# OVC PROGRAMME MONITORING

# GUIDELINES FOR OVC PROGRAMME PARTNERS IN SOUTH AFRICA

Version 5, issued December 2024

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## *What's new in this version of the guidelines?*

(1) **Improved integration with the Department of Social Development (DSD) programs and PEPFAR's Site Improvement through Monitoring System (SIMS) guidelines.**

Guidelines now incorporate references to key documents, including:

- The South Africa Department of Social Development's (DSD) Risiha Implementation Manual 2nd Edition July 2024
- Guidelines for Social Services Practitioners (DSD SSPs) 1st Edition October 2019.
- The Children's Act 38 of 2005
- Site Improvement through Monitoring System (SIMS) Site Level Master CEE library, Version 4.2, released on August 15, 2022
- SIMS 4.2 Site Level CEE Narratives October 13, 2022

These references are included in footnotes to promote alignment, streamline implementation, and enhance practitioners' awareness and use of case management standards for ensuring program and service quality. However, the Monitoring Guidelines' primary purpose is to provide practical monitoring and reporting guidance.

(2) **No changes to OVC_HIVSTAT or OVC_SERV indicators exist in MER 2.8. (September 2024)**

- Reminders from MER 2.7 Guidance:
    - A new disaggregate for the 18–20 youth age band was added to OVC_HIVSTAT, so HIVSTATs are required for all OVC Comprehensive children/youth aged 0–20.
    - Highly recommended: Obtain HIVSTATs for OVC Comprehensive caregivers to support the GRA requirement that all children/youth and their primary caregiver have a known HIV status.
- USAID Requirements
    - Clinical confirmation for ART: HIV status for clients on ART must be confirmed by the facility to count towards OVC_HIVSTAT_ON_ART and related custom indicators (e.g., OVC_VL_Eligible, OVC_VLR, OVC_VLS).
    - Youth 18–20 Eligibility: Comprehensive program enrolment for youth aged 18–20 requires either enrolment in secondary school OR living with HIV. (Note: Economic strengthening interventions alone no longer qualify youth 18+ for program enrolment.)
    - CBIMS will verify school enrolment and HIV status based on participant records, ensuring only eligible youth are included in report results.

(3) **Tools for enhanced monitoring of CLHIV**

In COP24/FY25, an OVC program dashboard will be embedded in CBIMS to provide close-to-real-time monitoring of OVC program participants, focusing on CLHIV in the Comprehensive program. For example, the dashboard flags gaps in data collection and case management flags to prompt enhanced service delivery (e.g., identifying children on ART who may be eligible for DTG but are not yet on DTG). USAID can use this dashboard to identify programmatic gaps and successes, and IPs can use related case management reports to identify individual participants for case management follow-up. **The dashboard will be released in Q2 alongside an orientation training for IPs.**

(4) **Guidance on capturing transgender program participants**

In CBIMS and DATIM, the "Sex" data field refers to whether someone is categorised as male or female based on their sexual characteristics at birth. However, some participants may have a gender identity that is different from the sex they were assigned at birth. In some instances, this has led to confusion among IPs about how to record their sex and their eligibility for DREAMS services. This version of the guidance defines key terms (sex, gender, transgender) and explains how to capture the sex of transgender participants.

## (5) **Updated eligible service list and alignment with Risiha service domains**

USAID OVC Comprehensive IPS are encouraged to integrate the community-based prevention and early intervention programme (RISIHA) to support and sustain families. Risiha fills a critical implementation gap by providing standardised age-appropriate needs assessments and case plan development. To align monitoring and implementation practices, the USAID standardised forms were reviewed against Risiha tools and enablers to identify gaps and alignment.

Sixteen new services were added to align the OVC Monthly Activity form with those recommended under the Risiha care plan builder. Services are organised by the seven Risiha domains and count towards OVC_SERV:

- Designated Child Protection Organisations (DCPO) referral
- Thuthuzela Care Centre Referrals
- Disability support
- Care & Dependency Grant
- Disability Grant
- Social Relief of Distress Grant
- Youth Development Agency (YDA) - Entrepreneurial training
- Motivational Counselling (Risiha Enablers)
- Dignity Packs/Hygiene Support
- Families Matter!
- Ke Moja (substance abuse)
- Men Championing Change
- Boys Championing Change
- ZAZI
- Brothers for Life
- STARS (adherence support group)
- Early Intervention Skills for Emotion (EASE)

