage of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management			WHO/UNAIDS Care & Support Guide (2004) Indicator CS6
C2.2.N	National Outcome		3	Percentage of HIV-positive patients who are given cotrimoxazole preventive therapy			GF,care & support #HIV-CS1

C2.10.N	**National Impact**	**Periodic special studies: Cohort study (MOS-HIV scale, SF 12, which includes both physical and mental domains)**	**3**	Quality of life for People Living with HIV/AIDS (PLHIV)	Care and Support M&E Working Group/ World Bank
C2.11.N	**National Outcome**	**Routine Program**	**3**	The number and proportion of PLHIV in care and treatment who were nutritionally assessed during the reporting period	Harmonized Nutrition and HIV indicator; Global HIV/AIDS Indicator Registry
C2.12.N	**National Outcome**	**Routine Program**	**3**	The number and proportion of PLHIV in care and treatment who were identified as undernourished at any point during the reporting period	Harmonized Nutrition and HIV indicator; Global HIV/AIDS Indicator Registry
C2.13.N	**National Outcome**	**Routine Program**	**3**	The number and proportion of PLHIV in care and treatment who were nutritionally assessed with anthropometric measurement who also received nutrition counseling at any point during the reporting period	Harmonized Nutrition and HIV indicator; Global HIV/AIDS Indicator Registry
Care Sub Area 3: Clinical/Preventive Services - Additional TB/HIV					
C3.1.D	**PEPFAR Output**	**Routine Program**	**3**	Number of TB patients who had an HIV test result recorded in the TB register	UNAIDS Additional #6; GF TB/HIV-3
C3.1.N	**National Outcome**	**National TB Registry**	**2**	Percentage of TB patients who had an HIV test result recorded in the TB register	UNAIDS Additional #6; GF TB/HIV-3
C3.2.N	**National Outcome**	**Intermittent: Program, survey, special study**	**2**	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	UNGASS #6
C3.3.N	**National Outcome**		**3**	Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	Partially GF C-TB/HIV
See section titled "Clinical Services" for additional TB/HIV program indicators					
Care Sub Area 4: Clinical/Preventive Services - Additional Pediatric					
C4.1.D	**PEPFAR Output**	**Routine Program**	**1**	Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth	UNAIDS additional #8; GF HIV-P15; Partial GARPR #3.2
			1	Infants who received virological testing in the first 2 months	
			1	Infants who were tested virologically for the first time between 2 and 12 months or who had an antibody test between 9 and 12 months	
C4.2.D	**PEPFAR Outcome**	**Routine Program; special study**	**2**	Percentage of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	UNAIDS additional #9; GF prevention #HIV-P14
C4.2.N	**National Outcome**	**Intermittent: Facility survey, special study**	**2**	Percentage of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	UNAIDS additional #9; GF prevention #HIV-P15
C4.3.N	**National Outcome**		**3**	Percentage of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood Spots (DBS)	PMTCT Guide Additional #2

OVC

See section titled "CARE/Support Services" for OVC program indicators

Care Sub Area 5: Support Care

C5.1.D	PEPFAR Output	Routine Program	1		Number of eligible clients who received food and/or other nutrition services		PEPFAR Food and Nutrition Technical Guidance
			1			By Age: <18, 18+	
			1			Pregnant/lactating women	
C5.2.D	PEPFAR Output	Routine Program	3		Number of eligible children provided with shelter and care-giving		OVC TWG
C5.3.D	PEPFAR Output	Routine Program	3		Number of eligible children provided with health care referral		OVC TWG
C5.4.D	PEPFAR Output	Routine Program	3		Number of eligible children provided with Education and/or vocational training		OVC TWG
C5.5.D	PEPFAR Output	Routine Program	3		Number of eligible adults and children provided with Protection and Legal Aid services		OVC TWG
			3			By Age: <18, 18 +	
C5.6.D	PEPFAR Output	Routine Program	3		Number of eligible adults and children provided with psychological, social, or spiritual support		OVC TWG
			3			By Age: <18, 18 +	
C5.7.D	PEPFAR Output	Routine Program	3		Number of eligible adults and children provided with Economic Strengthening services		OVC TWG
			3			By Age: <18, 18 +	
C5.8.N	National Outcome	Intermittent: survey, special study	3	Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child			UNGASS #10
C5.9.N	National Impact		3	Quality of life for OVC			World Bank

Treatment

Treatment Sub Area 1: ARV services

T1.1.D	PEPFAR Output	Routine Program	1	Number of adults and children with advanced HIV infection newly enrolled on ART			ART TWG
			1		By age and sex: <1, <15 Male, 15+ Male, <15 Female, 15+ Female		
			1		Pregnant women		
T1.2.D	PEPFAR Output	Routine Program	1	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]			UNGASS #4; GF HIV-T1; GARPR #4.1

			1		By age and sex: <1, <15 Male, 15+ Male, <15 Female, 15+ Female	
T1.3.D	PEPFAR Outcome	Routine Program	1	Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy		UNGASS #24; GF HIV-I6; GARPR #4.2
			1		By age: <15, 15+	
			3		By age and sex: <15 Male, 15+ Male, <15 Female, 15+ Female	
T1.4.D	PEPFAR Output	Routine Program	3	Number of adults and children with advanced HIV-infection who ever started on ART		ART TWG
			3		By sex: Male and Female	
			3		By age: <15 and 15+	
T1.5.D	PEPFAR Output	Routine Program	3	Number of health facilities that offer ART		UNAIDS Additional #2
			3		by type of site: Public, Private, NGO	
T1.2.N	National Outcome	Routine Program	1	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy		UNGASS#4; GF HIV-T1
			1	By age: <15, 15+		
			3	By age: <1		
			1	By sex: Male and Female		
T1.5.N	National Outcome	Intermittent: Facility survey, special study	2	Percentage of health facilities that offer ART		UNAIDS Additional #2; GF Treatment #HIV-T2
T1.6.N	National Outcome		2	Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral		UNAIDS Additional #4

Health System Strengthening

Health System Strengthening Sub Area 1: Laboratory

H1.1.D	PEPFAR Output	Routine Program	1	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	Draft WHO Guidelines
H1.2.D	PEPFAR Output	Routine Program	1	Number of testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation	Draft WHO Guidelines
H1.3.N	National Outcome	Intermittent: Program, survey, special study	3	Percentage of laboratories with satisfactory performance in external quality assurance/proficiency testing (EQA/PT) program for CD4 (patient monitoring)	PEPFAR Lab TWG

H1.4.N	National Outcome		3	Percentage of HIV rapid test facilities with satisfactory performance in external quality assurance/proficiency testing (EQA/PT) program for HIV rapid test (HIV diagnostics)	PEPFAR Lab TWG
H1.5.N	National Outcome		3	Percentage of laboratories with satisfactory performance in external quality assurance/proficiency testing (EQA/PT) program for AFB smear microscopy (TB Diagnostics)	PEPFAR Lab TWG
H1.6.N	National Outcome		3	Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines	WHO/UNAIDS Care & Support Guide (2004) Indicator CS8
Health System Strengthening Sub Area 2: Human Resources for Health					
H2.1.D	PEPFAR Output	Program records, Educ institutions, Prof assoc., MoHealth, MoEducations, HRIS	1	Number of new health workers who graduated from a pre-service training institution	Partially WHO and GF
			1	By Specific Types: Doctors, Nurses, Midwives	
			2	By Specific Types: Other cadres	
			2	By Specific Types: Clinical/Non-clinical	
H2.2.D	PEPFAR Output		1	Number of community health and para-social workers who successfully completed a pre-service training program	Partially WHO
H2.3.D	PEPFAR Output		1	Number of health care workers who successfully completed an in-service training program	PEPFAR HRH TWG
			1	By Specific Types: Male Circumcision, Pediatric Treatment	
H2.1.N	National Output	Educ institutions, Prof assoc., MoHealth, MoEducations, HRIS	1	Number of new health workers who graduated from a pre-service training institution	Partially WHO and GF
H2.4.N	National Output		3	Ratio of health workers to 10,000 population	WHO
Health System Strengthening Sub Area 3: Health Systems Financing					
H3.1.N	National Outcome	Intermittent: NASA, NHA	2	Domestic and international AIDS Spending by categories of financial sources (NASA or NHA)	(NASA) UNGASS #1; GAPR #6.1
H3.2.N	National Outcome	Intermittent: NHA	3	Total health expenditures per capita	WHO
Health System Strengthening Sub Area 4: Service Delivery					
H4.1.N	National Impact	National mortality statistics, Sample Vital Registration with Verbal Autopsy (SAVVY)/DSS	3	Proportion of all deaths attributable to HIV	PEPFAR Surveillance TWG
See program indicators under Care and Treatment					

Health System Strengthening Sub Area 5: Medical Products, etc					
H5.1.N	National Output	SCMS / AMD	3	Ratio between the median price paid by the country for each ARV in the last 12 months to the median international price	Partially WHO
H5.2.N	National Outcome	SCMS, National pharma records	3	Proportion of generic to branded drugs procured	PEPFAR HSS TWG
H5.3.N	National Outcome	Intermittent: SCMS, Facility survey, special study	2	Percentage of health facilities providing ART that experienced stock-outs of ARV in the last 12 months	UNAIDS Additional #3; GF HIV-T2
See additional indicators under Prevention in sub areas 2 (blood Safety) and 3 (Injection Safety and Waste Disposal)					
Health System Strengthening Sub Area 6: Health Systems Governance					
H6.1.D	PEPFAR Outcome	Program Records National Policy Review; NCPI	2	Monitoring policy reform and development of PEPFAR supported activities (Policy Tracking Table - Required for Partnership Framework Countries)	PEPFAR Partnership Framework
			2*	Human Resources for Health (HRH)	
			2*	Gender	
			2*	Orphans and other Vulnerable Children	
			2*	Counseling and Testing	
			2*	Access to high-quality, low-cost medications	
			2*	Stigma and Discrimination	
			2*	Strengthening a multi-sectoral response and linkages with other health and development programs	
			3	Pain Management for People Living with HIV/AIDS	
			3	Post Exposure Prophylaxis	
			3	Laboratory Accreditation	
			3	Injection safety and waste management	
			3	Other policy areas identified by country team	
H6.2.N	National Outcome	National Policy Review; NCPI	2	Monitoring policy reform and development of PEPFAR supported activities (Policy Tracking Table - Required for Partnership Framework Countries)	PEPFAR Partnership Framework
H6.3.N	National Outcome	Intermittent: NCPI	2	National Composite Policy Index (NCPI)	UNGASS #2; GARPR #7.1
H6.4.N	National Outcome	Intermittent: NCPI	3	Existence of national costed HIV implementation plan	Partially WHO
H6.5.N	National Outcome	WB: Worldwide Governance Indicators; NCPI	3	Existence of effective civil society organizations	Partially WHO

*PEPFAR countries with Partnership Frameworks may have Headquarter reporting requirements associated with these policy areas. See Appendix 4 of guidance for more information on monitoring policy reform.

Health System Strengthening Sub Area 7: Health Information Systems

H7.1.N	**National Outcome**	**National System Review**	**2**	National Human Resource Information System in place with key elements	HRH TWG
H7.2.N	**National Outcome**	**NCPI**	**3**	Existence of one agreed upon M&E plan for overall national monitoring and evaluation	UNAIDS
H7.3.N	**National Outcome**	**National Health Sector Reports; NAC Reports**	**3**	Percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	WHO/UNAIDS Care & Support Guide (2004) Indicator CS-A2
H7.4.N	**National Outcome**	**SCMS, National pharma records**	**3**	Percentage of ARV distribution nodes that report on inventory consumption, quality, losses, and adjustments on a monthly basis	WHO 3x5
H7.5.N	**National Outcome**	**National Health Sector Reports; NAC Reports**	**3**	Existence of a national and sub-national databases that enable stakeholders to access relevant data for policy formulation and program management and improvement	WHO
H7.6.N	**National Outcome**		**3**	Existence of a designated and functioning institutional mechanism charged with analysis of health statistics, synthesis of data from different sources and validation of data from population and facility sources	Partially WHO
H7.7.N	**National Outcome**		**3**	Availability of HIV prevalence data for relevant surveillance populations published within 12 months of preceding year	Partially WHO and GF
H7.8.N	**National Outcome**		**3**	Existence of a nationally coordinated multi-year disease Monitoring and Evaluation plan with a schedule for survey implementation and data analysis prepared and implemented	WHO
H7.9.N	**National Outcome**	**National Mortality Registration; Mortality Surveillance**	**3**	Availability of maternal mortality data	WHO
H7.10.N	**National Outcome**	**National Mortality Registration; Mortality Surveillance**	**3**	Availability of child mortality data	WHO

**See further definition of terms (Essential and Recommended) in the Next Generation Indicator Reference Guide

1	Essential Indicators with HQ reporting requirements
2	Essential Indicators without HQ reporting requirements
3	Recommended Indicators

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DIRECT

PEPFAR Program

Essential Indicators

PREVENTION
Prevention of Mother to Child Transmission (PMTCT)

Indicator #P1.1.D Essential/Reported	**Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of pregnant women who were tested for HIV and know their results.
Denominator: Recommended	Number of new ANC and L&D clients
Disaggregation: Essential/Not reported	By: Known positives at entry Number of new positives identified
Purpose:	This indicator reflects one goal of PMTCT, which is to increase the number of pregnant women who know their HIV status. Identification of a pregnant woman's HIV status is the key entry point into PMTCT services and other HIV care and treatment services. These data will be important to PEPFAR Headquarters, TWGs and USG country-level managers in order to: • Identify progress toward the USG goal to reach 80% of pregnant women with HIV testing and counseling • Determine PEPFAR and PEPFAR-funded partners' performance in providing HIV testing to pregnant women • Identify countries/ partners needing assistance with program implementation
Applicability:	All countries with PEPFAR funded partners supporting PMTCT direct service delivery
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Facility registers and other program monitoring tools
Method of Measurement	The numerator is a composite of the following two data components: The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period The number of women attending ANC, L&D who were tested for HIV and received results (***These should also be counted in indicator #P11.1.D***) The numerator can be summed from categories a-d below: a) Number of pregnant women who received an HIV test and result during ANC b) Number of pregnant women attending L&D with unknown HIV status who were tested in the L&D and received results c) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results d) Pregnant women with known HIV infection attending ANC for a new pregnancy. <u>Explanation of Numerator:</u> The numerator is calculated using national and/or PEPFAR program records aggregated from facility registers in the ANC and L&D. In countries with high L&D

	attendance rates (>90%), data can be collected from L&D registers only. Health facility registers should reflect known HIV infection among HIV-positive pregnant women coming to the ANC for a new pregnancy, such as through a code, circle, or other method, in order for them to receive subsequent PMTCT interventions. *Pregnant women with unknown status*: women who were not tested during ANC or at L&D for this pregnancy or did not have documented proof of having been tested during ANC or at L&D for this pregnancy. *Pregnant women with known HIV-infection*: women who were tested and confirmed HIV-positive at any point prior to the current pregnancy, who are attending ANC for a new pregnancy. Pregnant women with known HIV infection attending ANC for a new pregnancy do not need retesting if that is in line with the national guidelines on testing pregnant women and/or, as long as they bring documented proof of their positive status with them. However, these women do need subsequent PMTCT services, and so should be counted in the numerator. In this case, documented proof may include (but is not limited to), a health card with HIV status noted in it, test results from another testing center, or any other document that denotes that the bearer of the document is HIV positive. <u>PEPFAR denominator:</u> The total number of new clients attending ANC and L&D services at USG-supported sites should be used as the denominator. This total will include the number of new clients who attend PMTCT services at USG-supported ANC sites and the number of women who present at L&D sites supported by USG with unknown status (as a proxy for those who have not attended ANC with PMTCT services). USG country team is to identify the best source of data for unduplicated individuals. If the country has high facility delivery rates (>90%), the L&D data may be used as the denominator, otherwise ANC data should be used. Note: This indicator is meant to measure the number of pregnant women who know their HIV status and is not meant to provide programmatic guidance around the types of services that should accompany HIV testing (i.e. counseling). All HIV testing programs should be adhere to national or international standards.
Interpretation:	This indicator enables the USG PEPFAR team to monitor trends in HIV testing among pregnant women and uptake of testing at USG-funded sites. The points at which drop-outs occur during the testing and counseling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counseling. It also does not capture the number of women who received pre- or post- test counseling. There is a risk of double counting with this indicator, as a pregnant woman could be tested multiple times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, countries should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place.
Additional Information:	- #7, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on

	HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Partially harmonized with Prevention indicator (HIV-P10), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Fourth Edition, November 2011 http://www.theglobalfund.org/documents/monitoring_evaluation/ME_Part2HIV_Toolkit_en/ - Global Monitoring Framework and Strategy for the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (EMTCT). http://apps.who.int/iris/bitstream/10665/75341/1/9789241504270_eng.pdf

Prevention

Prevention of Mother to Child Transmission (PMTCT)

Indicator #P1.2.D Essential/reported	**Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery**
Type of Indicator:	Direct
Numerator: Essential/reported	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission
Denominator: Essential/ reported	Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)
Disaggregation: Essential/ reported	By regimen type (mutually exclusive choices): 1. Life-long ART (including Option B+) disaggregated by a. newly initiated on treatment during the current pregnancy b. already on treatment at the beginning of the current pregnancy 2. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery) 3. Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery) 4. Single-dose nevirapine (with or without tail)
Purpose:	This indicator measures the provision and coverage of antiretroviral prophylaxis and treatment, by regimen type, for HIV-positive pregnant women in order to: • Identify progress toward the USG and global goals of increasing ARV coverage (prophylaxis and treatment) among pregnant women living with HIV • Assess progress toward implementing more efficacious PMTCT ARV regimens • Determine the coverage of HIV+ pregnant women on ARV prophylaxis and ART for life among all HIV+ pregnant women identified • Provide data for models estimating the country-specific and global impact of USG-supported PMTCT programs
Applicability:	All countries with PEPFAR funded partners supporting PMTCT direct service delivery
Data collection frequency:	Data for this indicator should be collected continuously at the facility level in accordance with national guidance. USG country teams may request periodic aggregation for the purposes of program management and review. At minimum, the PEPFAR country team must aggregate data in time for PEPFAR reporting cycles.
Measurement tool:	Facility registers and other program monitoring tools
Method of measurement:	Explanation of Numerator: The number of HIV-positive pregnant women who received antiretrovirals for prophylaxis or treatment during pregnancy or during labor and delivery (L&D), deduplicated. Disaggregation of regimen definitions

Categories	Further clarification	Common examples
1) Life-long antiretroviral therapy (including	A three-drug regimen intended to provide ART for life	Standard national treatment regimen, for example:

	Option B+) disaggregated by 1a) newly initiated on treatment during the current pregnancy 1b) already on treatment at beginning of pregnancy	1a) # of HIV-positive pregnant women identified in the reporting period newly initiated on ART for life 1b) # of HIV-positive pregnant women identified in the reporting period who were already on ART at their first ANC visit. If a woman is initiating ART for life (including Option B+) at L&D then she should be counted in category 1a.	• TDF+3TC+EFV • AZT+3TC+NVP
	2) Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	A three-drug regimen provided for MTCT prophylaxis started antenatally or as late as during L&D with the intention of stopping at the end of the breastfeeding period (or stopping at delivery if not breastfeeding) If a woman is receiving ARVs for the first time at L&D then she should still be counted in this category if the facility is implementing Option B.	• TDF+3TC+EFV • AZT+3TC+EFV • AZT+3TC+LPV/r
	3) Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	A prophylactic regimen that uses AZT (or another NRTI) started as early as 14 weeks or as late as during L&D to prevent HIV transmission If a woman is receiving ARVs for the first time at L&D, then she should still be counted in this category if the facility is implementing Option A.	• AZT at any point before L&D + intrapartum NVP • AZT at any point before L&D + intrapartum NVP +7 day post-partum tail of AZT/3TC • Intrapartum NVP +/- 7 day post-partum tail + extended NVP for infant
	4) Single-dose nevirapine (with or without a tail)	Count SD-NVP if: • It is the **ONLY** option provided to an HIV-positive pregnant woman either antenatally or during L&D (this includes use of a tail*) Do NOT count SD-NVP if: • NVP is provided as part of Option A antenatally or • An HIV+ pregnant woman is initiated on Option A, B, or B+	• SD-NVP for mother ONLY at onset of labor • SD-NVP + 7 day AZT/3TC tail ONLY • SD-NVP for mother at onset of labor and SD NVP for baby ONLY

	at labor and delivery *The tail is used to prevent NVP resistance. It does not alter risk of transmission and therefore does not constitute a different regimen.	

The following should be considered in reporting:

- A woman should only be counted in a regimen category if she actually received the regimen. Referral alone for ARVs or ART should not be counted unless regimen initiation is confirmed.
- Each ARV regimen category is mutually exclusive. Each pregnant woman should only be counted once. If a pregnant women receives different ARV regimens at different points during the pregnancy, count only the most recent regimen provided to her in the reporting period.
- Because ARVs for prophylaxis or treatment can be provided to HIV-positive women at different sites including ANC, L&D and care & treatment, Ssteps should be taken to deduplicate patients counted at multiple sites. For example:
    - A woman, who is already on treatment, becomes pregnant and enrolls in ANC/PMTCT because she is HIV-positive. While she may not be receiving drugs at the ANC/PMTCT site, she should be counted within the life-long ART disaggregation for this indicator.
    - A woman receives AZT prophylaxis at her first ANC visit. After receiving her CD4 results, she is moved to a life-long ART regimen. In this case she should be counted and reported only once under life-long ART
    - In settings with high facility delivery rates (>90%), countries may consider aggregating the numerator entirely from the L&D register by counting the number of HIV-positive pregnant women who received a specific ARV regimen by the time of delivery. This method likely minimizes double-counting.
- The number of HIV-positive pregnant women receiving ART (disaggregation of P1.2.D) and the number individuals newly initiated on ART who are pregnant (disaggregation of T1.1.D) likely have large overlaps, but in many countries are not the same groups of women. The indicator narrative should clearly explain the source of the data for P1.2.D ART disaggregation and how it relates to what is reported in T1.1.D.

<u>Explanation of the denominator:</u> Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry)

This denominator includes a sum of categories a-d below, at USG-supported sites:

a) number of pregnant women who were tested and received an HIV+ result at ANC
b) pregnant women *known* to be HIV-positive attending ANC for a new pregnancy
c) pregnant women tested during L&D and received a new HIV+ result
d) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested for HIV and received their result

Interpretation:	It is recognized that due to the way in which data is collected and reported in

	many countries, some level of duplication may be inevitable. Additionally, there may be over or undercounting of certain regimens based on data collection methodologies.
Additional Information:	- Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive Monitoring Framework http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-elimination-HIv-Children_en.pdf - Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/manual/2009/jc1676_core_indicators_2009_en.pdf - Core Indicators for National AIDS Programmes. Guidance and Specifications for Additional Recommended Indicators. April 2008 http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/JC1768-Additional_indicators_v2_en.pdf - The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit 4th Edition. November 2011 http://www.theglobalfund.org/en/me/documents/toolkit/Global AIDS Progress Reporting 2013: Construction of Core indicators for monitoring the 2011 UN Political Declaration on HIV/AIDShttp://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

Prevention

Injection and Non-injection Drug Use

Indicator #P4.1.D Essential/Reported	**Number of injecting drug users (IDUs) on opioid substitution therapy**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of injecting drug users (IDUs) on opioid substitution therapy
Denominator: Recommended	Total estimated number of IDUs *Recommended at partner level only
Disaggregation:	N/A
Purpose:	Medication-assisted treatment programs have been demonstrated to be an effective HIV prevention strategy. Substance abuse treatment reduces the frequency of drug use which in turn reduces HIV risk behaviors (Metzger, 1993, Gowing, 2008, and IOM, 2006). It also improves adherence to disease treatment regimens (Gowing, 2008 and IOM, 2006). Treatment modalities include non-pharmacological and pharmacological approaches; often, a combination of the two is used (National Institute on Drug Abuse, 1999b). An extensive body of evidence shows that medication assisted therapy (MAT) reduces the frequency of heroin injection and improves substance abuse treatment retention (Gowing, et al, 2008). Methadone maintenance therapy (MMT) is associated with reduced HIV risk behaviors including reduced frequency of injecting and sharing of injection equipment, reductions in the number of sex partners, and exchanges of sex for drugs or money (Gowing, et al, 2008) Medication assisted therapy program should be an access point for IDUs and the program should refer and link to ARV treatment programs, PMTCT for female IDUs and a range of other prevention services. It is important to know how many people are reached in order to monitor how well programs are reaching IDUs with medication-assisted treatment. This information can be used to plan and make decisions on how well an IDU audience is being reached with medication-assisted treatment. If a small percentage of the intended audience is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who implement medication-assisted IDU treatment programs.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	Explanation of Numerator: The numerator is generated by counting the total number of individuals who

	have been on treatment for at least 3 months since initiation of opioid substitution therapy or medication-assisted treatment (e.g. using methadone or buprenorphine to treat drug dependency in order to reduce frequency of injections and potentially reduce other behavioral risk factors) at any point in time within the reporting period. The numerator should equal the number of adults who initiated and remain on opioid substitution therapy or medication-assisted treatment for at least 3 months prior to the end of the reporting period. Adults who initiated or transferred in during the reporting period should be counted only if they have been on treatment for at least 3 months after initiation prior to the end of the reporting period. Count all individuals who complete at least 3 months of treatment even if they drop-out, die, or are otherwise lost to follow-up. Do not count individuals who initiate treatment too late in the reporting period to be able to reach a minimum of 3 months. These individuals will be counted in the next reporting period assuming they complete at least 3 months of treatment. *For example: If an adult initiates his/her treatment in the last few months of reporting period, however, s/he does not complete at least 3 months in treatment before the end of the reporting period, then count this individual in the next reporting period*. It is highly recommended that PEPFAR Teams have systems in place to monitor individuals who have been on opioid substitution therapy or medication-assisted treatment for different time intervals: for at least 3 months, for at least 6 months, for at least 12 months, etc. Partners providing referrals only should not use this indicator. See MARP Indicator #P8.3.D for possible alternative. <u>Explanation of Denominator (recommended at partner level):</u> Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. IDU estimates for subdistricts/districts/regions can be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of IDUs that received medication-assisted therapy. These interventions are based on evidence. The information collected will allow the country and the PEPFAR to assess any changes in risk behaviors as a result of the implemented interventions. The information will also help the country to understand the efficacy and effectiveness of evidence-based interventions and help in further expansion of similar interventions.
Additional Information	- Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries - http://www.aidsmap.com/en/news/93E2DEB4-9AC2-4DFC-A236-4F910CA7016A.asp

Prevention
Male Circumcision

Indicator: **P5.1D** Essential/Reported	**Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period**
Type of Indicator:	Direct
Numerator:	Number of males provided with voluntary medical circumcisision. Services are provided as part of a minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia.*[1] This number is comprised of those circumcised within the reporting period and disaggregated by age (required), HIV status (recommended), and service delivery location setting (recommended).
Denominator:	N/A
Disaggregation:	

Required for HQ reporting and aggregation to program summary level	<1
Required for HQ reporting and aggregation to program summary level	1-9
Required for HQ reporting and aggregation to program summary level	10-14
Required for HQ reporting and aggregation to program summary level	15-19
Required for HQ reporting and aggregation to program summary level	20-24
Required for HQ reporting and aggregation to program summary level	25-49
Required for HQ reporting and aggregation to program summary level	50+

Recommended for in country partner level tracking
HIV positive by test(s) on site
HIV negative by test(s) on site
HIV indeterminate result by test(s) on site
Documented HIV positive result from other HTC provider
Documented HIV negative result from other HTC provider
Unknown HIV status/refused HIV test
Self-reported HIV negative and declined re-test (HIV status not verifiable)
Self-reported HIV positive and declined re-test (HIV status not verifiable)

Recommended for in country partner level tracking
Fixed/permanent location
Temporary (including mobile) location

Purpose:	Three randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls).[2,3,4] This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-positive

	female sexual partners, and may be particularly beneficial in populations where HIV prevalence is high and male circumcision prevalence is low. **For maximal population impact, uptake of male circumcision should be as high and as rapid as safely possible and aligned with national policy**. The total number of males circumcised indicates a change in the supply of and/or demand for VMMC services. Additionally, disaggregated information may be useful to evaluate whether prioritized services have been successful at reaching the intended population (by age), set targets have been achieved, and modeling inputs should be adjusted.
Applicability:	All countries with PEPFAR-funded partners providing VMMC for HIV prevention services as part of the WHO-defined minimum package of services should report on this indicator.
Data collection frequency:	Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and review.
Measurement tool:	VMMC Registry or client medical records maintained by each program/site
Method of measurement:	The sum of clients documented as having received VMMC within the reporting period in VMMC Registries or clients' medical records maintained by programs. Explanation: Males who are provided with circumcision as part of the VMMC for HIV prevention program and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] and per national standards by funded programs/sites in the reporting period meet the definition for the numerator. PEPFAR does not provide funding to perform male circumcision under general anesthesia or sedation, and cases of MC under general anesthesia/sedation should not be paid for by PEPFAR and should not be counted in the indicator. Children may receive PEPFAR-funded VMMC as long as the procedure is performed using local anesthesia and in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*.[1] VMMC using local anesthesia should be deferred if the maturity level of the child precludes use of local anesthesia. Programs should focus on compiling data for the numerator from MC Registers or client medical records maintained by funded programs/sites. A program site is a fixed or mobile facility that is able to provide all components of the minimum package of MC for HIV prevention services. The **VMMC minimum package of services** must include elective surgical male circumcision using local anesthesia provided after education and consent and delivered in the context of comprehensive HIV prevention messages/services that include the following age-appropriate services: on-site pre-operative HIV counseling and testing (offer of); active exclusion of symptomatic STIs and syndromic treatment when indicated; post-operative wound care and abstinence instructions; counseling on risk reduction, reducing number and concurrency of sexual partners, and delaying/abstaining from sex; and, provision and promotion of correct and consistent use of male and/or female condoms. It is anticipated that some programs may establish formal referral relationships with voluntary counseling and testing (VCT) services to provide the HIV testing components of the MC minimum package of services. In these cases, a repeat HIV test 'on-site' may not be necessary, if the VMMC program and VCT service have agreed upon what constitutes 'certifiable results.' Though it is not possible

	to mandate a specific length of time before the MC surgery that an HIV test must have been done, it is suggested that the HIV test be done within the prior 3 months. Clients who present without a 'certifiable result' and wishing to defer HIV testing are should be encouraged to re-test for HIV at the MC site. Those who decline re-testing and insist on self-reporting should have their information recorded in the appropriate 'HIV status not verifiable' disaggregation category; however, self-reported results equate to an unknown HIV status. Clients circumcised in a fixed/permanent location, such as a hospital or clinic, should be counted in the 'fixed/permanent location' recommended disaggregation category. Those circumcised in a school, tent, mobile facility, or in any location intended for use as another purpose but temporarily established for MC, should be counted in the 'temporary (including mobile) location' recommended disaggregation category.
Interpretation:	Programs are required to report on the actual number of males circumcised in accordance with the WHO/UNAIDS/Jhpiego *Manual for Male Circumcision Under Local Anesthesia*[1] so that the overall uptake and delivery of the PEPFAR-funded VMMC for HIV prevention services in the country can be monitored, outcomes evaluated, and impact of male circumcision on HIV incidence at a population level can be modeled. Comparing current and previous values of this indicator may reflect newly implemented service delivery or changes in volume of supply and/or demand. When the number of male circumcisions is disaggregated by age and HIV status, it will be possible to adjust inputs used in models to determine impact of male circumcision programs on HIV incidence. Disaggregation by age may be particularly helpful in determining whether age-specific communication strategies are working to create demand. Disaggregation by service delivery location/setting may allow for evaluation of resource allocations. Non-PEPFAR funded providers also performing MCs within the reporting period will not be captured by this indicator, and any broader evaluations of population-level uptake will need to be interpreted accordingly.

Prevention
Male Circumcision

Indicator: #P5.2.D Essential/ Reported	**Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery, within the reporting period**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of clients circumcised that experience (reporting back to the respective circumcising program) one or more moderate or severe AE(s) during the reporting period, according to the date of MC surgery.
Denominator:	N/A
Disaggregation:	

Recommended for	Severe AE(s) (number of clients with at least one (or more) severe AE(s) reported)
Recommended for	Moderate AE(s) (number of clients with at least one (or more) moderate AE(s) reported, no AE(s) qualify as severe)

Recommended for	First AE(s) onset day 0, intra-operative/prior to discharge from the facility
Recommended for	First AE(s) onset day 0, following discharge from the facility
Recommended for	First AE(s) onset post-operative days 1-6
Recommended for	First AE(s) onset post-operative day $\geq$ 7

Recommended for	Moderate/Severe anesthesia reaction
Recommended for	Moderate/Severe bleeding
Recommended for	Moderate/Severe infection
Recommended for	Moderate/Severe pain
Recommended for	Moderate/Severe wound disruption
Recommended for	Moderate/Severe sexual dysfunction/undesirable sensory change
Recommended for	Moderate/Severe scarring/disfigurement/poor cosmetic result; excess skin removal; injury to glans/shaft of penis
Recommended for	Occupational exposure to blood/body fluids
Recommended for	Moderate/Severe other AE(s): excess swelling of penis/scrotum (including hematoma); difficulty urinating; other

Purpose:	3 randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls). This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-infected female sexual partners, and may be particularly beneficial in generalized HIV epidemics and where HIV

	prevalence is high and male circumcision prevalence is low. **Like all surgeries, male circumcision is not without risk, and the performance and reporting of safe MC services depends in part upon skill and quality of surgery, effectiveness of post-operative instructions, willingness or ability of the patient to follow post-operative instructions, suitability of the surgical candidate, level of CD4 count if HIV-positive, and the judgment of the healthcare personnel assessing AEs. Intra- and post-operative complications must be monitored to ensure maximization of the provision of safe, quality MC services**, and in turn engender trust in communities and foster high demand for MC services.
Applicability:	All countries with PEPFAR-funded partners providing the VMMC minimum package of services should report on this indicator.
Data collection frequency:	Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and review.
Measurement tool:	VMMC Register, Adverse Event Register, or client medical records maintained by each service provider
Method of measurement:	Sum of clients experiencing moderate and severe adverse events documented in Adverse Event Monitoring Logs or client medical records maintained by programs. Explanation: Clients who have documentation in the facility record that they experienced one or more moderate or severe AEs (AEs would necessarily have to be reported back to the respective circumcising program) during or following MC surgery meet the definition for the numerator. It is the date of surgery, not the date of AE(s), that must fall within the reporting period. For instance, if the reporting period is October 1, 2009, through December 31, 2009, and a client was circumcised December 29, 2009 and had a moderate adverse event on January 2, 2010, then this client would meet the definition and be included in the numerator (since his surgery was performed within the reporting period, even though his adverse event occurred after the reporting period). Adverse events must be documented in a client's clinic record or registry by the facility that performed the surgery. For this reason, it is anticipated that the indicator reporting may reflect fewer adverse events than actually occurred (as clients experiencing AE(s) may not return to the facility at all, seek care for AE(s) elsewhere, or the facility may fail to document occurrence of the AE(s) in the appropriate record). For reporting purposes, AEs include MC cases involving an occupational exposure to blood/body fluids. Occupational exposure to blood/body fluids (splash, sharps injuries) are based upon guidelines set forth in the WHO/ILO *Post-exposure Prophylaxis to Prevent HIV Infection* (http://www.who.int/hiv/pub/guidelines/PEP/en/index.html) For the specific moderate/severe AEs listed in the disaggregation above, the following guidance for distinguishing between moderate and severe is offered. Routine reporting of moderate and severe AEs is all that is recommended. AEs of seriousness less than moderate should not be reported. ANESTHESIA REACTION: **Moderate:** Reaction to anesthetic including lightheadedness, nervousness, dizziness that resolves spontaneously and **not** requiring use of medicines or equipment from the emergency cart/kit/list of emergency commodities at MC site and no transfer to another facility or admission to hospital (localized itching at the injection site would not qualify as a moderate AE).

