Malawi EMPOWER Activity

USAID Expanding Malawi HIV/AIDS Prevention with Local Organizations Working for an Effective Epidemic Response (EMPOWER)

Performance Indicator Reference Sheet (PIRS)

CHAM
Christian Health Association of Malawi

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1. INTRODUCTION

Ensuring indicator data quality and consistency is an integral part of the United States Agency for International Development (USAID) Expanding Malawi HIV/AIDS Prevention with Local Organizations Working for an Effective Epidemic Response (EMPOWER) M&E system. One of the ways that Malawi EMPOWER uses to promote its data quality is by use of the Performance Indicator Reference Sheet (PIRS) which aids in defining all of its performance indicators as per project Monitoring, Evaluation & Learning Plan and PEPFAR Monitoring, Evaluation and Reporting (MER) guidance.

In accordance with the project ME&L Plan, the indicator's PIRS will be accessible to all technical program staff–front line providers, their supervisors, clinical/technical staff and M&E staff, who use and collect data for the indicators. In addition, the reference sheets have been incorporated into the system as defined in the MER guidance. The first part of the document includes a snapshot on categories of the project indicators and their reporting timelines. The second part presents performance indicators in granular details. In the last section of the document we present the indicator data flow diagrams.

1.1 INDICATOR SUMMARY TABLE

Indicators Group Summary Key

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Indicator Colour Code	Indicator Description	Reporting Frequency
PrEP_NEW	Number of individuals who have been newly enrolled on an oral antiretroviral pre-exposure prophylaxis to prevent HIV infection in the reporting period [by age, district]	Semi-Annual
PrEP_CURR	Number of adults and adolescents inclusive of newly enrolled, that received oral antiretroviral pre-exposure prophylaxis to prevent HIV infection in the reporting period **[by age, district]**	Semi-Annual
PrEP	Number of clients returning for any subsequent follow up visits.	Semi-Annual
AGYW_PREV	Percentage of (AGYW) that completed the DREAMS primary package of evidence-based services/interventions. [by age, district	Semi-Annual
GEND_GBV	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package **[by age, district, exposure type]**	Annual

GEND_NORM	Number of AGYW completing an intervention pertaining to gender norms, that meets minimum criteria. **[by age, district]**	Annual
TX_NEW	Number of positive AGYW newly enrolled on ART [by age district & pregnancy status]	Quarterly
TX_CURR	Number of AGYW currently receiving ART [by age, district & pregnancy status]	Quarterly
TX_RTT	Percentage of AGYW patients with no clinical contact (or ARV drug pick-up) for greater than 28 days since their last expected contact who restarted ARVs within the reporting period **[by age, district & pregnancy status]**	Quarterly
TX_MML	Number of AGYW patients (who were on ART at the beginning of the quarterly reporting period) and then had no clinical contact since their last expected contact **[by age, district & pregnancy status]**	Quarterly
PMTCT_ARV	% of HIV positive pregnant women who received to reduce the risk of mother to child transmission [MTCT] during pregnancy and delivery [by age, district]	Quarterly
HTS_TST	Number of AGYW who received HIV testing and counselling services for HIV and received their test results [by age, district]	Quarterly
HTS_TST_POS	Number of AGYW who received HIV testing and counselling services for HIV who test HIV positive [by age, district, modality]	Quarterly
HTS_SELF	Number of individual HIV self-test kits distributed [by age, sex & district and assisted vs non assisted]	Quarterly
HTS_INDEX	Number of individuals who were identified and tested using Index testing services and received their results	Quarterly
PMTCT_STAT	% of pregnant women with known HIV status [includes women who knew their status for HIV prior to ANC and those who tested for HIV and received their results] [by age, district]	Quarterly
TX_PVLS	Percentage of AGYW ART patients virally suppressed with a viral load documented in the medical records in the past 12 months with a suppressed viral load [<1,000 copies/ml] **[by age, district & pregnancy status]**	Quarterly

2. PERFORMANCE INDICATOR DEFINITIONS

This section presents, by indicator group, the Malawi EMPOWER performance indicator definitions, as per the PEPFAR MER guidance definitions.

3. PREVENTION INDICATORS

3.1 AGYW_PREV

Description:	Percentage of adolescent girls and young women (AGYW) that completed at least the DREAMS primary package of evidence-based services/interventions.
Numerator:	Number of individual AGYW that have completed at least the DREAMS primary package of services/interventions as of the end of the reporting period
Denominator	Number of individual AGYW that have started or completed any DREAMS service/intervention as of the end of the reporting period
Reporting level:	Community (Reported by USG team, not implementing partners)
Reporting Frequency:	Semi-Annually
How to use:	This indicator reflects program data on how many AGYW are being

	served in DREAMS and whether all active DREAMS beneficiaries have received the intended layered services/interventions to ensure that they remain HIV-free. Specifically, this indicator will measure how many active DREAMS beneficiaries have completed the DREAMS primary package of services/interventions, the primary package plus any secondary services/interventions, and how many have not yet completed the primary package. Of note, a DREAMS Beneficiary is when an AGYW is enrolled in DREAMS and has started or completed at least one DREAMS service/intervention.

3.2 GEND_GBV

Description:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package
Numerator:	Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package
Denominator	N/A
Reporting level:	Facility & Community
Reporting Frequency:	Semi-Annually
How to use:	This indicator measures delivery of a basic package of post-GBV clinical services (including PEP and EC). NOTE: This indicator DOES NOT include GBV Prevention activities or non-clinical community-based GBV response (e.g., shelter programs, case management). This indicator will enable PEPFAR to: a) To determine the number of individuals that are suffering from GBV and reporting to clinical partners. b) To assess whether post-GBV clinical services are being used. c) Gain an understanding of the uptake of post-GBV clinical services offered across PEPFAR countries. d) Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. e) Support efforts to assess the impact of post-GBV clinical services by correlating the reach (i.e., number of people served) of these services over time with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as survey data (DHS/PHIA/VACS). f) Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.
How to Collect data:	Data sources are standard program monitoring tools, such as Clinic Visit Forms (along with the GBV assessment screening tool and crisis Management form).

3.3 GEND_NORM - Tracked as a custom indicator

Description:	Number of people completing an intervention pertaining to gender norms that meets minimum criteria.
Numerator:	Number of people completing an intervention pertaining to gender norms that meets minimum criteria.
Denominator	N/A
Reporting level:	Facility & Community
Reporting Frequency:	Annually
How to use:	This indicator measures delivery of a basic package of interventions pertaining to gender norms that meets minimum criteria.