COVID-related services were removed for COP24/FY25 and no longer count towards OVC_SERV:

- Covid-19 vaccination
- Nutrition-related support for COVID-19, and
- COVID-19 unemployment grant
- As a reminder, multiple services were removed in COP23/FY24: Health, hygiene, water & sanitation messaging, Material support for education, Vhutshilo 1, Vhutshilo 2, Stepping Stones, Personal Career Plan/Ngena 1 & SATE/Ngena 2

A challenge identified during USAID site visits was the ubiquitous use of "psychiatric care and/or intensive counselling services" for services that professional mental health practitioners did not provide. On the monthly activity form, this service has now been disaggregated to more clearly describe the intended service as either "Professional mental health care services" or "Motivational Counselling (Risiha Enablers)."

- "Professional mental health care services" include professional services provided by a psychiatrist, social worker, educational psychologist, in-patient mental health facilities, etc.
- In contrast, "motivational counselling (Risiha Enablers)" is for capturing counselling and structured psychosocial support that is provided by care workers using Rishiha "enablers" as part of home visits or drop-in centres. Care workers should select the appropriate Risiha enabler based on the participant's care plan.

## (6) **Increased emphasis on quarterly case plan monitoring**

MER guidance on OVC_SERV requires that children and youth in the OVC Comprehensive programme are monitored at least quarterly, but as often as is necessary, according to the child's safety, schooling, stability, and health status. Monitoring includes establishing contact in person or virtually where needed to ensure that the case plan progresses and that documentation of this contact is recorded in the case plan. A new indicator in the OVC Dashboard and OVC DQA/SQA report monitors the number and percentage of children whose care plan was monitored in at least the past six months based on intervention capture of 'Case plan monitoring - Updated' or 'Case plan monitoring – Not updated' (under the 'Admin processes' section of the Monthly Activity form).

# INTRODUCTION

USAID Southern Africa OVC Implementing Partners (IPs) use a minimum standard set of forms and procedures for monitoring the family-centred, HIV-inclusive case management, primary prevention and DREAMS programming they provide with PEPFAR support. Monitoring covers a range of program processes, including enrolment, service delivery, and HIV and ART status tracking. In general, partners are required to use CBIMS, the Community-Based Intervention Monitoring System database, and the forms detailed in these implementation guidelines. Push-button reports in CBIMS generate the Monitoring, Evaluation and Reporting (MER) indicator results that partners report in DATIM (Data for Accountability, Transparency, and Impact), PEPFAR's centralised reporting system, as well as custom indicator results for inclusion in DATIM narratives and other reports.

## PURPOSE

These monitoring guidelines aim to improve the availability of high-quality routine data from South Africa to inform PEPFAR-supported OVC programming by facilitating standardised indicators, procedures, and forms for case management monitoring. Technical support for using the case management monitoring system, including orientation for new users, troubleshooting, and training related to system updates, is also offered in line with partners' needs. Guidelines also reference key national program standards to facilitate coordination between USAID-funded activities and South Africa's government initiatives.

## OVC PROGRAMME OVERVIEW

The OVC Comprehensive, Preventive and DREAMS Family Strengthening programmes are called programme models in this guide. The programme models differ by the type and intensity of OVCY services needed by participants and, by extension, the kinds of services targeted to them. This field is essential to OVC_SERV since service and reporting requirements differ between models:

| | |
|---|---|
| Comprehensive case management | • **is selectively targeted to children who require comprehensive, family-centred care, including:**<br>○ Promoting index testing of children with HIV-positive mothers and ensuring treatment and adherence support as needed.<br>○ Providing proactive referrals between clinic and community and providing socio-economic and home-based support to subgroups at high risk (i.e., parents/guardians living with HIV).<br>○ Conducting ongoing needs assessment and monitoring child and family outcomes toward graduation against established benchmarks. |
| Primary Prevention | • **is targeted to children aged 10-14 not known to have HIV** and living in high HIV prevalence and impoverished areas, who do not require comprehensive case management as described above, but would benefit from time-bound, evidence-based interventions designed to prevent sexual violence and HIV. |
| DREAMS Family Strengthening | • **is targeted to AGYW ages 10-17 not known to have HIV**, who are expected to receive the DREAMS core package of layered services/interventions as well as needs-based secondary and contextual services from DREAMS providers and their referral networks. |

This manual primarily focuses on the OVC Comprehensive program which has the most intensive monitoring requirements due to the nature of case management programming.