	Severe: Symptoms of severe allergic reaction to local anesthetic including rash, urticaria, angioedema and shortness of breath, or symptoms of overdosage of local anesthetic including lightheadedness, nervousness, confusion, dizziness, drowsiness, ringing of ears, blurred or double vision, sensations of heat, cold or numbness, twitching, tremors, convulsions, unconsciousness, respiratory depression, bradycardia, hypotension requiring use of medicines or equipment from the emergency cart/kit/list of emergency commodities or hospitalization to manage the reaction. BLEEDING: Moderate: Intra-operative bleeding that requires a pressure dressing to control; or post-operative bleeding that requires a special return to the clinic for a pressure dressing or additional skin sutures without surgical re-exploration of the wound. (Intra-operative bleeding that is easily controlled or post-operative spotting of the bandage with blood would not qualify as a moderate AE). Severe: Intra-operative bleeding requiring blood transfusion, transfer to another facility, or hospitalization; or post-operative bleeding that requires surgical re-exploration, hospitalization, or transfer to another facility. INFECTION: Moderate: Discharge from the wound, painful swelling with erythema or elevated temperature or use of oral antibiotics (Erythema around the incision line, by itself, would not be serious enough to qualify as a moderate AE) Severe: Cellulitis or abscess of the wound, or infection severe enough to require surgical intervention, hospitalization or intravenous or intramuscular antibiotic therapy. PAIN (INTRA- AND POST-OPERATIVE): Moderate: Pain serious enough to result in disability (as evidenced by loss of work or cancellation of normal activities) that lasting for at least 1 day after surgery. Pain that results in early termination of surgery would also be considered a moderate pain AE. Severe: Pain serious enough to result in disability (as evidenced by loss of work or cancellation of normal activities) more than one day after surgery. WOUND DISRUPTION: Moderate: Wound disruption that is extensive enough to require suturing or other clinical intervention (but not surgery). Severe: Surgical re-exploration is required, or referral/transfer to another facility or hospitalization is required. SEXUAL DYSFUNCTION/UNDESIRABLE SENSORY CHANGES: Moderate: Post-operative changes that impair or preclude sexual function for between 3 and 6 months after the date of surgery that were not present prior to surgery (sexual dysfunction for a shorter period would not qualify as a moderate AE) Severe: Post-operative changes that impair or preclude sexual function for greater than 6 months after the date of surgery and were not present prior to surgery SCARRING/DISFIGUREMENT/POOR COSMETIC RESULT; EXCESS SKIN REMOVAL; INJURY TO GLANS: Scarring/disfigurement/poor cosmetic result

	Moderate: Scarring/disfigurement is discernible but re-operation not required (absence of discernible scarring/disfigurement, despite a client's complaint about the surgical outcome, would not be considered a moderate AE). Excess skin removal Moderate: Tightening of the skin is discernible but re-operation not required (absence of discernible tightening of skin, despite a client's complaint about the surgical outcome, would not be considered a moderate AE). Injury to glans/shaft Moderate: Abrasion of the glans or shaft requiring pressure dressing, but surgical repair is not required. Scarring/disfigurement/poor cosmetic result Severe: Requires re-operation or referral/transfer to another facility Excess skin removal Severe: Requires re-operation or referral/transfer to another facility Injury to glans/shaft Severe: Injury that requires additional surgical intervention to stop bleeding or to repair, including additional surgical intervention at the time of the initial surgery. Severing of the glans or shaft is also considered a severe AE. OCCUPATIONAL EXPOSURE: Moderate: All occupational exposures are moderate (none are mild or severe) OTHER: EXCESS SWELLING OF PENIS/SCROTUM (INCLUDING HEMATOMA); DIFFICULTY URINATING; OTHER: Excess swelling of penis/scrotum (including hematoma) Moderate: Symptoms /signs that require clinical intervention (not surgery). Difficulty urinating Moderate: Partial obstruction requiring a special return to the clinic but not surgical intervention nor placement of a catheter (transient difficulty urinating that resolves on its own would not be considered a moderate AE). Other Moderate: Other adverse events related to the surgery that result in disability (as evidenced by loss of work or cancellation of normal activities) lasting for at least 4 days after surgery but not more than 7 days. Excess swelling of penis/scrotum (including hematoma) Severe: Surgical re-exploration required or symptoms /signs so extraordinary as to cause disability (as evidenced by loss of work or cancellation of normal activities) lasting for at least 8 days after surgery Difficulty urinating Severe: Complete obstruction and/or requires placement of a catheter, referral for treatment or surgery to correct. Other Severe: Other AE(s) related to the surgery that result in disability (as evidenced by loss of work or cancellation of normal activities) lasting for at least 8 days after surgery, or result in hospitalization or referral/transfer to another facility. It is anticipated that some programs may establish formal referral relationships with voluntary counseling and testing (VCT) services to provide the HIV testing components of the VMMC minimum package of services. In these cases, a repeat HIV test 'on-site' may not be necessary, if the VMMC program and VCT service have agreed upon what constitutes 'certifiable results.' Though it is not possible to mandate a specific length of time before the MC surgery that an HIV test must have been done, it is suggested that the HIV test be done within the prior 3 months. Clients who present without a 'certifiable result' and wishing to defer HIV testing are not able to self-report their result. Such clients should be counted in the 'unknown/refused HIV test' recommended disaggregation category. Clients circumcised in a fixed/permanent location, such as a hospital or clinic, should be counted in the 'fixed/permanent location' recommended disaggregation category.

	Those circumcised in a school, tent, mobile facility, or in any location intended for use as another purpose but temporarily established for VMMC, should be counted in the 'temporary (including mobile) location' recommended disaggregation category.
Interpretation:	Programs are recommended to report the number clients experiencing moderate or severe adverse events to allow for monitoring of safe, quality service provision. Frequency, and frequency of severity, of AEs above 'an acceptable level' is an indication of the need for investigation into causes and possible interventions. Further, disaggregation by timing of adverse event may inform planning of post-operative care considerations, particularly from mobile/remote services that may have limited availability following surgery. Disaggregation by specific type of AE may help determine the need for additional training to prevent or manage certain complications.

Prevention
Post-exposure Prophylaxis (PEP)

Indicator #P6.1.D Essential/Reported	**Number of persons provided with post-exposure prophylaxis (PEP)**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.
Denominator:	None
Disaggregation: Essential/Reported	By exposure type: Occupational, Rape/Sexual Assault Victims, Other Non-Occupational
Purpose:	A key consensus at the 2005 Joint International Labor Organization/World Health Organization Technical Meeting for the Development of Policy and Guidelines regarding occupational and non-occupational HIV-PEP was that HIV-PEP must be part of comprehensive HIV prevention, occupational health, and post-rape care service policies (UNAIDS). PEPFAR considers availability of PEP to be a cross-cutting issue that addresses concerns in multiple program areas. The data that will be collected through this indicator provides information to answer questions around prevention, program quality, human resources for health, gender, and overall health system strengthening. PEPFAR HQ will use this data to report to Congress, other U.S., and international stakeholders, to monitor coverage of PEP services and to track progress of PEP scale-up over time.
Applicability:	All countries with PEPFAR-funded partners providing PEP services for either occupational or non-occupational purposes
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Program monitoring tools, reports, and registers
Method of measurement:	The indicator can be generated by counting the number of individuals receiving PEP for occupational and non-occupational purposes. Individuals should be counted only one (1) time, not incidence. This indicator should not include infants who receive neonatal prophylaxis. <u>Explanation:</u> Countries should regularly update their program records on the availability of PEP services in health facilities, and supplement these data with those obtained through a health facility survey or census every few years. <u>PEP services for occupational exposure include:</u> PEP services include a comprehensive package of services for occupationally exposed health care workers and patients. Individuals should be counted only if they have received PEP drugs (in accordance with international or national protocols). <u>PEP services for non-occupational exposure include</u>

	PEP service delivery for sexual violence or other non-occupational includes PEP services as part of a larger, comprehensive package of services for sexual violence victims. Individuals should be counted only if they have received PEP drugs (in accordance with international or national protocols).
Interpretation:	This indicator does not intend to capture the type and quality of PEP services provided. PEP services may include first aid, counseling, testing, provision of ARVs, medical care, trauma counselling, linkages with police, and other follow-up and support. Simple monitoring of PEP availability through program records does not ensure that *all* PEP-related services are *adequately* provided to those who need them. It is anticipated that access to PEP for sexual violence victims will be low initially. This number will remain low in countries where HIV prevalence is relatively low and incidence of sexual violence is low. However, in those countries where sexual violence and HIV are prevalent, percentages are expected to increase.
Additional information:	- Occupational and Non-occupational Post-exposure Prophylaxis for HIV Infection (HIV-PEP), Joint ILO/WHO Technical Meeting for the Development of Policy and Guidelines: Summary Report (2005) http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Techpolicies/HIV_post_Technical_policies.asp - Post-exposure prophylaxis to prevent HIV infection. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (http://www.who.int/hiv/pub/guidelines/PEP/en/index.html - Refer to the PEPFAR Palliative Care Indicator TWG with further inquiries

Prevention

Prevention with People Living with HIV (PwP)

Indicator #P7.1.D Essential/Reported	**Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions**
Type of Indicator:	Direct
Numerator:	**Number of People Living with HIV reached with a minimum package of PwP interventions**
Denominator: Recommended	Total estimated number of PLHIV in the catchment area*
Disaggregation: Recommended	By Setting: Number reached in a clinic/facility-based setting; Number reached in a community/home-based setting
Purpose:	Prevention efforts with HIV positive persons (PwP) are part of a comprehensive prevention strategy and include both behavioral and biomedical interventions. The purpose of this indicator is to measure how well clinic/facility-based and community-based programs are reaching PLHIV with a minimum package of prevention interventions and services that includes evidenced based behavioral and biomedical interventions designed to protect the health of the infected person and reduce the spread of HIV to their sex partners and children. Headquarter staff can use this information to plan and make decisions on how well PLHIV are being reached with PwP interventions. If a small percentage of the intended target population is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who deliver the minimum package of PwP interventions to HIV positive persons (and their partners) in either clinic/facility or community/home settings should report on this indicator.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	The numerator can be generated by counting the number of PLHIV who are reached with a minimum package of PwP interventions (see definition below). The sexual partner(s) or family members of a PLHIV may also receive a service as part of the PwP intervention. While these services may contribute to the minimum standards that are required to count the PLHIV, only the PLHIV should be counted under this indicator. Do not additionally count the partner or family member. Note: The service provided to the partner or family member may meet the defined criteria for another indicator and (if so) should be counted there, i.e. Testing and Counseling (#P11.1.D), CARE (#C1.1.D), or Early Infant Diagnosis (#C4.1.D).

	Explanation of Numerator: **Minimum Package of PwP interventions required for the indicator:** In order to count under this indicator, PLHIV must have received at last visit (in a clinic/facility-based or community/home-based program) the following interventions that constitute the minimum package of PwP: • Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counseling (if indicated) • Assessment of partner status and provision of partner testing or referral for partner testing • Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment • Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services • Assessment of adherence and (if indicated) support or referral for adherence counseling • Assessment of need and (if indicated) refer or enroll PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc. **Description:** All clinic/facility-based and community/home-based programs serving PLHIV should include a package of behavioral and biomedical prevention interventions that are consistent with the guidelines outlined in the PWP technical considerations. These interventions should be provided at each client encounter and delivered either onsite or (where specifically noted above) through a referral program in which the client is enrolled. Partners using referral sites must confirm that they are accessible and providing the referral service. All PLHIV should be provided with an adequate supply of condoms (and lubricant) and risk reduction counseling which addresses condom use, partner reduction, and alcohol reduction. All negative or unknown status partners of PLHIV should be tested at least every year; discordant couples should be identified and provided with appropriate prevention counseling and services. Regular screening and treatment for STIs should be part of routine care and prevention for PLHIV, and STI treatment for partners of PLHIV should also be provided. Provision of family planning counseling, contraceptive methods or safer pregnancy counseling should be provided to HIV–positive women and their partners as part of routine care to reduce unintended pregnancy and prevent maternal-to-child transmission. Adherence to ARVs and all medications is also important for maintaining low viral loads and reducing risk of transmission. Finally, all interventions delivered through clinics/facilities should be reinforced through community-based programs, and linkages and referrals from community programs to clinics should be incorporated into all community programs serving PLHIV. **Explanation of Denominator:** **Catchment area:** Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. For PLHIV, depending on the target sites, there may be registration available at the local health facility. Alternatively, PLHIV estimates for subdistricts/districts/regions/the nation can be used if available.

	The percent coverage can be determined if both the numerator and denominator are included. Country teams and partners are encouraged to consider ways to estimate denominators, using similar methods used in estimating targets. **<u>Note on Disaggregation</u>:** Given that the same individual may be reached with services in both a facility and community based setting, when aggregating this indicator across multiple partners, country teams may choose to allow the double counting, in which case the "Number reached in community" + "Number reached in facility" ≥ "Total number reached."
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received a minimum package of PwP interventions according to the PwP technical considerations. The indicator will help the country teams to determine reach (if no denominator) and coverage (if denominator is also collected) to help country programs understand the extent and reach of evidence-based programs for further expansion.

Prevention

Sexual and other Risk Prevention for General Population

Indicator #P8.1.D Essential/Reported	**Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of the **target population** reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
Denominator: Recommended	Total number of intended target population in the catchment area *Recommended at partner level only
Disaggregation: Recommended	By Sex: Male, Female By Age: 10-14, 15+
Purpose:	Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity (including intended number of sessions) to the appropriate populations is an important component of comprehensive HIV prevention strategies. It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended audience with HIV prevention programming. This information can be used to plan and make decisions on how well a certain audience is being reached with individual and/or small group level interventions. If a small percentage of the intended audience is being reached with either one intervention, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who implement individual and/or small group level prevention interventions that seek to modify behaviors that lead to HIV transmission among general populations, including adult and youth (both in and out of school youth).
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	This indicator is intended to capture programs targeting **general populations**. Programs that specifically target MARP or PLWHA populations should **not** be counted under this here. Instead count these populations under indicators #P8.3.D and #P7.1.D respectively. Explanation of Numerator The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached with and complete the defined prevention intervention.

	This indicator only counts those interventions at the individual and/or small group level. Individual and small group level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in. In order to be counted, an individual should complete the intended number of sessions that were implemented with fidelity to the intervention. *Number reached:* Number of individuals in the target population who are reached with and complete individual and/or small group level HIV Prevention interventions that are based on evidence and/or meet the minimum standards required. *Intended Target Population*: The specific target population around which a prevention intervention was intentionally designed. Populations to be counted in this indicator are general population adult and/or youth, including both in school and out of school youth. For this indicator, populations that participate in a variety of behavioral risks could be counted, including but not limited to the following illustrative examples: individuals who engage in: transactional sex (giving or receiving a gift in exchange for sex); sex under the influence of alcohol; other behaviors that could place them at risk of transmission. Only individuals representing the specific 'intended audience' will count under this indicator. For example: If a program activity is designed to target youth (ages 10-15) and individuals who are much older or much younger than the intended target population participate in the activity, then these individuals should not be counted. Only the 10-15 year olds for which the program was designed should be counted. *Individual-level interventions (ILI):* Interventions that are provided to one individual at a time (e.g., individual counseling). The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counseling associated with testing and counseling should not be counted here. *Small group level interventions (GLI):* Interventions that are delivered in small group setting (less than 25 people) and that assist clients in making plans for behavior change and appraisals of their own behavior. Small group can include a family or couple. *Evidence-based interventions*: Interventions based on the country's epidemic, the drivers of that epidemic, and the most current understanding of behavioral and/or social science. Evidence based HIV behavioral interventions have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. elimination or reduction of risky sexual or drug taking behaviors). These interventions are considered to be scientifically sound, provide sufficient evidence of efficacy in other contexts and/or target populations, and address HIV prevention needs of the communities by targeting

	the specific target population. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required. *Minimum Standards Required:* In the absence of evidence-based interventions, other interventions that could be considered for implementation are those who meet the minimum standards required. These interventions are based on sound behavioral science theory and do have some empirical evidence in the form of being based on formative assessment results. They can also be based on a past successful program. All programs should use process monitoring data to continually gage the appropriateness of the intervention and plan to collect outcome monitoring data to determine effectiveness. In order to count persons reached, the interventions must: – have a clearly defined audience – have clearly defined goals and objectives – be based on sound behavioral and social science theory – be focused on reducing specific risk behaviors – have activities that address the targeted risk behaviors – employ instructionally sound teaching methods – provide opportunities' to practice relevant risk reduction skills *Intended number of sessions:* The number of sessions defined in the program description and as prescribed in the intervention. One component linked to the effectiveness of curriculum-based programs is completing the intended number of sessions of that curriculum. If fewer sessions are conducted, then that program is not following one of the criteria for effective curriculum based sessions. Activity narratives or partner plans should define the number of sessions that are planned and how many (percent of) sessions that must be attended/completed by an individual in order to "count." This may be done activity by activity with oversight from PEPFAR in-country team or the in-country team may wish to set a standard for all partners working in the area of prevention. *Comprehensive Prevention Programs:* Implementing a comprehensive prevention program at the country level involves multiple components such as setting epidemiologically sound priorities, developing a strategic prevention portfolio, employing effective program models, supporting a coordinated and sustainable national response, establishing quality assurance/monitoring/evaluation mechanisms, and expanding and strengthening PEPFAR prevention staff. Comprehensive prevention programs include interventions at multiple levels (e.g., mass media, community-based, workplace, small group, and individual) as well as providing a range of messages that are appropriate for the country's epidemic and the specific target group. Prevention programs should appropriately link to services such as male circumcision and counseling and testing, address stigma and discrimination, and increase awareness of social norms that affect behaviors. Effective ABC messages are also a goal. The ABC paradigm includes abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. The most appropriate mix of programs and messages will depend on the country's epidemic, what populations are being focused on, the circumstances

	they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required. *Explanation of Denominator (recommended at partner level):* Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. For the general population, depending on the target sites, there may be a registration available of individuals between the ages of 25 and 49. Population estimates for sub-districts/districts/regions can also be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received individual-level and/or small-group level interventions.
Additional Information	Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries.

Prevention
General Populations - AB Interventions

Indicator #P8.2.D Essential/Reported	**Subset of indicator #P8.1.D: Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of the **target population** reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required
Denominator: Recommended	Total number of intended target population in the catchment area *Recommended at partner level only
Disaggregation: Recommended	By Sex: Male, Female By Age: 10-14, 15+
Purpose:	This information will be used to report to congress on AB only interventions.
Applicability:	All countries with PEPFAR-funded partners who implement individual and/or small group level HIV prevention interventions that seek to modify behaviors that lead to HIV transmission through programs focused primarily on AB interventions.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	Explanation of Numerator The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached primarily through AB prevention intervention. *Primarily focused:* The messages and content of the activities spend the *majority* of their time discussing; increasing individual and group's self-risk assessments; building the skills; and other supportive behavioral, cognitive and social components to increase the AB behaviors. *Abstinence and/or being faithful:* AB interventions can include programs, services, and messages which encourage sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, and social and gender norms which promote mutual respect and open communication about sexuality. AB interventions can also include programs, services, and messages which discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices. AB interventions targeting youth should support skills-based sexuality and AIDS education as well as involve parents and guardians to improve communication with children and parenting skills.

	See Indicator #P8.1.D for definitions of additional terms required to define this indicator: *Comprehensive Prevention Programs* *Intended Target Population* *Small group level interventions (GLI)* *Evidence-based interventions* *Number reached* *Minimum Standards Required* *Intended number of sessions* <u>Explanation of Denominator (recommended at partner level):</u> *Catchment area:* Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. Population estimates for subdistricts/districts/regions can also be used to help define target populations if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received individual-level and/or small-group level interventions. These interventions are based on evidence and/or meet the required minimum standards. The information collected will allow the country and the PEPFAR to assess any changes in risk behaviors as a result of the implemented interventions. The information will also help the country to understand the efficacy and effectiveness of evidence-based interventions and help in further expansion of similar interventions.
Additional Information	Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries.

Prevention

Sexual and other Risk Prevention - Most at Risk Populations (MARP)

Indicator #P8.3.D Essential/Reported	**Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required**
Type of Indicator:	Direct
Numerator:	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required
Denominator: Recommended	Total estimated number of MARP in the catchment area* *Recommended at partner level only
Disaggregation: Essential	Essential/Reported: By MARP type: CSW, IDU, MSM, Other Vulnerable Populations Essential/Not reported: By sex: Male/Female
Purpose:	Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity to the appropriate populations is an important component of combination HIV prevention strategies. It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended target population with HIV prevention programming. Headquarter staff can use this information to plan and make decisions on how well a certain target population is being reached with individual and/or small group level interventions. If a small percentage of the intended target population is being reached with either one intervention, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who implement individual and/or small group level prevention interventions that seek to modify behaviors that lead to HIV transmission should report on this indicator.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	Explanation of Numerator: The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached with and complete a prevention intervention designed for the intended MARP. This indicator only counts those interventions at the individual and/or small group level. Individual and small group level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive

program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in.

Additional Disaggregation – Other Vulnerable Populations

Please note, there may be other populations that have increased vulnerability to HIV due to a combination of behavioral, social, or environmental factors. Groups that should be counted in the category of Other Vulnerable Populations include:

- Military and other uniformed services
- Incarcerated persons
- Mobile populations (e.g. migrant workers, truck drivers)
- Clients of sex workers
- Non-injecting drug users

Core Package of Services for MARPS: Based on the epidemiologic profile for each country the aim of the country team should be to scale-up a combination of targeted interventions adapted for different sub-groups especially vulnerable to HIV. These interventions could include but are not limited to:

- Community-based peer outreach
- Voluntary testing and counseling (*If providing these services,* also u*se indicator #P11.1.D*)
- Behavior change programs including targeted condom distribution for those who practice high-risk sexual behavior
- Diagnosis and treatment of STIs (*If providing these services,* also u*se indicator #C2.1.D*)
- Referrals to a range of substance abuse and treatment services
- Linkages through referral networks with other health services
- Programs to prevent alcohol/drug- related sexual risk-taking behaviors and HIV transmission
- Vocational skills training or other income-generation activities
- Drop-in centers for creation of "safe space"

Service models (e.g. VCT) developed for a general population may need to be adapted to reach, engage and meet the needs of most-at-risk populations. The country team is encouraged to incorporate tailored or innovative approaches that are likely to increase access and remove barriers to services for these populations. Use of qualitative methods to guide these adaptations has proven to be an effective strategy.

The network model encourages and supports linkages to care and treatment as well. Keeping linkages in mind as care and treatment programs are planned will help achieve the overall PEPFAR goals and assist MARP populations.

Commercial Sex Workers (CSW): Effective CSW prevention programming should:

- Ensure participation of target group in the development, implementation and monitoring of prevention programs
- Promote consistent and proper use of condoms to achieve >90% use with both clients and regular non-paying partners/boyfriends/husbands
- Ensure consistent availability of quality male and female condoms and lubricant
- Ensure availability of comprehensive health care services with special

	emphasis to quality VCT, STI and FP services and provision of or linkages to HIV treatment and care services (*If actually providing these services*, also use *indicators #P11.1.D and C2.1.D*) • Integrate violence reduction (both social and structural) in prostitution settings • Link with relevant social welfare services for the target group and their families • Provide vocational training (*If vocational training is HIV/health related, then also use indicator #H2.3.D*) Men Who Have Sex With Men (MSM): Effective MSM prevention programming should: • Ensure participation of MSM in the development, implementation and monitoring of prevention programs • Promote consistent and proper use of condoms to achieve >90% use with both regular and non-regular partners • Ensure consistent availability of quality male condoms and lubricant • Ensure availability of comprehensive health care services with special emphasis to quality VCT and STI services and provision of or linkages to HIV treatment and care services. (*If actually providing these services, also use indicators #P11.1.D and #C2.1.D*) Injection Drug Users: Generally speaking, PEPFAR promotes three approaches to HIV prevention for injecting drug users: 1. Tailoring HIV prevention programs to injecting drug users: these programs should rely on tools, guidelines and evidence-based interventions designed to reduce risk of HIV transmission. A comprehensive program should include, information and education, community based outreach, risk reduction counseling, targeted condom distribution activities and substance abuse treatment, and to address HIV prevention and risk reduction. These services should be provided in multiple venues to reach this hard to reach population and engage them in activities to enable them to eliminate/reduce risks for acquiring and or transmitting HIV 2. Offering HIV-infected drug users a comprehensive program to reduce their risk of transmission: a comprehensive multi-component HIV/AIDS treatment program for injecting drug users should promote recovery through confidential HIV counseling and testing, ART, palliative care, STI and tuberculosis treatment, substance abuse treatment (including medication-assisted therapies) and transitional services between treatment facilities and the community. 3. Supporting substance abuse programs as an HIV prevention measure: these programs may include behavioral models or medication-assisted treatment (e.g. using methadone or buprenorphine), or a combination of the two, and should also include case management and counseling services. Medication-assisted treatment programs have been demonstrated to be an effective HIV prevention strategy. Medication assisted therapy program should be an access point for IDUs and the program should refer and link to ARV treatment programs, PMTCT for female IDUs and a range of other prevention services. *(If actually providing opioid substitution therapy, also use indicator #P4.1.D*)

	See Indicator #P8.1.D for definitions of additional terms required to define this indicator: *Comprehensive Prevention Programs* *Intended Target Population* *Small group level interventions (GLI)* *Evidence-based interventions* *Number reached* *Minimum Standards Required* *Intended number of sessions* **Explanation of Denominator (recommended at partner level):** **Catchment area:** Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. MARP estimates for subdistricts/districts/regions can be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received and completed individual-level and/or small-group level interventions. These interventions are based on evidence and/or meet the required minimum standards. The indicator will help the country teams to determine reach (if no denominator) and coverage (if denominator is also collected) to help country programs understand the extent and reach of evidence-based programs for further expansion.

Prevention
Testing and Counseling

Indicator #P11.1.D Essential/Reported	**Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of individuals who received HTC services and received their test results during the past 12 months
Denominator:	N/A
Disaggregation:	Essential/Reported: By Age/Sex: <15 Male Essential/Reported: By Age/Sex: <15 Female, 15+ Essential/Reported: By Age/Sex: 15+ Male Essential/Reported: By Age/Sex: 15+ Female Essential/Reported: By test result: Positive, Negative Recommended: By type of counseling: Individual, Couples* Recommended: By MARP type: CSW, IDU, MSM
Purpose:	This indicator is intended to monitor trends in the uptake of HTC services within a country, regardless of the type of HTC setting type or strategy. Further the disaggregation by serotype provide information about the overall % HIV-positive yields of persons tested and contribute to an understanding of linkage through proxy (new diagnoses to new care/treatment enrollments). The recommended levels of disaggregation are intended to monitor access to and uptake of HTC by specific populations that are most affected by the epidemic. Data could also be useful for projecting programmatic needs such as test kits and other staffing resources, although individuals are counted.
Applicability:	All countries with PEPFAR-funded partners directly supporting HTC services regardless of where the service is being delivered and the population groups receiving the services, including TB patients, pregnant women, HIV-exposed infants, and circumcised males.
Data collection frequency:	Data collection at the PEPFAR funded site should be ongoing. Data analysis and review should be done quarterly to monitor progress towards achieving the targets, and to identify and correct any data quality issue. . Data should be collected, analyzed, and aggregated in time for PEPFAR reporting cycles.
Measurement tool:	Existing HTC registers and reporting forms that are already being used to capture HTC encounters could be revised to include the disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as STI registers, HMIS registers and NGO records.
Method of measurement:	Data for the numerator should be generated by counting the total number of individuals who received HTC from any service delivery point. Service delivery points could include fixed health care facilities such as, hospitals, public and private clinics, VCT, ANC, L&D, PMTCT, or TB sites; standalone sites such as free standing sites not associated with medical institutions; and, mobile testing such as, HTC services offered in a specific location for a limited period of time, e.g. outreach, door-to-door services and workplace testing events.

	All individuals receiving HTC should be counted in this indicator regardless of where the service is provided. These individuals will include TB patients, pregnant women, men receiving circumcision, and HIV-exposed infants. To adequately collect data for this indicator, a minimum provision of the following services is required: counseling, testing, return and receipt of test results. *Couples counseling describe those sessions where two or more people in a relationship come together for HTC services. If a couple comes for services together, they should be counseled together and receive their test results together, where possible. When this happens data should be collected for each individual and it should be indicated on the form that this was a couple session as opposed to an individual session.
Interpretation:	This indicator is intended to monitor individuals and the trends in the uptake of testing and counseling over time. However, in some cases, data for this indicator might include repeat testers. If data on persons who retest are not available, this indicator will give information on the number of times HTC services were delivered, rather than the number of individuals who received HTC services. Repeat testing is common practice among most HTC programs and it is important to recognize this and interpret the aggregated data with caution. Over time, the number of people who are expected to be tested and counseled within a country will vary depending on numerous factors such as, the numbers of people with previously confirmed positive status, or the number of people who may be at perceived risk of HIV infection, and hence this indicator should be interpreted accordingly. In addition, the type and focus of a HTC program for each respective country has an impact on its interpretation. For example, a program that targets high-risk groups or areas of highest prevalence, may have smaller numbers tested, and yet higher yield in HIV infection identification than a program providing general HTC services. Given that this indicator is intended to count individuals and not tests, data produced through this indicator would need further interpretation for use in commodities planning. Finally, this indicator does not provide information on whether those who were tested were adequately referred and linked to and are receiving follow up services (e.g., HIV care, VMMC) to benefit from knowing their HIV status.
Additional Information:	- Partially harmonized with #7, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf • Partially harmonized with Prevention indicator (HIV-P8b), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Prevention

Gender Based Violence *(pilot)*

Indicator #12.5.D: *Pilot Indicator*	**Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)**
Type of Indicator:	Direct
Numerator:	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion
Denominator:	N/A
Disaggregation:	**By Sex:** Male, Female **By Age[3]:** 0-4, 5-9, 10-14, 15-17, 18-24 and 25+ **By geography:** Districts* *Countries will have some latitude to determine the optimal geographical unit for the monitoring of their proposed activities. If the geographical unit is smaller than a district, the PEPFAR team will be responsible for aggregating this data to the district and regional levels.
Purpose:	This indicator will enable headquarters to: • Gain a basic, but essential, understanding of the geographic reach and scale-up of programs that address GBV within and across PEPFAR countries. • Provide important information to Congress and other stakeholders about PEPFAR programs that reduce women and girls' vulnerability to HIV/AIDS. • Demonstrate the United States' global leadership in reducing women and girls' vulnerability to HIV/AIDS by addressing GBV. • Analyze whether PEPFAR programs are addressing identified needs at the national and regional levels, and to strategically focus technical assistance and future gender programming. At the country level, this indicator will enable PEPFAR country teams, governments, implementing partners, and other in-country counterparts to: • Help assess whether GBV interventions and services are addressing identified needs within the country based on the country's epidemic, national strategy, and social, political, economic, and cultural context. • When possible, support efforts to assess the impact of GBV interventions and services by correlating the scale-up of these activities over time and by geographic area with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as the DHS. This indicator can be used to triangulate results from program evaluations that aim to assess direct

[3] **Note:** Recent studies of GBV in sub-Saharan Africa suggest that rates of sexual violence among adolescents are shockingly high. There is clear evidence that the majority of people using existing GBV care services are children. In order to ensure that our GBV prevention programs are reaching younger people at risk, it is critical that PEPFAR programs addressing GBV disaggregate their data to ages lower than those currently used. The Gender TWG is asking that DRC, Mozambique and Tanzania pilot this age disaggregation for this indicator.

	linkages between GBV and HIV/AIDS interventions and outcomes. • Identify programmatic gaps by analyzing the number and types of people (male/female, age group) being reached by GBV interventions or services. • Advocate for greater resources and technical assistance for GBV programming.
Applicability:	Applicable to the region(s) where GBV services are being implemented and scaled up in the Democratic Republic of Congo, Mozambique, and Tanzania with PEPFAR-funded partners conducting programs that explicitly address GBV and coercion. Based on experiences during this period of initial scale up, this indicator may be revised to reflect lessons learned and be applicable to additional PEPFAR countries.
Data collection frequency:	Data should be collected continuously at the organization/community level. During the pilot phase, data should be aggregated semi-annually for reporting in the SAPR and APR. USG country teams are encouraged to undertake more periodic (ie. quarterly) collection and review of the data for program management and use.
Measurement tool:	Standard program monitoring tools, such as forms, log books, spreadsheets and databases that partners develop or already use.
Method of measurement:	The result can be generated by counting the number of adults and children who were reached by an individual, small group or community-level intervention or service that explicitly addressed GBV during the reporting period. These interventions or services are cross-cutting and contribute to results across a range of PEPFAR program areas**.** Individuals reached by mass media interventions are not counted in this indicator. Individuals counted under this indicator may also be captured under other relevant prevention indicators. For a definition of Gender-based violence and coercion (GBV) and more information on how PEPFAR programs address it, please see the forthcoming publication "Guidance for Integrating a Gender-Based Violence Response in PEPFAR Programming," as well as in the 2012 PEPFAR Technical considerations, which can be found online at: http://www.pepfar.gov/documents/organization/169737.pdf. **Number of adults and children reached** is the number of individuals who are provided with the intended intervention as defined in the program description and as prescribed in the intervention or service. **Individual-level** interventions or services are those that explicitly address GBV and are provided to one individual at a time, e.g. job skills training, tuition grants, etc. **Small-group-level** interventions or services are those that explicitly address GBV and are delivered in small group settings (less than 25 people), e.g. empowerment training for women in microfinance projects, men's support groups addressing gender norms, information dissemination to women's groups, etc. **Community-level** interventions or services that explicitly address GBV and are delivered in community-wide settings (25 or greater people), e.g., awareness raising forums, town hall meetings, large discussion groups, etc.

Interpretation:	This indicator provides information about the number of adults and children reached by interventions or services that explicitly address GBV. Increases or decreases in the indicator value over time could reflect a range of circumstances, such as scale-up (or decline) of these interventions and services within and across PEPFAR countries; changes in program strategy toward more targeted/intensive individual-level interventions and services (resulting in a decrease) or toward more community-based approaches (resulting in an increase); poorer performance of existing projects (resulting in a decrease); or saturation of the interventions (resulting in a slower rate of increase over time). Program monitoring data will be used to help interpret time trends at the country level. There are several limitations to this indicator. First, the indicator cannot provide information about the quality or intensity of GBV interventions. Second, because the indicator is a basic count without a denominator, and because distinctions between individual-, small group-, and community-level interventions are not being made: (1) program coverage is difficult to estimate and (2) comparisons across programs or countries will be difficult to interpret. Additionally, the indicator could be subject to double-counting (e.g., a beneficiary could be reached by both individual- and community-level interventions and counted twice) which could inflate estimates of the number of people reached. Further, due to the fact that individuals reached under this indicator may also be counted under separate prevention indicators (e.g. P8.1.D, P8.3.D, P8.5.D, etc.), any data comparisons must be performed and interpreted with caution. Programmatic monitoring indicators will be used to address some of the limitations of this reporting indicator. For example, at the programmatic level, the target population (denominator) can be defined, and the percentage of people reached from the target population can be measured, thereby allowing for comparisons between programs, communities, and countries. Furthermore, at the programmatic level, data can be collected and linked to a given individual, thereby diminishing opportunities for double-counting and increasing knowledge of participant dosing.
Additional Information:	Addressing Gender and HIV/AIDS PEPFAR Fact Sheet: http://www.pepfar.gov/press/2011/157860.htm# Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators (http://www.cpc.unc.edu/measure/publications/pdf/ms-08-30.pdf) provides a number of monitoring and evaluation indicators for GBV services. Some of the indicators measure reach and quality of services, and might be helpful as country teams and individual programs develop more detailed monitoring and evaluation plans to more fully understand implementation processes and program outcomes. Please refer further inquiries to the PEPFAR Gender TWG.

Prevention
Gender Based Violence

Indicator #P12.6.D: *Pilot Indicator*	**Number of GBV service-encounters at a health facility**
Type of Indicator:	**Direct**
Numerator:	**Number of GBV-related service-encounters.*** **These encounters can be screening encounters or post-GBV care encounters, as defined below.*
Denominator :	N/A
Disaggregation:	**By Type of service:** 1) GBV screening. In order to be eligible, GBV screening must include appropriate referrals to at least one of the services listed below.[4] 2) Post GBV-care. In order to be eligible, post-GBV care must include: a. an assessment of need, and b. either provision of OR referral to all of the following as appropriate for the individual: - Rapid HIV testing with referral to care and treatment as appropriate - Post exposure prophylaxis (PEP)STI screening/testing and treatment - Emergency contraception, where legal - Counseling (other than counseling for testing, PEP, STI and EC) - Referrals (e.g. psycho-social, legal, child protection) **By Sex:** Male, Female **By Age[5]:** 0-4, 5-9, 10-14, 15-17, 18-24, 25+
Purpose:	This output indicator measures delivery of GBV screening and a basic package of post-GBV services to survivors who choose to disclose and seek services in health care facilities for experiences of sexual violence. This indicator will enable headquarters to: • Gain a basic, but essential, understanding of the uptake of post-GBV services offered in health facilities within and across PEPFAR countries participating in this initiative to scale up GBV programs and services. Data, for example, may be triangulated with country plans, other GBV indicators, and other programmatic monitoring data to understand the factors that facilitate disclosure and use of these services. • Provide important information to Congress and other stakeholders about PEPFAR programs that reduce women and girls' vulnerability to HIV/AIDS. • Demonstrate the United States' global leadership in reducing women and girls'

[4] Screening of children for GBV is a complex and sensitive issue. PEPFAR-funded programs should work with partner governments and implementing partners to establish or follow national policies and guidelines for screening children and follow those guidelines within PEPFAR- funded activities. Once these policies and guidelines are implemented, such screening encounters should be counted by this indicator.