	Under Malawi EMPOWER GEND_NORM is a custom indicator but results are not included in PP_PREV reporting, and GEND_NORM results are reported in the narrative. This indicator will enable PEPFAR to: a. To determine the number of individuals that are suffering from GBV and reporting to clinical partners. b. Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. c. Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.
How to Collect data:	Data sources are standard program monitoring tools, such as Clinic Visit Forms.

3.3.1 GENDER NORMS STRATEGIES

Gender norms are social norms that relate specifically to gender differences. Refers to informal rules and shared social expectations that distinguish expected behavior based on gender. For example, a common gender norm is that women and girls will and should do most of the domestic work.

No	Gender Norm	Message	Activity/Strategy
1.	Girls are expected to be submissive, docile and shy, and not to be outspoken and opinionated.	Girls have the right/ can express their sexuality and sexual curiosity	1. Health Talks
2.	It is important for boys to be more educated than girls	Boys and girls should have equal access to education opportunities	2. Health Talks 3. Interface meetings with parents or guardians 4. Engagement with traditional/key opinion leaders
3.	Parents or guardians have the right to decide when to a girl should abandon school and get marriage	Girls have the right to decline early marriage and rather stay in school	5. Health Talks 6. Interface meetings with parents or guardians 7. Engagement with traditional/key opinion leaders
4.	Men/Boys should have a final say on whether a Women/Girls should access SRH/HIV/GBV services	Women/Girls can discuss with men or boys but they should have a decision on accessing SRH/HIV/GBV services	8. Health Talks 9. Interface meetings with parents or guardians 10. Engagement with traditional/key opinion leader

5.	Girls who are under the age of 13 have no right to access HIV services	Girls who are under the age 13 have the right to access HIV services but should be consented by their parents or guardians	11. Health Talks 12. Interface meetings with parents or guardians 13. Engagement with traditional/key opinion leaders
6.	Girls should be more concerned with becoming good wives and mothers than desiring a professional or business career	Girls have equal opportunities of desiring a professional or business career	**14.** Health Talks

3.4 PrEP CURR

Description:	Number of individuals, inclusive of those newly enrolled , that received oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV during the reporting period
Numerator:	umber of individuals that received oral PrEP during the reporting period
Denominator	N/A
Reporting level:	Facility
Reporting Frequency:	Semi-Annually
How to use:	Tenofovir-containing oral PrEP reduces the risk of HIV acquisition among numerous populations when taken consistently. WHO guidelines recommend offering oral PrEP to those at substantial risk of HIV infection, (incidence rate of 3 per 100 persons per year). This level of elevated risk has been seen among serodiscordant couples with inconsistent condom use when the partner living with HIV is not virally suppressed, men who have sex with men (MSM), transgender people (TG), sex workers (SW) of all genders, and people who inject drugs (PWID), as well as adolescent girls and young women (AGYW) in many parts of sub-Saharan Africa. PEPFAR supports WHO guidelines on the use of PrEP as part of a package of comprehensive structural, biomedical and behavioral prevention services. In most settings, PrEP will be integrated into existing prevention or treatment services for the target population. As PEPFAR continues to scale up PrEP service delivery, monitoring the PrEP cascade will be important to understand which populations are using this prevention intervention, as well as their length of time using it and their HIV outcome. Understanding the PrEP cascade by population will help improve implementation strategies for those in highest incidence communities initiating PrEP and the retention strategies to support them to stay on PrEP
How to Collect data:	The numerator can be generated by counting the number of individuals that have received PrEP during the reporting period, in accordance with national guidelines or WHO standards, including both those individuals newly initiating on PrEP and those continuing to receive PrEP. PREP_CURR reflects all persons receiving PrEP during the reporting period.

3.5 PrEP_NEW

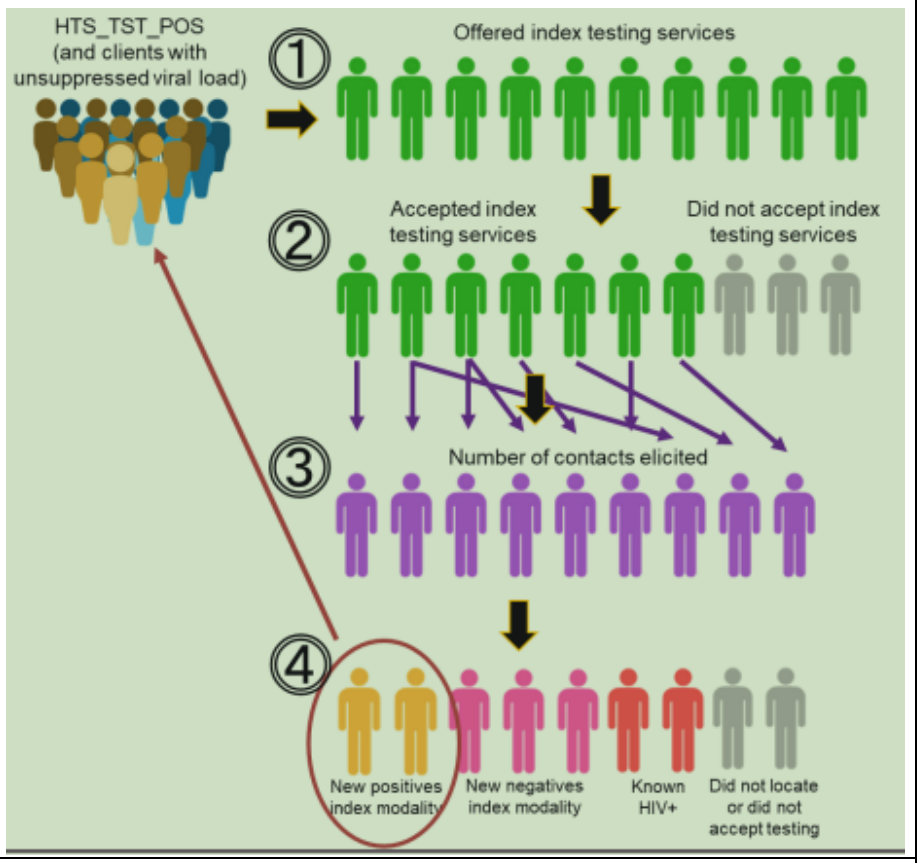
Description:	Number of individuals who were newly enrolled on oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period.