## INDICATORS OVERVIEW

Results values for all indicators and metrics are detailed here.[1] are derived automatically in CBIMS reports based on data entered from standardised monitoring forms. Reports include values for required disaggregates as applicable and a variety of filters that can be applied to show results by age group, gender, and other standard variables of interest. Partners can use the reports to help fulfil their monthly, quarterly, and semi-annual results reporting requirements, as well as for case management and data quality improvement.

Additional source and calculation information can be found in the Indicator Reference Sheets provided in the appendices and the PEPFAR MER indicator reference guidance, also available online.[2] While indicator results are examined comprehensively at least annually for the snapshot reports prepared by Tulane, IPs are encouraged to monitor indicator results internally more frequently and use the case management reports in CBIMS to help correct any identified data and service quality issues.

**PEPFAR MER Indicators**

PEPFAR MER indicator guidance details two required OVC programme-specific indicators reported in DATIM. In addition to OVC_SERV and OVC_HIVSTAT, OVC implementing partners in South Africa who are also implementing DREAMS family strengthening interventions are required to report source data for the PEPFAR MER indicator AGYW_PREV.

[1] Except for OVC_OFFER and OVC_ENROLL, which have source data captured outside of CBIMS

[2] Complete PEPFAR MER 2.0 (Version 2.8; September 2024) Indicator Reference guidance is available at https://help.datim.org/hc/en-us/articles/360000084446-MER-Indicator-Reference-Guides

**OVC_SERV**

- reflects the number of individuals actively receiving PEPFAR OVC programme services for children and families affected by HIV ("served") in accordance with criteria specific to programme model (Comprehensive, Primary Prevention, DREAMS).
- It also tracks the number of beneficiaries graduating from the comprehensive programme, those transferred to other partners (PEPFAR-supported or otherwise), and those who exited without graduation due to service lapse, aging out, or other reasons.

**OVC_HIVSTAT**

- reflects the percentage of children (<18) and youth (18-20) served in the comprehensive programme whose HIV status has been reported to the implementing partner, and the percentage of children/youth living with HIV (CLHIV) served who are reported to the partner as currently on antiretroviral therapy (ART).

**AGYW_PREV**

- is a DREAMS-specific indicator designed to measure service layering, or how many adolescent girls and young women (AGYW) ages 10-24 have completed the primary package of evidence-based services/interventions intended for all DREAMS beneficiaries and how many of these have received secondary services based on individual need.
- IPs do not report AGYW_PREV results into DATIM, because data on DREAMS services provided to individuals must be aggregated across partners to generate results on this indicator. Currently, partners import individual-level data to the centralized database, CBIMS.Net, where service receipt layering is measured.

**Global and Local OVC Custom Indicators**

USAID headquarters and the PEPFAR-funded ACHIEVE project have designated a series of custom (non-MER) indicators for reporting by OVC partners.[3] These custom indicators go beyond MER standard indicators to showcase the OVC Comprehensive programme's case-finding and treatment support efforts. The USAID OVC custom indicators included in CBIMS reflect supplemental data related to OVC_SERV and OVC_HIVSTAT, HIV testing cascade results, and treatment and viral load suppression outcomes among children living with HIV.

In addition to these USAID OVC custom indicators for global use, custom indicators have been designated by USAID Southern Africa to aid IPs' performance management. These local custom indicators reflect the reach of group-based, structured interventions for all ages, pre-exposure HIV prophylaxis (PrEP) services for adolescent girls and young women, and HTS and ART service referrals to DSP sites.