[5] Recent studies of GBV in sub-Saharan Africa suggest that rates of sexual violence among adolescents are shockingly high. There is clear evidence that the majority of people using existing GBV care services are children. In order to ensure that our GBV prevention programs are reaching younger people at risk, it is critical that PEPFAR programs addressing GBV disaggregate their data to ages lower than those currently used. The Gender TWG is asking that DRC, Mozambique and Tanzania pilot this age disaggregation for this indicator.

	vulnerability to HIV/AIDS by addressing GBV. • Analyze whether PEPFAR programs are addressing identified needs at the national and regional levels, and to strategically focus technical assistance and future gender programming. At the country level, this indicator will enable PEPFAR country teams, governments, implementing partners, and other in-country counterparts to: • Help assess whether people disclose experiences of physical and sexual violence, and whether post-GBV care services are being used in facilities. • Support efforts to assess the impact of GBV clinic-based services by correlating the reach (i.e., number of service encounters) of these services over time with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as the DHS. This indicator can be used to triangulate results from program evaluations that aim to assess direct linkages between GBV services and HIV/AIDS interventions and outcomes. • Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas. • Advocate for greater resources and technical assistance for GBV programming.
Applicability:	Applicable to the region(s) where GBV services are being implemented and scaled up in the Democratic Republic of Congo, Mozambique, and Tanzania with PEPFAR-funded partners conducting programs that explicitly address GBV and coercion. Based on experiences during this period of initial scale up, this indicator may be revised to reflect lessons learned and be applicable to additional PEPFAR countries.
Data collection frequency:	Data should be recorded continuously at the facility level (e.g., Community Centers, Health Centers, Hospitals). During the pilot phase, data should be aggregated semi-annually for reporting in the SAPR and APR. USG country teams are encouraged to undertake more periodic (ie. quarterly) collection and review of the data for program management and use.
Measurement tool:	Standard program monitoring tools, such as forms, log books, spreadsheets and databases that partners develop or already use (adapted as necessary).
Method of measurement:	The indicator can be generated by counting the number of GBV screening and post-GBV care encounters, disaggregated by the age group and sex of the client receiving the service. The indicator can and will count a given individual multiple times (for example, the same patient may be screened multiple times, may receive post-GBV care on multiple occasions, etc.). The focus of the indicator is on assessing the uptake of service provision, rather than on the number of individuals accessing services. Explanation of services **<u>GBV screening and referral services</u>** Using checklists or other screening tools, and following nationally or regionally determined guidelines and plans, providers should screen for various forms of GBV. Screening should assess potential for or actual experiences of emotional, physical, and sexual violence with and without force (e.g., coercion). Based on results of screening (e.g., threat of violence, experience of violence) provider should make and document referrals to relevant services. Referrals should include name of service organization or provider, as well as contact information (e.g., location, phone number, hours of service), though contact information need not be documented for purposes of this indicator.

	GBV screening and referrals may be offered in multiple facilities (e.g., Dispensaries, Community Centers, Health Posts, Health Centers, Hospitals) and services (e.g., Family Planning, Ante-natal care, HIV testing and counseling, outpatient care). **<u>Post-GBV care services</u>** Although guidelines for post-GBV care will vary from country to country, in addition to treatment of serious or life-threatening medical issues (e.g., lacerations, broken bones) and the necessary forensic interviews and examinations, *the minimum package of post-GBV care services should always begin with an assessment of the client's specific needs and include, as appropriate, provision of or referral to the following services:* - Rapid HIV testing with referral to care and treatment as appropriate - Post exposure prophylaxis (PEP) - STI screening/testing and treatment - Emergency contraception, where legal - Counseling (other than counseling for testing, PEP, STI and EC) - Referrals (e.g. psycho-social, legal, child protection) These services may be offered by one provider (e.g., in a Health Center) or may be offered in different units by different providers in the same facility (e.g., in a Hospital). However, the client must have an initial assessment as part of the package. To adequately capture the provision of these services, logs and monitoring forms will need to be used wherever the services are offered. These forms will need to track both the outcome of the initial assessment and the provision of referrals or services.
Interpretation:	This indicator uses the number of service encounters of both screening and post-GBV care as a proxy to measure service uptake. An increase in the number of screening encounters will indicate that more patients are being screened; an increase in the number of post-GBV care encounters will indicate that more patients are disclosing to providers and using the services. Willingness to disclose sexual violence may increase slowly overtime, as GBV screening increases and as community-based efforts to address GBV raise awareness and lower stigma have impact. Thus, we may expect to see an initial increase in screening, followed by an increase in service encounters and eventually a decline in service encounters as rates of GBV decline in response to programming. This indicator does not measure the quality of services provided, but it does provide important information to help us understand whether and how services are used.
Additional Information:	Addressing Gender and HIV/AIDS PEPFAR Fact Sheet: http://www.pepfar.gov/press/2011/157860.htm# Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators (http://www.cpc.unc.edu/measure/publications/pdf/ms-08-30.pdf) provides a number of monitoring and evaluation indicators for GBV services. Some of the indicators measure reach and quality of services, and might be helpful as country teams and individual programs develop more detailed monitoring and evaluation plans to more fully understand implementation processes and program outcomes. Please refer further inquiries to the PEPFAR Gender TWG.

Prevention
Gender Based Violence

Indicator #P12.7.D: *Pilot Indicator*	**GBV Service Provision: Percentage of health facilities with Gender-Based Violence and Coercion (GBV) services available**
Type of Indicator:	Direct
Numerator:	Number of health facilities reporting that they offer (1) GBV screening and/or (2) assessment and provision or referral to the relevant service components for the management of GBV-related health needs as defined below.
Denominator:	Total number of health facilities in the region or country being measured. During the pilot phase, at the discretion of the PEPFAR team, this indicator may only be applied to PEPFAR-supported health facilities in the defined regions where GBV services are being scaled up in the Democratic Republic of Congo, Mozambique, and Tanzania. Where data exists on the number of community facilities in the region or country, the PEPFAR team may, at its own discretion, use this value as a separate denominator and track percentage of non-clinical community facilities offering either GBV screening and/or post-GBV care.
Disaggregation:	**By Type of Service:** 1) GBV screening. In order to be eligible, GBV screening must include appropriate referrals to at least one of the services listed below.[6] 2) Post GBV-care. In order to be eligible, post-GBV care must include: a. an assessment of need, and b. either provision of OR referral to all of the following as appropriate for the individual: - Rapid HIV testing with referral to care and treatment as appropriate - Post exposure prophylaxis (PEP) - STI screening/testing and treatment - Emergency contraception, where legal - Counseling (other than counseling for testing, PEP, STI and EC) - Referrals (e.g. psycho-social, legal, child protection) **By Type of Facility:** 3) By clinical facility (as defined under method of measurement) 4) By community facility, where data exists about the number of community facilities present in the region or country Note that a given facility either does or does not offer screening and does or does not offer post-GBV care.
Purpose:	This output indicator provides basic information on the coverage of GBV screening, referral and service provision to meet the immediate needs of survivors of GBV (as defined below) within PEPFAR-supported health facilities. It is aimed at measuring progress towards the provision of a comprehensive package of services for identifying and treating survivors of GBV.

[6] Screening of children for GBV is a complex and sensitive issue. PEPFAR-funded programs should work with partner governments and implementing partners to establish national policies and guidelines for screening children and follow those guidelines within PEPFAR-funded activities..

	This indicator will enable headquarters to: • Gain a basic, but essential, understanding of the reach and scale-up of GBV services provided by PEPFAR-supported facilities. • Provide important information to Congress and other stakeholders about PEPFAR programs that reduce women and girls' vulnerability to HIV/AIDS. Such programs are critical in facilitating the achievement of PEPFAR program goals for prevention, care, and treatment. Assess whether PEPFAR programs are addressing identified gender needs at national and regional levels, and strategically focus technical assistance and future gender programming. At the country level, this indicator will enable PEPFAR country teams, governments, implementing partners, and other in-country counterparts to: • Help assess whether facilities are providing GBV services that address the identified needs within the country based on the country's epidemic, national strategy, and social, political, economic, and cultural context. • Support efforts to assess the scale-up of GBV services in the specified region(s) by tracking the growth in the percentage of facilities offering these services over time. Eventually, this data may be compared with outcomes related to GBV, collected through other tools such as the DHS. Such comparisons can help to assess direct linkages between the provision of GBV-services and broader changes in norms and behavioral outcomes. • Identify programmatic gaps by analyzing the number of PEPFAR-supported facilities and types of services (PEP, GBV screening, etc.) being offered by facilities attempting to scale up these services. • Advocate for greater resources and technical assistance for GBV programming.
Applicability:	Applicable to the region(s) where GBV services are being implemented and scaled up in the Democratic Republic of Congo, Mozambique, and Tanzania with PEPFAR-funded partners conducting programs that explicitly address GBV and coercion. Based on experiences during this period of initial scale up, this indicator may be revised to reflect lessons learned and be applicable to additional PEPFAR countries.
Data collection frequency:	It is recommended that data collection for piloting this indicator happen on a quarterly basis (baseline, 3, 6, 9, and 12 months) to best monitor the progress of scale up. However, this can be modified depending on the monitoring needs of the region(s) and country. Data should be aggregated semi-annually for reporting in the SAPR and APR.
Measurement tool:	Standard program monitoring tools, such as forms, log books, spreadsheets and databases that partners develop or already use **(adapted as necessary)**. A checklist should be developed to use with existing program monitoring tools as a means of documenting, at a minimum, which services are available and when they became available at each separate health facility.
Method of measurement:	The numerator can be generated by summing the number of PEPFAR-supported health facilities that report availability of GBV screening and/or post-GBV care, as defined here. **A clinical health facility** is a health delivery site that falls under one of the following categories: tertiary/third level hospital, second level referral hospital (provincial hospital), first level hospital (district level hospital), hospital affiliated health center, health center (urban/rural), clinic, or health post/dispensary. **A community facility** is any non-clinical site where health services are offered. This includes community support groups, collectives, shelters or safe houses, food bank,

	etc. **GBV Screening** can be done in any health encounter and should be based upon recognized protocols, ideally endorsed by a national standard. All providers engaged in GBV screening should be trained and monitored. Only facilities that can offer appropriate referrals to post-GBV care as defined below can be considered to offer screening. In other words, facilities offering GBV screening but not referrals may not be included in this indicator. **Post-GBV Care** is the assessment of an individual who has been identified as having experienced some form of GBV and the provision of or referral to all of the following elements, as appropriate for that individual: 1. Rapid HIV testing and referral to care and treatment 2. Post exposure prophylaxis (PEP) * 3. STI treatment 4. Emergency contraception (EC) where legal 5. Counseling (other than counseling for testing, PEP, STI and EC) 6. Referral (psychosocial, legal, and child protection) * The full range of Post Exposure Prophylaxis (PEP) includes first aid, counseling, HIV testing, provision of ARVs, and patient follow-up and support. For example, a health clinic where a counselor meets with a GBV survivor and offers HIV testing and STI treatment, and then offers referrals for PEP, EC, counseling and other services would count as offering post-GBV care. Likewise, a community center that offers assessment for GBV survivors and can refer to other facilities for the other required services would also be counted. However, a facility that cannot either offer or refer to all of the services listed would not qualify. The denominator is calculated by summing the total number of PEPFAR-supported health facilities in the region(s) where GBV services are being scaled up.
Interpretation:	This indicator assesses coverage of services that identify and address the needs of survivors of GBV by counting the number of PEPFAR-supported health facilities that provide these services. An increase in this proportion over time would suggest that scale up efforts are successful, and might suggest the potential for services to reach a larger proportion of the population of women in general and survivors, in particular. There are several limitations to this indicator. First, the indicator cannot provide information about the quality and completeness of each of the GBV services provided. Simple monitoring of availability of services through program records does not ensure that all GBV-related services are adequately provided to those who need them. Second, there are factors such as accessibility of services that this indicator does not measure, which determine whether and to what extent these services reach survivors. Third, the use of a denominator that initially only includes PEPFAR-supported health facilities in select regions of scale-up will not inform national coverage, plans for national scale up, and comparison of this indicator across PEPFAR programs. As programs progress, the denominator for this indicator should be expanded to include all facilities in the region, and eventually, all facilities nationally.
Additional information:	Addressing Gender and HIV/AIDS PEPFAR Fact Sheet**:** http://www.pepfar.gov/press/2011/157860.htm# Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators (http://www.cpc.unc.edu/measure/publications/pdf/ms-08-30.pdf) provides a number of monitoring and evaluation indicators for GBV services. Some of

	the indicators measure reach and quality of services, and might be helpful as country teams and individual programs develop more detailed monitoring and evaluation plans to more fully understand implementation processes and program outcomes. Please refer further inquiries to the PEPFAR Gender TWG.

CARE
"Umbrella" Total Care

Indicator #C1.1.D Essential/Reported	**Number of eligible adults and children provided with a minimum of one care service**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of adults and children provided with a minimum of one care service
Denominator:	N/A
Disaggregation:	Essential/Reported: Males Essential/Reported: Females Essential/Reported: *<18 years of age* Essential/Reported: *18+ years of age* *Recommended*: *<1* *Recommended*: *<5* *Recommended*: *<15* Age represents an individual's age at the end of the reporting period or when last provided with a support service.
Purpose:	PEPFAR has a legislative 5-year goal to care for 12 million individuals, including care services to 5 million children orphaned or made vulnerable by HIV. PEPFAR recognizes that individuals, families, and communities are being 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. A variety of services are supported through PEPFAR to mitigate these effects in order to improve health outcomes for HIV positive individuals, improve the developmental growth of children, and optimize the quality of life of adults and children living with and affected by HIV This indicator measures the number of individuals receiving care services through PEPFAR. Data collected through this indicator will inform country programs and PEPFAR about the scale-up of services for individuals infected and affected by HIV. Data collected from this indicator can inform program planning, budget allocations, and will be used to report against the legislative 5-year goal of 12 million individuals. The age disaggregation (<18) will be used to report on the goal of 5 million children who are orphaned or made vulnerable due to HIV.
Applicability:	All countries with PEPFAR-funded partners providing services that traditionally fell under the Care and Support or OVC technical program areas. (see appendix 2 for menu of support services and clinical services)
Data collection frequency:	Data should be collected continuously at facility and/or community/home-based sites. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Registers/databases, client records and registers, or other program monitoring tools. Programs may need to modify the revised WHO Pre-ART/ART registers to capture this data.
Method of measurement:	The numerator is generated by counting the number of eligible individuals, i.e. HIV-infected and HIV-affected (family members, caregivers, or other household members living with or caring for an HIV-positive individual or an OVC), who

received at least one care service from facilities and/or community/home-based organizations. This is the number of **unique individuals** receiving at least one care service. Individuals receiving more than one care service should be counted only once.

All individuals receiving ART should also be receiving care services (at a minimum, periodic clinical assessment, and optimally a full range of care services). Thus every individual counted as receiving ART (under indicator #T1.2.D) should actively be receiving clinical care services and thus also be counted under indicator #C2.1.D, which is a subset of #C1.1.D. Therefore, these individuals would also be captured and counted under C1.1.D.

Definitions:
PEPFAR CARE programs include support, preventative, and clinical services

Clinical Services – Include a broad range of services related to the specific clinical needs of HIV-positive persons. Clinical services may be provided in facilities, the community, or in the home, and may include both *assessment* of the need for interventions (for example assessing pain, clinical staging, and eligibility for Cotrimoxizole, or screening for tuberculosis) or provision of needed interventions. These services are further defined under the CARE indicator for Clinical Services for HIV-positive. See appendix 2 for the full menu of clinical services.

Individuals eligible for clinical services:
People living with HIV/AIDS (PLWHA), including pregnant women

Preventive Services - Include a range of services related to the prevention of the transmission or acquisition of HIV. Services may include both *assessment* of risk and need for interventions or provision of needed interventions.

Support Services – Include a broad range of services, which provide social, psychological, or spiritual support and are appropriate for all persons who are affected by HIV, including people living with HIV/AIDS (PLWHA).

Support services fall into these broad categories: Psychological, spiritual, preventive, food support*, shelter, protection, access to health care, education/vocational training, and economic strengthening. See appendix 2 for the full menu of support related services.

Individuals eligible for preventive and support services:

-Adults and children living with HIV (PLWHA), including pregnant women-Family members, caregivers, or other household members living with or caring for an HIV-positive individual or an OVC -Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS, who live in households made increasingly vulnerable because of HIV/AIDS. In high prevalence communities, all children may be affected due to break down in community support, loss of teachers, or other social support as a result of HIV epidemic.-Infants born to HIV-positive mothers

To count under this indicator, individuals must receive a minimum of one service. However, PEPFAR programs should seek to provide a comprehensive set of support and clinical services appropriately tailored to the status of the individual or

	family. This comprehensive set of services should include linkages to partners providing other types of services as indicated. For HIV-infected persons, programs should ensure that patients receive services through the full continuum of care, which extends specifically to clinical services (see indicator #C2.1.D) and eventually to anti-retroviral therapy (see indicator #T1.1.D). The aggregated total for this indicator is not simply the sum of the individuals served by all partners. Overlap of services provided by facility-based care and support and community/home-based care and support partners must be adjusted for so that individuals are counted only once in the aggregated total. Individuals who receive services from more than one partner or provider should be de-duplicated at the program summary reporting level. *For example: individuals may receive services from different partners and still be counted at the partner level (i.e. social service from partner A and psychological services from partner B), individuals should only be reported once at the summary program level.* *Food Support may also fall under clinical support when provided as therapy for clinically malnourished HIV-positive clients. See indicator #C2.3.D
Interpretation:	This is a high-level indicator that provides the total number of all individuals receiving care services through PEPFAR from facilities and/or community/home-based organizations. While an individual must receive at least one care service to be counted, this indicator does not articulate what type of service was provided, or where it was provided. However, subsets of this high-level indicator provide more specificity regarding types of populations and services received (For example, see indicators #C2.2.D, #C2.3.D, and #C2.4.D) This indicator does not currently provide measures of coverage, nor does it measure quality or effectiveness of services.
Additional Information:	• Partially harmonized with Care and support (HIV-CS2), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf • WHO Pre-ART/ART registers http://www.who.int/hiv/pub/imai/imai_registers_preart.pdf Refer to the PEPFAR Care/OVC Indicator TWGs with further inquiries

CARE
Clinical Services – HIV-Positive

Indicator #C2.1.D Essential/Reported	**<u>Subset of Care indicator #C1.1.D</u>: Number of HIV-positive adults and children receiving a minimum of one clinical service**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of HIV-positive individuals receiving a minimum of one clinical service
Denominator:	N/A
Disaggregation:	Essential/Reported – Males Essential/Reported – Females Essential/Reported – <15 years of age Essential/Reported – 15+ years of age *Recommended* – <1, <5, years of age Age represents an individual's age at the end of the reporting period or when last provided with a clinical care service.
Purpose:	People living with HIV/AIDS (PLWHA) should receive a comprehensive package of services in order to improve quality of life, extend life and delay the need for ART. The goal should be to provide services in each of 5 domains described in PEPFAR care and support guidance (clinical, psychological, spiritual, social, and prevention) and to provide these services using a holistic approach, from the time of HIV diagnosis. While the goal of programs should be to ensure a comprehensive package of care and support services, clinical services are essential for all HIV-positive individuals. All HIV-positive individuals should receive clinical services, including for example *assessment* for symptoms of tuberculosis or need for OI prophylaxis or ART. To be counted for this indicator, HIV-positive individuals must receive a minimum of one clinical service. This indicator attempts to track progress in providing care and support services to all HIV-positive individuals. Please refer to Appendix 2 for a list of services. This indicator attempts to measure how many HIV-positive individuals received care and support services, defined by receipt of at least one clinical service. Data collected through this indicator will inform country programs and PEPFAR about scale up of care services for HIV-positive individuals. With these data, HQ can provide additional support and technical assistance to countries in strengthening network systems that assure access and use of care services by HIV-positive individuals.
Applicability:	All countries with PEPFAR-funded partners providing clinical services, including partners providing home-based care services. Partners who are not directly providing clinical services as defined in appendix 2 should not report on this indicator. Partners who refer patients but do not actually provide clinical services should not report on this indicator.
Data collection frequency:	Data should be collected continuously at facility and community/home-based sites. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes

	of program management and review.
Measurement tool:	Facility registers/databases, patient/client records and registers, or other program monitoring tools.
Method of measurement:	The numerator can be generated by counting the number of HIV positive adults and children who received at least one clinical service. The numerator should equal the number of adults and children with HIV infection who have received at least one clinical service and specifically have received at least one clinical service during the reporting period. Individuals may receive care and support services from different partners. For example, a patient may receive a clinical service from partner A and social services from partner B. In this case the patient will be counted under indicator #C2.1.D, as well as this indicator (#C1.1.D). However, if an HIV-positive patient receives a care service that does not include a clinical service, he/she may be counted under indicator #C1.1.D only and may not be counted be counted under this indicator. The aggregated total for this indicator is not simply the sum of the individuals served by all partners. Overlap of services provided by facility-based care and support and community/home-based care and support partners must be adjusted for so that individuals are counted only once in the aggregated total. As noted above, this indicator is a subset of Care indicator #C1.1.D. Thus, every individual counted towards this indicator should also be counted towards indicator #C1.1.D. All individuals receiving ART should also be receiving clinical care services (at a minimum, periodic clinical assessment, and optimally a full range of clinical care services). Thus every individual counted as receiving ART (under indicator #T1.2.D) should also actively be receiving clinical care services and therefore would also be counted under indicator #C2.1.D. Individuals receiving a clinical care service should only be counted once under #C2.1.D, regardless of the number of clinical care services received. **Clinical services** may be provided in facilities, the community, or in the home, and may include both *assessment* of the need for interventions (for example assessing pain, clinical staging, eligibility for Cotrimoxizole, or screening for tuberculosis) and *provision* of needed interventions: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA. While partners may be supported to provide services only in a single domain (for example only social support), individuals receiving that support should be linked to other providers who provide clinical services to meet the criteria to count an individual as receiving one clinical service. Please refer to appendix 2 for a list of clinical services. While a minimum of one clinical service is sufficient to count an HIV-positive individual for this indicator, PEPFAR requires that programs strive to provide comprehensive care to all HIV-positive individuals by providing other needed services (clinical and support services) either directly or through referral.

	Individuals who receive services from more than one partner or provider should be de-duplicated at the program summary level.
Interpretation:	This indicator is the total number of unduplicated HIV-positive individuals receiving a minimum of one clinical service from facilities and/or community/home-based organizations. While an individual must receive at least one clinical care service to be counted, this indicator does not articulate what type of clinical service was provided, or where it was provided, nor does it capture other care and support services (from the other domains of care (i.e. support services) that may have been provided. Data from this indicator will not assess linkages within or between care and support sites. This indicator allows country programs and PEPFAR Headquarters to monitor trends and coverage of at least one clinical service to HIV-positive persons. The specific clinical or other care and support services an individual may require will vary according to several factors including stage of disease, treatment, service availability, and cost. This indicator does not measure quality or effectiveness of services.
Additional Information	Refer to the PEPFAR Care/OVC Indicator TWGs with further inquiries.

Clinical Services – HIV-Positive
Cotrimoxizole

Indicator #C2.2.D Essential/Reported	**Subset of indicator #C2.1.D** **Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis
Denominator Recommended:	Program coverage: Use numerator from Indicator C2.1.D Population coverage: Number of HIV-positive individuals who are eligible for CTX, (according to national guidelines)
Disaggregation:	Essential/Not reported: <15, 15+, years of age *Recommended: <1, <5* *Recommended: Males* *Recommended: Females* Age represents an individual's age at the end of the reporting period or when last provided with CTX.
Purpose:	CTX prophylaxis is a simple and cost-effective intervention that reduces the risk of opportunistic infections (OIs) and mortality in HIV-positive children and adults. WHO recommends administration of CTX for the following groups: adults with HIV infection, including pregnant women, children with HIV infection, and infants exposed to HIV. The WHO guidelines offer countries a choice of whether to provide CTX broadly or according to disease stage. This indicator is important to country teams and HQ for several reasons including: • Assesses scale-up and coverage of CTX prophylaxis • Identifies gaps in services to improve scale-up and coverage • Provides data to assess quality of care • Focuses on a primary intervention for HIV-positive infants, children, and adults • Informs program planning and budget allocations to improve utilizations of resources to focus on this essential intervention
Applicability:	All countries with PEPFAR-funded partners providing clinical services to HIV positive individuals should report on this indicator, including all partners reporting on indicator #C2.1.D
Data collection frequency:	Data should be collected continuously at the facility level (or community level). Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Program monitoring tools, including Pre-Art and ART registers and electronic databases that routinely record provision of CTX, including pharmacy records
Method of measurement:	The numerator can be generated by counting the number of HIV-positive individuals receiving CTX prophylaxis at some point during the reporting period. Explanation of Numerator Individuals should be considered to be "receiving" CTX prophylaxis if CTX has been prescribed and obtained by the patient (provided by a program or procured by the patient e.g. from a pharmacy). The indicator is not meant to account for short

	term lapses in adherence or short term stock outs. If a patient received CTX at any time during the reporting period, the individual should be counted towards this indicator. If individuals are served by more than one program that might provide CTX prophylaxis, the figure should be adjusted as needed so that the numerator represents only unique individuals receiving CTX within the reporting period. Countries should focus on compiling data for the numerator from patient registers at facilities. Where patient level data are not available, countries may develop program or facility level estimates of coverage with CTX and apply these estimates to the total number of individuals receiving care and support services through those programs or facilities. HIV-positive individuals receiving CTX in both the private sector and the public sector should be included in the numerator where data for both are available. Individuals counted as receiving ART (under indicator #T1.2.D) should also actively be receiving CTX according to national guidelines, and therefore would also be counted under indicator #C2.1.D. However, if a person receives CTX in addition to other clinical care services, they should only be counted once under #C2.1.D since the indicators track number of individuals. Provision of Cotrimoxizole is one of the key services included under "clinical" services. [The information will be considered in the context of the national policy on CTX in the country, the total numbers of HIV-positive individuals in the country, WHO guidelines, and the numbers of HIV-positive individuals receiving HIV care services.]
Interpretation:	Countries may be at different phases in developing national guidelines on provision of CTX for HIV-positive individuals. The figure of individuals served by more than one program should be adjusted as needed so that the numerator represents only unique individuals receiving CTX within the reporting period, which would be impossible without unique IDs and electronic monitoring systems. Although countries may not have a system in place yet to collect and report coverage of CTX among HIV-positive individuals, the goal should be to develop such a system. This indicator permits monitoring trends in the numbers and proportion of HIV-positive persons receiving CTX prophylaxis. Since countries have different guidelines for provision of CTX to HIV-positive individuals, cross-country comparisons of aggregate estimates and proportions must be interpreted with caution and with reference to eligibility criteria. In addition to tracking the numbers of persons on prophylaxis, this indicator can be interpreted as a proportion, or measure of coverage, using various denominators as appropriate. Coverage can be considered using different denominators, for example the proportion of HIV-positive persons in care (receiving at least one clinical service) receiving CTX, the proportion of the estimated number of HIV-positive persons in the country (or area receiving PEPFAR support) receiving CTX, or the proportion of HIV-positive individuals who are eligible for CTX, (according to national guidelines) who are receiving CTX. This indicator attempts to track progress in scale-up of CTX to HIV-positive individuals in a country. The indicator does not attempt to capture interruptions in drug availability or patient adherence to prescribed therapy. The reports will need to be interpreted in the context of national policies (some countries recommend CTX for all HIV-positive individuals, some prioritize specific sub-groups). As countries strengthen systems to collect data, there should be regular reporting to

	PEPFAR Headquarters on changes in eligibility criteria and on systems to track individuals receiving CTX.
Additional Information	• WHO Pre-ART/ART registers http://www.who.int/hiv/pub/imai/imai_registers_preart.pdf • Refer to the PEPFAR Treatment Indicator TWG with further inquiries

Clinical Services – HIV-Positive

Clinical malnutrition

Indicator #C2.3.D Essential/Reported	**Number and proportion of undernourished people living with HIV (PLHIV) who received therapeutic or supplementary food during the reporting period**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of undernourished people living with HIV (PLHIV) who received therapeutic or supplementary food during the reporting period.
Denominator: Essential/Reported	Number of clients who were nutritionally assessed and found to be clinically undernourished during the reporting period.
Disaggregation:	Essential/Reported: <18, 18+ Recommended: By sex, age < 24 months, 24-59 months, 5-14 years, 15+, and pregnancy status/postpartum status
Purpose:	The purpose of this indicator is to monitor the number and proportion of clinically undernourished PLHIV who receive therapeutic or supplementary food. Provision of therapeutic and supplementary food to undernourished PLHIV is a key component of care and support and treatment for PLHIV. Undernutrition significantly increases mortality risk for HIV-infected individuals, both those on treatment and those not on treatment (van der Sande et al. 2004; Paton et al. 2006). Therapeutic and supplementary foods are essential and proven interventions to manage and treat undernutrition, recommended and supported by WHO, UNICEF, WFP and other global authorities, as well as by PEPFAR. Programs in several countries provide food support to clinically undernourished clients, including therapeutic food products for severely undernourished PLHIV and supplementary food products for moderately and mildly undernourished PLHIV. The indicator enables the scale and coverage of these services to be tracked, and monitors the extent to which these services are reaching those who need them. Provision of therapeutic and supplementary food is generally accompanied by other nutrition services such as nutrition assessment and nutrition counseling, and measuring coverage of therapeutic and supplementary food is a strong indicator of the extent to which the larger package of nutrition care services is reaching PLHIV. PEPFAR-supported programs provide food support to clinically undernourished clients, including therapeutic food products for severely undernourished clients and supplementary food products for moderately and mildly undernourished clients. This indicator measures the coverage achieved for food support of clinically malnourished clients. It can be used to plan interventions and allocation of resources for food and nutrition as needed, and also to assess the impact of interventions. DEFINITION: PLHIV are individuals who have tested positive for HIV. For the purpose of this indicator, the definition includes adults (including pregnant or lactating women), adolescents, children, and infants. The definition includes both those on ART and those not on ART. Undernourished is defined for the purpose of this indicator to mean those who

	have been nutritionally assessed using anthropometric measurement and found to be undernourished using the cutoffs presented in the "Method of measurement" below. Only PLHIV meeting specific anthropometric criteria for undernourishment are included in this indicator. Therapeutic foods are defined as foods designed for the management of severe acute malnutrition and include therapeutic fortified milks, such as F75 and F100, and ready-to-use therapeutic foods (RUTFs) such as Plumpy'Nut, an energy dense, fortified peanut -based paste and other locally produced RUTFs nutritionally equivalent to F100 therapeutic milk. Supplementary foods, used to manage mild and moderate malnutrition, are primarily fortified, blended foods (e.g. corn-soya blend). Staple food commodities provided for general household use do not meet the definition of therapeutic and supplementary food because the indicator refers to specialized food products provided for consumption by undernourished individuals to manage undernutrition.
Applicability:	All countries with PEPFAR-funded partners providing clinical services or food by prescription to HIV positive individuals. All partners reporting on indicator #C2.2.D.
Data collection frequency:	Data should be collected continuously at the facility or program level by documenting on program records each time a client is assessed to be undernourished and each time a client receives therapeutic or supplementary feeding. Data collected by this indicator would likely be reviewed and reported annually at the national and global levels and could be reviewed more frequently at the program level as needed.
Measurement tool:	Program and site records that document provision of therapeutic and/or supplementary food to clients, and client records that document the nutritional status of clients.
Method of measurement:	The numerator can be generated by counting the number of clinically undernourished clients who received therapeutic and/or supplementary food. Each time a client is nutritionally assessed using anthropometric measurement, the measurement is recorded on the client record and/or clinic register indicating whether the client is undernourished or not. Each time therapeutic or supplementary food is provided to a client, this is also recorded in the clinic register or program records. To tabulate the number of clinically undernourished PLHIV receiving therapeutic or supplementary food, program staff review individual client records, clinic registers or program records to tally the number of clinically undernourished clients who received nutrition therapeutic or supplementary feeding at any point during the reporting period. When the proportion of individuals receiving therapeutic or supplementary feeding is being measured, the numerator is the number of clinically undernourished PLHIV who received therapeutic or supplementary feeding at any point during the reporting period. The denominator is the number of PLHIV who were nutritionally assessed and found to be clinically undernourished. Since the measurement unit is PLHIV, every clinically undernourished PLHIV who was nutritionally assessed and found to be clinically undernourished at any point during the reporting period is counted once in the denominator (and once in the numerator if they received therapeutic or supplementary feeding at least once

<table>
<tr><td></td><td>during the reporting period), irrespective of whether they received services once or several times during the reporting period. The duration of the reporting period is likely to be annual at the national level.

The criteria for undernutrition for this indicator are in the table below. These criteria and cutoffs have been established and published by WHO[7].

<table>
<tr><td>Non-pregnant adults > 18 years of age</td><td>BMI < 18.5 kg/m2</td></tr>
<tr><td>Pregnant women and women with infants < 6 months of age</td><td>MUAC <220 mm</td></tr>
<tr><td>Children < 5 years of age</td><td>W/H < -2z scores or MUAC < 125 mm</td></tr>
<tr><td>Children 5-9 years of age</td><td>BMI-for-age < -2z scores or MUAC < 129 mm</td></tr>
<tr><td>Children 10-14 years of age</td><td>BMI-for-age < - 2z scores or MUAC < 160 mm</td></tr>
<tr><td>Children 15-17 years of age</td><td>BMI-for-age < - 2z scores</td></tr>
</table>

Data Collection Method:
The measures associated with this indicator require collection of the number of individuals who were found to be undernourished using anthropometric assessment and the number of these clients who received therapeutic or supplementary food. Each time a PLHIV is nutritionally assessed and found to be undernourished, clinic or program staff record this information on individual, clinic or program records. And each time the client is provided with therapeutic or supplementary food, clinic or program staff record this information. Tools needed for nutrition assessment may include weight scales, MUAC measurement tapes, stadiometers / height measuring devices, and recumbent length devices, among others. Maintenance of records about nutritional status and food provision is required.

Since the indicator includes ART and pre-ART clients, PMTCT clients, and pediatric HIV clients, in some settings information will be drawn from multiple record systems, such as routine health information systems and reporting systems for large-scale food distribution programs, especially those that target PLHIV. This may require aggregation at the district or national level.</td></tr>
<tr><td>Interpretation:</td><td>To address undernutrition and strengthen care and support for PLHIV, a number of countries have introduced therapeutic and supplementary food provision in their HIV programs. Results from the indicator provide information about the extent to which therapeutic and supplementary food support is reaching eligible PLHIV and where gaps may exist.