Numerator:	Number of individuals who were newly enrolled on oral antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period
Denominator	N/A
Reporting level:	Facility
Reporting Frequency:	Semi-Annually
How to use:	The indicator measures the ongoing growth of PrEP services. This measure is critical to assess progress in the program's response to the epidemic in specific geographic areas, and the uptake and utility of PrEP among persons at substantially increased risk of HIV infection. This indicator permits monitoring trends in PrEP use but does not attempt to distinguish between different modes or regimens of PrEP or to measure the cost, quality, or effectiveness of PrEP provided. These will each vary within and between countries and are liable to change over time. PrEP has been shown to reduce incident infections among several populations including serodiscordant heterosexual couples, MSM, FSW, and transgender people (TG). The WHO now recommends that oral PrEP containing tenofovir should be offered as an additional prevention choice for people at substantial risk, defined as HIV incidence > 3/100 personyears.
How to Collect data:	The numerator can be generated by counting the number of people who are newly enrolled on PrEP in the reporting period, in accordance with national guidelines (or WHO/UNAIDS standards). NEW is a state defined by an individual's beginning in a PrEP program. It is expected that the characteristics of new clients are recorded at the time they newly initiate into a program. Patients are "new" on PrEP only if they are naive to antiretroviral therapy for prevention of HIV infection and have not received oral or topical prophylaxis previously in any program

4. TESTING INDICATORS

4.1 HTS_INDEX

Description:	Number of individuals who were identified and tested using Index testing services and received their results
Numerator:	Number of individuals who were identified and tested using Index testing services and received their results. This indicator aims to monitor the scale and fidelity of implementation of HIV index testing-related services
Denominator	N/A
Reporting level:	Facility & Community
Reporting Frequency:	Quarterly

How to use:	This is the first MER indicator to monitor PEPFAR programming of HIV Index Testing services (often also referred to as Partner Notification Services or contact tracing , etc.) Index testing, also referred to as partner testing/partner notification services, is an approach whereby the exposed contacts (i.e. , sexual partners, biological children and anyone with whom a needle was shared) of an HIV-positive person (i.e. , index client), are elicited and offered HIV testing services. In this context, index testing refers to any HIV testing of the contacts of an index client (i.e. , a person known to be HIV positive). **Only the following persons count as contacts: current or past sexual partner(s), biological children parents (if index case is a c hild) or anyone with whom a needle was shared.** Biological children reported under HTS_INDEX should only include children of an HIV- positive mother. Children of male-index clients (fathers) should only be included when the biological mother is HIV-positive, she is deceased, or her HIV status is not known or not documented. Conversely, if the index client is the child, his/her mother should be tested, and if the mother is HIV-positive or deceased, the father should be tested as well. In addition, all biologic siblings of the index child should be tested. In this way, provision of index testing services is non-directional, whereby we are trying to follow transmission of the disease. Every newly diagnosed i ndividual becomes a subsequent index client from whom to elicit contacts. Like HTS_TST and HTS_SELF, HTS_INDEX is reported at the facility and community levels. 
How to Collect data:	The suggested data source is a designated HIV Index Testing Services register or logbook. This will allow easier collection of the data for each step in the index testing cascade shown above (see Steps 1 -4 above). Alternatively, existing HTS registers, log books, and reporting forms already in use to capture HTS can be revised to include the steps mentioned above and the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems, and non-governmental organization records.

4.2 HTS_SELF

Description:	Number of individual HIV self-test kits distributed
Numerator:	Number of individual HIV self-test kits distributed. This indicator aims to monitor trends in the distribution of HIV self-test kits within a country at the lowest distribution point.
Denominator	N/A
Reporting level:	Facility & Community
Reporting Frequency:	Quarterly
How to use:	This is the first MER indicator to monitor PEPFAR programming of HIV self-testing approaches and distribution HIV self-test kits. HIV self-testing refers to a process in which a person collects his or her own specimen (oral fluid or blood), performs an H IV test, and then interprets the results. This is often done in a private setting, either alone or with a trusted person. HIV self-testing is a **screening test** and requires self-testers with a reactive (preliminary positive) result to receive further testing from a trained provider using a validated national testing algorithm. HIV self-testing approaches range from unassisted self-testing (with limited or no instruction provided) to directly assisted self-testing (where a testing provider demonstrates how to use the self-test kit). Self-test kits can be distributed in various ways (i.e., by providers or outreach workers, over-the-counter, etc.). Secondary distribution of HIV self-test kits may also occur (e.g., to partners of ANC attendees, or clients of FSWs). This indicator aims to monitor trends in the distribution of HIV self-test kits within a country at the lowest distribution point (i.e., between the distributer and the intended user(s)/recipient). The implementation of HIV self-testing programs should facilitate and enhance access to and uptake of HIV testing services for populations where HIV test uptake is low and undiagnosed HIV infection is high (i.e., men, adolescents/young adults, and key populations).
How to Collect data:	he suggested data source is a (newly developed) HIVST (HIV self-test) register or logbook. This will minimize any potential confusion with HTS_TST data collection and reporting since HIV self-testing is only a screening test and should not be reported under HTS_TST which only includes diagnostic testing. If a standalone HIVST register or logbook is not possible, revise existing HTS registers, log books, and reporting forms already in use to include very clear labels to indicate self-testing to prevent information entered in an HTS register from being counted and reported under TS_TST or HTS_TST_POS.

4.3 HTS_TST

Description:	Number of individuals who received HIV Testing Services (HTS) and Received their test results
Numerator:	Number of individuals who received HIV Testing Services (HTS) and received their test results
Denominator	N/A
Reporting level:	Facility & Community
Reporting Frequency:	Quarterly
How to use:	This indicator is intended to monitor trends in the uptake of HTS (regardless of the service delivery modality and population group) within a country. The disaggregation by test result provides information about the proportion of persons testing HIV positive and the effectiveness of HTS programs in identifying people living with HIV (PLHIV) over time. Further disaggregations are intended to monitor access to and uptake of HTS by population (age, sex, and test result), HTS setting and service delivery modality.

	The findings can support national governments and PEPFAR programs to determine the coverage and identify gaps in HTS services. These data may also be useful for projecting programmatic commodities and system needs such as HIV test kits and other staffing resources, although the numerator reflects the number of individuals tested, not the number of tests performed. Please reference the WHO Consolidated Guidelines on HIV Testing services for information "relevant to the provision of HTS and…issues and elements for effective delivery of HTS that are common in a variety of settings, contexts and diverse populations". http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/
How to Collect data:	Existing HTS registers, log books, and reporting forms already in use to capture HTS can be revised to include the updated disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as HTS registers, health information systems and non-governmental organization records. Data for the numerator should be generated by counting the total number of individuals who received HTS and their test results.