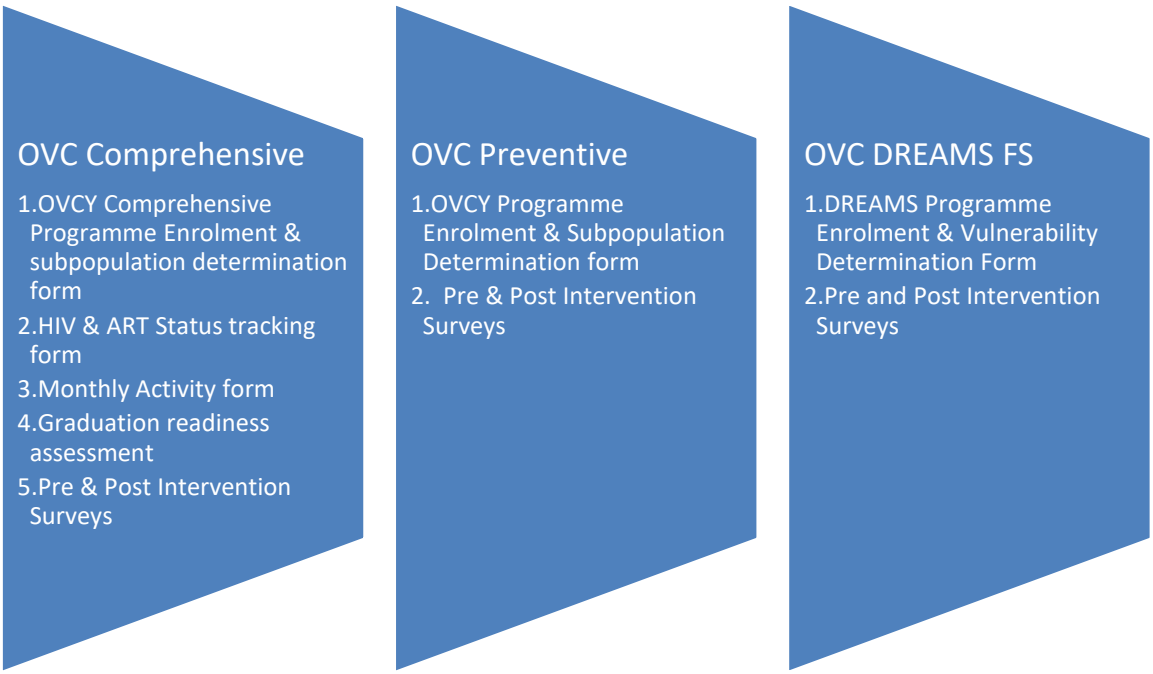
**Department of Social Development NSP Indicators**

The DSD NSP indicators within South Africa's National Strategic Plan for HIV, TB, and STIs (2023-2028) measure key outcomes in social protection, child welfare, and health integration. They include access to psychosocial support, social grants, food programs, Risiha services (drop-in centres), GBV shelter services, social behaviour change programs, substance abuse prevention, and TB-related psychosocial support. IPS are encouraged to review the DSD indicators and identify similarities with the PEPFAR MER and Global and Local OVC custom indicators outlined in these guidelines. CBIMS will monitor and report on a selected set of NSP indicators.

[3] https://ovcsupport.org/resource/electronic-case-management-system-key-considerations-document-2/.

## FORMS OVERVIEW

Multiple standardised forms have been developed to help partners collect the data necessary for monitoring their programs and meeting PEPFAR and custom reporting requirements. Form requirements and content vary by programme model:




Additional forms and procedures, such as the Risiha Screening and assessment tools, are also encouraged to align with governmental initiatives and assist implementers in providing effective and timely service delivery.

**DSD Risiha recommended tools (Risiha Tools & Enablers 2nd Edition July 2024, p14)**
Ungubani assessment
Girl/Boy Index
Substance abuse screen
UNICEF MICS disability screen
Psychosocial support Assessment REPSI
CAGE-AID screen for alcohol and drug use for adults
GBV Risk Assessment
Intervention and linkages key for each domain
Prioritisation framework
Contracting and consent forms
Care plan builder/Care plan forms
Client Referral Form/Referral log

Anyone who uses programme forms or data obtained from them must protect participants' confidentiality and handle personal information appropriately. Partners may require case managers and supervisors to sign and adhere to a written confidentiality policy and/or to take part in specialised training for handling personal and sensitive data. Case managers should always follow their organisation's protocols for responding to a known or possible breach of confidentiality and contact their supervisor with questions or concerns. New or updated data access and handling

procedures may also be required by South Africa's Protection of Information Act (POPIA) and other relevant international and national standards. **Please see Sections 1 and 2 for copies of each USAID form and detailed guidance on form completion and use.**

## ENROLMENT FORMS

Enrolment criteria differ by program model, and participants cannot be enrolled in multiple programs. As a result, the enrolment forms for the OVC Comprehensive, Preventive and DREAMS programmes are distinct. The enrolment process for all three program models provides information on demographic details, such as age, gender, and location, used for case management and reporting purposes.