When the proportion of undernourished PLHIV receiving food support is measured, the indicator result will be affected by how many and which clients</td></tr>
</table>

[7] **Exceptions: WHO has not established MUAC cutoffs to classify adult nutritional status, and the cutoff of 220 mm is based on common practice, though different programs may use different cutoffs. MUAC < 125 mm for children < 5 years of age is not a published cutoff by WHO but is very commonly used in many countries.**

	are anthropometrically assessed. If there are changes in the population receiving anthropometric assessments (e.g. introduction of nutrition assessment services in new geographic areas where therapeutic and supplementary food products are not yet provided) the denominator may change significantly without any commensurate change in the numerator. Interpretation of changes in this indicator needs to consider these factors so changes in the indicator may reflect a combination of program impacts and the influx (or exit) of populations to (or from) the indicator's measurement universe. This consideration applies to many other indicators as well. *Uses*: By measuring the coverage achieved for food support to clinically undernourished PLHIV, the indicator can be used at the global level to gauge the extent to which nutrition support services are reaching the PLHIV who require them as part of care and support and treatment globally and in specific countries. At the national and program levels, the indicator can also be used to monitor and track progress in the implementation of nutrition components of comprehensive HIV care and support. This information can support national governments and programs to identify strengths and gaps, plan interventions, and determine allocation of resources for food and nutrition as needed. At the facility level as well, information from the indicator can inform service providers and managers about coverage within the facility, and measurement of the indicator can serve as an incentive and reminder to assess the nutritional status of clients and provide therapeutic and supplementary foods to those who are undernourished. *Strengths and Weaknesses*: *Strengths:* The indicator directly measures the number and proportion of undernourished PLHIV receiving therapeutic or supplementary food, which is a critical care and support service for undernourished clients. Provision of therapeutic and supplementary food is widely seen as the most powerful and impactful nutrition intervention provided to undernourished individuals. Furthermore, because most programs providing such food also provide other complementary nutrition services, this indicator can be interpreted as indicating the extent to which the fuller package of nutrition services is provided. By measuring both the number and the proportion, the indicator provides information about the overall scale of these services as well as information about coverage among clients needing such food support. The indicator is quite straightforward to measure, especially since most facilities and programs measuring nutritional status already record the result of this measurement, and most programs providing therapeutic and supplementary foods maintain records of the food provision. *Weaknesses:* There are limitations to comparing results for this indicator across countries. Different countries and programs may use different types of food products, may provide the food for different durations, and possibly even apply different entry and exit criteria for food eligibility. Also, the indicator provides information about coverage, but not about the impact of the food support, quality of the foods, duration of food support, or adherence and drop-out rates. As described in the Interpretation section above, changes in the proportion measure of the indicator may be caused by changes in the number or population of clients being assessed in addition to changes in the number receiving therapeutic or supplementary food support. For this reason, it is recommended

	to collect the indicator as both a number and a proportion.
Additional Information	PEPFAR Food and Nutrition Technical Guidance and the OVC Programming Guidance on Food and Nutrition. www.pepfar.net under "Guidance" under the "Food and Nutrition" program area as well as the "OVC" program area. Additional Sources of Information: Castleman, Tony, Megan Deitchler and Alison Tumilowicz. A Guide To Monitoring and Evaluation of Nutrition Assessment, Education and Counseling of People Living with HIV. Washington, DC: Food and Nutrition Technical Assistance (FANTA) Project, Academy for Educational Development, 2008. www.fantaproject.org/publications/NAEC.shtml Food and Nutrition Technical Assistance (FANTA) Project. 2006. Compilation of Monitoring and Evaluation (M&E) Indicators Used for Food and Nutrition Interventions Addressing HIV/AIDS. Washington, D.C: Academy for Educational Development. Paton NI, S Sangeetha, A Earnest, and R Bellamy.the impact of malnutrition on survival and the CD4 count response in HIV-infected patients starting antiretroviral therapy. HIV Medicine 2006, 7: 323-330. The President's Emergency Plan for AIDS Relief. Next Generation Indicators Reference Guide. Version 1.1, August 2009. www.pepfar.gov/documents/organization/81097.pdf The President's Emergency Plan for AIDS Relief. "Policy Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs". September 2006. Tumilowicz, Alison. Guide to Screening for Food and Nutrition Services Among Adolescents and Adults Living With HIV. Washington, DC: Food and Nutrition Technical Assistance II Project (FANTA-2), Academy for Educational Development, 2010. www.fantaproject.org/publications/Screening4FNS.shtml Van der Sande MAB, MFS van der Loeff, AA Aveika, S Sabally, T Togun, R Sarge-Njie, AS Salabi, A Jaye, T Corrah, and HC Whittle. Body Mass Index at Time of HIV Diagnosis: A Strong and Independent Predictor of Survival. *J Acquir Immune Defic Syndr* 2004, 37:1288–1294. WFP. 2009. *The M&E Guide for Food-Assisted Programming (Draft).* Rome, Italy: Nutrition, MCH, and HIV/AIDS Units. World Food Program. WHO. *Guidelines for an Integrated Approach to the Nutritoinal Care of HIV-Infected Children (6 months – 14 years)*. Geneva, 2010. www.who.int/nutrition/publications/hivaids/9789241597524/en/index.html WHO. *Management of Severe Malnutrition: A Manual for Physicians and Other Senior Health Workers*. Geneva, 1999. whqlibdoc.who.int/hq/1999/a57361.pdf WHO. "Nutrition and HIV: Report by the Secretariat to the 59th World Health Assembly". May 2006.

	WHO. "WHO Child Growth Standards". 2007. www.who.int/childgrowth/en/ WHO and UNICEF. *WHO Growth Standards and the Identification of Severe Acute Malnutrition in Infants and Children: A Joint Statement by WHO and UNICEF*. Geneva, 2009. www.who.int/nutrition/publications/severemalnutrition/9789241598163_eng.pdf

Clinical Services – HIV-Positive
TB/HIV

Indicator #C2.4.D Essential/Reported	**Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting
Denominator: Essential/Reported	Denominator is indicator number #C2.1.D (HIV+ Care indicator)
Disaggregation:	N/A
Purpose:	TB disease is the leading cause of mortality among PLWH. Screening for TB among PLWH at initial and subsequent visits is recommended to identify TB suspects and link them to diagnosis and treatment. Currently, available data indicates that despite successes in selected sites, national scale-up of TB screening has been slow in most countries. This indicator will help USG to monitor the proportion of HIV-positive patients who are screened for active TB disease. The data collected from countries using this indicator will allow USG to monitor increases over time. HQ can use this data to identify countries that are making progress and document experiences and lessons learned that may be useful to other countries. HQ can also use this data to identify countries that may require additional programming and technical assistance. Similarly, country teams and partners can use this data to assess scale-up of TB screening among PLWH in specific sites.
Applicability:	All countries with PEPFAR-funded partners providing HIV care or treatment services.
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Program should modify the revised WHO Pre-ART/ART registers to capture this data in the HIV registers.
Method of measurement:	The numerator can be generated by counting the number of HIV-positive adults and children in HIV care or treatment (pre-ART or ART) who were screened for TB disease during the reporting period, at last visit. Denominator: Indicator #C2.1.D **<u>Explanation:</u>** <u>Numerator:</u> HIV positive patients should be screened for TB on a regular basis to identify TB suspects and link them to diagnosis and treatment for active TB disease. Currently this information is not fully documented in the revised WHO Pre-ART and ART register. Programs should modify the register as needed to easily capture this information. The TB screening algorithm applied to identify TB suspects who require additional evaluation for TB disease should be consistent with National TB Program recommendations and best practices. This may include a symptom

	screening questionnaire (i.e. cough, fever, night sweats, recent weight loss, lymphadenopathy) or chest x-ray. Patients who "screen positive" should be referred for further evaluation, diagnosis, and treatment as appropriate. IPT may be considered for eligible patients in whom TB has been excluded if recommended in National Guidelines.
Interpretation:	This indicator is intended to provide information on the proportion of HIV-positive patients in HIV care and treatment who are screened for TB at last visit. We assume that if we check to see if a patient was screened for TB at last visit, this will reflect regular TB screening at each visit. An increase in this indicator suggests that a higher proportion of HIV patients are being screened for TB and increased efforts. For example, developing a standard screening algorithm, training HIV staff, revising cards/registers, etc. A decrease in this indicator suggests that a lower proportion of PLWH are being screened for TB and change in policy or program. For example, a turnover in trained staff, decreased supervision visits, shortage of screening tools, etc.
Additional information:	Partially harmonized with Collaborative activities indicator (TB/HIV-1), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Clinical Services – HIV-Positive

TB/HIV

Indicator #C2.5.D Essential/Reported	**Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of HIV-positive patients in HIV care who started TB treatment
Denominator: Essential/Reported	Program coverage: Indicator number #C2.1.D (HIV+ Clinical care indicator)
Disaggregation:	N/A
Purpose:	All HIV-positive patients should be screened for TB disease. Those patients who "screen positive" are TB suspects and should be linked to additional evaluation, diagnosis, and treatment for TB disease. This indicator will help monitor the proportion of HIV-positive patients who are diagnosed with active TB disease and receive TB treatment. The data collected from countries using this indicator will allow USG to monitor increases over time. HQ can use this data to identify countries that are making progress that might point to best practices and lessons learned that may be useful to other countries. HQ can also use this data to identify countries that may require additional programming and technical assistance. Similarly, country teams and partners can use this data to assess the increase of TB diagnosis and treatment in specific sites.
Applicability:	All countries with PEPFAR-funded partners providing HIV care or treatment services, which include TB screening, diagnosis and treatment.
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Revised WHO Pre-ART/ART registers, PEPFAR Facility ART registers/databases, and program monitoring tools.
Method of measurement:	The numerator can be generated by counting the number of HIV-positive adults and children in HIV care or treatment (pre-ART or ART) who were started on TB treatment during the reporting period. Denominator: Indicator #C2.1.D **<u>Explanation:</u>** <u>Numerator -</u> HIV care and treatment sites should screen HIV patients for TB disease at every visit to identify TB suspects accordingly the national TB screening algorithm for PLWH e.g. symptom screening questionnaire, chest X-ray. In some HIV care and treatment sites, TB diagnosis may be made at the HIV site, but patients may be referred to the TB clinic to start and complete TB treatment. In other HIV care and treatment sites, patients may be screened for TB and then referred to TB clinic for diagnosis and treatment for TB disease as appropriate. Patients identified as TB suspects should be diagnosed for active TB disease based on national diagnostic algorithm in the country. Regardless, linkage between HIV and TB sites is critical to ensure that PLWH who have active TB disease start (and complete) TB treatment accordingly to national TB treatment guidelines in the country. HIV sites should document whether a patient starts TB treatment in the appropriate column on the WHO pre-ART/ART

	register.
Interpretation:	This indicator is intended to provide information on the proportion of HIV-positive patients in care and treatment that are started on TB treatment. An increase in this indicator over time would suggest improvements in TB screening and access to TB diagnosis and treatment services among HIV patients. This indicator should be interpreted along with the indicator on TB screening. If the results on the TB screening indicator increase, it is expected that the results on this indicator on TB treatment will also increase. Similarly, if the results on the TB screening indicator go up, but the results on the TB treatment indicator go down, this may suggest a problem with linking HIV patients to TB diagnosis and treatment services. The indicator would be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral treatment, and poor access to TB diagnosis and treatment. Separate indicators exist for each of these and should be referred to when interpreting the results of this indicator. This indicator has several limitations that result from the minimal TB data that is collected in HIV sites. The WHO pre-ART/ART register indicates TB treatment start date and stop date but does not indicate whether patients successfully complete TB treatment (i.e. are cured). HIV programs are encouraged to closely monitor TB patients once they start TB treatment and if possible be in contact with TB clinics to ensure that those patients who start TB treatment do complete successfully. Similarly, although it is difficult to obtain data on how many patients were identified as TB suspects and how many patients were actually diagnosed with TB treatment, ideally programs would collect data at each point in the cascade to know what proportion of HIV patients were screened for TB, screened positive (identified as a TB suspect), diagnosed with TB, and treated for TB. However, the data sources and additional time required to report this data may not be realistic for most programs.
Additional Information:	Partially harmonized with indicator #6, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2008 Reporting, United Nations General Assembly Special Session [UNGASS]. April 2007 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf

Clinical/Preventive Services
Additional Pediatric

Indicator #C4.1.D Essential/Reported	**Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of infants who received an HIV test within 12 months of birth during the reporting period
Denominator Essential/Reported	Number of HIV- positive pregnant women identified in the reporting period (include known HIV- positive at entry)
Disaggregation:	Essential/reported: Infants who received virological testing in the first 2 months Essential/reported: Infants who were tested virologically for the first time between 2 and 12 months or who had an antibody test between 9 and 12 months
Purpose:	This indicator measures the extent to which infants born to HIV-positive women are tested to determine their HIV status within the first 12 months of life. While this indicator aggregates infants tested at both 2 months and 12 months, it is important that all program staff remember that the goal of early infant diagnosis (EID) is to test all infants within 2 months of birth. Realizing that many infants test after two months, the indicator collects data at both time points. Infants infected with HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. WHO recommends national programs to establish the capacity to provide early virological testing of infants for HIV at 6 weeks, or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. Where virological testing is unavailable, initial antibody testing at 9-12 months is recommended. Data from this indicator will be used to: • Determine the rate of scale up and progress with Early Infant Diagnosis with PEPFAR funds; • Help countries to strategize scale-up programs.
Applicability:	All countries with PEPFAR funded partners supporting HIV testing for infants under the age of 12 months.
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Lab databases, patient records, service outlet log books, HIV-exposed infant registers or other auditable source documentation at PEPFAR supported facilities.
Method of measurement:	**Numerator:** The numerator is calculated from PEPFAR supported lab databases or program records (if they can easily disaggregate by age) compiled from data collected in registers at facilities. If the facility registers cannot disaggregate by age easily, using lab databases is strongly encouraged as these will likely have the infants' age and test information easily available.

	Explanation of Numerator: The numerator, Number of infants who received an HIV test within 12 months in the reporting period, should be disaggregated as follows: 1) infants who received virological testing in the first 2 months 2) Infants that were tested either virologically between 2 and 12 months, or by serology between 9 and 12 months. Infants tested should only be counted once. The numerator should only include the initial test and not any subsequent tests Data should be aggregated from the appropriate facility registers, which could include integrated MCH registers, HIV-exposed infant follow-up registers, lab records, or pre-ART registers. The register used may vary depending on the country context. For example, where HIV-exposed infant follow-up takes place in the care and treatment setting, countries may aggregate information either from a pre-ART register adapted for HIV-exposed infant follow-up or in a separate HIV-exposed infant register. **Denominator:** Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry). This serves as a proxy for the number of infants born to HIV-positive women. This denominator will provide a coverage estimate for all of the HIV-positive pregnant women that PEPFAR supports and has identified. If a national level coverage is desired, then the national level estimate of HIV-positive pregnant women should be used as the denominator.
Interpretation:	This indicator allows countries to monitor progress in reaching HIV-exposed infants with early infant testing as a critical tool for providing appropriate follow-up care and treatment. PEPFAR has established EID as a priority program area and has designated a 65% EID coverage target over the next 5 years. This target should be interpreted as 65% of infants tested for HIV by the time they are 2 months. The numerator will be the number of infants tested under 2 months and the denominator will be the number of HIV-positive pregnant women identified during the time period. While ideally the indicator captures infants born to known HIV-positive women, it may not be feasible in some settings to exclude infants who were tested for HIV using virological testing or antibody testing through provider initiated testing, such as in pediatric wards, malnutrition centers, and other settings where infants may be identified as exposed or infected. In these cases, their mothers would not be a part of the denominator. Countries may have difficulty distinguishing between initial and subsequent tests, which need to be done to avoid double-counting. As such, double counting may skew the number of reported tests. Because many countries do not have a unique identifier system set up for testing infants, and many infants are tested more than once, it is likely that the numerator may indicate a higher number of infants receiving a test than what is happening in reality. It does not capture the number of children with a definitive diagnosis (i.e. either confirmed or excluded of HIV infection), or measure whether appropriate follow-up services were provided to the child based on interpretation of test results. The indicator does not measure the quality of testing or the system in place for testing. A low value of the indicator could, however, signal potential bottlenecks in

	the system, including poor management of HIV testing supply in country, poor data collection, and mismanagement of testing samples.
Additional Information:	- #8, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Prevention indicator (HIV-P13), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Clinical/Preventive Services
Additional Pediatric

Indicator #C4.2.D Essential/Not reported	**Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth**
Type of Indicator:	Direct
Numerator:	Number of infants born to HIV-infected women that are started on Cotrimoxizole prophylaxis within two months of birth at USG supported sites within the reporting period
Denominator:	Number of HIV- positive pregnant women identified in the reporting period (include known HIV- positive at entry)
Disaggregation:	N/A
Purpose:	Cotrimoxizole prophylaxis is a simple and cost-effective intervention to prevent Pneumocystis jirovecipneumonia (PCP) among HIV-exposed and -infected infants. PCP is the leading cause of serious respiratory disease among young HIV-infected infants in resource-limited countries and often occurs before HIV infection can be diagnosed. Because diagnosing HIV infection among young infants is difficult, all infants born to women living with HIV should receive co-trimoxazole prophylaxis starting at 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
Applicability:	All countries with PEPFAR-funded partners providing either direct or indirect support to PMTCT programs should report on this indicator.
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, at least quarterly, for the purposes of program management and review.
Measurement tool:	Numerator: Patient records, service outlet log books, HIV-exposed infant registers or other auditable source documentation at PEPFAR supported facilities. Denominator: Patient records, service outlet log books, or other auditable source documentation at PEPFAR supported facilities.
Method of measurement:	Numerator: The numerator is the sum of infants having received CTX within 2 months of birth during the reporting period at PEPFAR-supported facilities. Denominator: This denominator will include a sum of categories a-d below, at USG-supported sites: a) pregnant women who received an HIV+ test and result during ANC b) pregnant women attending L&D with *unknown* HIV status who were tested HIV+ in the L&D and received their results c) women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested HIV+ and received their results d) pregnant women with *known* HIV infection attending ANC for a new pregnancy.
Interpretation:	A limitation of this indicator is that it does count mother-infant pairs in the numerator and denominator. Therefore there will be some women in the PEPFAR denominator that deliver in the reporting period whose children may receive Cotrimoxizole prophylaxis in the next reporting period. It is anticipated that this will happen consistently during each reporting period and therefore the children who receive Cotrimoxizole in a different reporting period from when they were actually be born will be captured.

Additional Information:	- Adapted from #9, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Adapted from Prevention #HIV-P14, The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Support Services
Nutritional Support

Indicator #C5.1.D Essential/Reported	**Number of eligible clients who received food and/or other nutrition services**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of clients who received food and/or nutrition services during the reporting period
Denominator:	None
Disaggregation:	Recommended: Males Recommended: Females Essential/reported: <18, 18+ years of age Essential/reported: Pregnant or lactating women *Recommended: < 24 months, 24-59 months, 5-17 years* *Recommended: By service type: Food* *Recommended: By service type: Nutrition services* *Recommended: By service type: Food security support (Non-food)*
Purpose:	This indicator measures how many clients receive supplemental food, food security support and/or nutrition services, including therapeutic or supplementary food for OVC whose HIV status is negative or unknown. Results from the indicator provide information about the extent that food support is reaching vulnerable clients and where gaps may exist. It can be used to plan interventions and allocation of resources for food and nutrition. This indicator may also be used for reporting to the U.S. Congress on the number of clients benefiting from PEPFAR-supported food supplementation.
Applicability:	All countries with PEPFAR-supported partners providing food and nutrition services will report on this indicator.
Data collection frequency:	Data should be collected continuously at the facility level (or community level). Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, preferably quarterly for the purposes of program management and review.
Measurement tool:	Program records that document provision of food support to clients.
Method of measurement:	The numerator can be generated by counting the total number of clients who received supplemental food (for nutritionally vulnerable clients), therapeutic and supplementary food for OVC whose HIV status is negative or unknown, food security support and/or nutrition services during the reporting period. Clients that receive supplemental food for OVC whose HIV status is negative or unknown, food security support and/or nutrition services more than once during the reporting period should only be counted one time. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. The numerator should equal the number of clients who received supplemental, therapeutic, and supplementary food, food security support, and/or nutrition services. It is strongly recommended that these services be provided based a nutrition needs assessment that may include anthropometric assessment, biochemical assessment, clinical assessment of nutritional status, dietary assessment, and food security assessment. For the purposes of reporting on this indicator, individuals receiving at least one of

	the following food and/or nutrition services should be counted: • Supplemental food support for nutritionally vulnerable children (OVC) • Therapeutic and supplementary food for clinically malnourished orphans and vulnerable children whose HIV status is negative or unknown. (Note: OVC who are HIV positive and receiving therapeutic or supplementary food should be counted in Indicator #C2.3.D). • Supplemental food support for nutritionally vulnerable PMTCT clients • Micronutrient supplements • Nutrition counseling • Promotion of optimal infant and young child feeding • Services to improve food security • School and after-care feeding • Household and community gardens In the absence of unique IDs and electronic monitoring systems it would be challenging to avoid double-counting of clients that receive food supplementation and/or nutrition services more than once during the reporting period. Effort should be made to avoid double-counting at the program level. *Note: Therapeutic and supplementary feeding for severe malnutrition of HIV-positive individuals should be counted under indicator #C2.3.D (See reference sheet for complete definition). If, HIV-positive individuals are receiving additional food services defined by this indicator, they may be counted in this indicator. For example, HIV-positive persons receiving services to improve food security or benefiting from household and community gardens may be counted here. OVCs known HIV positive and receiving therapeutic or supplementary food should be counted in Indicator #C2.3.D.
Interpretation:	It is important to note that the indicator includes a variety of types of food support, including supplemental feeding, addressing food insecurity among PMTCT women and OVC, and other food related services. These are distinct food interventions with distinct objectives, and the total indicator does not provide information about coverage of each individually. If this indicator is compared across countries, it is important to note that different countries and programs may use different types of foods and possibly even different entry and exit criteria for food support. Also, the indicator provides information about the number of clients receiving food and/or nutrition services, but not about the proportion of total clients receiving such food and/or nutrition services, the duration of support provided to clients, drop-out rates, quality of the foods, quality of nutrition services, or existence of complementary interventions with the food; additional alternative types of studies would be need to be conducted to collect the information needed to understand these factors.
Additional information:	PEPFAR Food and Nutrition Technical Guidance and the OVC Programming Guidance on Food and Nutrition. www.pepfar.net under "Guidance" under the "Food and Nutrition" program area as well as the "OVC" program area.

Treatment
ARV Services

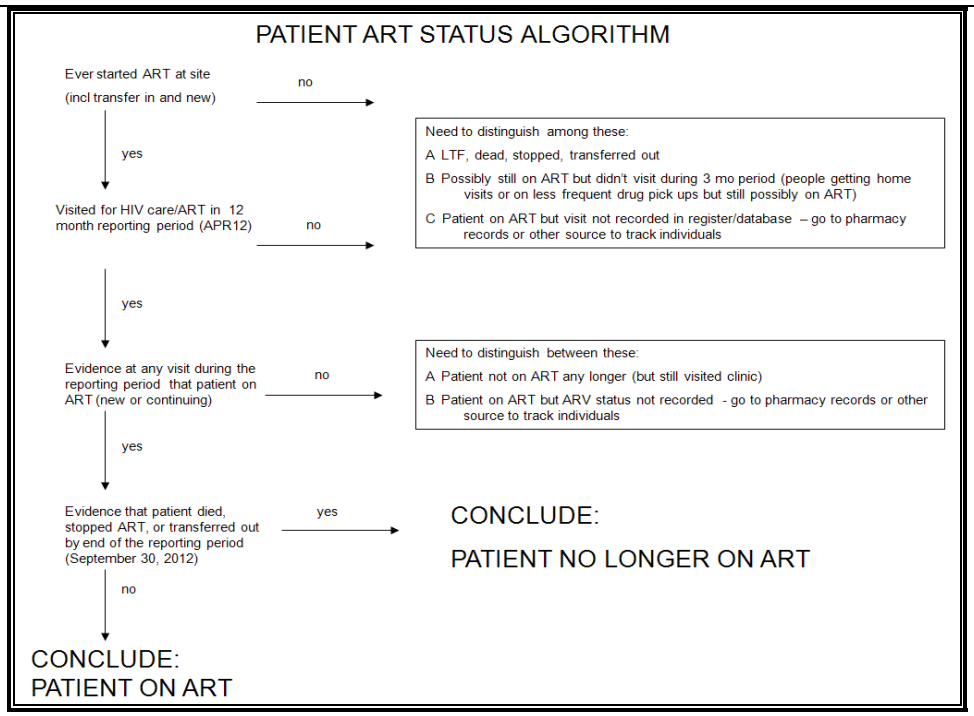
Indicator #T1.1.D Essential/Reported	**New: Number of adults and children with HIV infection <u>newly</u> enrolled on ART**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of adults and children with HIV infection newly enrolled on ART
Denominator:	N/A
Disaggregation:	Essential/Reported: <1 *Recommended: <5* Essential/Reported: <15 Males Essential/Reported: <15 Females Essential/Reported: 15+ Males Essential/Reported: 15+ Females Essential/Reported: Pregnant Women
Purpose:	Measures scale-up of ART program and for pregnant women disaggregation promotes linkages between PMTCT and treatment programs.
Applicability:	All countries with PEPFAR-funded partners supporting direct ART services should report on this indicator. The approach to determining direct support for the ART program varies by country or program model as guided by Appendix 5 of this guidance. As such, this indicator should be reported for sites that are counted as directly supported by PEPFAR
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, e.g. quarterly, for the purposes of program management and review.
Measurement tool:	Facility ART registers/databases, program monitoring tools, or drug supply management systems
Method of measurement:	The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards). Patients with records that transfer in from another facility, or who temporarily stopped therapy and have started again in the time period should not be counted. NEW is a state defined by an individual's *beginning* in a program, it is expected that the characteristics of new clients are recorded at the time they newly initiate into a program. Patients are "new" on ART only if they are naive to lifelong HAART, even though they may have received ARVs for the purposes of prevention of mother to child transmission (PMTCT) or post-exposure prophylaxis (PEP). ART taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are eligible for and initiate antiretroviral drug therapy for their own treatment are included in this indicator.

	HIV-positive pregnant women initiating lifelong ART through PMTCT (including Option B+) will also count as "new" on ART under this indicator. These include HIV-positive pregnant women who newly initiated ART during the current pregnancy. **DO NOT count** other HIV-positive pregnant women taking other ARV regimens for PMTCT in this indicator, including those taking maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery), maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery), and single-dose nevirapine (with or without tail). Patients are counted as pregnant if they were pregnant at initiation of ART. Age represents an individual's age at initiation of therapy. For example, if a 14 year old child begins ART and then shortly after turns age 15, the child will still be counted under NEW in the <15 age category. The number of adults and children with HIV infection who are newly receiving ART can be obtained through data collected from drug supply management systems or facility-based ART registers. **WHO Recommendations for initiating ART:** *Antiretroviral therapy of HIV infection in infants and children: towards universal access: recommendations for a public health approach - 2010 revision.* World Health Organization.ISBN 978 92 4 159980 1 (NLM classification: WC 503.2) © World Health Organization 2010 *Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach.– 2010 rev.* ISBN 978 92 4 159976 4 (NLM classification: WC 503.2) © World Health Organization 2010
Interpretation:	This indicator permits monitoring trends in initiation but does not attempt to distinguish between different lines or regimens of ART or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. CURRENT is a state defined by vital/treatment status when *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. On the contrary, NEW and CUMMULATIVE are states defined by *beginning* in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program and will remain at that same status over time.
Additional information:	Refer to the PEPFAR Adult Treatment TWG with further inquiries

Treatment
ARV Services

Indicator #T1.2.D Essential/reported	**CURRENT: Number of adults and children with HIV infection receiving antiretroviral therapy (ART)**
Type of Indicator:	Direct
Numerator: Essential/reported	Number of adults and children with HIV infection receiving antiretroviral therapy (ART)
Denominator:	N/A
Disaggregation:	Essential/reported <1 *Recommended* *<5* Essential/reported <15 Males Essential/reported <15 Females Essential/reported 15+ Males Essential/reported 15+ Females
Purpose:	To assess progress towards providing ART to all people with advanced HIV infection; Coverage; Track progress towards legislative 5-year and World AIDS Day goals.
Applicability:	All countries with PEPFAR-funded partners supporting direct ART services should report on this indicator. The approach to determining direct support for the ART program varies by country or program model as guided by Appendix 5 of this guidance. As such, this indicator should be reported for sites that are counted as directly supported by PEPFAR
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, e.g. quarterly, for the purposes of program management and review.
Measurement tool:	Facility ART registers/databases, program monitoring tools, or drug supply management systems.
Method of measurement:	Data for this indicator can be generated by counting the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. The Current on ART count should equal the number of adults and children with advanced HIV infection who ever started ART minus those patients who are not currently on treatment prior to the end of the reporting period. • Patients on ART who initiated or transferred in during the reporting period should be counted. • Patients that pick up several months of antiretroviral drugs at one visit, which could include ART received for the last months of the reporting period, but not be recorded as visits for the last months should be included in the count. • HIV-positive pregnant women who are eligible for and are receiving antiretroviral drugs for their own treatment are included. HIV-positive pregnant women initiating lifelong ART through PMTCT (including Option B+) will count as "current" on ART under this indicator. These include HIV-infected pregnant women who:

	○ Have newly initiated ART during the current pregnancy ○ Are already on ART at the beginning of the current pregnancy Patients excluded from the Current on ART count are patients who died, stopped treatment, transferred out or are lost to follow-up (patient not seen for 3 months from last visit). **DO NOT count** other HIV-positive pregnant women taking other ARV regimens for PMTCT in this indicator, including those taking maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery), maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery), and single-dose nevirapine (with or without tail). ART taken only for the purpose of post-exposure prophylaxis is NOT included in this indicator. The number of adults and children with HIV infection who are currently receiving ART can be obtained through data collected from drug supply management systems (e.g. found at the pharmacy) or facility-based ART registers. Patients receiving ART in the private sector and public sector should be included in the numerator for the country as a whole. CURRENT is a state defined by vital/treatment status when *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Age represents an individual's age at the end of the reporting period or when last seen at the facility. For example, a 14-year-old child will be counted as currently receiving treatment in the <15 age category at the end of reporting period "A". During reporting period "B" the child turns age 15 and so at the end of this reporting period the child will be counted under the 15+ age category.



SEE INDICATOR #T1.1.D FOR WHO RECOMMENDATIONS FOR ART INITIATION

Interpretation:

This indicator permits monitoring trends in coverage but does not attempt to distinguish between different regimens of ART or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. The proportion of people needing ART varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of ART among adults and children. Countries will have varying ways of collecting the inputs for the modeling the number of HIV-infected people in need of ART. The degree of utilization of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counseling and testing services, and perceptions of effectiveness and possible side effects of treatment.

A basic level of retention (or attrition) can be calculated as current clients divided by cumulative clients; that is the proportion of clients that remain on ART at the end of the reporting period of those ever started on ART. This crude approximation should not supplant cohort analysis of retention (T1.3.D).

Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. CURRENT is a state defined by vital/treatment status when *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. On the contrary, NEW is a state defined by *beginning* in a program, it is expected that the characteristics of new clients are recorded at the time they newly initiate or transfer into a program and will remain at that same status over time.

Additional information

- #4.1, Global AIDS Response Progress Reporting 2013. Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS. January 2013

	• Treatment indicator (HIV-T1), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Fourth Edition, November 2011 http://www.theglobalfund.org/documents/monitoring_evaluation/ME_Part2HIV_Toolkit_en/ Refer to the PEPFAR Adult Treatment TWG with further inquiries.

Treatment
ARV Services

Indicator #T1.3.D Essential/Reported	**Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of adults and children who are still alive and on treatment at 12 months after initiating ART
Denominator: Essential/Reported	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.
Disaggregation:	Essential/reported: <15 Essential/reported: 15+ *Recommended*: <15 Males *Recommended*: <15 Females *Recommended*: 15+ Males *Recommended*: 15+ Females Age represents an individual's age at initiation of therapy.
Purpose:	High retention is one important measure of program success and is a proxy for overall quality of program.
Applicability:	All countries with PEPFAR-funded partners supporting direct ART services should report on this indicator. The approach to determining direct support for the ART program varies by country or program model as guided by Appendix 5 of this guidance. As such, this indicator should be reported for sites that are counted as directly supported by PEPFAR
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, e.g. quarterly, for the purposes of program management and review.
Measurement tool:	Program monitoring tools; ART registers/databases and cohort/group analysis forms.
Method of measurement:	Explanation of Numerator: The numerator requires that adult and child patients must be alive and on ART at 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected: • Number of adults and children in the ART start-up groups initiating ART at 12 months prior to the end of the reporting period (denominator) • Number of adults and children still alive and on ART at 12 months after initiating treatment (numerator) The reporting period is defined as a continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. The pre-defined number of months can be determined by PEPFAR or national reporting requirements. If the PEPFAR reporting period is 1 October 2011 to 31 September 2012, countries will calculate this indicator by using all patients who started ART any time during the 12-month period from 1 October 2010 to 30 September 2011. A 12-month outcome is defined as the outcome (i.e. whether the patient is still alive and on ART, dead or lost to follow-up) 12 months after starting. For example, patients who started ART during October 2010 will have

	reached their 12-month outcomes in October 2011. Patients who started ART during January 2011 will have reached their 12-month outcomes in January 2012. The numerator does not require patients to have been on ART continuously for the 12-month period. Patients may be included in the numerator (and denominator) if they have missed an appointment or drug pick-up or temporarily stopped treatment during the 12 months since initiating treatment, as long as they are recorded as still being on treatment at month 12. On the contrary, those patients who have died, stopped treatment, or been lost to follow-up as of 12 months since starting treatment are not included in the numerator. For example, for those patients who started ART in October 2010, if at any point during the period October 2010 to October 2011 these patients die, are lost to follow-up (and do not return), or stop treatment (and do not restart), then at month 12 (October 2011), they are **NOT** on ART, and **NOT** included in the retention numerator. Conversely, a patient who started ART in October 2010 and who missed an appointment in December 2010, but is recorded as on ART in October 2011 (at month 12) is on ART and will be included in the numerator. The number of adults and children on ART at 12 months includes patients who have transferred in (and their initiation date is known) at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. What is important is that the patient who has started ART in October 2010 is recorded as being alive and on ART 12 months after initiation, regardless of what happens after that initiation date within the reporting period of interest (i.e. for this example, 1 October 2010 to 30 September 2011). Explanation of Denominator: The denominator is the total number of adults and children in the (monthly) ART start-up groups who initiated ART at a point 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome. (i.e. died, LTFU, stopped); this includes those "New" on ART as well as those who "Transferred In" if they have a cohort-start date within the reporting period of interest. At the facility level, the Transfers Out (TO) will be taken out of the denominator as well as the numerator. It is assumed that if a patient transfers out from an ART facility, that patient will be a "transfer in" at a new ART facility. Logically, facilities and programs may visualize this calculation of the denominator as the facility or program is no longer responsible for an ART patient who has officially transferred out to another ART facility. For example, for the reporting period October 1, 2010 to September 30, 2011, this will include all patients who started ART during the 12-month period from October 1, 2009 to September 30, 2010. This includes all patients, both those on ART as well as those who are dead, have stopped treatment or are lost to follow-up at month 12. Again the denominator includes patients that have transferred in (and their initiation date is known) and excludes patients that transferred out during the time period. This indicator should NOT be estimated. This indicator should be calculated

	directly from information gathered in standard cohort ART registers or tabular analysis from electronic patient level databases. Country teams should ensure that all sites are reporting on the same 12 ART start-up groups. Only sites that have been operational for at least 24 months prior to the end of the reporting period should report, so that all sites report on the same 12 ART start-up groups. PEPFAR country teams may use the USG FY annual reporting period as the timeframe for the 12 ART start-up groups. Teams may also wish to 'lag' by 1-3 months the cohort-months comprising the annual cohort, in order to allow sufficient time for reporting from data sources (i.e. implementing partners and/or national systems). Country teams should record how many ART sites are reporting on this indicator and seek to ensure reporting among all eligible ART sites (i.e., operational for 24 months) by the end of FY 2012. Sites are encouraged to disaggregate retention by health status at initiation (e.g. CD4 count or WHO stage), to review the retention of every ART start up group on a continuous basis, to summarize the data at regular intervals (e.g. monthly), and to use this information to improve follow-up and retention of patients.
Interpretation:	At the national level, the number of transferred-in patients should match the number of transferred-out patients. Therefore, the net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior. Using this denominator may underestimate true "survival", since a proportion of those lost to follow-up are alive. The number of people alive and on ART (i.e. people retained on ART) in a treatment cohort is captured here. Priority reporting is for aggregate survival reporting. If comprehensive cohort patient registries are available then it is encouraged for countries to track survival at 24, 36, and 48 months. This will enable comparison over time of survival on ART. As it stands, it is possible to identify whether survival at 12 months increases or decreases over time. However, it is not possible to attribute cause to these changes. For example, if survival at 12 months increases over time, this may reflect an improvement in care and treatment practices or earlier initiation of ART. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term success of ART.
Additional Information:	- #24, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf - HIV impact indicator (HIV-I3), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf - Refer to the PEPFAR Adult Treatment TWG with further inquiries