4.4 PMTCT_STAT

Description:	percentage of pregnant women with known HIV status at antenatal care (includes those who already knew their HIV status prior to ANC)
Numerator:	Number of pregnant women with known HIV status at first antenatal care visit (ANC1) (includes those who already knew their HIV status prior to ANC1)
Denominator	Number of new ANC clients in reporting period
Reporting level:	Facility
Reporting Frequency:	Quarterly
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR-supported antenatal care (ANC) know their HIV status and those newly testing positive are initiated on ART.
How to Collect data:	The data source is the ANC register. There is a risk of double counting as a pregnant woman could be tested multiple times during one pregnancy; therefore, partners should ensure a data collection and reporting system is in place to minimize double counting, including a longitudinal ANC register (meaning a register that is able to record all information about one pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy). Subsequent testing during pregnancy and breastfeeding should be counted in the HTS modality: Post ANC1: Pregnancy/L&D/BF. There is also a risk of undercounting if those women who already knew their HIV status prior to attending ANC are not documented, therefore the ANC register should at a minimum document both "previously known positive" and "newly tested positive". It may be appropriate to report "known negative" women under the "Recent Negative" disaggregate if national guidelines do not require retesting women known to be HIV negative (often women tested in the last 3 months, however exact timing depends on local guidelines). See disaggregate definitions below for additional information. Women reported under the "Newly Tested Positive" and "New Negative" disaggregations will auto-populate the HTS_TST ANC1 modality. Women who are tested later in pregnancy, during L&D, and/or during breastfeeding should be reported under the HTS_TST Post ANC1: Pregnancy/L&D/BF modality.

5. TREATMENT INDICATORS

5.1 PMTCT_ART

Description:	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy.
Numerator:	Number of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission during pregnancy
Denominator	**PMTCT_STAT_POS** (see PMTCT_STAT)
Reporting level:	Facility
Reporting Frequency:	Quarterly
How to use:	Track progress toward ensuring that all pregnant women who attend PEPFAR-supported antenatal care (ANC) know their HIV status and are initiated on ART.
How to Collect data:	Data source is the ANC or PMTCT register depending on country context (in many high HIV prevalence settings information on the number of women receiving ART regimens is integrated into the ANC register). There is a risk of double counting, as a pregnant woman receiving ART at ANC should have multiple visits for each pregnancy. Therefore partners should ensure a data collection and reporting system is in place to minimize double counting of the same pregnant woman across visits including a paper based longitudinal ANC or PMTCT register (meaning a register that is able to record all information about 1 pregnancy in one location, with rows or columns that allow for recording information on multiple visits during that pregnancy) or an electronic medical record/patient tracking system. There is also a risk of under-counting if those women who are already on ART prior to attending ANC are not documented, therefore the ANC register should document both "New on ART" and "Already on ART at the beginning of the current pregnancy". Note: Those women reported in PMTCT_ART including newly enrolled on ART and already on ART at the beginning of pregnancy should also be reported in the TX_NEW and TX_CURR indicators, respectively. Women who are already on ART should not be counted in TX_NEW. PMTCT_ART is about initiation of ART (yes/no) or already on ART (yes/no). This will most likely be captured at ANC1 but may be captured at a future ANC visit. Women initiated on ART during L&D or breastfeeding should not be reported under PMTCT_ART but should still be reported under TX_NEW.

5.2 TX_CURR

Description:	Number of adults and children currently receiving antiretroviral therapy (ART)
Numerator:	Number of adults and children currently receiving antiretroviral therapy (ART). Count the number of adults and children who are currently receiving ART.
Denominator	N/A
Reporting level:	Facility
Reporting Frequency:	Quarterly
How to use:	This indicator measures the ongoing scale-up and uptake of ART and retention in ART programs as a critical step in the HIV service cascade and assesses progress towards coverage of ART for all eligible HIV-positive individuals when reviewed against the number of PLHIV that are estimated to be eligible for treatment. It allows us to track the response to the epidemic in specific geographic areas and among specific populations as well as at the national level. Disaggregations by age

	and sex can help better understand which populations are at epidemic control and which populations are lagging behind. Lastly, newly added disaggregations on ARV dispensing quantity can be used to determine uptake of MMD at PEPFAR sites, in PEPFAR SNUs, and across PEPFAR partners.
How to Collect data:	This indicator should be collected from facility ART registers/databases, program monitoring tools, and drug supply management systems. Count the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. Importantly, **patients who have not received ARVs within four weeks (i.e., 28 days) of their last missed drug pick-up should not be counted.**

5.3 TX_ML

Description:	Number of ART patients (who were on ART at the beginning of the quarterly reporting period) and then had no clinical contact since their last expected contact.
Numerator:	Number of ART patients with no clinical contact or ARV pick-up for greater than 28 days since their last expected clinical contact or ARV pick-up. Clinical contact is defined as any clinical interaction with the patient, such as clinical assessment by a healthcare worker or provision of medication.
Denominator	N/A
Reporting level:	Facility
Reporting Frequency:	Quarterly
How to use:	TX_ML (treatment mortality and lost to follow up) is intended to: (1) help better understand fluctuations or steady growth in TX_CURR over time, (2) encourage tracing of patients when a patient has had no clinical contact for greater than 28 days since their last expected contact and (3) promote timely identification of patient outcomes among patients known to have missed clinical visits or drug pickups. PEPFAR implementing partners must ensure that immediate programmatic action is being taken to locate patients that have had no clinical contact for greater than 28 days since their last expected clinical contact. Serious and repeated attempts should be made to reengage any such patients and return them to treatment. In case of death, mortality data should be analyzed and investigated to determine causes of death, where possible. From a public health perspective, treatment adherence and retention are essential to achieve and maintain viral suppression and ultimately reduce or eliminate disease transmission. Not uncommonly, patients who are lost-to-follow up, may have died or have self-transferred to another health care facility; as such, it is important to understand and make these distinctions as each one may require different programmatic interventions. Serious attempts should be made to reengage any patient that has not returned for clinical services or drug pick-up and return them to treatment, and mortality data should be analyzed and investigated to determine causes of death amenable to programmatic intervention (e.g., TB, opportunistic infection, cervical cancer). It is important to note that this is not a cohort monitoring indicator. TX_ML is meant to be used in conjunction with TX_CURR to help better understand fluctuations or steady growth of the ART patient population.
How to Collect data:	This indicator should not count or report those patients who were already lost and not counted in TX_CURR at the beginning of the reporting period. Clinical contact is defined as reporting to the clinic for ART pick-up or clinical assessment, or a documented community visit with a community health worker or peer from an ART refill group. Attempts to reach and re-engage patients into treatment should be made as soon as a patient misses a clinical visit. When a patient has missed their most recent expected clinical contact, the clinic or

	other related staff should attempt to reach and reengage the patient as soon as possible. Once a PLHIV has reached 28 days past their expected clinical contact or drug pick-up, s/he should be removed from TX_CURR, the clinic should again attempt to reach and re-engage the patient, and his/her current outcome should be determined. The outcomes are defined as not currently on ART at the facility if the patient: 1. Died 2. Lost to follow-up a. On treatment for <3 months when LTFU b. On treatment for >3 months when LTFU 3. Transferred out 4. Refused (stopped) treatment