The OVC Comprehensive and Preventive programme models require all potential child participants to be assessed for eligibility based on whether they meet the criteria for one or more priority subpopulations (see Table 1), age, and service needs. This process aligns with Risiha's SOP 2 (Intakes) to ensure that the client meets the service conditions of the organisation.[4]

| **Table 1. OVC Comprehensive & Preventive subpopulation category** |
|---|
| Child living with HIV |
| HIV-exposed infant |
| HIV+ Caregiver |
| Child is double orphaned |
| Child is single orphaned |
| Teen mother or their child |
| Child/Youth at risk for HIV |
| Child Survivor |
| Key population caregiver |
| Household eligibility |

The OVC DREAMS Family Strengthening model does not require that a specific subpopulation is met. Instead, AGYW are referred to OVC partners from primary package partners, so it is generally accepted that their eligibility has already been confirmed. Nonetheless, it is recommended that partners monitor the relevant vulnerability criteria met by the AGYW upon enrolment into the OVC family strengthening program.

## RISIHA ASSESSMENT TOOLS

After initial eligibility screening and intake, DSD guidance highlights the importance of comprehensive screening and assessment to determine appropriate service intensity and type.[5] Risiha tools supporting this process include the *Ungubani Assessment Tool* [6] for children aged 6 – 12, and their caregivers, and the *Girl/Boy Index*[7] for adolescents aged 13-18. (For children under 5, IPs should use their discretion based on age and developmental stage.) These tools help identify a child's vulnerabilities and strengths in line with Risiha SOP 3 (Screening & Assessment).[8] Comprehensive and routine assessment is critical for case management, informing care plans, detailed intervention strategies and determining graduation readiness within the Risiha model.

## HIV AND ART STATUS TRACKING FORM

The *OVC Programme HIV and ART Status Tracking Form* includes self- or caregiver-reported information about a participant's HIV testing history and treatment status. It also captures individual HIV risk factors identified during a risk assessment and provides information about HTS referrals in

[4] Risiha Tools and Enablers 2nd Edition July 2024: SOP2 (Intake) (p. 10-12)
[5] Risiha Services Implementation Manual 2nd Edition July 2024: Chapter 6 details the early intervention strategy and assessment process (pg. 23-27).
[6] Risiha Tools and Enablers 2nd Edition July 2024: UNGUBANI? / WHO ARE YOU? (p. 27-36)
[7] Risiha Tools and Enablers 2nd Edition July 2024: Girl Index p. 37-46 & Boy Index (p. 47-56)
[8] Risiha Tools and Enablers 2nd Edition July 2024: SOP3 (Screening & Asssessment) (p. 13-14)

response. The form enables OVC_HIVSTAT and related indicator reporting and helps improve the quality of case management by ensuring that IPs have access to the information needed to target HIV-related services appropriately to individuals. The form also supports a more in-depth assessment of HIV-specific issues per Risiha SOP 3 (Screening & Assessment).[9]

The form must be completed at enrolment for all OVC participants in the Comprehensive programme, anytime a case manager becomes aware of a change in the participant's risk profile, and anytime a child or adolescent enrolled in the Comprehensive program receives results from an HIV test or ART monitoring details. Additionally, the form should be completed at least semi-annually for children living with HIV, even in the absence of new ART monitoring results, to ensure that ART status is up to date.

### MONTHLY ACTIVITY TRACKING FORM

Case management services and referral and service delivery dates should be recorded on the *OVC Programme Monthly Activity Form* and entered into the participant's record in CBIMS. These monthly activity data are used to source OVC_SERV and many custom indicators. Services listed on the form are organised under service area headings aligned with Risiha domains and global guidance for PEPFAR partners providing OVC services. Service provision should be based on case planning, as detailed in Risiha SOP 4 (Plan and Contract), SOP 5 (Implement) and SOP 6 (Evaluation)[10], and partners may use their Risiha Screening Tools to assess participants' priority needs.

### GRADUATION READINESS ASSESSMENT FORM

This form tracks progress towards PEPFAR's global graduation benchmarks for households, such as HIV status, viral load suppression, HIV prevention knowledge, child nutrition, financial stability, absence of violence, stable caregiving, and school attendance. This form also supports the implementation of Risiha SOP 7 (Termination/Graduation) by providing a structured process for evaluating whether a family's circumstances have changed, service can end, and the household can graduate from the OVC comprehensive program.[11] Ideally, the form should be completed at enrolment and annually. All applicable household members must meet benchmarks, and the form should be captured in CBIMS. The data generates reports to facilitate case management and ensure households graduate appropriately.