Health System Strengthening
Laboratory Support

Indicator #H1.1.D Essential/Reported	**Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
Denominator:	None
Disaggregation:	N/A
Purpose:	An important component for clinical care is laboratory services. In order to support PEPFAR programs, an adequate number of clinical laboratories are needed to perform testing for HIV/AIDS diagnostics, and care and treatment services. Determining the number of laboratories that can perform testing would measure the USG support to build laboratory capacity. This indicator will also serve as a proxy for measuring coverage of HIV/AIDS patient monitoring testing. Countries are encouraged to monitor the numbers of laboratories doing HIV/AIDS related testing and the capacity of these laboratories. This effort seeks to evaluate USG support for laboratory capacity that will provide access to high quality, rapid, affordable diagnostic tests for care, treatment, prevention, and surveillance for HIV/AIDS. Knowing the number of HIV/AIDS clinical laboratories can indicate if testing coverage is adequate or if more capable laboratories are needed.
Applicability:	All countries with USG agencies and/or PEPFAR-funded partners providing HIV/AIDS diagnostics and monitoring test services should report on this indicator.
Data collection frequency:	Data should be aggregated in time for PEPFAR reporting cycles.
Measurement tool:	The number of laboratories is obtained from program records of the PEPFAR-funded partners.
Method of measurement:	A clinical laboratory is counted if it meets the criteria of 1) having the capacity (infrastructure, personnel, and equipment) **and** 2) is performing testing for any of the following: • diagnosis of HIV infection with either rapid test, EIA or molecular methods • HIV/AIDS care and treatment monitoring with CD4 testing or HIV viral loads • hematology • clinical chemistry • serology • microbiology • TB diagnostics • malaria infection diagnostics • STI diagnostics • OI (Opportunistic Infection) diagnostics All laboratories that meet the minimum definition of being capable of performing laboratory testing should be counted. A laboratory can be a physical or mobile structure and must have dedicated laboratory personnel. A facility that does testing

	for the following should **not** be counted: • **Only** HIV rapid test diagnosis, such as a VCT or PMTCT site • **Only** point-of-care testing services at clinical facilities performed by non-laboratory personnel. This indicator represents the sum of all PEPFAR-supported laboratories that perform HIV/AIDS-related clinical laboratory testing for HIV diagnostics Engagement Mechanism This indicator captures laboratories that PEPFAR supports through financial, human, and/or other capacity-building resources. This support includes any of the following examples: • Rehabilitation/upgrade • Ongoing provision of laboratory equipment/reagents • Maintenance/implementation of laboratory information systems • Technical advisor for four weeks or longer • Provide for maintenance and support of laboratory equipment • Emergency provision of lab equipment and supplies • Formal training of laboratory staff • Informal training of laboratory staff • Regular site supervision
Interpretation:	Monitoring the number of laboratories capable of providing testing for PEPFAR programs seeks to evaluate USG-support to build laboratory capacity. This indicator, because of different capacities of laboratories, does not measure adequacy of coverage of laboratory services, but will give indication of trends in delivering laboratory services. It should be noted, laboratories at the higher level will have greater capacity for testing than those at lower levels. This indicator also does not attempt to measure the quality, cost, and effectiveness of services provided.
Additional Information	• Nkengasong, J. *et al* (2010). Laboratory systems and services are critical in global health. Time to end the neglect? *American Journal of Clinical Pathology*, *134*, 368-373. doi: 10.1309/AJCPMPSINQ9BRMU6 • Gershy-Damet, G. *et al* (2010). The World Health Organization African Region laboratory accreditation process improving the quality of laboratory systems in the African Region. *American Journal of Clinical Pathology*, *134*, 393-400. doi: 10.1309/AJCPTUUC2V1WJQBM

Health System Strengthening
Laboratory Support

Indicator #H1.2.D Essential/Reported	**Number of testing facilities (laboratories) that are recognized by national or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation**
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation
Denominator: N/A	None
Disaggregation:	None
Purpose:	Laboratory services are an essential component in the diagnosis and treatment of persons infected with the human immunodeficiency virus (HIV), and other related diseases of public health significance, including malaria and TB. Presently, the laboratory infrastructure for HIV, malaria, and TB testing and quality assurance remains weak in most PEPFAR-supported countries. There is therefore an urgent need to strengthen the laboratory. The establishment of accreditation systems will help countries to improve and strengthen the capacity of their laboratories. Accreditation provides documentation that the laboratory has the capability and the capacity to detect, identify, and promptly report all diseases of public health significance that may be present in clinical and research specimens. The accreditation process further provides a learning opportunity, a pathway for continuous improvement, a mechanism for identifying resource and training needs, and a measure of progress. This indicator measures the progress and extent to which USG-support has built laboratory capacity, quality, and sustainability by determining the number of accredited clinical laboratories and the laboratories' ability to maintain accreditation over time.
Applicability:	All countries with USG agencies and/or PEPFAR-funded partners providing HIV/AIDS diagnostics and monitoring test services should report on this indicator.
Data collection frequency:	Data should be aggregated in time for PEPFAR reporting cycles.
Measurement tool:	Counts of both the number of accredited laboratories as well as laboratories that have achieved the minimum level of recognition in an accreditation preparedness program are obtained from program records of the PEPFAR-funded partners.
Method of measurement:	A PEPFAR-supported clinical laboratory is counted as being accredited if it has received national, regional, or international accreditation. Full accreditation and levels of accreditation are assessed by a standardized set of criteria defined by acceptable international, regional, and national standards. Full accreditation is defined by meeting acceptable criteria in order to receive certification by a recognized approved accreditation organization, such as College of American Pathologists (CAP), International Organization for Standardization (ISO), regional accreditation bodies such as South African National Accreditation System (SANAS), or other approved accreditation

	organizations. Accreditation certificates are a formal recognition that a laboratory is competent to perform clinical testing. Laboratories that have achieved the minimum level of recognition in accreditation preparedness (i.e. a laboratory with at least one star on the WHO-AFRO SLIPTA checklist) should be counted. Laboratories will be assessed in a step-wise process towards full laboratory accreditation using scores on the checklist. Levels of accreditation preparedness will be assigned after assessment and laboratories that meet a minimal acceptable level of recognition (e.g. one star on the WHO-AFRO SLIPTA checklist) will be counted. Laboratories working towards accreditation should be counted as long as they maintain the equivalent of one star on the WHO-AFRO SLIPTA checklist even if the level of accreditation preparedness has fallen from the previous year (e.g. from three stars to two stars on the WHO-AFRO SLIPTA checklist). Any accredited laboratory that loses accreditation compared to the last reporting year will not be counted. Laboratories that have only enrolled in an accreditation process, but have not achieved any officially recognized progress towards accreditation should not be counted.
Interpretation:	This indicator monitors the scale up of accreditation practices in testing facilities (laboratories) supported by PEPFAR. This indicator assesses the quality systems of a laboratory and the ability of a laboratory to maintain quality. Determining the number of accredited clinical laboratories, the progress of a laboratory towards accreditation, and the laboratory's ability to maintain accreditation over time provides documentation that the laboratory has the capability and the capacity to perform quality-assured clinical laboratory testing for HIV diagnostic and care and treatment services. Maintaining accreditation is a continuous process and can serve as a measure of sustainability of quality laboratory service. This indicator also counts the number of laboratories working towards accreditation, which may not deliver full quality services necessary to support PEPFAR. However, it will measure a laboratory's effort to improve on quality as compared to if the laboratory was unmonitored or unaccredited. Accreditation is an assessment of the ability of a laboratory to deliver quality laboratory service. This indicator will not measure the effectiveness of lab accreditation on the delivery of quality services for HIV/AIDS diagnosis, care and treatment. However, the process of assessing labs for accreditation will produce information that can help determine the effectiveness of the laboratory service. These processes include determining testing turn-around times, development of effective workflow, document management, and others. This indicator may undercount the number of accredited facilities as some countries may not at present have the ability to monitor progress toward accreditation or to implement an inspection scheme to accredit a clinical laboratory. Some labs may be capable of receiving an acceptable level of

	accreditation, but currently the system may lack the means to conduct an accreditation assessment. Development of these monitoring processes and accrediting schemes with the assistance of USG PEPFAR support and implementing partners will help to strengthen in-country laboratory networks and build sustainability.
Additional Information:	• Nkengasong, J. *et al* (2010). Laboratory systems and services are critical in global health. Time to end the neglect? *American Journal of Clinical Pathology*, *134*, 368-373. doi: 10.1309/AJCPMPSINQ9BRMU6 • Gershy-Damet, G. ***et al*** (2010). The World Health Organization African Region laboratory accreditation process improving the quality of laboratory systems in the African Region. *American Journal of Clinical Pathology*, *134*, 393-400. doi: 10.1309/AJCPTUUC2V1WJQBM

Health System Strengthening

HRH - Pre-Service Training – Health Workers

Indicator #H2.1.D Essential/Reported	**Number of new health workers who graduated from a pre-service training institution within the reporting period**
Type of Indicator:	Direct
Numerator: Essential/Reported	A count of the number of new health workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts
Disaggregation: Essential	Essential/Reported — By doctors, nurses, midwives Essential/Not Reported — By other cadres Essential/Not Reported — By clinical/non-clinical
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. PEPFAR's legislative goal for new health workers is intended to support the production of health workers in each country through pre-service training. The data will tell us the number of new health workers who are available to enter the health work force each year as a result of full or partial PEPFAR support. This indicator is meant to capture the spirit of PEPFAR legislation and will be used in conjunction with other indicators and measures to report to congress on PEPFAR contributions to the national health workforce.
Applicability:	All USG PEPFAR countries programming in this area will be responsible for reporting on this indicator for Direct and/or National as applicable. This indicator may not be appropriate for tracking a single partner's performance, unless that partner is focused on the mission of increasing the number of health professionals in the workforce. You may need to consider multiple smaller activities and how they fit together to determine if the support to the graduates of a particular institution is sufficient to count them in your program summary result. Applicability for partner level performance tracking: All partners working in PEPFAR-funded activities with a focus on workforce expansion through support to pre-service training institutions, tuition support, or education system strengthening and expansion should report on this indicator.
Data collection frequency:	Data should be collected and aggregated in time for PEPFAR reporting cycles.
Measurement tool:	MOH Human Resource Information Systems (HRIS), pre-service training institutions, professional associations, Ministry of Education, Public Service , and/or private sector HRIS , Ministry of Social Welfare HRIS, professional boards and councils, alumni or graduates networks, Health Sector or HRH Strategic Plans, Implementing partners.
Method of measurement:	The number is the sum of new health workers from the host country who graduated from a pre-service training institution within the reporting period with full

	or partial PEPFAR support. Individuals may be in pre-service training over a number of years, but can be counted as graduated when they have completed their program. Graduates do not need to attend a formal ceremony – completing the program and being eligible to enter into service is sufficient. Local pre-service institutions may support other host country nationals under their program but those graduates should not be included in a country's report on this indicator. Explanation: Training under this indicator is defined as "pre-service" training – the training of "new" health workers (see definition below). All training must occur prior to the individual entering the health workforce in his or her new position. A health worker who advances to a higher cadre (e.g., nurse completes medical school to become a doctor, clinical assistant completes training to become a clinical officer) shall be counted as a "new" health worker for the purposes of this indicator. The intent of the legislative goal is to expand the number of workers in the workforce and increase access to care, this could occur through advancing current workers to higher level cadres through additional training and education. Pre-service training institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre's entry into the workforce. "In-service" and "continuing education" training should not be included in the count for this indicator, but continue to be encouraged by PEPFAR. These types of training are captured byindicator #H2.3.D. In order to count for #H2.1.D the duration of training must meet or exceed a minimum of 6 months. The 6-month training period may consist of a combination of classroom and practical training. Health workers who receive a 3-month training course cannot be counted here (use indicator #H2.2.D for pre-service training under 6 months). A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted. Successful completion of training may be documented by diploma, certificate, or other evidence of completion of the program and subsequent eligibility to enter service. Individuals not meeting these documented requirements should not be counted in this indicator. "Health workers" refers to individuals involved in safeguarding and contributing to the prevention, promotion and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. This is not

	an exhaustive list of all health workers and position titles may vary from country to country. For the purposes of this indicator, health workers include the following: 1) Clinical health workers – Clinical health workers play clinical roles in direct service delivery and patient care: a) Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, social workers, medical technologists, and psychologists; They usually have a tertiary education and most countries have a formal method of certifying their qualifications. b) Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counselors. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals. 2) Non-clinical health workers - Non-clinical workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support. Disaggregation of doctors, nurses, and midwives is Essential/Reported. Countries are asked to also disaggregate by other cadres and clinical/non-clinical (as defined below) but this will not be reported to OGAC (Essential/Not reported). Other disaggregation which is up to the USG team to decide could include geographical location, training duration, urban/rural, public/private, gender etc. Other disaggregation for this indicator will not be collected at OGAC however, if the data were available by these disaggregations in country and reviewed along with survey or other human resources data, country teams could assess if the numbers and mix of health workers trained adequately match the human resource demands of the health system, according to each country's HRH strategy or plan. Based on this assessment, countries can determine how to prioritize investments in the education, recruitment, deployment and retention and training of health workers to maximize workforce expansion within the varieties of professionals that are most needed in line with national priorities around HRH. <u>Definition of PEPFAR **Direct** support</u> Direct PEPFAR support includes funding in the areas of curriculum development, teacher training and support, tuition/scholarships, infrastructure, materials/equipment, and practica/internships. For example, full or partial support of student tuition or scholarships, teacher salaries, expansion/refurbishment of pre-service training facilities, and remuneration to recent graduates to 'bridge' the time period between graduation and hiring/deployment could all count under this indicator depending on if the investment meets the criteria for Direct contained in this indicator reference guide. Refer to the principles of the Direct definition contained in this indicator reference guide in Appendix 5. In order to be counted, partial support must substantially

	contribute to pre-service training, meaning that individual or collective PEPFAR contributions must comprise the predominate quantity of support or be critical to production of a health worker.
Interpretation:	This indicator does not measure the quality of the pre-service training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals from their host country. Pre-service training is an essential component of human resources for health that is planned as part of an overall HRH strategy, which links the production of new health workers with service delivery needs and health systems capacity to recruit and retain newly trained health workers.

Health System Strengthening

HRH - Pre-Service Training – Community and Social Workers

Indicator #H2.2.D Essential/Reported	**Number of community health and para-social workers who successfully completed a pre-service training program**
Type of Indicator:	Direct
Numerator:	Number of community health and para-social workers who successfully completed a pre-service training program
Denominator:	NA
Disaggregation: Recommended	by sex
Purpose:	CHSWs are an important part of overall HRH strategies in countries but may not be captured through more formal training institutions and, in the case of PEPFAR Phase II, not captured in the indicator for 140,000 new health workers. It is important to quantify CHSWs for planning, expansion and setting supervisory ratios. Becoming a community health or para-social worker is often also an important first step to entering the heath workforce. In this way, supporting the development of CHSWs contributes to the pipeline for health workers.
Applicability:	All countries with PEPFAR-funded partners with a focus on expanding the quality and capacity of the workforce through the provision pre-service training to community health and social workers should report on this indicator.
Data collection frequency:	Data should be collected continuously from training facilities and HRIS and aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation from partners for the purposes of program management and review.
Measurement tool:	Training registries, HRIS
Method of measurement:	The number is the sum of community health and para-social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. "Pre-service" training comprises training that equips CHSWs to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. In the absence of international or national standards, the minimum requirement will be determined by the PEPFAR country team. "Para-social workers" and social support workers as defined for the purposes of this indicator receive anything from a few days of training up to 6 months of training. There is no exclusion for unpaid workers. It is up to countries to decide if they want to include unpaid workers and/or if they choose to disaggregate paid/unpaid workers. "Para-social" workers often work under the supervision of a professional social worker, nurse, or physician; this is a descriptor only for 'para-social' worker and not a condition/criterion in order to count for this indicator.

	Social support workers and unpaid workers provide some type of health related service and do not have the length or breadth of training to qualify as a health care professional or para-professional as defined in the pre-service Indicator #H2.1.D. An illustrative, but not exhaustive, list of examples of social support and unpaid workers: community health aides, community health workers, care givers, family support workers, peer educators, adherence counselors, expert patients, home health aides, lay counselors, lay health workers, palliative care givers, village health assistants, accompagnateurs, etc. Professional social workers generally have 4-7 years of training, and have completed undergraduate and/or graduate training in social work and are nationally recognized as a professional social worker. These professionals are NOT counted in this indicator, but should be counted under indicator #H2.1.D. Definition of PEPFAR Support: PEPFAR support includes funding for full or partial support of a pre-service training activity, including course development, training materials, trainer salaries, training site rental or renovation, participant per diem and travel costs. When unclear about the level of PEPFAR support, refer to the principles of the Direct definition. You will need to apply these principles to what you are counting.
Interpretation:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals. Although training is an essential component of human resources for health, programs should plan it in the context of effective human resources management and an overall HRH strategy.

Health System Strengthening
HRH - in-Service Training

Indicator #H2.3.D Essential/Reported	**Number of health care workers who successfully completed an in-service training program within the reporting period**
Type of Indicator:	Direct
Numerator: Essential/Reported	The number of health care workers who successfully completed an in-service training program
Denominator:	N/A
Disaggregation:	Essential/Reported: Male Circumcision and Pediatric Treatment Training Essential/Not Reported: All program areas
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. The data will tell us the number of health care workers who are available to support the mitigation of the HIV/AIDS epidemic each year as a result of full or partial PEPFAR support. This indicator will not be collected at OGAC by cadre of health care worker; however, if the data are available by cadre in country and reviewed along with survey or other human resources data, country teams could gain some understanding about whether the participants completing in-service training programs represent the correct ratio of health care worker cadres and whether the 'mix' of health care workers is the correct 'mix' to meet the human resource demands of the health system, according to each country's epidemiological profile and other factors. Based on this data, countries can determine how to prioritize investments in the education and on-going training of health care workers to maximize workforce expansion and capacity building within the cadres of professionals that are most needed.
Applicability:	All countries with PEPFAR-funded partners with a focus on expanding the quality and capacity of the workforce through the provision of in-service training should report on this indicator.
Data collection frequency:	Data should be collected continuously from training facilities and aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation from partners, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Program reports, Human Resource Information Systems, educational institutions, professional associations, Ministry of Education, Labor or Health. Note: these data were collected under PEPFAR I, however, it was done so by program area. Now, it will all be collected under one indicator, but will be disaggregated by program area, so that no new data forms need to be developed.
Method of measurement:	The number is the sum of health care workers who successfully completed an in-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. In the absence of international or national standards, the minimum requirement will be determined by the PEPFAR country team. Any individual involved in safeguarding and contributing to the prevention,

	promotion, and protection of the health of the population may be counted in this in-service training indicator. Refer to the pre-service training indicators #H2.1.D and #H2.2.D for illustrative, but not exhaustive, examples of the types of workers one might include. This in-service training indicator includes health workers as illustrated in indicator #H2.1.D and community health and para-social workers as illustrated in #H2.2.D. There are no specific exclusions to this in-service training indicator #H2.3.D. <u>Explanation:</u> Training is a learning activity taking place in in-country, a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently. Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or "hands-on" training such as clinical mentoring or structured supervision so long as the following three criteria are met: 1) Training objectives are clearly defined and documented 2) Participation in training is documented (e.g. through sign-in sheets or some other type of auditable training) 3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.) The unit of measure is the number of persons trained or retrained. A person is counted as having been trained if he or she participates in a workshop or course, sponsored with USG support (in whole or in part), with a specific training subject, area, theme or topic. Some examples of training domains are: (1) Delivering home-based care to HIV infected persons; (2) New methods for ensuring financial accountability; (3) Treatment of resistant HIV Infection; (4) Provincial M&E training. If a person attended all four of the above courses, for example, that person should be counted four times. If a person repeats the same training course, he/she should not be counted twice. Please count the staff/volunteers of your organization who were trained, as well as any additional individuals (e.g. from a different organization) that you may have trained in a USG-supported training course that your organization implemented. Only participants who complete the full training course should be counted. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training course should be counted in the next reporting period. Individuals attending more than one training in a particular program area during a reporting period should only be counted once. Individuals participating in training that covers more than one program area may be counted in each of the respective areas. If two partners are providing different aspects of training to the same individuals in the same program area (e.g. one partner provides classroom training, another provides clinical mentoring), each partner should report the number of persons uniquely trained by their respective organization, but should note which partner is

	providing the complementary training role and estimate the number of persons counted by both partners. In the specific case where USG-supported partners conduct training events that include the staff of sub-grantees, then the prime partner should report all the persons trained, in order to avoid double counting. In-service training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. In-service training may update existing knowledge and skills, or add new ones. Care should be taken to base trainee selection on content and skill needs. It requires a shorter, more focused period of time than pre-service education, and is often more "hands-on." It can be a workplace activity (led by staff, peers or guest lecturers) or an external event. In-service training can occur through structured learning and follow-up activities, or through less structured means, to solve problems or fill identified performance gaps. In-service training can consist of short non-degree technical courses in academic or in other settings, non-academic seminars, workshops, on-the-job learning experiences, observational study tours, or distance learning exercises or interventions. An in-service training program must meet national or international standards and have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. This indicator is distinct and separate from the indicator for pre-service training and education – a health care worker may be counted under both indicators ONLY if that worker has completed pre-service training and education distinct and separate from their in-service training in the same reporting period. Types of In-service Training: 1. Continuing education: Education/training offered to current providers to either update or add new knowledge and skills. While in-service training is often limited to practitioners in the public sector and/or managed by the Ministry of Health (or similar entity), continuing education is often used to describe education/training that is provided by other sources, such as professional associations, that reaches private sector practitioners and which can be linked to re- licensure and/or certification. 2. On-the-job training: Instruction in a specific task or skill is provided via mentoring by a practitioner using explanations, demonstration, practice and feedback. On-the-job training may be combined with academic or technical training to provide a practical experience component. 3. Computer based training: An interactive learning experience in which the computer provides most of the stimuli, the learner responds, and the computer analyzes the responses and provides feedback to the learner. Components most often consist of drill-and practice, tutorial, or simulation activities offered alone or as supplements to traditional instruction. CBT is sometimes also used as a component of a pre-service education course. 4. Distance learning: Distance learning is characterized by a geographic

	separation of instructor and learner where learners work on their own. It uses a range of mechanisms such as self-guided lesson plans, mailings, radio, and computer based activities. Usually it is tied to an educational facility and uses sequential instructional material that is corrected by the instructor. Regardless of methodologies chosen, it requires motivation on the part of the learner and regular feedback on the part of the learning institution. It can also be used for pre-service education. Explanation of Subsets: MALE CIRCUMCISION TRAINING: CIRCUMCISION TRAINING: Persons who receive in-service training in one or more of the following functions in the delivery of MC for HIV prevention services should be counted in this sub-set: 1) MC provider/surgeon (persons who surgically remove the foreskin, regardless of whether they are a physician, nurse, clinical officer, etc.); 2) surgical assistant; 3) counselor (persons who provide education and counseling of clients on MC); and/or 4) ancillary staff (persons who perform sterilization and preparation of surgical instruments/equipment). Training may be for infant or adolescent/adult MC surgical methods. Persons who receive training to perform multiple functions (i.e., as both counselor and surgical assistant), and persons trained in multiple methods (infant and adolescent/adult methods) should only be counted once. Programs should focus on compiling data on male circumcision training from Training Registers maintained by funded programs. MC for HIV prevention services in adolescents/adults is comprised of a minimum package of components that includes elective surgical male circumcision using local anesthesia provided after education and consent and delivered in the context of comprehensive pre-operative HIV counseling and testing (offer of), pre-operative STI assessment (and treatment when indicated), post-operative HIV risk reduction counseling and abstinence/healing instructions, and provision of condoms. PEDIATRIC TREATMENT TRAINING: Persons who receive in-service training to perform a key function in the pediatric treatment should be counted in this sub-set. Pediatric treatment in-service training will fall into the following categories for this indicator: - Nurse - Counselor - Clinical Officer - Physician - Health Surveillance Advisor (HSA) - Pharmacist In-service training for the purposes of this indicator includes the following modalities in addition to traditional classroom training and workshops: - Issues in pediatric treatment - Dosing for children - Adherence counseling for children - Appropriate clinical monitoring of therapy Definition of PEPFAR support: PEPFAR support includes funding for full or partial support of an in-service training activity, including course development, training materials, trainer salaries, training site rental or renovation, participant per diem and travel costs.

	When unclear about the level of PEPFAR support, refer to the principles of the Direct definition. You will need to apply these principles to what you are counting.
Interpretation:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals. Although training is an essential component of human resources for health, programs should plan it in the context of effective human resources management and an overall HRH strategy.

National Level Indicators

ESSENTIAL Reported to HQ

Summary ESSENTIAL National Indicators Reported to HQ

Indicator #	Indicator Label
P1.1.N	Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
P1.2.N	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
C2.1.N	Number of eligible adults and children provided with a minimum of one care service
T1.2.N	CURRENT: Percent of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)
H2.1.N	Number of new health workers who graduated from a pre-service training institution within the reporting period

Prevention

Prevention of Mother to Child Transmission (PMTCT)

Indicator P1.1.N Essential/Reported	**Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results**
Type of Indicator:	National
Numerator: Essential/Reported	The number of women attending ANC, L&D, and postpartum services who were tested for HIV and received their results, and women with known HIV infection attending ANC for a new pregnancy in the last 12 months. -The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period -The number of women attending ANC, L&D who were tested for HIV and received results
Denominator: Essential/Reported	Estimated number of pregnant women in the last 12 months *Note: The denominator will be incorporated into COPRs by PEPFAR Headquarters. However, PEPFAR in country teams will have the opportunity to add an additional source of data.*
Disaggregation Essential/Not reported	Numerator: Known positives at entry Number of new positives identified
Purpose:	This indicator reflects one goal of PMTCT, which is to increase the number of pregnant women who know their HIV status. Identification of a pregnant woman's HIV status is the key entry point into PMTCT services and other HIV care and treatment services. These data will be important to: • Identify progress toward the USG goal to reach 80% of pregnant women with HIV testing and counseling • Determine national coverage of PMTCT HIV testing and support national scale-up
Applicability:	All PEPFAR country programs supporting PMTCT direct service delivery and programs supporting the national PMTCT program through system strengthening or other capacity building activities.
Data collection frequency:	Annually, according to national reporting cycles
Measurement tool:	Facility registers and other program monitoring tools
Method of Measurement	The numerator is the sum of categories a-d below: a) Number of pregnant women who received an HIV test and result during ANC b) Number of pregnant women attending L&D with unknown HIV status who were tested in the L&D and received results c) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results d) Pregnant women with known HIV infection attending ANC for a new pregnancy. <u>Explanation:</u> Numerator: The numerator is calculated using national and/or PEPFAR program records aggregated from facility registers in the ANC and L&D. In countries with high

	L&D attendance rates (>90%), data can be collected from L&D registers only. Health facility registers should reflect known HIV infection among HIV-positive pregnant women coming to the ANC for a new pregnancy, such as through a code, circle, or other method, in order for them to receive subsequent PMTCT interventions. *Pregnant women with unknown status*: women who were not tested during ANC or at L&D for this pregnancy or did not have documented proof of having been tested during ANC or at L&D for this pregnancy. *Pregnant women with known HIV-infection*: women who were tested and confirmed HIV-positive at any point prior to the current pregnancy, who are attending ANC for a new pregnancy. Pregnant women with known HIV infection attending ANC for a new pregnancy do not need retesting if that is in line with the national guidelines on testing pregnant women and/or, as long as they bring documented proof of their positive status with them. However, these women do need subsequent PMTCT services, and should be counted in the numerator. In this case, documented proof may include (but is not limited to), a health card with HIV status noted in it, test results from another testing center, or any other document that denotes that the bearer of the document is HIV positive. <u>Denominator:</u> The denominator is generated through a population estimate of the number of pregnant women giving birth in the last 12 months, which can be obtained from the Central Statistics Office estimates of births or the UN Population Division estimates Note: This indicator is meant to measure the number of pregnant women who know their HIV status and is not meant to provide programmatic guidance. All HIV testing programs should be based on national or international standards.
Interpretation:	This indicator enables the USG PEPFAR team to monitor trends and uptake in HIV testing among pregnant women at the National level The points at which drop-outs occur during the testing and counseling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counseling. It also does not capture the number of women who received pre-test counseling. There is a risk of double counting with this indicator, as a pregnant woman could be tested multiple times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, countries should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place.
Additional Information:	- #7, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

	- Partially harmonized with Prevention indicator (HIV-P11), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Prevention

Prevention of Mother to Child Transmission (PMTCT)

Indicator #P1.2.N Essential/Reported	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Type of Indicator:	National
Numerator: Essential/Reported	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission
Denominator: Essential/Reported	Estimated number of pregnant HIV-positive women in the last 12 months *Note: The denominator will be incorporated into COPRS by PEPFAR Headquarters using SPECTRUM estimates. However, PEPFAR in country teams will have the opportunity to add an additional source of data.*
Disaggregation: Essential/Not reported	Denominator disaggregated by: Known positive at entry Newly tested positive Numerator disaggregated by regimen type (mutually exclusive choices). 1. Life-long ART (including Option B+) disaggregated by a. newly initiated on treatment during the current pregnancy b. already on treatment at the beginning of the current pregnancy 2. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery) 3. Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery) 4. Single-dose nevirapine (with or without tail)
Purpose:	This indicator measures the provision and coverage of antiretroviral prophylaxis and treatment, by regimen type, for HIV-positive pregnant women in order to: • Identify progress toward the global goals of increasing ARV coverage (prophylaxis and treatment) among pregnant women living with HIV • Assess progress toward implementing more efficacious PMTCT ARV regimens • Determine the coverage of HIV+ pregnant women on ARV prophylaxis and ART for life among all HIV+ pregnant women identified • Provide data for models estimating the country-specific and global impact of PMTCT programs
Applicability:	All PEPFAR country programs supporting PMTCT direct service and programs supporting the national PMTCT program through system strengthening or other capacity building activities.
Data collection frequency:	Annually, according to national reporting cycles
Measurement tool:	Facility registers and other program monitoring tools
Method of measurement:	The numerator can be generated by counting the number of HIV-positive pregnant women who received antiretrovirals to reduce MTCT in the reporting period, by regimen. <u>Explanation of Numerator:</u> The number of HIV-positive pregnant women who received antiretrovirals for prophylaxis or treatment during pregnancy or during labor and delivery (L&D),

deduplicated.

Disaggregation of regimen definitions

Categories	Further clarification	Common examples
1) Life-long antiretroviral therapy (including Option B+) disaggregated by 1a) newly initiated on treatment during the current pregnancy 1b) already on treatment at beginning of pregnancy	A three-drug regimen intended to provide ART for life 1a) # of HIV-positive pregnant women identified in the reporting period newly initiated on ART for life 1b) # of HIV-positive pregnant women identified in the reporting period who were already on ART at their first ANC visit. If a woman is initiating ART for life (including Option B+) at L&D then she should be counted in category 1a.	Standard national treatment regimen, for example: • TDF+3TC+EFV • AZT+3TC+NVP
2) Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	A three-drug regimen provided for MTCT prophylaxis started antenatally or as late as during L&D with the intention of stopping at the end of the breastfeeding period (or stopping at delivery if not breastfeeding) If a woman is receiving ARVs for the first time at L&D then she should still be counted in this category if the facility is implementing Option B.	• TDF+3TC+EFV • AZT+3TC+EFV • AZT+3TC+LPV/r
3) Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	A prophylactic regimen that uses AZT (or another NRTI) started as early as 14 weeks or as late as during L&D to prevent HIV transmission If a woman is receiving ARVs for the first time at L&D, then she should still be counted in this category if the facility is implementing Option A.	• AZT at any point before L&D + intrapartum NVP • AZT at any point before L&D + intrapartum NVP +7 day post-partum tail of AZT/3TC • Intrapartum NVP +/- 7 day post-partum tail + extended NVP for infant
4) Single-dose nevirapine (with or without a tail)	Count SD-NVP if: • It is the **ONLY** option provided to an HIV-positive pregnant woman either antenatally or during L&D (this includes use	• SD-NVP for mother ONLY at onset of labor • SD-NVP + 7 day AZT/3TC tail ONLY • SD-NVP for mother at

	of a tail*) Do NOT count SD-NVP if: • NVP is provided as part of Option A antenatally or • An HIV+ pregnant woman is initiated on Option A, B, or B+ at labor and delivery *The tail is used to prevent NVP resistance. It does not alter risk of transmission and therefore does not constitute a different regimen.	onset of labor and SD NVP for baby ONLY

The following should be considered in reporting:

- A woman should only be counted in a regimen category if she actually received the regimen. Referral alone for ARVs or ART should not be counted unless regimen initiation is confirmed.
- Each ARV regimen category is mutually exclusive. Each pregnant woman should only be counted once. If a pregnant women receives different ARV regimens at different points during the pregnancy, count only the most recent regimen provided to her in the reporting period.
- Because ARVs for prophylaxis or treatment can be provided to HIV-positive women at different sites including ANC, L&D and care & treatment, Ssteps should be taken to deduplicate patients counted at multiple sites. For example:
    - A woman, who is already on treatment, becomes pregnant and enrolls in ANC/PMTCT because she is HIV-positive. While she may not be receiving drugs at the ANC/PMTCT site, she should be counted within the life-long ART disaggregation for this indicator.
    - A woman receives AZT prophylaxis at her first ANC visit. After receiving her CD4 results, she is moved to a life-long ART regimen. In this case she should be counted and reported only once under life-long ART
    - In settings with high facility delivery rates (>90%), countries may consider aggregating the numerator entirely from the L&D register by counting the number of HIV-positive pregnant women who received a specific ARV regimen by the time of delivery. This method likely minimizes double-counting.

<u>Denominator</u>:

Two methods can be used to generate the estimate for the denominator:

1) Estimates generated by a projection model such as Spectrum, or
2) Multiplying: The total number of women who gave birth in the last 12 months, which can be obtained from the Central Statistics Office estimates of births or the UN Population Division estimates, by the most recent national estimate of HIV prevalence in pregnant women, which can be derived from HIV sentinel surveillance in antenatal clinic estimates.[1]

(1) Where services are offered in *different service units* (ie. SD-NVP is dispensed at ANC and AZT is dispensed at care and treatment) - it is recommended that countries

	use a single register source from which to compile data, such as the ANC/PMTCT register. This could be done by transferring data on ARVs provided, from one service unit to the ANC/PMTCT register. (2) Where ARVs are dispensed at *different points in time*, countries could include a mechanism to subtract women who have already received another drug during pregnancy in the summary reporting form, and to then report by regimen. (3) Report data retrospectively by reviewing data at the end of pregnancy period. National estimates of HIV-infected pregnant women should be derived by adjusting surveillance data from antenatal clinic sentinel sites and other sources, taking into consideration characteristics such as rural/urban patterns of HIV prevalence that may affect the representation of surveillance sites.
Interpretation:	This indicator allows countries to monitor: 1) the coverage of antiretrovirals given to HIV-positive pregnant women to reduce the risk of HIV transmission to the child; and 2) increased access to more efficacious ARV regimens for PMTCT in countries that are scaling up newer regimen categories. One weakness of this indicator is the exclusion of mother-infant pairs who only received infant prophylaxis. Therefore, partial prophylaxis for the infant only is not measured. The indicator measures ARVs dispensed and not ARVs consumed, thus it is not possible to determine adherence to the ARV regimen. It is recognized that due to the way in which data is collected and reported in many countries, some level of duplication may be inevitable. Additionally, there may be over or undercounting of certain regimens based on data collection methodologies.
Additional Information:	- Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive Monitoring Framework http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-elimination-HIv-Children_en.pdf - Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/manual/2009/jc1676_core_indicators_2009_en.pdf - Core Indicators for National AIDS Programmes. Guidance and Specifications for Additional Recommended Indicators. April 2008 http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/JC1768-Additional_indicators_v2_en.pdf - The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit 4th Edition. November 2011 http://www.theglobalfund.org/en/me/documents/toolkit/

CARE

Indicator #C1.1.N Essential/Reported	Number of eligible adults and children provided with a minimum of one care service
Type of Indicator:	National
Numerator: Essential/Reported	Number of adults and children provided with a minimum of one care service
Denominator:	N/A
Disaggregation:	*Recommended* Males *Recommended* Females **Required** *<18 years of age* **Required** *18+ years of age* *Recommended* *<1* *Recommended* *<5* *Recommended* *<15* Age represents an individual's age at the end of the reporting period or when last provided with a support service.
Purpose:	PEPFAR has a legislative 5-year goal to care for 12 million individuals, including care services to 5 million children orphaned or made vulnerable by HIV. PEPFAR recognizes that individuals, families, and communities are being 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. A variety of services are supported through PEPFAR to mitigate these effects in order to improve health outcomes for HIV positive, improve the developmental growth of children, and optimize the quality of life of adults and children living with and affected by HIV This indicator measures the number of individuals receiving care services through PEPFAR. Data collected through this indicator will inform country programs and PEPFAR about the scale-up of services for individuals affected by HIV, and will be used to report against the legislative 5-year goal of 12 million individuals. The age disaggregation (<18) will be used to report on the goal of 5 million children who are orphaned or made vulnerable due to HIV.
Applicability:	All PEPFAR country programs providing direct support to activities that traditionally fell under the Care and Support or OVC technical program areas (see appendix 2 for menu of support services and clinical services). All PEPFAR country programs supporting the national OVC or CARE programs through system strengthening or other capacity building activities
Data collection frequency:	Annually, according to national reporting cycles
Measurement tool:	Registers/databases, client records and registers, or other program monitoring tools. Programs may need to modify the revised WHO Pre-ART/ART registers to capture this data.
Method of measurement:	The numerator is generated by counting the number of eligible individuals who received at least one care service from facilities and/or community/home-based organizations. This is the number of **unique individuals** receiving care services.