5.4 TX_NEW

Description:	Number of adults and children newly enrolled on antiretroviral therapy (ART)
Numerator:	Number of adults and children newly enrolled on antiretroviral therapy (ART)
Denominator	N/A
Reporting level:	Facility
Reporting Frequency:	Quarterly
How to use:	The indicator measures the ongoing scale-up and uptake of ART programs. This measure is critical to monitor along with number of patients currently on ART in relation to the number of PLHIV that are estimated to be eligible for treatment to assess progress in the program's response to the epidemic in specific geographic areas and populations as well as at the national level. This is particularly critical in the context of current revisions to countryspecific ART eligibility. Reporting the number of new patients enrolled on ART at both the national and overall PEPFAR program levels is critical to monitoring the HIV services cascade, specifically the successful linkage between HIV diagnosis and initiating ART. Disaggregation of new on ART by age/sex at ART initiation, and breastfeeding status at ART initiation is important to understand the percentage of new ART initiations coming from priority populations. Note that pregnancy status at ART initiation is captured in the PMTCT_ART indicator.
How to Collect data:	Facility ART registers/databases, program monitoring tools, or drug supply management systems.

5.5 TX_RTT

Description:	Number of ART patients with no clinical contact (or ARV drug pick-up) for greater than 28 days since their last expected contact who restarted ARVs within the reporting period
Numerator:	Number of ART patients with no clinical contact or ARV pick-up for greater than 28 days since their last expected contact who restarted ARVs within the reporting period
Denominator	N/A
Reporting level:	Facility
Reporting	Quarterly

Frequency:	
How to use:	TX_RTT counts those who are lost to TX_CURR for more than 28 days past the last expected clinical contact and who return to care and restart ARVs in the reporting period. Monitoring this indicator may also help to identify those PLHIV who were diagnosed and started ART in the past but have been lost to the health care system. This indicator seeks to encourage ongoing contact with patients who miss appointments and/or to encourage supportive services to facilitate restarting ARV therapy. It also seeks to encourage identification and the return to treatment of those PLHIV with a history of ART but are currently lost or unknown to the health care system. National clinical guidelines typically recommend that patients with ART history are restarted on ARVs, rather than newly initiate clients as if they were treatment-naïve. Nonetheless, many clinics – lacking sufficient clinical history or documentation – newly initiate patients with prior ART history. From a public health perspective, treatment adherence and retention are essential to achieve and maintain viral suppression and ultimately reduce or eliminate disease transmission. Serious attempts should be made to reengage and return to treatment any patient that has not returned for clinical services or drug pick-up.
How to Collect data:	When a patient has missed their most recent expected clinical contact, the clinic or other related staff should attempt to reach and reengage the patient as soon as possible. A patient is counted under TX_RTT in the reporting period in which s/he returns to care and restarts ARVs. As with TX_NEW, the TX_RTT patient joins the TX_CURR population; if the patient remains on ART to the end of the reporting period, the patient should be counted as TX_CURR in that reporting period. A patient should not to be counted as TX_RTT if they have been traced and returned to treatment within 28 days of the last expected contact (clinical or ARV pick up). Clinical contact is defined as reporting to the clinic for ART pick-up or clinical assessment, or a documented community visit with a community health worker or peer from an ART refill group

6. VIRAL SUPPRESSION INDICATORS

6.1 TX_PVLS

Description:	Percentage of ART patients with a suppressed viral load (VL) result (<1000 copies/ml) documented in the medical or laboratory records/laboratory information systems (LIS) within the past 12 months
Numerator:	Number of ART patients with suppressed VL results (<1,000 copies/ml) documented in the medical or laboratory records/LIS within the past 12 months If there is more than one VL result for a patient during the past 12 months, report the most recent result.

	Only patients who have been on ART for at least 3 months should be considered.
Denominator	Number of ART patients with a VL result documented in the medical or laboratory records/LIS within the past 12 months. Only patients who have been on ART for at least 3 months should be considered.
Reporting level:	Facility
Reporting Frequency:	Quarterly
How to use:	**VL SUPPRESION OUTCOMES:** This indicator monitors the proportion of documented viral load results from adult and pediatric ART patients who have been on ART for at least 3 months (or according to national guidelines) with a suppressed result (<1,000 copies/ml). This allows ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression. This indicator will provide data on patients who have a viral load (VL) test in the past 12 months and the percentage who were virally suppressed at the most recent test. **VL TESTING COVERAGE:** Comparison of the denominator for this indicator with the result for TX_CURR from 6 months earlier (i.e., two quarters prior) can be used to crudely estimate VL testing coverage supported by PEPFAR. For example, a comparison may be made between the FY20 Q1 denominator for TX_PVLS and FY19 Q3 TX_CURR, given that patients newly initiating ART and included in TX_CURR in FY19 Q4 and FY20 Q1 may not be eligible for a viral load test. In calculating this estimate, it is important to ensure that individuals, not tests are being reported for TX_PVLS. Analyzing both VL testing coverage and suppression rates by geography, sub-population, and implementing mechanisms is essential for program management and quality of care. Real-time review of VL results should trigger an immediate response to follow-up on patients who are not suppressed (i.e., VL ≥1000).
How to Collect data:	This indicator should be collected from clinical sources (e.g., electronic or paper patient records), where possible, to ensure de-duplicated patient counting and receipt of results to inform patient care. Ideally, data for this indicator should be collected from an electronic medical records system (EMR) to minimize data collection errors and ensure that results are informing patient care. If data collection from an EMR is not possible, indicator data may be collected from paper-based registers or reports that reflect the VL results. If standard patient registers do not contain all the required information, individual patient records should be reviewed. If a clinical source does not exist or does not contain the desired information, data may be extracted from an electronic laboratory information system (LIS). VL results from an LIS must be linked to back to the individual patients and their record at sites. NOTE: If patient-linked VL results from LIS is used for reporting, it is incumbent that the implementing partner ensure this information is transcribed into the patient record for timely VL results utilization/patient management. The data source used for reporting on this indicator should be specified and data reported should be de-duplicated and used to inform patient care at sites. If the LIS is used, please explain why clinical sources could not be used to report on this indicator in the narrative (see guiding narrative question section below). **VL results should be reported for patients who have been on ART for at**

	least 3 months (or according to national guidelines). It is important to ensure that the data sources used to collect and aggregate data are updated to be able to report VL results data for patients who have been on ART for at least 3 months.