	Definitions: PEPFAR CARE programs include both support and clinical services Clinical Services – Include a broad range of services related to the specific clinical needs of HIV-positive persons. Clinical services may be provided in facilities, the community, or in the home, and may include both *assessment* of the need for interventions (for example assessing pain, clinical staging, eligibility for cotrimoxazole, or screening for tuberculosis) or provision of needed interventions. These services are further defined under the CARE indicator for Clinical Services for HIV-positive. See appendix 2 for the full menu of clinical services. Support Services – Include a broad range of services, which provide social, psychological, or spiritual support and are appropriate for all persons who are affected by HIV, including people living with HIV/AIDS (PLWHA). Support services fall into these broad categories: Psychological, spiritual, preventive, food support*, shelter, protection, access to health care, education/vocational training, and economic strengthening. See appendix 2 for the full menu of support related services. Individuals eligible for care services -People living with HIV/AIDS (PLWHA) -Family members, caregivers, or other household members living with an HIV-positive individual -Children orphaned by HIV (<18 years old) -Children made vulnerable due to HIV (<18 years old) (e.g. in high prevalence communities due to break down in community support, loss of teachers, or other social norms as a result of HIV epidemic) -Infants born to HIV-infected mothers The aggregated total for this indicator is not simply the sum of services but rather a de-duplicated count of individuals in CARE. Overlap of services provided by facility-based care and support and community/home-based care and support partners must be adjusted for so that individuals are counted only once in the aggregated total.
Interpretation:	This is a high-level indicator that provides the total number of all individuals receiving care services through PEPFAR from facilities and/or community/home-based organizations. While an individual must receive at least one care service to be counted, this indicator does not articulate what type of service was provided, or where it was provided. However, subsets of this high-level indicator counting individuals services can provide more specificity regarding types of populations and services received.
Additional Information:	• Partially harmonized with Care and support (HIV-CS2), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009
	http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf • WHO Pre-ART/ART registers http://www.who.int/hiv/pub/imai/imai_registers_preart.pdf

Treatment
ARV Services

Indicator #T1.2.N Essential/Reported	**CURRENT: Percent of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)**
Type of Indicator:	National
Numerator: Essential/Reported	Number of adults and children with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period
Denominator: Essential/Reported	The estimated number of adults and children with advanced HIV infection. *Note: The denominator will be incorporated into COPRs by PEPFAR Headquarters using SPECTRUM estimates. However, PEPFAR in country teams will have the opportunity to add an additional source of data.*
Disaggregation:	Recommended: <1 Essential/reported: <15 Essential/reported: 15+ Essential/reported: Males Essential/reported: Females
Purpose:	To assess progress towards providing ART to all people with advanced HIV infection; Coverage; Track progress towards legislative 5-year goals.
Applicability:	All PEPFAR country programs supporting ART direct service delivery and programs supporting the national ART program through system strengthening or other capacity building activities.
Data collection frequency:	Annually, according to national reporting cycles
Measurement tool:	Numerator: Facility ART registers/databases, program monitoring tools, or drug supply management systems. Denominator: SPECTRUM model
Method of measurement:	The numerator can be generated by counting the number of adults and children who received ART at the end of the reporting period. The numerator should equal the number of adults and children with advanced HIV infection who ever started ART minus those patients who are not currently on treatment prior to the end of the reporting period. Patients excluded from the numerator are patients who died, stopped treatment, transferred out or are lost to follow-up (patient not seen for 3 months from last visit). Patients on ART who initiated or transferred in during the reporting period should be counted. Patients that pick up several months of antiretroviral drugs at one visit, which could include ART received for the last months of the reporting period, but not be recorded as visits for the last months should be included in the count. ART taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are eligible for and on antiretroviral drugs for their own treatment are included in this indicator. The number of adults and children with advanced HIV infection who are currently receiving ART can be obtained through data collected from drug supply

	management systems or facility-based ART registers. Patients receiving ART in the private sector and public sector should be included in the numerator for the country as a whole. CURRENT is a state defined by vital/treatment status when *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Age represents an individual's age at the end of the reporting period or when last seen at the facility. For example, a 14-year-old child will be counted as currently receiving treatment in the <15 age category at the end of reporting period "A". During reporting period "B" the child turns age 15 and so at the end of this reporting period the child will be counted under the 15+ age category. **SEE INDICATOR #T1.2.D FOR THE WHO CASE DEFINITIONS OF HIV FOR SURVEILLANCE AND REVISED CLINICAL STAGING AND IMMUNOLOGICAL CLASSIFICATION OF HIV-RELATED DISEASE IN ADULTS AND CHILDREN (2007)**
Interpretation:	This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of ART or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. The proportion of people needing ART varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of ART among adults and children. The degree of utilization of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counseling and testing services, and perceptions of effectiveness and possible side effects of treatment.
Additional information	#4, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2008 Reporting, United Nations General Assembly Special Session [UNGASS]. April 2007http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf • Treatment indicator (HIV-T1), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Health System Strengthening
HRH - Pre-Service Training – Health Workers

Indicator #H2.1.N Essential/ Reported	**Number of new health workers who graduated from a pre-service training institution within the reporting period**
Type of Indicator:	National
Numerator: Essential/Reported	A count of the number of new health workers who graduated from a pre-service training institution or program
Disaggregation: Essential/Not Reported	By doctors, nurses, midwives By other cadres By clinical/non-clinical
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. PEPFAR's legislative goal for new health workers is intended to support the production of health workers in each country through pre-service training. The data will tell us the number of new health workers who are available to enter the health work force each year as a result of full or partial PEPFAR support. This indicator is meant to capture the spirit of PEPFAR legislation and will be used in conjunction with other indicators and measures to report to congress on PEPFAR contributions to the national health workforce.
Applicability:	All USG PEPFAR countries supporting HRH or training programs
Data collection frequency:	Annually, according to national reporting cycles
Measurement tool:	Human Resource Information Systems, pre-service training institutions, professional associations, Ministry of Education or Health Public Service Database HRIS, MOH HRIS, Ministries of Social Welfare HRIS, Councils and other professional associations, Alumni Networks/Graduates Networks, HRH Plans, Implementing partners. MOH Human Resource Information Systems (HRIS), pre-service training institutions, professional associations, Ministry of Education, Public Service , and/or private sector HRIS , Ministry of Social Welfare HRIS, professional boards and councils, alumni or graduates networks, Health Sector or HRH Strategic Plans, Implementing partners.
Method of measurement:	The number is the sum of new health workers from the host country who graduated from a pre-service training institution within the reporting period. Individuals may be in pre-service training over a number of years, but can be counted as graduated when they have completed their program. Graduates do not need to attend a formal ceremony – completing the program and being eligible to enter into service is sufficient. Local pre-service institutions may support other host country nationals under their program but those graduates should not be included in a country's report on this indicator. <u>Explanation:</u> Training under this indicator is defined as "pre-service" training – the training of "new" health workers (see definition below). All training must occur prior to the individual entering the health workforce in his or her new position. A health worker who

	advances to a higher cadre (e.g., nurse completes medical school to become a doctor, clinical assistant completes training to become a clinical officer) shall be counted as a "new" health worker for the purposes of this indicator. Pre-service training institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre's entry into the workforce. "In-service" and "continuing education" training should not be included in the count for this indicator, but continue to be encouraged by PEPFAR. These types of training may be captured by other indicators. A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted. Successful completion of training may be documented by diploma, certificate, or other evidence of completion of the program and subsequent eligibility to enter service. Individuals not meeting these documented requirements should not be counted in this indicator. In order to count the duration of training must meet or exceed a minimum of 6 months. For example, community health care workers who receive a 3-month training course cannot be counted here (use indicator H2.2.D to account for direct pre-service training under 6 months). "Health workers" refers to individuals involved in safeguarding and contributing to the prevention, promotion and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. This not an exhaustive list of all health workers and position titles may vary from country to country. For the purposes of this indicator, health workers include the following: 1) Clinical health workers – Clinical health workers play clinical roles in direct service delivery and patient care: a) Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, social workers, medical technologists, and psychologists; They usually have a tertiary education and most countries have a formal method of certifying their qualifications. b) Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counselors. They usually have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.

	2) Non-clinical health workers - Non-clinical workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, human managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support. Additional recommendations on disaggregation include geographical location, training duration, urban/rural, public/private, gender etc. if the data were available by these disaggregation in country and reviewed along with survey or other human resources data, countries could assess if the numbers and mix of health workers trained adequately match the human resource demands of the health system, according to each country's HRH strategy or plan. Based on this assessment, countries can determine how to prioritize investments in the education, recruitment, deployment and retention and training of health care workers to maximize workforce expansion within the varieties of professionals that are most needed in line with national priorities around HRH.
Interpretation:	This indicator does not measure the quality of the pre-service training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals from their host country. Pre-service training is an essential component of human resources for health that is planned as part of an overall HRH strategy, which links the production of new health workers with service delivery needs and health systems capacity to recruit and retain newly trained health workers.

National Level Indicators

ESSENTIAL
Not Reported to HQ

Summary ESSENTIAL National Indicators Not Reported to HQ

Indicator#	Indicator Label
P1.7.N	Percentage of infants born to HIV-infected mothers who are infected
P2.1.N	Percentage of donated blood units screened for HIV in a quality assured manner
P6.2.N	Percentage of health facilities with HIV post-exposure prophylaxis (PEP) available
P8.8.N	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
P8.9.N	Percent of never married young men and women aged 15–24 who have never had sex
P8.10.N	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.
P8.11.N	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
P8.12.N	Percent of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom their last sexual intercourse.
P8.19.N	Percentage of young people aged 15-24 who report they could get condoms on their own
P8.22.N	Percent of the general population with accepting attitudes toward PLWHA
P8.23.N	Percentage of young women and men aged 15–24 who are HIV infected
P9.1.N	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
P9.2.N	Percentage of female and male sex workers reporting the use of a condom with their most recent client
P9.3.N	Percent of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse
P9.4.N:	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
P9.5.N	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
P9.17.N	Percentage of most-at-risk populations (IDU, MSM, SW) who are HIV-infected
P11.2.N	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their test results
C3.1.N	Number of TB patients who had an HIV test result recorded in the TB register
C3.2.N	Percent of estimated HIV-positive incident TB cases that received treatment for TB and HIV
C4.2.N	Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth
T1.5.N	Percentage of health facilities that offer ART
T1.6.N	Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral
H3.1.N	Domestic and international AIDS spending by categories and financing sources
H5.3.N	Percentage of health facilities providing ART that experienced stock-outs of ARV in the last 12 months
H6.3N	National Composite Policy Index (NCPI)

Prevention
PMTCT

Indicator #P1.7.N Essential/Not reported	**Percentage of infants born to HIV-infected mothers who are infected**
Type of Indicator:	National Outcome
Numerator:	The numerator is the number of infants (born to HIV-infected mothers) who are HIV-infected. This is calculated with a statistical model drawing on the following data: a) Number of HIV-infected pregnant women (denominator of several Core Indicators described in this guide); b) Number or percentage of HIV-infected pregnant women who received the different combination ARV prophylactic and treatment regimens, disaggregated by regimen category (indicator P1.2D); c) Distribution of infant-feeding practices: EBF, RF, MF (indicator C4.1D); d) Default values for mother-to-child transmission rates based on various ARV regimen and infant-feeding practice categories. The mother-to-child transmission rate differs depending on the ARV regimen category received and infant-feeding practice. Based on the proportion of women who fall into various categories of b) and c), above, an overall mother-to-child HIV transmission rate can be calculated.
Denominator:	Estimated number of HIV-infected pregnant women.
Disaggregation:	N/A
Purpose:	In the absence of preventative interventions, infants born to, and breastfed by, HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labor and delivery, or after delivery through breastfeeding. The risk of MTCT can be reduced through the complementary approaches of antiretroviral prophylaxis for the mother, with or without prophylaxis to the infant, implementation of safe delivery practices, and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months. This indicator allows assessment of progress toward eliminating mother-to-child HIV transmission.
Applicability:	All countries
Data collection frequency:	Annual, or more frequently, depending on country's monitoring needs
Measurement tool:	Statistical modeling based on program coverage and efficacy studies
Method of measurement:	The indicator is calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving the various combination ARV prophylactic and treatment regimens, as well as the distribution of infant-feeding practices. Data for the numerator is drawn from national program records. Data required for the modeling can be collected through indicators P1.2D and C4.1D. The data can be inputted into a computer-modeling program, such as Spectrum, commonly used for HIV projections. This will assess the impact of the PMTCT programs by estimating the proportion of infants born to HIV-infected women who are infected. Other Excel-based spreadsheets, such as

	the "MTCT rate calculator", (developed by the United States Centers for Disease Control and Prevention), also facilitate this estimation.
Interpretation:	This indicator focuses on the prevention of mother-to-child transmission of HIV through increased provision of antiretroviral drugs. Thus, the effect of breastfeeding on mother-to-child transmission of HIV is ignored and the indicator may yield underestimates of true rates of mother-to-child transmission in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of mother-to-child transmission of HIV (e.g. caesarean section) are widely practiced, the indicator will typically provide overestimates of mother-to-child transmission. For these reasons, trends in this indicator may not reflect overall trends in mother-to-child transmission of HIV. This indicator allows one to assess the impact of PMTCT programs by *estimating* the percentage of infants who are HIV-infected out of those born to HIV-infected pregnant women. Where possible, countries should try to monitor the impact of PMTCT using actual data on the HIV status and survival of infants born to HIV-infected women, gathered during follow-up health care visits with these infants. It is difficult to follow-up on mother-infants pairs, particularly at the national level, due to the time lag in reporting and wide range of health facility sites. However, in countries where data are available and confirmatory tests are systematically being conducted, an effort should be made to monitor the percentage of HIV-infected infants born to HIV-infected mothers using actual data for the numerator and denominator. For further information on Spectrum please consult the webpage of the UNAIDS/ WHO Estimates and Projections Reference Group listed below.
Additional Information:	- Draft Guide to Monitoring and Evaluating National Programs for the Prevention of Mother-to-Child Transmission, Core Indicator 11 - #25, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf

Prevention
Blood Safety

Indicator #P2.1.N Essential/Not reported	**Percentage of donated blood units screened for HIV in a quality assured manner**
Type of Indicator:	National Outcome
Numerator:	Number of donated blood units screened for HIV in a quality assured manner.
Denominator:	Total number of blood units donated.
Disaggregation:	N/A
Purpose:	Blood safety programs aim to ensure that all blood units are screened for transfusion-transmissible infections, including HIV, and that only those units that are non-reactive on screening tests are released for clinical use. In many countries, blood units are not screened for all the major transfusion-transmissible infections. Often, even when screening does occur, the safety of blood is compromised by inaccurate test results due to the poor quality or incorrect storage of test kits. Furthermore, inadequate staff training or a lack of standard operating procedures may result in laboratory errors. This could lead to blood units being classified as safe even when they are infectious, posing a serious risk of transmission of HIV through unsafe blood. Universal (100%) screening of donated blood for HIV and other transfusion-transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. In some countries, interruptions to supplies of test kits and reagents, or emergency situations, can result in the use of blood for transfusion without screening for transfusion-transmissible infections. The development of systems for reliable and regular supplies of low-cost, high-quality test kits and reagents and effective stock management are therefore essential to ensure universal quality screening of blood units. Thus, it is crucial that all donated blood units be screened for HIV in a quality-assured manner. The following methodologies are two key components of quality assurance in screening. 1. The use of documented and standardized procedures (standard operating procedures) for the screening of every blood unit. 2. Participation of the laboratories in an External Quality Assessment Scheme for HIV screening in which external assessment of the laboratory's performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.
Applicability:	All countries
Data collection frequency:	Annual
Measurement tool	Program monitoring. FRAME Tool (Framework for Assessment, Monitoring and Evaluation of blood transfusion services): a rapid assessment tool used by the WHO Global Database on Blood Safety
Method of measurement:	Explanation of numerator: For the purposes of data collection screening in a quality assured manner if defined as screening performed in blood centers/ blood screening laboratories that (i) follow documented standard operating procedures *and* (ii) participate in an external quality assurance (EQA) scheme Explanation of denominator: In this context, donation refers to any blood collected for the purposes of medical use. This includes all possible types of providers of

blood, regardless of whether they receive remuneration or not.

The information relates to data from the previous 12 months (January–December). This information should be available from the National Blood Transfusion Service or the officers responsible for the National Blood Program in the Ministry of Health.
The following information is required to measure this indicator.
1. The total number of blood units that were donated in the country
2. For each blood center and blood screening laboratory that screens donated blood for HIV:
   i. The number of units of blood donated in each blood center/blood screening laboratory;
   ii. The number of donated units screened in the blood center/blood screening laboratory;
   iii. If the blood center/blood screening laboratory followed documented standard operating procedures for HIV screening;
   iv. If the blood center/blood screening laboratory participated in an External Quality Assessment Scheme for HIV screening.

From this information, the indicator can be calculated.
Examples of the data needed to calculate this indicator are shown below:

	Quality Assurance in HIV screening		Blood units		
Name of the blood center or blood screening laboratory	Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Screened blood	Blood screened in quality-assured manner
A	Yes	Yes	1000	1000	1000
B	Yes	No	800	450	0
C	No	Yes	150	50	0
D	No	No	50	0	0
Total	2	2	2000	1500	1000
	[number of facilities]		[number of blood units]		

Thus, the percentage of donated blood units screened for HIV in a quality-assured manner in the previous 12 months is: 1000 / 2000 = 50%.

Interpretation:

If the blood screening laboratory follows documented and standardized procedures for the screening of blood, this implies a certain level of uniformity, reliability and consistency of performance by staff trained to use the standard operating procedures. If a blood screening laboratory participates in an External Quality Assurance Scheme, this implies that the quality of HIV screening performed is being assessed at regular intervals. It is important to view the percentage of screened blood units in relation to these two basic components of quality as both are required to ensure the quality of procedures.
Countries provide data to the WHO Global Database on Blood Safety on this indicator annually. Locally, these data can be obtained by contacting the National Blood Transfusion Service, the National Blood Program and/or the National AIDS Program.

Additional Information:

- #3, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009
http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf
- www.who.int/bloodsafety
- www.who.int/diagnostics_laboratory
- www.who.int/worldblooddonorday

Prevention
Post-exposure Prophylaxis (PEP)

Indicator #P6.2.N Essential/Not reported	**Percentage of health facilities with HIV post-exposure prophylaxis (PEP) available**
Type of Indicator:	National Outcome
Numerator:	Number of health facilities with PEP available for those who are at risk of HIV infection through occupational and/or non-occupational exposure to HIV
Denominator:	Total number of health facilities.
Disaggregation:	By exposure type: Occupational and Non-Occupational
Purpose:	This indicator measures the availability of post-exposure prophylaxis (PEP) in health facilities. PEP reduces the probability of HIV infection after exposure to potentially HIV-infected blood or body fluids. For maximum effectiveness, PEP should be provided within hours after exposure. PEP may be provided following occupational exposure (for example, in healthcare facilities) or non-occupational exposure (such as after sexual assault). Within the health sector, PEP should be provided as part of a comprehensive standard precautions package that reduces staff and patient exposure to infectious hazards in health care settings. PEP for non-occupational exposure should be considered for sexual assault survivors, particularly in high HIV prevalence countries.
Applicability:	Countries with generalized epidemics.
Data collection frequency:	Annual for program records; every 2-3 years for facility survey/census.
Measurement tool:	Program monitoring tools and reports, facility surveys/census, including Service Provision Assessment (SPA), Service Availability Mapping (SAM). National monitoring and evaluation system* or other source documentation provided by host government.
Method of measurement:	*(Number of health facilities with PEP available/ Total number of health facilities) x 100* The numerator is calculated by summing of the number of facilities reporting availability of PEP services. Information on the availability of specific services is usually kept at the national or sub-national level. National AIDS Programs should have a record of all health facilities that provide PEP services. A health facility census or survey can also provide this information, along with more in-depth information on available services, provided the information is collected from a representative sample of health facilities in the country. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years. Countries should regularly update their program records on the availability of PEP services in health facilities, and supplement these data with those obtained through a health facility survey or census every few years. The denominator is calculated by summing the total number of health facilities included in the sample. Information for construction of the denominator may come from program records, facility listings, and/or national strategy or planning documen

Interpretation:	This indicator provides valuable information about the availability of post-exposure prophylaxis (PEP) in health facilities, but it does not capture the type and quality of PEP services provided. The full range of PEP services includes first aid, counseling, HIV testing, provision of ARVs, and patient follow-up and support. Simple monitoring of PEP availability through program records does not ensure that all PEP-related services are adequately provided to those who need them. Nevertheless, it is important to know what percentage of health facilities provide PEP services in order to plan for service expansion as needed.
Additional Information:	- #1, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Partially harmonized with Prevention indicator (HIV-P15), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.8.N Essential/Not reported	**Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**
Type of Indicator:	National Outcome
Numerator:	Number of respondents aged 15-24 years who gave the correct answer to all five questions
Denominator:	Number of all respondents aged 15–24
Disaggregation:	By Sex: Male, Female By Age: 15-19, 20-24
Purpose:	To assess progress towards universal knowledge of the essential facts about HIV transmission
Applicability:	All countries
Data collection frequency:	Preferred: every two years; minimum: every 4–5 years
Measurement tool:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected? The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: "Can a person get HIV by hugging or shaking hands with a person who is infected?" and "Can a person get HIV through supernatural means?" Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of "don't know" should be recorded as an incorrect answer. The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15-19 and 20–24 years. Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.
Interpretation:	The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behavior, while belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with HIV/AIDS. This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it

	can be used to ensure that pre-existing high levels of knowledge are maintained.
Additional Information:	#14, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.9.N Essential/Not reported	**Percent of never married young men and women aged 15–24 who have never had sex**
Type of Indicator:	National Outcome
Numerator:	Number of never married young women and men who have never had sex
Denominator:	Number of never married young women and men aged 15–24 surveyed
Disaggregation:	By Sex: Male, Female By Age: 15-16, 17-18, 19-20, 21-22, and 23-24
Purpose:	This indicator measures the percentage of never married young people surveyed who report they have never had sex (i.e., the self-reported prevalence of virginity among young people). Abstinence and delayed sexual initiation can help young people protect themselves against sexually transmitted infections, including HIV. Looking at this prevalence within narrow age ranges (15-16, 17-18, 19-20, 21-22, and 23-24, or by age years) over time allows program managers to assess if the age at first sex is changing.
Applicability:	All countries
Data collection frequency:	Preferred: every 2 years; Minimum: Every 4-5 years.
Measurement tool:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey, Reproductive and Health Survey or other representative survey)
Method of measurement:	Respondents (15–24 year olds) are asked if they have ever had sex. If the indicator is calculated for groupings of ages that are broader than the period of time that has passed, the indicator will not be able to reflect changes that may in fact be occurring. It is therefore recommended that this indicator be reported by single age.
Interpretation:	Abstinence from sex, being faithful to one partner, and using condoms are the ways of preventing HIV infection that form the central message of USG programs. This indicator describes the extent to which abstinence is practiced among youth. In some settings, the proportion of those aged 20–24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases. The other parts of the ABC composite should be considered as additional indicators as the composite shows movement of youth among the different behaviors if collected across time. Considering all six aspects of behavior together makes sense, as each component affects the other and each component is of progressively riskier behavior.
Additional Information:	#12, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf Prevention indicator (HIV-02), The Global Fund to Fight AIDS, Tuberculosis and

	Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.10.N Essential/Not reported	**Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.**
Type of Indicator:	National Outcome
Numerator:	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
Denominator:	Number of all respondents aged 15–24 years
Disaggregation:	By Sex: Male, Female By Age: 15-19, 20-24
Purpose:	To assess progress in increasing the age at which young women and men aged 15–24 first have sex
Applicability:	All countries
Data collection frequency:	Every 4-5 years
Measurement tool:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: How old were you when you first had sexual intercourse for the first time?
Interpretation:	Countries where very few young people have sex before the age of 15 might opt to use an alternative indicator: percentage of young women and men aged 20–24 who report their age at sexual initiation as under 18 years. The advantage of using the reported age at which young people first had sexual intercourse (as opposed to the median age) is that the calculation is simple and allows easy comparison over time. The denominator is easily defined because all members of the survey sample contribute to this measure. It is difficult to monitor change in this indicator over a short period because only individuals entering the group, i.e. those aged under 15 at the beginning of the period for which the trends are to be assessed, can influence the numerator. If the indicator is assessed every two to three years, it may be better to focus on changes in the levels for the 15–17 age group. If it is assessed every five years, the possibility exists of looking at the 15–19 age group. In countries where HIV-prevention programs encourage virginity or delaying of first sex, young people's responses to survey questions on this issue may be biased, including a deliberate misreporting of age at which they first had sex.
Additional Information:	- #15, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Prevention indicator (HIV-01), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.11.N Essential/Not reported	**Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months**
Type of Indicator:	National Outcome
Numerator:	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	Number of all respondents aged 15–49
Disaggregation:	By Sex: Male, Female By Age: 15–19, 20–24 and 25–49
Purpose:	Prevention messages should focus on abstinence and also on mutual monogamy. But because sexual relationships among young people are frequently unstable, relationships that were intended to be mutually monogamous may break up and be replaced by other relationships in which similar intentions prevail. Particularly in high HIV prevalence epidemics, serial monogamy is not greatly protective against HIV infection. This indicator measures the proportion of people that have been exposed to more than one partner in the last year.
Applicability:	All countries
Data collection frequency:	4–5 years
Measurement tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: In the last 12 months, how many different people have you had sexual intercourse with?
Interpretation:	This indicator gives a picture of levels of higher-risk sex. If people have only one sexual partner, the change will be captured by changes in this indicator. However, if people simply decrease the number of sexual partners they have, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a program success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.
Additional Information:	#16, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.12.N Essential/Not reported	**Percent of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom their last sexual intercourse.**
Type of Indicator:	National Outcome
Numerator:	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
Denominator:	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months
Disaggregation:	By Sex: Male, Female By Age: 15-19, 20-24, 25-49
Purpose:	To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners
Applicability:	All countries
Data collection frequency:	Every 4-5 years
Measurement tool:	Population-based survey Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: 1. In the last 12 months, how many different people have you had sexual intercourse with? If more than one, the respondent is asked: 2. Did you or your partner use a condom the last time you had sexual intercourse?
Interpretation:	This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly). However, the broader significance of any given indicator value will depend upon the extent to which people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on the percentages of people that have had more than one sexual partner within the last year The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide the level of consistent condom use. However, the alternative method of asking whether condoms were always/sometimes/never used in sexual encounters with non regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use during the most recent sex act will generally reflect the trend in consistent condom use.
Additional Information:	#17, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.19.N Essential/Not reported	**Percentage of young people aged 15-24 who report they could get condoms on their own**
Type of Indicator:	National Outcome
Numerator:	Number of young women and men aged 15-24 who know a place where they can get condoms and who report they could get condoms on their own if they wanted.
Denominator:	The number of respondents aged 15-24.
Disaggregation:	By Sex: Male, Female By Age: 15-19, 20-24
Purpose:	This indicator measures the percentage of young people who can name at least one formal source of condoms and say that they can get a condom from that source if they want one. Studies have demonstrated that adolescents who know of at least one source of condoms are much more likely than other adolescents to use them.
Applicability:	All countries
Data collection frequency:	Preferred: every 2 years; Minimum: Every 4-5 years.
Measurement tool:	Surveys (UNAIDS, DHS, MICS, FHI BSS-youth)
Method of measurement:	*(Number of young women and men aged 15-24 who know a place where to get condoms and who report they could get condoms on their own if they wanted / The number of respondents aged 15-24) x 100* The numerator is measured by asking survey respondents to name at least one acceptable source where condoms are available. Subsequently, they are asked whether they can get a condom from that source if they want one. A definition of acceptable sources should be produced in each national setting. If respondents know of an acceptable source for condoms and respond that they can get a condom from that source if they want, then they are included in the numerator. The denominator includes all survey respondents aged 15-24.
Interpretation:	This indicator measures the reported self-efficacy of a young person to get a condom when he or she wants one. Various factors can prevent young people from accessing condoms, including the cost of condoms and the stigma associated with obtaining them. This indicator may highlight whether or not young people face barriers in accessing condoms despite their knowledge of where to get condoms.
Additional Information:	#11, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

STIGMA

Indicator #P8.22.N Essential/Not reported	**Percent of the general population with accepting attitudes toward PLWHA**
Type of Indicator:	National outcome
Numerator:	Number of women and men who report an accepting attitude on all four of these questions
Denominator:	Number of all women and men aged 15–49 surveyed who have heard of HIV
Disaggregation:	By Sex: Male, Female
Purpose:	This indicator measures accepting attitudes toward people living with HIV among women and men aged 15-49. HIV-related stigma refers to unfavorable attitudes, beliefs, and policies directed toward people living with HIV and their family members, close associates and communities. HIV-related stigma can reduce the effectiveness of programs and services designed for those living with HIV and those who are affected by the disease. For example, studies have shown that some families with orphans have chosen not to receive relief services in order to avoid the stigma attached to these benefits. Other studies found that some families cut themselves off from social support networks long before an AIDS death occurs in the family in order to avoid HIV-related stigma. HIV awareness programs are designed to increase accepting attitudes toward people living with HIV or those perceived to be living with HIV. This indicator provides a measure of the effectiveness of HIV awareness programs and can highlight whether more needs to be done to counter HIV-related stigma.
Applicability:	All countries
Data collection frequency:	Every 2-3 years
Measurement tool:	Population-based survey tools, such as the AIDS Indicator Survey (AIS) or Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS) can be used.
Method of measurement:	*(Number of women and men aged 15-49 who report accepting attitudes towards people/All respondents aged 15-49 who have heard of HIV)x 100* *All respondents aged 15-49 who have heard of HIV* The numerator is calculated by first asking survey respondents if they have ever heard of HIV. If they answer yes, then they are asked a series of questions about people with HIV, including: 1. If a member of your family became sick with the HIV virus, would you be willing to care for him or her in your household?; 2. If you knew that a shopkeeper or food seller had the HIV virus, would you buy fresh vegetables from him/her?; 3. If a female teacher has the HIV virus but is not sick, should she be allowed to continue teaching in school?; and 4. If a member of your family became infected with the HIV virus, would you want it to remain a secret? Only respondents who report an accepting or supportive attitude on all four of these questions is counted in the numerator. An accepting attitude for the respective

	questions is considered to be (1) yes; (2) yes; (3) yes; and (4) no. The denominator consists of all respondents in the survey who have heard of HIV.
Interpretation:	This indicator measures the percentage of the population with accepting attitudes toward people living with HIV, and it provides a measure of HIV-related stigma. It is not, however, a perfect measure of HIV-related stigma. While a low value for the indicator suggests high levels of HIV-related stigma, a high value for the indicator could be interpreted in several ways: that there are low levels of HIV-related stigma, or that people know they should not discriminate and therefore report accepting attitudes. High scores may also reflect the respondent's limited personal experience with HIV. Another limitation of this indicator is that there is frequently not a direct relationship between attitudes and behavior. What people actually do in the face of HIV may well differ from what they say they would do. Some studies have found, for example, that people expressing very negative attitudes toward those living with HIV actually provide supportive care for an HIV-infected relative in their own home. On the other hand, some people who deny having negative attitudes towards people with HIV may actively discriminate against them in specific settings, such as in the provision of health care.
Additional Information:	#14, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Prevention

Sexual and other Behavioral Risk Prevention

Indicator #P8.23.N Essential/Not reported	**Percentage of young women and men aged 15–24 who are HIV infected**
Type of Indicator:	National Outcome
Numerator:	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive
Denominator:	Number of antenatal clinic attendees (15–24) tested for their HIV infection status
Disaggregation:	By Age: 15-19, 20-24 The proportion of the total female population aged 15–24 living in the capital city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.
Purpose:	The ultimate goal in the fight against HIV/AIDS is to eradicate HIV infection. As the highest rates of new HIV infections typically occur among young adults, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people. This indicator allows assessment of progress toward eradicating HIV infection
Applicability:	Countries with generalized epidemics
Data collection frequency:	Annual
Measurement tool:	WHO guidelines for HIV sentinel surveillance
Method of measurement:	This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas.
Interpretation:	HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behavior change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behavior. Thus, reductions in HIV incidence associated with genuine behavior change should first become detectable in HIV prevalence figures for 15–19-year-olds. Where available, parallel behavioral surveillance survey data should be used to aid interpretation of trends in HIV prevalence. In countries where the age at which young people first have sexual intercourse is late and/or levels of contraception use are high, HIV prevalence among pregnant women of 15–24 years of age will differ from that among all women in the age group. This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV-epidemic trends in

	locations where most infections remain temporarily confined to most-at-risk populations.
Additional Information:	#22, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf

Prevention
Concentrated Epidemics

Indicator #P9.1.N Essential/Not reported	**Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**
Type of Indicator:	National Outcome
Numerator:	Number of most-at-risk population respondents who gave the correct answers to all five questions
Denominator:	Number of most-at-risk population respondents who gave answers, including "don't know", to all five questions
Disaggregation:	By Sex: Male, Female By Age: <25/25+
Purpose:	To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations
Applicability:	Countries with concentrated or low-prevalence epidemics, including countries with concentrated subepidemic within a generalized epidemic
Data collection frequency:	Every two years
Measurement tool:	Special behavioral surveys such as the Family Health International Behavioral Surveillance Survey for most-at-risk populations
Method of measurement:	Respondents are asked the following five questions. 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected? The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the country. Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator. Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.
Interpretation:	The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Correct knowledge about false beliefs of possible modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behavior, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS. This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to

	ensure that pre-existing high levels of knowledge are maintained. Surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.
Additional Information:	- #14, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf - #3, UNAIDS (2008). A Framework for Monitoring and Evaluating HIV Prevention Programs for Most-At-Risk Populations. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf

Prevention
Concentrated Epidemics

Indicator #P9.2.N Essential/Not reported	**Percentage of female and male sex workers reporting the use of a condom with their most recent client**
Type of Indicator:	National Outcome
Numerator:	Number of respondents who reported that a condom was used with their last client
Denominator:	Number of respondents who reported having commercial sex in the last 12 months.
Disaggregation:	By Sex: Male, Female By Age: <25/25+
Purpose:	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
Applicability:	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized Epidemic
Data collection frequency:	Every 2 years
Measurement tool:	Behavioral surveys Special surveys for the numerator and denominator, including the FHI Behavior Surveillance Survey for sex workers, Measure Evaluation PLACE studies
Method of measurement:	Respondents are asked the following question: Did you use a condom with your most recent client? Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.
Interpretation:	Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use. This indicator asks about commercial sex in the past twelve months. If you have data available on another time period, such as the last 3 or 6 months, please include this additional data in the comments section of the reporting tool. Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.
Additional Information:	- #4, UNAIDS (2008). A Framework for Monitoring and Evaluating HIV Prevention Programs for Most-At-Risk Populations. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf

	- UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

Prevention
Concentrated Epidemics

Indicator #P9.3.N Essential/Not reported	**Percent of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse**
Type of Indicator:	National Outcome
Numerator:	Number of men aged 15-49 surveyed who report they used a condom the last time they had sexual intercourse with a sex worker.
Denominator:	Number of men aged 15-49 surveyed who report that they had sexual intercourse with a sex worker (i.e., someone they paid in exchange for sex) in the last 12 months.
Disaggregation:	By Age: 15-19, 20-24, 25-49 By population group: migrant workers, military, truck drivers, other.
Purpose:	This indicator measures self-reported condom use among male clients of sex workers.
Applicability:	All countries
Data collection frequency:	Every 2-3 years
Measurement tool:	-Population-based survey tools, such as the AIDS Indicator Survey (AIS) or Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS). -Behavioral surveys, Special surveys including the Family Health International Behavioral Surveillance Survey, MEASURE Evaluation PLACE studies
Method of measurement:	*(Number of men aged 15-49 who report they used a condom the last time they had sexual intercourse with a sex worker/ Number of men aged 15-49 who report they had sexual intercourse with a sex worker in the last 12 months)x 100* The numerator is calculated as the number of men aged 15-49 who report that they used a condom the last time they had sexual intercourse with a sex worker. These data may be obtained from a population-based survey or from special surveys targeting potential clients of sex workers. The denominator is calculated as the number of men who report that they paid someone in exchange for sex (i.e., had sexual intercourse with a sex worker) in the last 12 months. Those who reply yes are counted in the denominator.
Interpretation:	For this indicator to be most useful, countries need to establish agreed upon definitions of what constitutes sex work (i.e., paying someone in exchange for sex). Once a country has established an agreed upon definition of sex work, it is unlikely to change significantly over time, and this indicator can then be used to track the success of programs that promote condom use between sex workers and their clients. This indicator provides a simple and robust measure of condom use during the last paid sexual intercourse with a sex worker, but it does not provide information about consistent condom use during paid sex. Program managers may also want to consider survey data on whether clients of sex workers always use condoms, sometimes, or never during paid sex, since this provides essential information for the design of intervention strategies to increase condom use. This indicator also does not provide detailed information about what type of sex worker a client had paid sex with in the last 12 months. In places where there are several distinct populations of sex workers (e.g., brothel-based, street-based, escort) with different perceived behavioral risks, data may need to be collected separately for each category of sex work in order to provide detailed information for prevention

	programming. For example, men may report high levels of condom use in brothels, but much lower levels with street-based sex workers.
Additional Information:	#13, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Prevention
Concentrated Epidemics

Indicator #P9.4.N: Essential/Not reported	**Percentage of men reporting the use of a condom the last time they had anal sex with a male partner**
Type of Indicator:	National Outcome
Numerator:	Number of respondents who reported that a condom was used the last time they had anal sex
Denominator:	Number of respondents who reported having had anal sex with a male partner in the last six months.
Disaggregation:	By Age: <25/25+
Purpose:	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
Applicability:	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
Data collection frequency:	Every 2 years
Measurement tool:	Behavioral surveys, Special surveys including the Family Health International Behavioral Surveillance Survey for men who have sex with men
Method of measurement:	In a behavioral survey of a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex. Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.
Interpretation:	For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. This indicator does not give any idea of risk behavior in sex with women among men who have sex with both women and men. In countries where men in the subpopulation surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for female and male partners. This indicator asks about male-to-male sex in the past six months. If you have data available on another time period, such as the last 3 or 12 months, please include this additional data in the comments section of the reporting tool. Surveying men who have sex with men can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.
Additional	- #19, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on

Information:	Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf - #5, UNAIDS (2008). A Framework for Monitoring and Evaluating HIV Prevention Programs for Most-At-Risk Populations. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf - UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

Prevention
Concentrated Epidemics

Indicator #P9.5.N Essential/Not Reported	**Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse**
Type of Indicator:	National Outcome
Numerator:	Number of respondents who reported that a condom was used the last time they had sex.
Denominator:	Number of respondents who report having injected drugs and having had sexual intercourse in the last month
Disaggregation:	By Sex: Male, Female By Age: <25/25+
Purpose:	To assess progress in preventing sexual transmission of HIV
Applicability:	Countries where injecting drug use is an established mode of HIV Transmission
Data collection frequency:	Every 2 years
Measurement tool:	Behavioral surveys Special surveys, including the FHI Behavior Surveillance Survey for injecting drug users, Measure Evaluation PLACE studies
Method of measurement:	Respondents are asked the following sequence of questions. 1. Have you injected drugs at any time in the last month? 2. If yes: have you had sexual intercourse in the last month? 3. If yes in answer to both 1 and 2: did you use a condom when you last had sexual intercourse? Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.
Interpretation:	Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which injecting drug users use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among injecting drug users and between injecting drug users and the wider population. This indicator provides partial information on the fourth factor. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.
Additional Information:	- #20, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009

	http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf - #6, UNAIDS (2008). A Framework for Monitoring and Evaluating HIV Prevention Programs for Most-At-Risk Populations. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf - WHO/UNODC/UNAIDS (2009). Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users. Geneva: WHO. http://www.who.int/hiv/pub/idu/OMSTargetSettingGuide.pdf - UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. Geneva: UNAIDS. http://data.unaids.org/pub/Manual/2007/jc1274-practguidelines_en.pdf

Prevention
Concentrated Epidemics

Indicator #P9.17.N Essential/Not reported	**Percentage of most-at-risk populations (IDU, MSM, SW) who are HIV-infected**
Type of Indicator:	National Outcome
Numerator:	Number of members of the most-at-risk population who test positive for HIV
Denominator:	Number of members of the most-at-risk population tested for HIV
Disaggregation:	By Sex: Male, Female By Age: <25/25+ By MARP population: IDU, MSM, SW
Purpose:	To assess progress on reducing HIV prevalence among most-at-risk populations
Applicability:	Countries with concentrated or low-prevalence epidemics, where routine surveillance among pregnant women is not recommended; also includes countries with concentrated subepidemic within a generalized epidemic
Data collection frequency:	Annual
Measurement tool:	HIV sentinel surveillance. UNAIDS/WHO *Second Generation Surveillance Guidelines*; Family Health International guidelines on sampling in population groups
Method of measurement:	This indicator is calculated using data from HIV tests conducted among members of most-at-risk population groups in the primary sentinel site or sites. The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time. In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available. In analyzing prevalence data of most-at-risk-populations for the assessment of prevention program impact, it is desirable not to restrict analysis to young people but to report on those persons who are newly initiated to behaviors that put them at risk for infection (e.g. by restricting the analysis to people who have initiated injecting drug use within the last year or participated in sex work for less than one year, etc.). This type of restricted analysis will also have the advantage of not being affected by the effect of antiretroviral therapy in increasing survival and thereby increasing prevalence. In the Country Progress Report, it is imperative to indicate whether this type of analysis is used to allow for meaningful global analysis.
Interpretation:	Due to difficulties in accessing most-at-risk populations, biases in serosurveillance data are likely to be far more significant than in data from a more general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the interpretation. An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviors is critical to the interpretation of this indicator. The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.

	Trends in HIV prevalence among most-at-risk populations in the capital city will provide a useful indication of HIV-prevention program performance in that city. However, it will not be representative of the situation in the country as a whole. The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to exclude new sites from the calculation of this indicator when undertaking trend analyses. A revised guideline on HIV surveillance on most-at-risk populations are currently being prepared by the WHO/UNAID Global Working Group on STI/HIV Surveillance.
Additional Information:	- #23, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/default.asp http://www.unaids.org/en/HIV_data/Methodology/default.asp

Prevention
Testing and Counseling

Indicator #P11.2.N: Essential/Not reported	**Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results**
Type of Indicator:	National Outcome
Numerator:	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of all respondents aged 15–49
Disaggregation:	N/A
Purpose:	To assess progress in implementing HIV testing and counselling
Applicability:	All countries
Data collection frequency:	Every 4 to 5 years
Measurement tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	Respondents are asked: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? 2. If yes: I don't want to know the results, but did you get the results of that test? The denominator includes respondents who have never heard of HIV or AIDS.
Interpretation:	In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. The introductory statement "I don't want to know the results, but…" allows for better reporting and reduces the risk of underreporting of HIV testing among people who do not wish to disclose their serostatus.
Additional Information:	#7, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf

CARE
TB/HIV

Indicator: #C3.1.N Essential/Not reported	**Number of TB patients who had an HIV test result recorded in the TB register**
Type of Indicator:	National Outcome
Numerator:	Number of TB patients registered during a given time period who had an HIV test result recorded in the TB register.
Denominator:	Total number of TB patients registered during the same time period.
Disaggregation:	N/A
Purpose:	TB is the leading cause of morbidity and mortality among people living with HIV in many countries. In addition, high rates of HIV co-infection are found among TB patients in settings with high HIV prevalence. In these settings, ensuring that TB patients receive HIV testing and counseling services should be a high priority. Knowledge of HIV status enables HIV-positive TB patients to access the most appropriate HIV prevention, treatment, care and support services. Trends over time will demonstrate progress towards national and international targets. This indicator measures the coverage of HIV testing among tuberculosis (TB) patients.
Applicability:	Countries with generalized epidemics.
Data collection frequency:	Annual
Measurement tool:	Routine recording and reporting forms and registers recommended by WHO http://www.who.int/tb/dots/r_and_r_forms/en/index.html Quarterly Report on TB Case Registration in Basic Management Unit.
Method of measurement:	*(Number of TB patients, registered during a given time period, who had an HIV test result recorded in the TB register/ Total number of TB patients registered during the same time period) x 100* Data for this indicator can be collected using national program records aggregated from facility registers, either the TB register or a separate HIV testing and counseling register. Where available, data should come from the national TB control program surveillance system and should include data from TB services delivered in public and private health facilities and prisons, as well as from TB services delivered by faith-based and nongovernmental organizations. Disaggregating the data by age and sex will enable assessment of equity of access to HIV counseling and testing services. Data should also be disaggregated based on the result of the HIV test.
Interpretation:	This indicator is generated from the WHO standardized M&E system recommended for national TB program. These data will help national TB control program to project national requirements for HIV tests and related commodities, as well as national requirements for human resources training. Tracking this number from year to year will provide information on whether provider-initiated HIV testing and counseling is being targeted and provided appropriately to patients with TB, so that HIV-positive TB patients can access appropriate HIV services. A limitation of the indicator is that health care providers may treat TB without registering with the national TB control program, which means that those individuals would not be counted in this indicator.
Additional Information:	#6, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

CARE
TB/HIV

Indicator #C3.2.N Essential/Not reported	**Percent of estimated HIV-positive incident TB cases that received treatment for TB and HIV**
Type of Indicator:	National Outcome
Numerator:	Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB program guidelines), within the reporting year
Denominator:	Estimated number of incident TB cases in people living with HIV
Disaggregation:	N/A
Purpose:	To assess progress in detecting and treating TB in people living with HIV
Applicability:	All countries
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here.
Measurement tool:	Program data and estimates of incident TB cases in people living with HIV, Facility antiretroviral therapy registers and reports; program monitoring tools
Method of measurement:	Denominator: Annual estimates of the number of incident TB cases in people living with HIV in high TB burden countries are calculated by WHO and are available at: http://www.who.int/tb/country/en
Interpretation:	Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. WHO provides annual estimates of the burden of TB among people living with HIV, based on the best available country estimates of HIV prevalence and TB incidence. All incident TB cases among people living with HIV should be started on TB treatment and depending on country specific eligibility criteria. Incident TB cases are defined as new a case that have occurred in that year, and specifically excludes latent cases. All or most people living with HIV who have TB should be on antiretroviral therapy, depending on local eligibility criteria. TB treatment should only be started in accordance with national TB program guidelines. This indicator provides a measure of the extent to which collaboration between the national TB and HIV programs is ensuring that people with HIV and TB disease are able to access appropriate treatment for both diseases. However, this indicator will also be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral therapy, and poor access to TB diagnosis and treatment. Separate indicators exist for each of these factors and should be referred to when interpreting the results of this indicator. It is important that those providing HIV care and antiretroviral therapy record TB diagnosis and treatment, as this information has important implications for antiretroviral therapy eligibility and choice of antiretroviral regimen. It is therefore recommended that the date of starting TB treatment is recorded in the antiretroviral therapy register. If possible, the number of patients started on TB treatment among those in HIV care but not yet on antiretroviral therapy should also be reported. This would capture additional cases of TB that are detected and treated among people living with HIV.
Additional	- #6, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on

Information:	Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf - WHO (2009). *Global Tuberculosis Control: Surveillance, Planning, Financing.* Geneva: World Health Organization http://www.who.int/tb/country/en

CARE
Additional Pediatric

Indicator #C4.2.N Essential/Not reported	**Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth**
Type of Indicator:	National Outcome
Numerator:	Number of infants born to HIV-infected women in the last 12 months started on Cotrimoxizole prophylaxis within two months of birth
Denominator:	Estimated number of HIV-infected pregnant women giving birth in the last 12 months
Disaggregation:	N/A
Purpose:	Cotrimoxizole prophylaxis is a simple and cost-effective intervention to prevent Pneumocystis jirovecipneumonia (PCP) among HIV-exposed and -infected infants. PCP is the leading cause of serious respiratory disease among young HIV-infected infants in resource-limited countries and often occurs before HIV infection can be diagnosed. Because diagnosing HIV infection among young infants is difficult, all infants born to women living with HIV should receive Cotrimoxizole prophylaxis starting at 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
Applicability:	All Countries
Data collection frequency:	Numerator: ongoing; Denominator: Annual.
Measurement tool:	Numerator: program or facility records; denominator: antenatal care surveillance, projection model, population estimates For more details on *calculation and interpretation* of the indicator, see Core indicators for national AIDS programs: guidance and specifications for additional recommended indicators.
Method of measurement:	Data for the numerator should be aggregated from the appropriate facility registers, which could include integrated maternal and child health registers, registers on the follow-up of HIV-exposed infants or pre–antiretroviral therapy registers. The register used may vary depending on the country context. For example, where HIV-exposed infants are followed up in the HIV care and treatment setting, countries may aggregate information either from a pre–antiretroviral therapy register adapted for follow-up of HIV exposed infants or from a separate register for HIV-exposed infants. The denominator is generated by estimating the number of HIV-infected women who were pregnant in the last 12 months. This is based on HIV surveillance data from antenatal clinics, and estimates can be generated by: *1) using a projection model, such as Spectrum; or* *2) multiplying: The total number of women who gave birth in the last 12 months × The most recent national estimate of HIV prevalence among pregnant women* The total number of women who gave birth in the last 12 months can be obtained from estimates of births from central statistics offices or the estimates of the United Nations Population Division. The most recent national estimate of HIV prevalence among pregnant women can be derived from HIV sentinel surveillance data collected in antenatal clinics.
Interpretation:	This indicator allows countries to monitor progress in the early follow-up of exposed infants by measuring provision of Cotrimoxizole in line with international guidelines. It can also be used as a proxy indicator for early follow-up visits of exposed infants within the recommended first 4-6 weeks of life. The indicator captures only those

	infants who return for HIV-exposed infant follow-up services within two months of birth. It does not measure actual coverage of Cotrimoxizole prophylaxis for HIV-exposed infants as some infants may have been started on treatment after 2 months. A low value of the indicator could signal potential bottlenecks in the system, including poor management of CTX supplies in country, poor data collection, and inadequate distribution systems.
Additional Information:	- #9, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Prevention #HIV-P14, The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Treatment
ARV Services

Indicator #T1.5.N Essential/Not reported	**Percentage of health facilities that offer ART**
Type of Indicator:	National Outcome
Numerator:	Number of health facilities that offer ART (i.e., prescribe and/or provide clinical follow-up).
Denominator:	Total number of health facilities, excluding specialized facilities where ART services are/will never be relevant.
Disaggregation:	By type of site: Public, Private, NGO
Purpose:	This indicator measures the capacity of health facilities to provide antiretroviral therapy (ART). Antiretroviral therapy is a cornerstone of effective HIV treatment, and measuring the percentage of health facilities that offer ART provides valuable information about ART availability. One strategy to scale up ART services is to make ART available in more health facilities. This may be achieved by decentralizing ART services from tertiary facilities (e.g., hospitals) to primary or secondary-level health facilities.
Applicability:	All countries.
Data collection frequency:	Annual for program records; every 2-3 years for facility survey/census.
Measurement tool:	Program records; health facility survey/census.
Method of measurement:	For health facility surveys or censuses, tools such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) can be used. Health facilities include public and private facilities, health centers and clinics (including TB centers), as well as health facilities that are run by faith-based or nongovernmental organizations. *(Number of health facilities that offer ART/ Total number of health facilities minus those where ART services are/will never be relevant) x 100* The numerator is calculated by summing of the number of facilities reporting availability of ART services. Information on the availability of specific services is usually kept at the national or sub-national level. National AIDS Programs should have a record of all health facilities offering ART services. A health facility census or survey can also provide this information, along with more in-depth information on available services, provided the information is collected from a representative sample of health facilities in the country. In a facility survey (e.g., Service Provision Assessment, Service Availability Mapping), the most knowledgeable person responsible for client services is interviewed using the AIDS Outpatient Department (OPD) module. Responses to a series of questions establish whether providers in that facility provide ART services directly (i.e., prescribe ART and/or provide clinical follow-up for ART patients) or refer patients to other health facilities for these services. In addition, facility records documenting the current status of service provision should be consulted. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years. Countries should regularly update their program records on health facilities offering ART services, and supplement these data with those obtained through a health facility survey or census every few years. The denominator is calculated by summing the total number of health facilities included in the sample. Information for construction of the denominator may come

	from program records, facility listings, and/or national strategy or planning documents.
Interpretation:	This indicator provides valuable information about the availability of ART services in health facilities, but it does not capture information about the quality of services provided. Antiretroviral therapy itself is complex, and it should be delivered as part of a package of care interventions, including the provision of Cotrimoxizole prophylaxis, the management of opportunistic infections and comorbidities, nutritional support and palliative care. Simple monitoring of ART availability does not ensure that all ART-related services are adequately provided to those who need them. Nevertheless, it is important to know what percentage of health facilities provide ART services in order to plan for service expansion as needed to meet universal access targets.
Additional Information:	- #2, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Treatment #HIV-T2, The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Treatment
ARV Services

Indicator #T1.6.N Essential/Not reported	**Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral**
Type of Indicator:	National Outcome
Numerator:	Number of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral.
Denominator:	Total number of all health facilities providing ART.
Disaggregation:	By type of site: Public, Private, NGO
Purpose:	This indicator measures the percentage of health facilities providing ART using CD4 monitoring. Although the unavailability of CD4 monitoring should not be a barrier to providing ART, WHO recommends CD4 monitoring for better and more accurate clinical decision-making. This indicator may also be used as a proxy measure of the quality of ART services provided in a country. Current WHO guidelines recommend that patients with advanced or severe symptomatic HIV disease should start ART irrespective of CD4 cell count. Although the optimum time to start ART has not been firmly established, it is known to be before patients become unwell or present with HIV-associated opportunistic diseases. Immunologic monitoring (i.e., CD4 testing), where possible, is the best approach to guide the decision on when to initiate ART in asymptomatic individuals and to monitor ART responses in patients receiving ART. In many resource-limited settings where ART services are being scaled up, decisions to initiate ART are based upon clinical assessment. As ART services expand, health system infrastructure should be strengthened where possible to make CD4 testing more readily available. Making CD4 testing available allows asymptomatic but immunologically compromised individuals to start ART earlier and improves the quality of care of HIV patients through better treatment monitoring. Furthermore, CD4 testing is also useful to expand access to Cotrimoxizole prophylaxis in HIV-infected patients as part of the pre-ART care package.
Applicability:	All countries.
Data collection frequency:	Annual for program records; every 2-3 years for facility survey/census.
Measurement tool:	Program records, laboratory network records, health facility survey such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) may be used.
Method of measurement:	Health facilities include public and private facilities, health center and clinics (including TB center), as well as health facilities that are run by faith-based or nongovernmental organizations. *(Number of health facilities providing ART using CD4 monitoring in line with national guidelines or policies, either on site or through referral/ Total number of health facilities providing ART)x 100* National ART Programs should have a record of all facilities that provide CD4 testing services, whether on site or through referral. This is a national list or inventory of sites with CD4 testing available, or of reference laboratory networks with a list of facilities that link with these laboratories to provide CD4 testing. A health facility census or survey can also provide this information as well as more in-depth information on services available, provided the information is collected from a representative sample of health facilities in the country. In a facility survey (e.g.,

	Service Provision Assessment, Service Availability Mapping), the most knowledgeable person responsible for client services is interviewed using the AIDS Outpatient Department (OPD) module. Responses to a series a questions establish whether the facility uses CD4 monitoring on site or through referral. In addition, facility records documenting the current status of service provision should be consulted. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years. Countries should regularly update their program records on health facilities offering ART services, and supplement these data with those obtained through a health facility survey or census every few years.
Interpretation:	This indicator measures the availability of CD4 monitoring in health facilities providing ART, and can provide a quick indication of improvement in earlier access to ART and the quality of ART services nationwide. It does not provide detailed information on the quality of ART services or improved treatment outcomes.
Additional Information:	#4, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Health System Strengthening

Heath Systems Financing

Indicator #H3.1.N Essential/Not reported	**Domestic and international AIDS spending by categories and financing sources**
Type of Indicator:	National
Numerator:	N/A
Denominator:	N/A
Disaggregation:	N/A
Purpose:	To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced
Applicability:	All countries
Data collection frequency:	Every two years
Measurement tool:	Primary tool/method: National AIDS Spending Assessment (NASA) Alternative tools/methods: 1) National Health Accounts—AIDS sub-accounts. There should not be any difference in the AIDS health spending measured by NASA or by the National Health Accounts sub-accounts. However, some activities performed outside the health system might not be included in National Health Accounts. 2) Resource Flows Survey. There has been an alignment process and countries that have been selected in the sample of this survey and have responded to the questionnaires may enter the information in the funding matrix at the aggregated level by main activities. Some activities performed outside the health system might not be included in this Resource Flows Survey. In addition, some population-related actions should be excluded from the total for AIDS. The outputs from any of these measurement tools are to be used to complete the National Funding Matrix, which is to be submitted as part of the Country Progress Report (see Appendix 3 in UNGASS Guidelines).
Method of measurement:	Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources: 1. Prevention 2. Care and treatment 3. Orphans and vulnerable children2 4. Program management and administration strengthening 5. Incentives for human resources 6. Social protection and social services (excluding orphans and vulnerable children) 7. Enabling environment and community development 8. Research (excluding operations research included under program management). (There are multiple subcategories in each AIDS Spending Category; see Appendix 3 in UNGASS Guidelines) Three main groups of financing sources: 1. Domestic public 2. International 3. Domestic private (optional for UNGASS reporting). (There are multiple subcategories for each source; see Appendix 3) The National Funding Matrix is available on the UNGASS 2010 reporting website: www.unaids.org/UNGASS2010

Interpretation:	The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. For example, the diagnosis and treatment of opportunistic infections would require a special costing estimate to track the specific resources allocated to AIDS-related diagnosis and treatment. Similarly, prevention activities in schools may benefit from a detailed estimation to calculate actual expenditures on AIDS activities. The AIDS expenditures might occur outside the health system given the nature of expanded responses to AIDS. Completing the National Funding Matrix will provide a more detailed picture of the situation at the country level, which is useful for both national and global decision-making. Reporting: The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix. Appendix 3 provides further instructions on how to submit the report of this indicator via the completed National Funding Matrix. The cover sheet as well as the information indicated in Appendix 3 needs to be submitted with the Country Progress Report.
Additional Information:	- #1, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf - UNAIDS (2009). National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions. http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp - UNFPA/UNAIDS/Netherlands Interdisciplinary Demographics Institute. Details on Resource Flows Surveys, instruments, countries sampled and more details on this tool: www.resourceflows.org - World Bank/WHO/USAID (2003). Guide to Producing National Health Accounts. This publication and other tools for National Health Accounts and AIDS sub-accounts: http://www.who.int/nha - Health Systems 20/20/USAID (2004). Methodological Guidelines for Conducting a National Health Accounts Sub-analysis for HIV/AIDS. http://www.healthsystems2020.org/

Health System Strengthening
Medical Products -ARV Drugs

Indicator #H5.3.N Essential/Not reported	**Percentage of health facilities providing ART that experienced stock-outs of ARV in the last 12 months**
Type of Indicator:	National Outcome
Numerator:	Number of health facilities dispensing ARVs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months.
Denominator:	Total number of health facilities dispensing ARVs.
Disaggregation:	By type of site: Public, Private, NGO
Purpose:	This indicator measures a key aspect of antiretroviral (ARV) drug supply management: whether health facilities dispensing ARV drugs have run out of stock of at least one required ARV in the last 12 months. As countries scale-up ART services, it is important to ensure that ARVs are available to those who need them. ART is a long-term treatment strategy for people living with advanced HIV infection, and treatment interruptions may lead to HIV drug resistance. Efficient supply management is needed to ensure that required ARVs do not run out of stock.
Applicability:	All countries.
Data collection frequency:	Annual for program records; every 2-3 years for facility survey/census.
Measurement tool:	Health facility surveys such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) may be used provided they include questions on ARV stock-outs. Program records; Logistics Management Information System (LMIS)
Method of measurement:	A stock-out is defined as the complete absence of a required ARV drug at a delivery point for at least one day. Health facilities include public and private facilities, health center and clinics (including TB center), as well as health facilities that are run by faith-based or nongovernmental organizations. *(Number of health facilities dispensing ARVs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months/ Total number of health facilities dispensing ARVs) x 100* If there is one national logistics management information system (LMIS) with details on ARV availability at the health facility level, information should be extracted from this system to construct this indicator. Alternatively, the information may need to be collected through a special survey or site visits. If there are only a limited number of health facilities where ARVs are dispensed in the country, all health facilities dispensing ARVs should be included in the survey or site visits. If the number of health facilities dispensing ARVs is large, it may be necessary to select a representative sample from the total number of health facilities dispensing ARVs (the full list should be available at the national level). When sampling, it is important to ensure that the sample includes facilities at different levels (such as central, district, and peripheral levels). In countries where ARV drugs are dispensed at pharmacies or other non-health facility delivery points, stock-outs should also be monitored in these venues; feasibility will depend on the coverage of the Logistics Management Information System.
Interpretation:	This indicator captures a crucial component of the ART program: whether or not there is a continuous, uninterrupted supply of ARV drugs at the health facility level. This indicator does not, however, provide information on why stock-out problems occur; which ARV drug(s) are/were out of stock; or how long the stock-out lasted for

	a particular ARV drug. It also does not provide information on the quality of ARV drug storage, delivery, and distribution. Simply monitoring stock-outs could be misleading because a facility may keep reserve stock, but may have a policy of not issuing the reserve stock. These facilities would not be counted as having experienced a stock-out using this indicator definition, though from a patient perspective, a required ARV drug would not be available for treatment. In settings where reserve stock is not issued during ARV stock-outs, it is preferable to collect information on a functional stock-out (i.e., the inability to access or make use of a required ARV drug).
Additional Information:	- #3, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Treatment #HIV-T3, The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Health System Strengthening

Sub Area 6: Health Systems Governance

Indicator #H6.3.N: Essential/Not Reported	**National Composite Policy Index (NCPI)**
Type of Indicator:	National Outcome
Numerator:	To assess progress in the development and implementation of national level HIV and AIDS policies and strategies
Denominator:	N/A
Disaggregation:	N/A
Purpose:	To assess progress in the development and implementation of national level HIV and AIDS policies and strategies
Applicability:	All countries
Data collection frequency:	Every two years
Measurement tool:	National Composite Policy Index (NCPI) questionnaire (see Appendix 7 UNGASS)
Method of measurement:	The composite index covers the following broad areas of policy, strategy and programme implementation: Part A 1. Strategic plan 2. Political support 3. Prevention 4. Treatment, care and support 5. Monitoring and evaluation Part B 1. Human rights 2. Civil society involvement 3. Prevention 4. Treatment, care and support
Interpretation:	It is important to analyse the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in (a) policy and strategy development and (b) implementation of policies and strategies, in order to tackle the country's HIV epidemic. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available.
Additional Information:	#2, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf

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APPENDIX 1: Summary of Changes to PEPFAR Indicators

Indicator Mapping Tool: Old Indicators to New PEPFAR Essential Indicators						
Old Indicator No.	**Old PEPFAR Indicator**	**Type**	**Reporting Requirements***	**New Indicator No.**	**New PEPFAR Indicator**	**Change to Indicator?**
PREVENTION						
Prevention Sub Area 1: PMTCT						
1.2	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	PEPFAR Output	1	P1.1D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Moderate to significant change
			2		Known positives at entry; Number of new positives identified	New
1.3	Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	PEPFAR Output	1	P1.2.D	Number and percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	Small change- should not impact trend analysis.
			1		Number of known positive pregnant women (denominator of #P1.1.D)	New
			1		By Regimen Type: • Life-long ART (including Option B+); - Newly initiated on treatment during the current pregnancy	

					• Already on treatment at the beginning of the current pregnancy • Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery); • Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery); Single-dose nevirapine (with or without tail)	
1.1	Number of service outlets providing the minimum package of PMTCT services according to national and international standards.	PEPFAR Output	3	P1.3.D	Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	Same - label change only
1.2	(Upstream + Downstream) Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	National Outcome	1	P1.1.N	Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Moderate to significant change
			2		Known positives at entry; Number of new positives identified	
1.3	(Upstream + Downstream) Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	National Outcome	1	P1.2.N	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission during pregnancy and delivery	Minimum change
			2		By Regimen Type: • Life-long ART (including Option B+); - Newly initiated on treatment during the current pregnancy - Already on treatment at the beginning of the current pregnancy • Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery); • Maternal AZT (prophylaxis component of WHO Option A during pregnancy and	

					delivery); • Single-dose nevirapine (with or without tail)	
Prevention Sub Area 3: Injection Safety and Waste Disposal						
3.1	Number of service outlets carrying out blood safety activities					Dropped
See training indicator below						
Prevention Sub Area 4: Injection and Non-injection drug use						
		PEPFAR Output	1	P4.1.D	Number of injecting drug users (IDUs) on opioid substitution therapy	New
Prevention Sub Area 5: Male Circumcision						
		PEPFAR Output	1	P5.1.D	Number of males circumcised as part of the minimum package of VMMC for HIV prevention services	New
			1		by age: <1, 1-9, 10-14, 15-19, 20-24, 25-49, 50+	
		PEPFAR Output	1	P5.2.D	Number of clients circumcised who experienced one or more moderate or severe adverse event(s) within the reporting period	New
			1		by severity (moderate and/or severe)	
Prevention Sub Area 6: Post-Exposure Prophylaxis						
		PEPFAR Output	1	P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP)	New
			1		By exposure type: Occupational, Rape/Sexual Assault Victims, or Other Non-Occupational	
Prevention Sub Area 7: Prevention with People Living with HIV (PwP)						
		PEPFAR Output	1	P7.1.D	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions	New

			3			By setting where reached: in a clinic/facility-based and in a community/home-based	
Prevention Sub Area 8: Sexual and other Behavioral Risk Prevention							
5.2 and 2.1	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	PEPFAR Output	1	P8.1.D		Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	Moderate to significant change
			3			By sex: Male and Female	
			3			By age: (10-14, 15+)	
2.1	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and or being faithful	PEPFAR Output	1	P8.2.D		Number of the targeted population reached with individual and/or small group preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	Moderate to significant change
2.1a	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence						Dropped
		PEPFAR Output	1	P8.3.D		Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	New
			3			By sex: Male and Female	
			1			By MARP type: CSW, IDU, MSM, Other Vulnerable Populations	
5.1	Number of targeted condom service outlets	PEPFAR Output	3	P8.4.D		Number of targeted condom service outlets	Same
Prevention Sub Area 11: Testing and Counseling							
9.2	Number of individuals who received counseling and testing for HIV and received their test results (including TB)	PEPFAR Output	1	P11.1.D		Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results	Same - label change only

			1			By age/sex: <15 Male, 15+ Male, <15 Female, 15+ Female	New
			1			By test result: Positive, Negative	New
			3			By type of counseling/test: Individual, Couple	New
			3			In concentrated epidemics, by MARP type (CSW, IDU, MSM)	New
9.1	Number of service outlets providing counseling and testing according to national and international standards		3	P11.3.N	Percentage of health facilities that provide HIV testing and counselling services		Moderate to significant change
			3			Healthcare facilities, Stand alone sites, Mobile Units	New
9.4	Number of individuals who received counseling and testing for HIV and received their test results (excluding TB) [for COP Table 3 only]		3				Dropped
Care							
Care Sub Area 1: "Umbrella" Care Indicators							
6.2 & 8.1	# OVCs receiving OVC services AND # receiving Care and support	PEPFAR Output	1	C1.1.D	Number of eligible adults and children provided with a minimum of one care service		Moderate to significant change
			1			By age/sex: <18 Male, 18+ Male, <18 Female, 18+ Female	
6.2 & 8.1	(Upstream + Downstream) # OVCs receiving OVC services AND # receiving Care and support	National Output	1	C1.1.N	Number of eligible adults and children provided with a minimum of one care service (By Age: <18, 18 +)		Moderate to significant change
6.1	Total number of service outlets providing HIV-related palliative care (including TB/HIV)						dropped
6.4	Total number of services outlets providing HIV-related palliative care (excluding TB/HIV) [for COP Table 3 only]						dropped
6.5	Total number of individuals provided with HIV-related palliative care (excluding TB/HIV) [for COP Table 3 only]						dropped

Care Sub Area 2: Clinical Care								
		PEPFAR Output	1	C2.1.D		Number of HIV-positive adults and children receiving a minimum of one clinical service		New
			1				By age/sex: <15 Male, 15+ Male, <15 Female, 15+ Female	
		PEPFAR Output	1	C2.2.D			Number of HIV-positive persons receiving cotrimoxazole prophylaxis	New
			2				By Age: <15, 15 +	
11.6	Number of individuals receiving ART with evidence of clinical malnutrition receiving food and nutritional supplementation during the reporting period	PEPFAR Output	1	C2.3.D			Number and proportion of undernourished people living with HIV (PLHIV) who received therapeutic or supplementary food during the reporting period	Moderate to significant change
			1				By Age: <18, 18 +	
		PEPFAR Output	1	C2.4.D	TB/HIV: Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings			New
7.2	Number of HIV-infected clients attending HIV/care and treatment services that are receiving treatment for TB disease	PEPFAR Output	1	C2.5.D	TB/HIV: Percentage of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment			Small Change - should not impact trend analysis for numerator
Care Sub Area 3: Clinical/Preventive Services - Additional TB/HIV								
7.4	Number of registered TB patients who received HIV counseling, testing and their test results at a USG supported TB service outlet.	PEPFAR Output	3	C3.1.D	Number of TB patients who had an HIV test result recorded in the TB register			Moderate to significant change - The actual testing of TB patients can still be counted under CT indicator

7.1	Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in palliative care setting						Dropped
Care Sub Area 4: Clinical/Preventive Services - Additional Pediatric							
		PEPFAR Output	1	C4.1.D	Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth		New
						Infants who received virological testing in the first 2 months	
						Infants who were tested virologically for the first time between 2 and 12 months or who had an antibody test between 9 and 12 months	
Care Sub Area 5: Support Care							
8.3 & 1.5	Number of OVC receiving food and nutritional supplementation through OVC programs AND Number of HIV-positive pregnant or lactating women receiving food and nutritional supplementation in a PMTCT setting	PEPFAR Output	1	C5.1.D		Number of eligible clients who received food and/or other nutrition services	Sig Modification to parent indicator - disaggregation can be mapped back to original indicators
			1			By Age: <18	
			1			Pregnant/lactating women	
Treatment							
Treatment Sub Area 1: ARV services							
11.2	Number of individuals newly initiating antiretroviral therapy during the reporting period	PEPFAR Output	1	T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART		Same- label change only. Addition of <1.
	Male (0-14), Male (15+), Female (0-14), Female (15+)		1			By age/sex: <1, <15 Male, 15+ Male, <15 Female, 15+ Female	
			1			Pregnant women	
11.4	Number of individuals receiving antiretroviral therapy at the end of the reporting period	PEPFAR Output	1	T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]		Same- label change only Change to

	Male (0-14), Male (15+), Female (0-14), Female (15+)		1			By age/sex: <15 Male, 15+ Male, <15 Female, 15+ Female	disaggregation: Pregnant female all ages dropped.
	Pregnant Female (All ages)		1				
11.3	Number of individuals who ever received antiretroviral therapy by the end of the reporting period	PEPFAR Output	3	T1.4.D	Number of adults and children with advanced HIV-infection who ever started on ART		Same - label change only. Pregnant female all ages dropped.
	Male (0-14), Male (15+), Female (0-14), Female (15+)		3			By sex: Male and Female	
	Pregnant Female (All ages)		3			By age: <15 and 15+	
11.1	Number of service outlets providing ART services according to national and international standards	PEPFAR Output	3	T1.5.D	Number of health facilities that offer ART		Same - label change only
			3			by type of site: Public, Private, NGO	New
		PEPFAR Outcome	1	T1.3.D	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		New
11.6	Number of individuals receiving ART with evidence of clinical malnutrition receiving food and nutritional supplementation during the reporting period	PEPFAR Output	1	C2.3.D		Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	Moderate to significant change
11.4	(Upstream + Downstream) Number of individuals receiving antiretroviral therapy at the end of the reporting period	National Outcome	1	T1.1.N	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy		Moderate to significant change
OVC							
		See CARE for OVC indicators					
Health System Strengthening							
Health System Strengthening Sub Area 1: Laboratory							
		PEPFAR Output	1	H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests		New

		PEPFAR Outcome	1	H1.2.D	Number of testing facilities (laboratories) that are recognized by national, regional, or international standards for accreditation or have achieved a minimal acceptable level towards attainment of such accreditation	New
12.1	Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests					Dropped
12.2	Number of individuals trained in the provision of laboratory-related activities					Dropped
12.3	Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring					Dropped
Health System Strengthening Sub Area 2: Human Resources for Health						
		PEPFAR Output	1	H2.1.D	Number of new health workers who graduated from a pre-service training institution	New
			1		By Specific Types: Doctors, Nurses	
			2		By Specific Types: Other cadres	
			2		By Specific Types: Clinical/non-clinical	
		PEPFAR Output	1	H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	New
1.4	Number of health workers trained in the provision of PMTCT services according to national and international standards	PEPFAR Output	1	H2.3.D	Number of health care workers who successfully completed an in-service training program	Change - All in-service training will be captured within this indicator. Only a few priority program areas will be subset for more
2.2	Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful					
3.2	Number of individuals trained in blood safety					

4.1	Number of individuals trained in medical injection safety	PEPFAR Output	1	H2.3.D	Number of health care workers who successfully completed an in-service training program	specific information on people trained. This change will have impact on ability to track the trends of disaggregates (at HQ), trends for total people trained will need to be interpreted with caution. Change - All in-service training will be captured within this indicator. Only a few priority program areas will be subset for more specific information on people trained. This change will have impact on ability to track the trends of disaggregates (at HQ), trends for total people trained will need to be interpreted with
5.3	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful					
6.3	Total number of individuals trained to provide HIV palliative care (including TB/HIV)					
7.3	Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)					
8.2	Number of providers/caregivers trained in caring for OVC					
9.3	Number of individuals trained in counseling and testing according to national and international standards					
11.5	Number of health workers trained to deliver ART services, according to national and/or international standards					
13.2	Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)					
14.2	Number of individuals trained in HIV-related policy development					