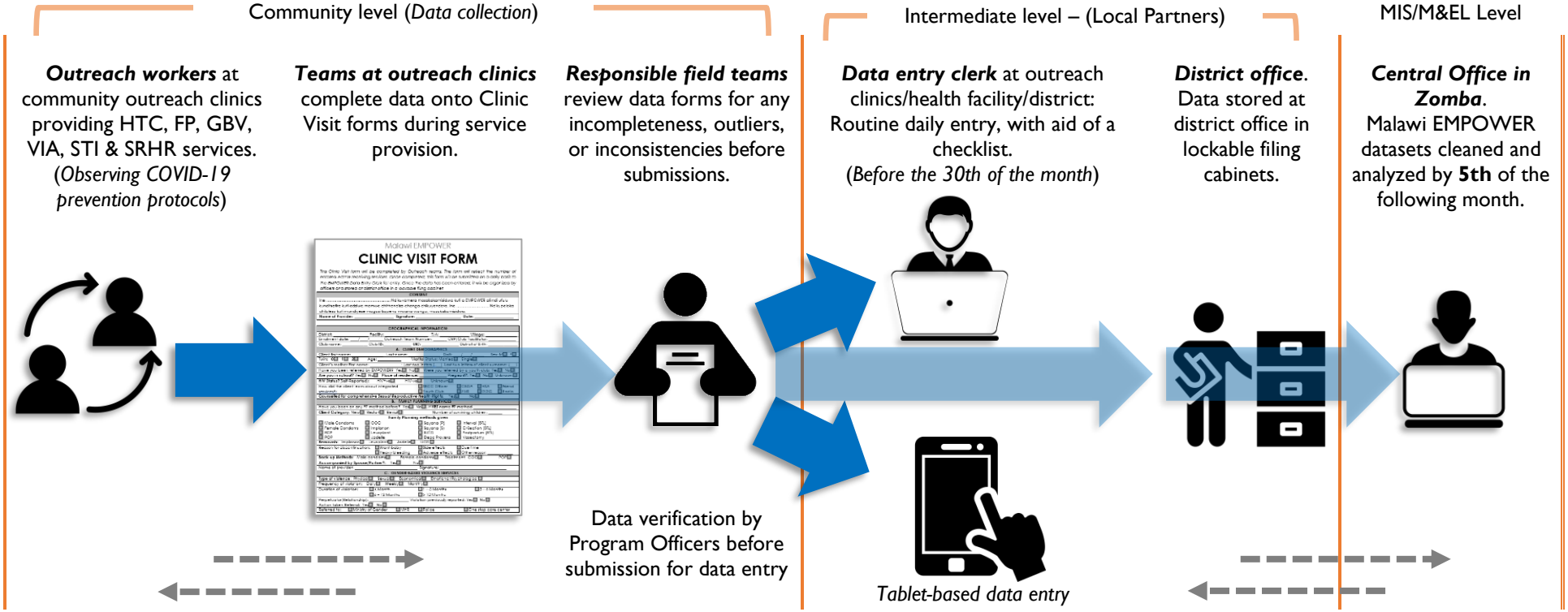
7. PERFORMANCE INDICATORS DATAFLOW

From this section going forward we present performance indicators data flow diagrams to aid outreach workers and programs teams understand the flow of report sat different levels.

7.1 Indicator: AGYW_PREV Data Flow Diagram:

AGYW_PREV definition: Percentage of adolescent girls and young women (AGYW) that completed the DREAMS primary package of evidence-based services/interventions, [by age, district]. This indicator is reported on a quarterly basis in line with the definition described in the performance indicator reference sheet (PIRS).

AGYW_PREV data sources: Data is provided by trained outreach personnel. AGYW data is collected through the Clinic Visit forms and the data is disaggregated by district, age, and sex.