14.4	Number of individuals trained in HIV-related institutional capacity development						caution.
14.5	Number of individuals trained in HIV-related stigma and discrimination reduction						
14.6	Number of individuals trained in HIV-related community mobilization for prevention care and /or treatment					By Specific Types: Male Circumcision, Pediatric Treatment	
Health System Strengthening Sub Area 6: Health Systems Governance							
		PEPFAR Outcome	2	H6.1.D		Monitoring policy reform and development of PEPFAR supported activities (Policy Tracking Table - Required for Partnership Framework Countries)	New
			2*			Human Resources for Health (HRH)	
			2*			Gender	
			2*			Orphans and other Vulnerable Children	
			2*			Counseling and Testing	
			2*			Access to high-quality, low-cost medications	
			2*			Stigma and Discrimination	
			2*			Strengthening a multi-sectoral response and linkages with other health and development programs	
			3			Pain Management for PLWHA	
			3			Post Exposure Prophylaxis	
			3			Laboratory Accreditation	
			3			Injection safety and waste management	
			3			Other policy areas identified by country team	
		National Outcome	2	H6.3.N		National Composite Policy Index (NCPI)	New
		National Outcome	3	H6.4.N		Existence of national costed HIV implementation plan	New

		National Outcome	3	H6.5.N	Existence of effective civil society organizations	New
*PEPFAR countries with Partnership Frameworks may have Headquarter reporting requirements associated with these policy areas. See Appendix 4 of guidance for more information on monitoring policy reform.						
Strategic Information/Policy Development and System Strengthening						
13.1	Number of local organizations provided with technical assistance for strategic information activities					Dropped
14.1	Number of local organizations provided with technical assistance for HIV-related policy development					Dropped
14.2	Number of local organizations provided with technical assistance for HIV-related institutional capacity building					Dropped

****See further definition of terms (Essential and Recommended) in the Next Generation Indicator Reference Guide**

1	**Essential Indicators with HQ reporting requirements**
2	**Essential Indicators without HQ reporting requirements**
3	**Recommended Indicators**

Appendix 2: PEPFAR CARE Services Menu

CLINICAL CARE SERVICES	
Desired Outcomes Prevention and treatment interventions implemented at appropriate disease stages Symptoms reduced Patients receive Cotrimoxizole Diseases/conditions prevented and managed Nutrition improved Adherence improved Activities of daily living conducted	Eligible Populations
Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Determine WHO stage	PLWHA
Assess eligibility for ART	PLWHA, INF
Assess eligibility for Cotrimoxizole	PLWHA, INF
Screen for active TB	PLWHA, INF, HH
Assess for STIs and other medical problems including OIs, and cancers	PLWHA
Assess nutritional status for clinical malnourishment such as: • Anthropometric assessment, BMI, MUAC • Symptom assessment (e.g. appetite, oral thrush, nausea, and diarrhea) • Dietary assessment of quality and quantity of foods consumed	PLWHA, INF
Assess for pain and other symptoms	PLWHA
Assess for depression and/or anxiety	PLWHA
Assess adherence to care in general and to specific medications	PLWHA, INF
Service	
Clinical monitoring Pre ART	PLWHA
Clinical monitoring of ART	PLWHA
Management of side effects related to ART	PLWHA
Immunologic monitoring (i.e. CD4 % and counts)	PLWHA
Cotrimoxizole Prophylaxis	PLWHA, INF
TB treatment (counted under TB/HIV)	PLWHA, HH

INH prophylaxis for TB	PLWHA
Prevention, diagnosis, treatment, and management of STIs, OIs, cancers, and other medical problems	PLWHA
Targeted therapeutic nutritional feeding or supplementary food provision, including monitoring, counseling, and support to clinically malnourished clients (e.g. PlumpyNut)	PLWHA, INF
Pain & Symptom management	PLWHA
Treatment adherence support (ART, TB, OI)	PLWHA
Treatment for drug and alcohol abuse (i.e. management and maintenance of detoxification; medical assisted therapy)	PLWHA
Treatment for mental disorders associated with HIV infection	PLWHA
Physical and occupational therapy/rehabilitation associated with HIV/AIDS condition	PLWHA
Relief of symptoms (palliative care) through assistance with activities of daily living (e.g. hygiene, oral care)	PLWHA
Early infant diagnosis with virologic testing (PCR testing with DBS or plasma) (This activity is not counted under CARE, use P11.1.D and/or C4.1.D)	INF
PREVENTIVE CARE SERVICES	
Desired Outcomes Increased HIV testing under among family members Behavioral messages delivered Increased access to condoms Increased access to family planning interventions	Eligible Populations
Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Risk Assessment (i.e. screening for behaviors associated with transmission or acquisition of HIV)	PLWHA, HH, OVC
Assessment on alcohol reduction (cross-referenced under 'social support' services)	PLWHA, OVC
Assess, refer, and follow-up for post-exposure prophylaxis (PEP) for rape victims	HH, OVC
Support in defining and reviewing goals to increase HIV prevention behaviors	PLWHA, HH, OVC
Service	
Provide HIV testing (PITC) (This activity is not counted under CARE, use P11.1.D)	HH, OVC
Provide family planning interventions as appropriate	PLWHA, HH, OVC
Counseling and linkage into PMTCT services	PLWHA
STI treatment (Also a clinical service)	PLWHA
Promote and provide condoms, including messages on correct and consistent use of condoms	PLWHA, OVC, HH
Counseling to encourage abstinence from alcohol or reduction in use (cross-referenced under 'social support' services)	PLWHA, OVC
Behavioral counseling and referral (i.e. risk reduction counseling with discordant couples, IDUs, MSMs, CSWs)	PLWHA, OVC, HH

SUPPORT CARE SERVICES	
Psychological Support ***Desired Outcomes*** Counseling provided HIV status disclosed appropriately Male/female involvement increased, stigma reduced Emotional health ensured Note: Note: OVC Programming traditionally groups the following 3 categories (Psychological, Social & Spiritual) under a single category called "Psychosocial"	Eligible Populations
Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Assess whether HIV status has been disclosed	PLWHA, HH, OVC
Assess needs for general supportive counseling	PLWHA, HH, OVC
Provide monitoring, referral, and follow-up for children and adolescents needing counseling by professionals or para-professionals, or other psychosocial support services	PLWHA, OVC
Mental Health Assessment	PLWHA, HH, OVC
Bereavement Care	PLWHA, HH, OVC
Service	
Provide culturally appropriate support and counseling for those who need it	PLWHA, HH, OVC
Disclosure support	PLWHA, HH, OVC
Support for psychological stress associated with HIV infection	PLWHA
Preparing for & coping with dying process	PLWHA, HH, OVC
Bereavement counseling	HH, OVC
Activities to increase male involvement (or female involvement) or reduce stigma	PLWHA, HH, OVC
Social Support ***Desired Outcomes*** Positive interpersonal relationships established Alcohol and drug abuse reduced Gender violence reduced Succession plans carried out Legal needs met Household and family needs met	Eligible Populations

Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Assess for alcohol & drug use (cross-referenced under 'preventive care' services)	PLWHA, HH, OVC
Social Support assessment (i.e. assess for gender violence, availability/capacity of caregivers, additional support for children living outside family)	PLWHA, HH, OVC
Service	
Support services for alcohol & drug abuse (treatment for alcohol & drug abuse is under 'clinical services') (cross-referenced under 'preventive care' services)	PLWHA, HH, OVC
Gender violence support services	PLWHA, HH, OVC
Succession planning	PLWHA, HH, OVC
Activities that encourage the integration of OVC into traditional support systems within the community in order to improve the relationships of vulnerable youth (mentoring, apprenticeship, etc.)	PLWHA, OVC
Gender-sensitive life skills and experiential learning opportunities that build resilience and self-esteem	PLWHA, OVC
Strengthening the capacity of caregivers to listen to and talk with children and support their emotional and social development	PLWHA, HH
Activities to support families and caregivers to better manage stress and improve parenting when they are in situations of chronic illness, are caring for multiple orphans, and have decreasing materials resources	PLWHA, HH
Rehabilitation/re-integration for children who are living outside of family care	PLWHA, OVC
Spiritual Support *Desired Outcomes* Spiritual needs met	Eligible Populations
Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Assess spiritual needs and resources	PLWHA, HH, OVC
Service	
Pastoral/spiritual care as requested by client (includes traditional healers)	PLWHA, HH, OVC
Nutrition and Food Security Support *Desired Outcome* Food secure with the required nutrition in accordance to age and circumstances. Note: Therapeutic feeding for severe malnutrition of HIV-positive individuals should be counted under clinical care services. However, HIV-positive individuals receiving additional food services defined by these illustrative services may be counted. For example, HIV-positive persons receiving services to improve food security or benefiting from household and community gardens may be counted.	Eligible Populations

Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Routine assessment, referral, or continued monitoring as appropriate for nutrition and counseling, including: • Supplemental and supplementary food support for nutritionally vulnerable children (OVC) • Supplemental food support for nutritionally vulnerable PMTCT clients • Micronutrient supplements • Nutrition counseling • Promotion of optimal infant and young child feeding • Services to improve food security • School and after-care feeding • Household and community gardens	PLWHA, HH, OVC, INF
Service	
Activities to support small-scale agriculture activities such as purchasing of seeds, irrigation equipment, and tools for household or community gardens or other agricultural production	PLWHA, HH, OVC
Providing instructional assistance for families and caregivers on nutrition, diet and food/meal preparation techniques, proper food storage, cooking or feeding	PLWHA, HH, OVC
Support to link families with other health and nutrition interventions (food assistance, food security, and other safety net programs)	PLWHA, HH, OVC
Provision of food on an emergency basis for food insecure person with a plan for increased food security.	PLWHA, HH, OVC
Replacement (weaning) feeding and support within the context of the WHO and national PMTCT and infant-feeding guidelines	INF
Micronutrient supplementation (according to WHO guidelines for infants; according to dietary assessments for children and adults)	PLWHA, OVC, INF
General Health Support *Desired Outcome* Receipt of preventive, curative, and promotive health care services as needed, such as primary health care, immunization, and treatment when they are sick.	Eligible Populations
Screening/Assessment/Referral *If, after the completion of a screening or assessment, it is deemed that further service provision (treatment and/or follow-up) is unnecessary, the individual who received the screening/assessment service performed may still be counted towards the indicator.*	
Initial assessment, referral and follow-up for general health support services (i.e. immunizations, health education, etc.)	PLWHA (<18), OVC
Assess water & sanitation	PLWHA, HH, OVC, INF
Service	
Routine growth and development monitoring	PLWHA (<18), OVC
Provision of health insurance	PLWHA (<18), OVC
Provide health education at the household and/or community-level	PLWHA, HH, OVC
Prevention of malaria and other diseases through provision of insecticide-treated bed nets and other necessary commodities	PLWHA, HH, OVC

Provide services to improve water & sanitation	PLWHA, HH, OVC, INF
Education / Vocational Training Support ***Desired Outcome*** Enroll, attend and progress through school and vocation or non-formal training, or an age-appropriate activity or job. Children get the stimulation they need to develop normally.	Eligible Populations
Assessment/Referral/Monitoring	
Assess and monitor educational and vocational needs, including early child development, enrollment, progress and retention in education/vocational training	PLWHA, HH, OVC
Service	
Activities that facilitate early childhood development for OVCs	PLWHA (<18), OVC
Activities that facilitate access to formal education systems and grade appropriate advancement	PLWHA, HH, OVC
Activities that facilitate literacy and numeracy skills	PLWHA, HH, OVC
Activities that facilitate access to or provide persons with individually-appropriate and market-driven vocational training	PLWHA, HH, OVC
Provide monitoring, advice and support as needed during transition from school to vocational training, and from vocational training to work	PLWHA, HH, OVC
Economic Opportunity/Strengthening Support ***Desired Outcome*** Basic needs of all members of the household are met by families, in spite of changes in the family situation due to HIV/AIDS.	Eligible Populations
Assessment/Referral/Monitoring	
Assess the need of households and participants for economic strengthening interventions	PLWHA, HH, OVC
Service	
Small-business development and activities to promote entrepreneurism among older HIV/AIDS OVCs and caregivers	PLWHA, HH, OVC
Support actual economic engagement such as identifying job opportunities, providing occupational counseling/guidance, and providing start-up resources.	PLWHA, HH, OVC
Household economic-strengthening activities focused on increasing coverage of school-related expenses, such as incentive-driven, conditional grants and training for HIV/AIDS OVC caregivers	PLWHA, HH, OVC
Setting-up small-scale animal husbandry for HIV/AIDS-vulnerable households, especially in collaboration with efforts supported by other international partners	PLWHA, HH, OVC
Activities that provide access to micro-finance, primarily opportunities to save, access credit, and in some cases, access insurance	PLWHA, HH, OVC
Community-based asset-building	PLWHA, HH, OVC
Establishing mechanisms to support community-based childcare	PLWHA, HH, OVC
Other Income Generating Activities	PLWHA, HH, OVC

Shelter and Care Support *Desired Outcome* Needs related to protective shelter, clothing, access to safe water, and sanitation facilities are met	Eligible Populations
Assessment/Referral/Monitoring	
Initial assessment of shelter and material care needs in accordance with context, and determination of referral, service provision, and monitoring	PLWHA, HH, OVC
Assess water & sanitation (see general health support services)	PLWHA, HH, OVC, INF
Service	
Provide services to improve water & sanitation (see general health support services)	PLWHA, HH, OVC, INF
Assist children and family members in identifying potential caregivers, prior to a parent's/caregiver's death	PLWHA, HH, OVC
Provide access to temporary shelter for children in transition	PLWHA, HH, OVC
Support child- or youth-headed households in maintaining their homes	PLWHA, HH, OVC
Support referrals and access to programs that provide incentives for adoption or the provision of foster care	PLWHA, HH, OVC

Protection / Legal Aid Support *Desired Outcome* Free from physical and sexual abuse, neglect, and exploitation Legally protected	Eligible Populations
Assessment/Referral/Monitoring	
Identification, assessment, referral, and monitoring of children in need of protective services.	PLWHA, HH, OVC
Service	
Assistance in accessing legal services or child protection interventions such as: • Facilitating basic birth registration and identification necessary for long-term access to education, health care and social services • Providing community-based assistance or other legal assistance to OVCs for inheritance claims	PLWHA, HH, OVC
Assistance in accessing government grants/social welfare support	PLWHA, HH, OVC
Strengthening child-headed households with the intent of promoting community support and preventing sibling separations	PLWHA, HH, OVC
Assessing and addressing the removal of children from abusive situations into safe, temporary or permanent placements, if appropriate	PLWHA, HH, OVC
Coaching caregivers to better access community and system-level support to which OVCs are entitled.	PLWHA, HH, OVC
Provision of support for survivors of sexual or physical abuse, and education and messaging to prevent abuse	PLWHA, HH, OVC

Eligible Populations Key
PLWHA - Adults and children living with HIV (PLWHA), including pregnant women
HH - Family members, caregivers, or other household members living with or caring for an HIV-positive individual or for an OVC
OVC - Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS, who live in households made increasingly vulnerable because of HIV/AIDS. (e.g. In high prevalence communities, all children may be affected due to break down in community support, loss of teachers, or other social support as a result of HIV epidemic.) HIV+ children (<18 years old) are included under PLWHA.
INF - Infants born to HIV-positive mothers

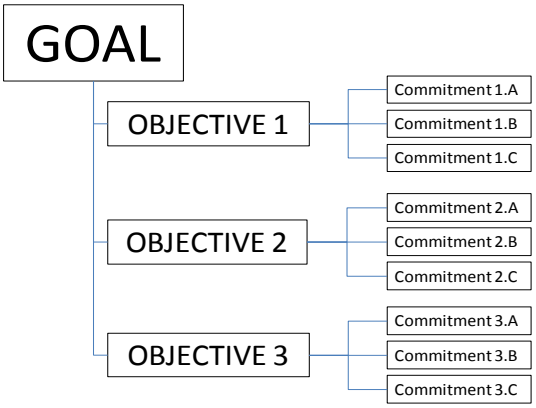
Appendix 3: Partnership Frameworks

Indicators and Reporting

As noted in the draft *Guidance for PEFPAR Partnership Frameworks and Partnership Framework Implementation Plans*, this approach defines a new way to conduct PEPFAR activities in the host countries. The fundamental content of the work remains the same, but couching these efforts within a context of national strategic plans and formal partnerships with government and other donors creates a more integrated, coherent, and strategic approach to address the local HIV epidemic.

One of the key elements of the Partnership Framework is the organization of the proposed work according to a Goals / Objectives / Commitment structure. The text states:

> The document [Partnership Framework] should propose a limited number (for example, three to five) of high-level goals that encompass the breadth of activities included within the Framework … Objectives should include the programmatic interventions proposed to achieve each goal. Commitments will describe the overall support from each partner to realize each objective.



Associated with this new approach is a monitoring and reporting system that is essentially identical to that employed currently by PEPFAR countries. Refer to the *Next Generation Indicators Reference Guide* for specifics regarding the full pool of indicators. In this same document indicators are classified according to their use within the PEPFAR system: for reporting at HQ, for reporting at country level, and recommended for use at programmatic level. Much greater and more detailed information is available in the reference documentation.
In the context of monitoring and reporting for the Partnership Frameworks, there are three indicator issues to be considered: 1) routine program indicators consistent with all PEPFAR country programs; 2) policy development indicators; and 3) health system strengthening indicators.

ROUTINE INDICATORS

The structure of the Partnership Frameworks requires commitments from PEPFAR, host country governments, and potentially other partners. Monitoring all contributions is essential to the success of these agreements, but, as with all PEPFAR programs, formal reporting of progress is associated only with PEPFAR and national governments efforts. One difference unique to Partnership Framework countries is a longer list of national indicators but with more flexibility around the specifics of these indicators.

A. PEPFAR Direct Indicators

All PEPFAR country programs are required to report on the indicators listed as Essential / Reported (E/R) within the *Next Generation Indicators Reference Guide*. These indicators represent most of the programmatic areas found in PEPFAR countries, and as long as a country supports these types of programs, results linked to these indicators must be reported to HQ. When countries do not support this type of work, reporting is not required (see 'Applicability' section of the NGI Guidance).

As noted in the Partnership Framework Goals/Objectives/Commitments schematic above, some country programs may be proposing activities for objectives that do not have associated E/R PEPFAR indicators. In these instances, country teams may use indicators already collected as part of the national M&E system or they may use the *Next Generation Indicators* as a reference guide to select applicable indicators (some of which may include Essential/Not Reported or recommended indicators), but these data will not be reported to HQ.

B. National Indicators

Consistent with the spirit and structure of the Partnership Framework, it is important to know how PEPFAR, as well as how national governments, measure against objectives and in relation to each other. In order to document these achievements, PEPFAR employs a full list of PEPFAR-program indicators (noted above) but only a short-list of national counterpart indicators. As a component of the E/R indicators identified in the NGI Guidance, all PEPFAR country programs are required to report data for a small selection of indicators based on national level data.

This national short-list does not permit the degree of monitoring necessary for the Partnership Framework, so additional national indicators are required. These additional indicators are limited to the national counterparts to E/R PEPFAR program indicators. Preference is for a national indicator that is an equivalent to the PEPFAR indicator, but it is recognized that some national systems do not have these types of data. Countries have the option to select a counterpart indicator from the national monitoring system, as long as it is sufficiently similar to that used for PEPFAR program reporting. Consult with the *Next Generation Indicators Reference Guide* to identify the PEPFAR program E/R list and to examine some examples of national counterparts.

POLICY

One of the principal elements of the Partnership Framework design is the required inclusion of policy reform efforts to promote more effective HIV/AIDS programs. Seven policy areas are listed in the Partnership Framework guidance document, and country teams are required to address all. Each area is relatively broad, and it is highly likely that country teams will propose any of a number of specific policy reform efforts consistent with one of these inclusive categories. Countries also may choose to include additional policy work outside of the seven PEPFAR areas. Given this potential breadth of response, it is expected that these policy reform specifics will be identified in the Partnership Framework (or Implementation Plan?).

Monitoring progress toward the achievement of these policy objectives highlights two issues: 1) at what level are policy reform efforts to be monitored; and 2) how are these efforts to be monitored?

A. Which Policy Efforts Are Monitored

Recognizing that countries may have different approaches and different directions to policy reform, there is no single, valid 'measure' that might be used to track progress to meet the PEPFAR Partnership Framework seven policy requirements. Consequently, each of the policy reform efforts described in a country's Partnership Framework as elements of the seven policy areas will require reporting. For example, a country may propose several different policy reform actions within the gender category; each of these should be identified in the framework document and monitored accordingly (See appendix 4 for additional guidance on Policy).

B. How Are Policy Efforts Monitored

In essence, a higher-level, generalized model is proposed to ease monitoring and reporting requirements and to reflect a straightforward progression toward policy reform goals. Six stages are proposed to track this progression, starting from initial conceptualization and assessment of policy change and continuing through to evaluation of policy implementation (i.e., 1) identify baseline policy issues by conducting situation assessment; 2) engagement of stakeholders in developing common policy agenda; 3) develop policy; 4) official government endorsement of policy; 5) implementation of policy; and 6) evaluation of policy implementation).

These six stages can be applied to any policy area, supporting a relatively simple and uniform monitoring process for all of the included issues. Greater specificity of activities and steps within each stage should be defined and monitored within the country setting. Given the unique circumstances of the country settings, these steps may occur in different stages than illustrated in the NGI Guidance, in multiple stages, or not at all (see Appendix 4).

Progress in policy reporting will be limited to the identification of the *completed* stages found in the framework. After identifying a 'baseline' stage or starting point for a policy area in the Partnership Framework, annual reporting will update progress along the trajectory toward final implementation and evaluation of the policy change. Completion of a stage likely will involve a series of steps, but only at the conclusion of these steps will fulfillment of a stage be achieved (potential final steps are highlighted in appendix 4). Country teams may select to submit additional information when reporting results, but only noting the achievement of a 'Stage' is required.

HEALTH SYSTEMS STRENGTHENING

Measures pertaining to health systems strengthening have attracted considerable attention in the international community over the last several years, but little consensus has emerged to provide uniform guidance. A large part of this problem is related to the breadth of issues falling within the scope of health systems strengthening and the impracticality of accounting for all of these areas. Avoiding some of these controversies, PEPFAR is defining indicator and reporting requirements in HSS to reflect a more narrow scope of interest tied to PEPFAR's focus on HIV. Simultaneously, recognizing that these indicators constitute an additional burden on the field, most data for reporting can be obtained from existing reporting requirements or from internationally available sources.

The indicators included for HSS represent the six building blocks of the WHO health systems framework (Table 2), consistent with PEPFAR's general HSS strategy. These blocks include: human resources for health; health systems finance; service delivery; medical products, commodities, etc.; governance and leadership; and information. All indicators reflect progress at the national level and are not intended to link solely to any PEPFAR activities. Most data sources are dependent on national systems, associated with reporting at the international level (e.g., UNGASS) and with national management of these programs. Other indicators require data from partner sources (e.g., SCMS), surveys, and special studies. Similarly to national reporting requirements associated with the Routine Indicators noted above, selection of the specific indicators and definitions should be guided by what information and systems are available in-country. Table 2 lists preferred indicators, since most follow international standards and harmonization, but some exceptions are likely to occur when applying these requirements to specific country systems.

Reporting results for these indicators should occur on a biennial basis (rather than annual), since many sources yield data only biennially and since measuring health systems changes is a long-term process.

Appendix 4: Monitoring Policy Reform

Measuring progress toward the achievement of policy reform goals and objectives is a relatively new focus for PEPFAR. In defining appropriate indicators and parameters of measurement, the potential burden of data collection and reporting, as well as the diversity of policy issues to be included, is recognized. Given these circumstances, a higher-level, generalized model is proposed to ease monitoring and reporting requirements and to reflect a straightforward progression toward policy reform goals. Six stages are proposed to track this progression (Table 1), starting from initial conceptualization and assessment of policy change and continuing through to evaluation of policy implementation.

Table 1. Stages of policy development

Stage		Potential steps within stage
1	Identify baseline policy issues by conducting situation assessment	Policy analysis research conducted Relevant stakeholders identified Stakeholders involved and engaged Situation assessment implemented National deliberative body (or individual) for policy change identified **Assessment report available as baseline**
2	Engagement of stakeholders in developing common policy agenda	Ongoing stakeholder participation Policy dialogue and advocacy Specific policy issues to be addressed in policy reform or development defined **"White paper" or equivalent defining the policy issue(s)/problem(s) and response completed**
*3	Develop policy	Policy and strategy developed Implications of proposed policy with existing legal, policy and regulatory environments assessed Operational barriers identified Operational policy issues integrated into policy draft **Jointly draft formal/vetted policy text circulated amongst stakeholders**
*4	Official Government endorsement of policy	Leadership engagement/mobilization Revise draft policy accordingly **Government act/approval making policy official (e.g., passage, endorsement, publication)**
5	Implementation of policy	Costed action/implementation plan developed Dissemination, awareness raising and education activities Strategy implementation/capacity strengthening activities carried out Accountability measures/monitoring plan for implementation determined **Resources to support implementation (resource mobilization) provided**
6	Evaluation of policy implementation	Implementation monitored Implementation barriers identified and mitigated Gaps between policy and practice evaluated **Health impact of policy reform evaluated**

These six stages can be applied to any policy area, supporting a relatively simple and uniform monitoring process for all of the included issues. Greater specificity of activities and steps within each stage should be

defined and can be monitored within the country setting. Illustrative policy area descriptions are presented in Table 2

Given the unique circumstances of the country settings, the steps that may occur through the stages and policy areas addressed may differ from those illustrated in the tables below.

Table 2. Policy Area Descriptions

Policy Area Descriptions		
Human Resources for Health (HRH):		
	Addressing policies required to develop a sustainable health worker system	
		Task-shifting to allow appropriately trained and supervised lay workers to provide services
		Other strategies to develop, retain, and rationalize best use of workforce
Gender:		
	Addressing policy factors placing women and girls at greater risk for HIV infection, including policies related to concurrent partners, male norms, gender-based violence and high-risk behaviors of male partners. The approach should take a comprehensive view of these factors and strive to address facilitators and barriers unique to the country context in order to decrease the risk of HIV infection among women and girls.	
	Addressing policy factors that influence men, including the role of men in terms of gender norms, access of men to treatment and, if applicable, opportunities for medical male circumcision.	
	Addressing policy and legal reforms needed to increase gender equity in land and property inheritance rights. Specifically:	
		Legal and policy interventions to safeguard the inheritance rights of women, particularly women in African countries, due to exponential growth in the number of young widows, orphaned girls, and grandmothers becoming heads of households.
		Institutional capacity-building of government ministries, universities, NGOs, and civil society to improve women's legal rights and indigenous women's access to justice.
		Legal and policy interventions that inform lawyers, prosecutors, law enforcement, and service providers on the legal rights of women, and encourage these groups to enforce these rights through the judicial and legal process.
		Working with governments and civil society to eliminate gender inequalities in the civil and criminal code.
	Addressing policy and legal reforms related to Gender-based Violence (GBV). Specifically:	
		Existence of National Anti-GBV/Sexual Violence Laws
		Attention to GBV within National HIV/AIDS Policies.
		Capacity-building of government ministries, institutions (education, health, legal, etc.), NGOs and civil society to prevent and respond to GBV.
		Policies and laws that address norms that perpetuate GBV.
Orphans and other Vulnerable Children:		

	Addressing the unique vulnerabilities of children infected and affected by HIV/AIDS. Includes key policy interventions that address access of children to care and treatment, and those that provide protection for orphans and vulnerable children for a range of issues from inheritance rights to protection against violence to access to education, shelter, food and social support. Policies should also support efforts to scale up antiretroviral therapy for children, including integrating HIV prevention, care, and treatment for children into both existing antiretroviral therapy sites focused on adult care and into maternal, newborn and child health services.	
Counseling and Testing:		
	Addressing implementation of policies that improve uptake of counseling and testing. Counseling and testing policies should enable voluntary and informed consent for all populations, including youth; enable the promotion of confidentiality and beneficial disclosure and guard against inappropriate disclosure; ensure non-discrimination in service provision, facilitating access for a range of population groups; and establish a monitoring and evaluation system that promotes an enabling environment. As epidemiologically appropriate, policies should include:	
		Implementation and promotion of provider-initiated opt-out counseling and testing, especially in PMTCT settings
		Task-shifting to allow appropriately trained and supervised lay workers to provide counseling and testing services
		Use of point-of-care rapid HIV testing
Access to high-quality, low-cost medications:		
	Addressing partner country policies that have a dramatic impact on the availability of drugs and other commodities essential to the care and treatment of PLWHA. Policies should include	
		Appropriate registration of antiretroviral and other important drugs and commodities. The national drug regulatory authorities (NDRAs) of partner countries should make every effort to work with drug manufacturers and assist in the timely registration of antiretroviral drugs, drugs for opportunistic infections, drugs for care and treatment, rapid HIV test kits, and other essential HIV/AIDS commodities that are purchased by PEPFAR. In the event that HIV/AIDS pharmaceuticals that can be purchased by PEPFAR are NOT registered in country, the partner country should provide import waivers to allow products that are available for purchase by PEPFAR to be imported without NDRA registration. For drugs receiving import waivers, PEPFAR should maintain due diligence to assure quality standards. Strengthening forecasting, procurement and logistics systems within the context of a strong partnership with partner country and other international partners to ensure a coordinated response is also critical.
Stigma and Discrimination:		
	Addressing non-discriminatory policies that support PLWHA inclusion in development of policy, community interventions, and program evaluation.	
	Addressing policies that have a positive impact on the causes and consequences of HIV-related stigma, and may support programmatic approaches such as: incorporating Prevention with Positives programs into the training of healthcare workers and lay counselors; utilizing PLWHA as lay counselors and peer educators; and employing effective measurement and documentation of stigma in program plans.	
Strengthening a multi-sectoral response and linkages with other health and development programs:		

	Addressing policies that broaden the multi-sectoral approach. As a starting point it is essential that government policies support linkage of HIV/AIDS programs with other health programs including maternal and child health, safe motherhood, malaria and TB programs. Policies should also support linkage with other development efforts, for example food and nutrition, economic strengthening, and education.
	Addressing policies that include civil society, including faith- and community-based organizations and groups of PLWHA, in the development and implementation of HIV/AIDS programs.
Pain Management for PLWHA:	
	Addressing policies that broaden access to quality pain management services for PLWHA.
Post Exposure Prophylaxis: occupational and non-occupational:	
	Addressing policies that broaden access to quality PEP services for occupational and non-occupational uses.
Laboratory Accreditation:	
	Addressing policies required to assure quality laboratories and accreditations processes.

Appendix 5: Assessing USG Direct Support for Service Delivery

In order to count individuals as receiving a direct service, the USG supported activity must be directly connected to site-specific service delivery. Completing the below checklist can help to verify that a PEPFAR activity is producing a direct service and justification for counting that service as direct.

Checklist: Assessing USG Direct Service Delivery Support

Assessment Criteria	YES	NO	DK
PANEL ONE			
1. Compared to other donors/partners, the dollar value that we invest at the service delivery site(s) is substantial.[8] OR:			
2. We have frequent (i.e. more than one day per week) contact with service delivery site personnel, patients, and/or clients. OR:			
3. We regularly assist with essential M&E functions provided at the service delivery site(s).			
AND:			
PANEL TWO			
4. Quality prevention, care and/or treatment services at the site(s) would not occur in the absence of our support. OR:			
5. The quality of the services provided at the service delivery site(s) would be unacceptably low without our support. OR:			
6. The support provided represents a substantial contribution toward sustainability of services at the service delivery site(s).			

[8] It is difficult to derive an acceptable PEPFAR-wide definition of "substantial" given the varying sizes of country programs, the absolute numbers diagnosed with AIDS, HIV sero-prevalence rates, USG staffing, the nature of the Emergency Plan country assistance, etc. Consequently, using this checklist as a starting point, in each country the USG needs to justify and document its assessment of direct service delivery.

If "YES" is checked for any of the items in Panel One AND in Panel Two of Checklist, then USG direct support is assumed to be direct and likely providing sufficient impact to justify claiming 100% of the site-specific results for the program-level indicator under consideration.

If "NO" or "DK" (Don't Know) is checked for all items in one or both panels, then the USG may not be directly supporting the service delivery activity or the support may be insufficient to claim 100% of the individuals at the site. The USG in-country team must determine if there is sufficient justification to claim direct results and justify a way to estimate the appropriate fraction of this total that is commensurate with USG support, and then document the estimation procedures that were used in order to create audit trail.

A frequent data quality challenge at the USG program level is the extent to which multiple partners are simultaneously reporting 100% of the individuals receiving services from the same service delivery site. USG PEPFAR in-country teams will need to account for double counting as a result of multiple partners working in the same service area when aggregating partner level results.

Note: This checklist helps to make determinations about direct service delivery. However, the term "Direct" can also be applied more broadly to describe other direct outputs of PEPFAR-funded activities, such as a policy developed, a protocol revised, a laboratory updated, or a person trained. See page 11 for full definition of "Direct".

Appendix 6: In-country Processes (additional information for country teams)

Harmonization and Negotiation

For USG PEPFAR country teams newly embarking on a process of in-country indicator harmonization with host governments and other major stakeholders, the following illustrative tips may be useful:

- Host Government should play lead role
- Use existing structures (NAC, National M&E TWG, etc) to engage key stakeholders
- Review of reporting requirements (UNGASS, GFATM, PEPFAR, and other donors)
- Review internal information needs (National, Regional, Facility-level)
- Review indicator resources (National set of indicators, UNGASS indicators, UNAIDS Core National Indicators, Global Fund (GFATM) M&E Tool Kit, and the Next Generation of PEPFAR indicators)
- Begin selection of indicators with highest level of harmonization
- Select additional indicators to fill program gaps
- Obtain consensus/commitment from all stakeholders to use National indicator set

For assistance in implementing a process like this, USG PEPFAR country teams may request technical assistance from headquarters through the normal TA channels.

ACRONYMS AND ABBREVIATIONS

ABC	**Abstinence, Be Faithful, and correct and consistent Condom use**
AIDS	**acquired immunodeficiency syndrome**
AIS	**AIDS Indicator Survey**
ANC	**antenatal care**
API	**AIDS Program Effort Index**
APR	**Annual Program Results**
ART	**antiretroviral therapy**
ARV	**antiretroviral (drug)**
BCC	**behavior change communication**
BSS	**behavioral surveillance survey**
CS, C&S	**care and support; UNAIDS document: *National AIDS Programs: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support* (see References)**
CDC	**Centers for Disease Control and Prevention**
COP	**Country Operational Plan**
CRIS+	**Country Reporting Information System Plus**
CSW	**commercial sex worker**
DHS	**Demographic and Health Survey**
DOD	**United States Department of Defense**
DQA	**Data Quality Assurance**
DSS	**Demographic Surveillance System**
EPP	**Estimate and Projection Package**
GFATM	**Global Fund to Fight AIDS, Tuberculosis and Malaria; *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria* (see references)**
HCD	**human capacity development**
HHS	**Health and Human Services**
HIV	**human immunodeficiency virus**
HMIS	**health management information system(s)**
HMN	**Health Metrics Network (WHO)**
HRSA	**Health Resources and Services Administration**
HQ	**Head Quarters**
IDU	**injecting drug user**
IEC	**information, education, communication**
IPC	**International Programs Center (U.S. Bureau of the Census)**
IWG	**Implementation Working Group (USAID HIV/AIDS Coordination)**
M&E	**monitoring and evaluation**
MDG	**Millennium Development Goals**
MICS	**Multiple Indicator Cluster Survey**
MIS	**management information system(s)**
MOS	**Medical Outcome Survey**
MSM	**men who have sex with men**
NAC	**National AIDS Councils**
NCPI	**National Composite Policy Index**
PEPFAR HQ	**Office of the Global AIDS Coordinator and USG Implementing Agency HQs**
OI	**opportunistic infection**
OVC	**orphans and vulnerable children**
PDB	**Programmatic Database (The Synergy Project)**
PLWHA	**people living with HIV/AIDS**
PMTCT	**prevention of mother-to-child transmission**
PMTCT+	**prevention of mother-to-child transmission plus treatment**

RARG	***WHO Injection Practices: Rapid Assessment and Response Guide*** **(see references)**
RHS	**Reproductive Health Survey**
SAPR	**Semi-Annual Program Results**
SAVVY	**Sample Vital Registration through Verbal Autopsy**
SI	**Strategic Information**
SIGN	**Safe Injection Global Network**
STI	**sexually transmitted infection**
TB	**tuberculosis**
UNAIDS	**Joint United Nations AIDS Programme; UNAIDS document:** ***National AIDS Programmes: A Guide to Monitoring and Evaluation*****. (See references)**
UNGASS	**United Nations General Assembly Special Session on HIV/AIDS**
USAID	**United States Agency for International Development**
USG	**United States Government**
VA	**verbal autopsy**
VCT	**voluntary counseling and testing**
WHO	**World Health Organization**
YPG	**UNAIDS document:** ***Guide to Monitoring and Evaluating National HIV/AIDS Programmes for Young People*** **(see References)**