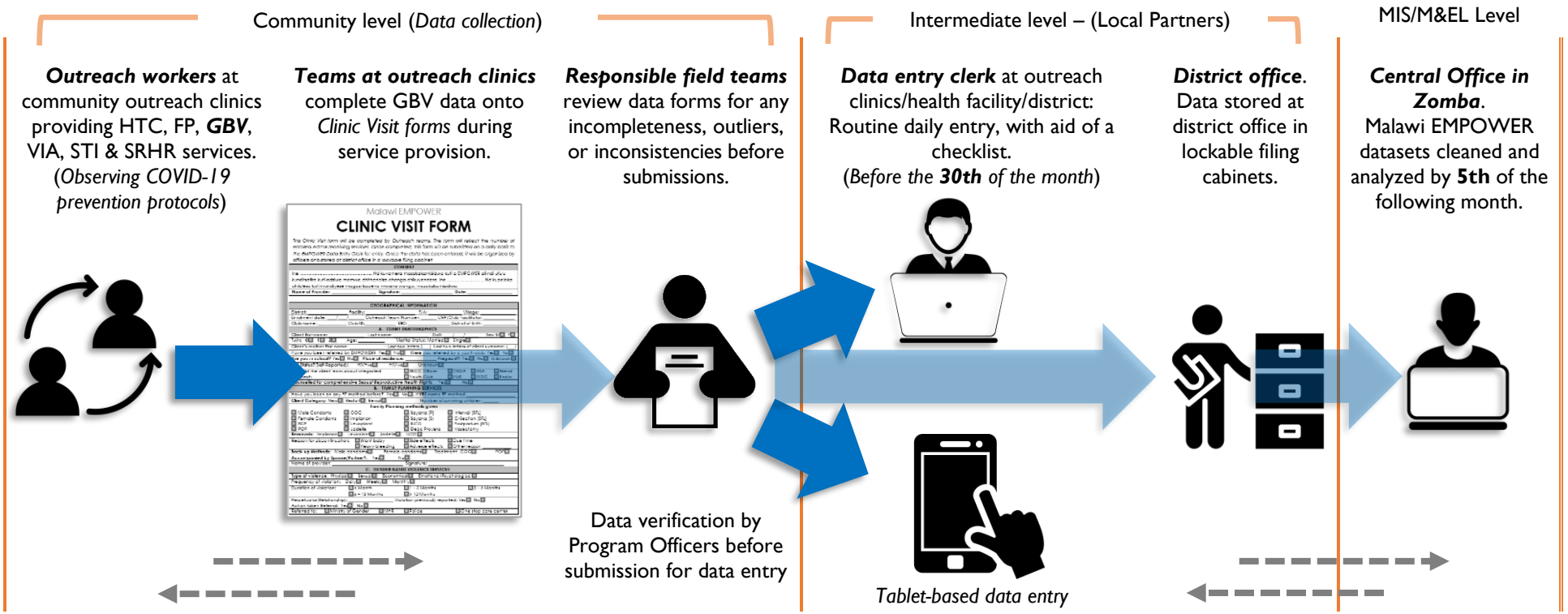


: *Communication and feedback between teams at different levels.*

7.2 Indicator: GEND_GBV Data Flow Diagram:

GEND_GBV definition: Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package [by age, district, exposure type]. This indicator is reported on a quarterly basis in line with the definition described in the performance indicator reference sheet (PIRS).

GEND_GBV data sources: Data is provided by trained outreach personnel. GBV data is collected through the Clinic Visit forms and the data is dis-aggregated by district, age, and sex.

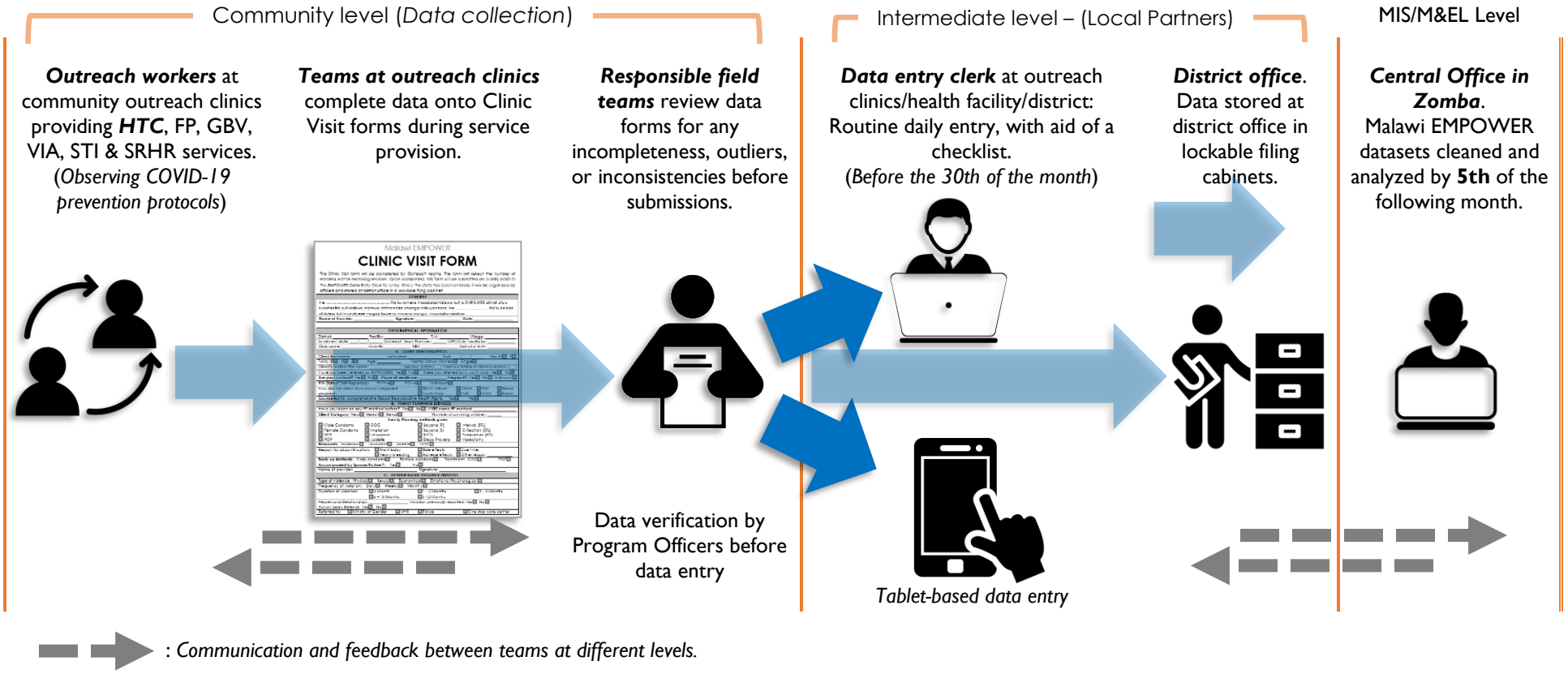


: *Communication and feedback between teams at different levels.*

7.3 Indicator: HTS_TST Data Flow Diagram:

HTS_TST definition: Number of AGYW who received HIV testing and counseling services for HIV and received their test results [by age, district]. This indicator is reported on a quarterly basis in line with the HTS definition described in the performance indicator reference sheet (PIRS).

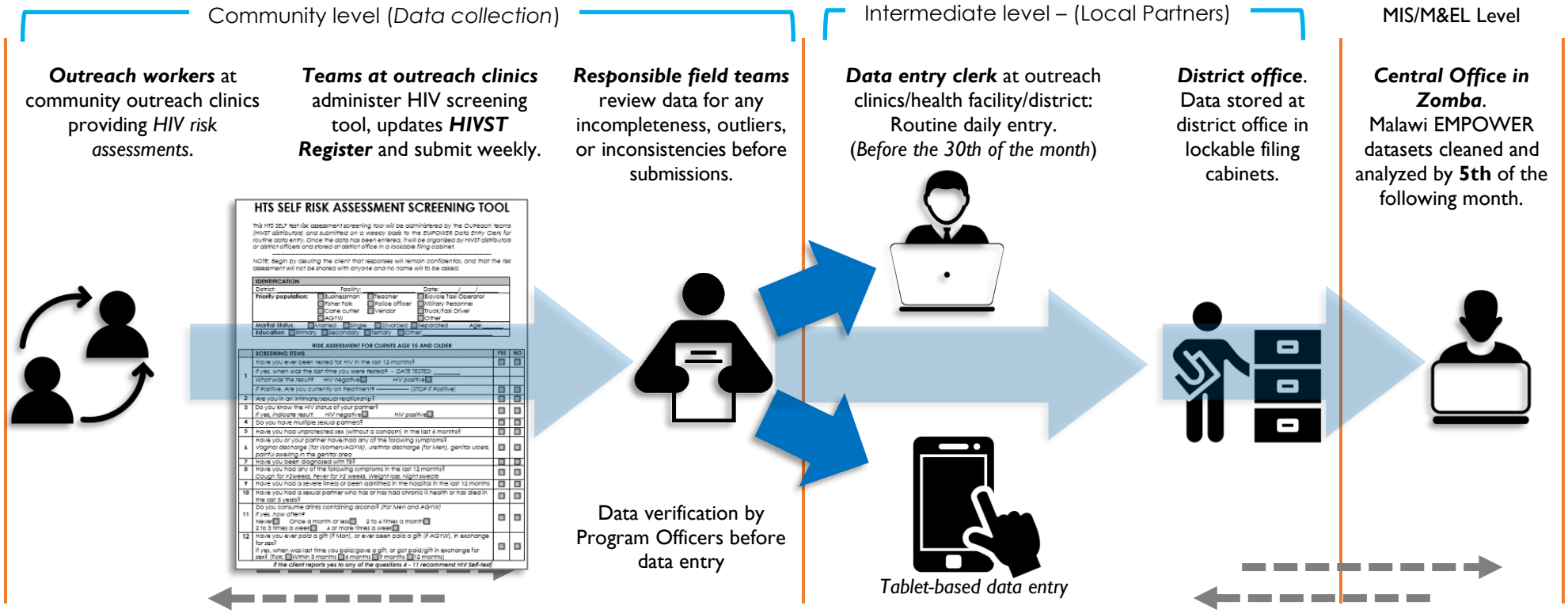
HTS_TST data sources: HTS_TST data is provided by trained outreach personnel. AGYW HTS data is collected through the Clinic Visit forms and the data reflects number of enrolled AGYW receiving services disaggregated by district, age, and sex.



7.4 Indicator: HTS_SELF Data Flow Diagram:

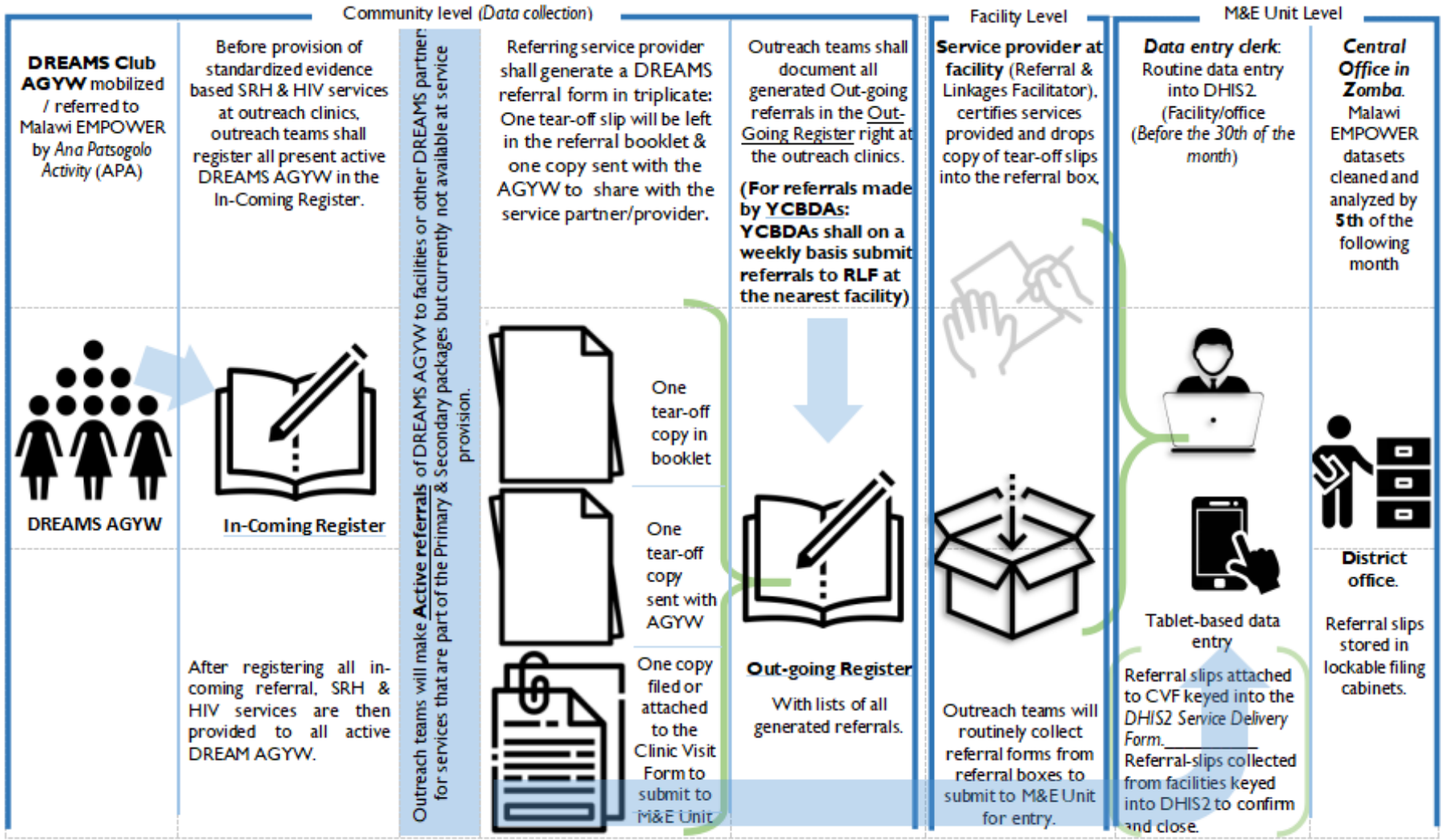
HTS_SELF definition: Number of individual HIV self-test kits distributed [by age, sex & district]. This indicator is reported on a quarterly basis in line with the HTS definition described in the performance indicator reference sheet (PIRS).

HTS_SELF data sources: HTS_TST data is provided by trained outreach personnel. AGYW HTS_SELF data is collected through the Clinic Visit forms disaggregated by district, age, and sex.



: *Communication and feedback betwee n teams at different levels.*

7.5 AGYW CLIENT REFERRAL Data Flow Diagram:



Note: The referring partner is also responsible for generating a DREAMS referral form in triplicate: one copy to be kept by the referring partner and two copies sent with the AGYW. Of the two copies sent with the AGYW, one remains with the receiving partner/facility for their records and the other remains with the AGYW so she can return this to the referring partner, (*DREAMS Database Referral & Linkages SOP, June 2020*).