## REPORTS OVERVIEW

Push-button reports in CBIMS fulfil diverse functions, including generating lists of participants who require follow-up for a pending referral or other unmet need, tracking the number of programme enrollees in each priority subpopulation, producing PEPFAR MER indicator results for entry into DATIM, and yielding information on custom indicators in key programmatic areas like the HIV service cascade. MER indicator reports can be run semi-annually to facilitate DATIM reporting, and some can be run on an ad hoc basis for additional monitoring of participant needs, program results, and data and service quality. **See Appendix 1 for a detailed description of each report, including indicators (if any) generated.**

[9] Risiha Tools and Enablers 2nd Edition July 2024: SOP3 (Screening & Assessment) (p. 13-14)
[10] Risiha Tools and Enablers 2nd Edition July 2024: SOP 4-6 Plan/contract, Implement & Evaluate (p.16-22)
[11] Risiha Tools and Enablers 2nd Edition July 2024: SOP 7 Termination/Graduation (p.23)

## ROLES AND RESPONSIBILITIES

**National Department of Social Development (DSD):** As the steward of the national social support system and PEPFAR counterpart, the DSD oversees the government of South Africa (GSA) and PEPFAR investments in the OVC sector. Based on their portfolios, partners will report to DSD as required.

**USAID:** USAID Southern Africa maintains financial and technical oversight for PEPFAR-supported OVC programmes in South Africa and issues guidance and directives related to programme standards, monitoring, and reporting at the country level. This includes interpreting global guidance for local implementation. The Mission approves partners' operational plans and targets and evaluates results regularly, identifying programmatic adjustments that may be needed.

**Implementing partners:** Implementing partner organisations are responsible for providing the necessary staff, infrastructure, and services for the regular conduct of programme operations, including routine monitoring using CBIMS. Partners implementing comprehensive OVC programming should be able to support participants' disclosure of their HIV status and linkages to testing, care and treatment, among other eligible services.[12] Partners agree to use the forms and systems detailed in this guidance document and to report any questions or issues to Tulane as soon as possible.[13]

**Tulane University/HVC-RC:** The Tulane HVC-RC team will be primarily responsible for developing OVC programme routine monitoring tools and systems required for use by partners in South Africa, as described in this guidance document. The team will continue to review the guidance against current standards, USAID priorities, and partner feedback and will issue revisions as needed. Orientation, training, and technical support for partners and other USAID-designated stakeholders will also be provided by Tulane and in collaboration with other experts.

At USAID's request, Tulane provides annual snapshot results reports. The reporting process involves replicating MER and custom indicator results after each APR submission and preparing a report that includes aggregate and partner-level results. The snapshot report frees partners from having to incorporate extensive information on custom indicator results and supplemental data in their report submissions. The exercise is also used to provide targeted feedback about selected aspects of data quality, with a focus on learning rather than strict accountability.

[12] Please refer to SIMS CEE #: S_06_08 on Services to support HIV Treatment Linkage, Engagement and Viral Suppression for OVC [AGYW, GBV, and OVC]; Risiha HIV/AIDS domain services and DSD SPP guidelines on adherence, retention and disclosure support (p.34 -35) for existing guidance.

[13] Please contact hvcteam@tulane.edu with any questions or concerns.

# SECTION 1. OVC COMPREHENSIVE PROGRAMME FORMS AND GUIDANCE

## FORM 1. ENROLMENT & SUBPOPULATION DETERMINATION

PEPFAR

*[Partner Logos]*

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**OVCY Programme Enrolment & Subpopulation Determination Form:**
**Comprehensive Case Management - Primary Caregiver**

*Project Details*

**Project Name** _____

**Personnel** *(First & Surname)* _____

**Personnel Cadre** _____

*Household Location Details*

**HH File Ref. No.** | | | | | | | | | | | | | | | | | | | | |

**House #** _____ **Province** _____

**Street** _____ **District** _____

**Town/Village** _____ **Sub-District** _____

**Area** *(optional description)* _____ **Ward** _____

*Household Referral Details*

**Referred from DSP/PEPFAR clinical setting:** _____

**Referred from other organisation:** _____

*Household Background*

**Headship** ☐ Child headed (<18) ☐ Youth headed (18-24) ☐ Adult headed (25-59) ☐ Older headed (60+)

*Caregiver Programme Details*

**Enrolment Date** D D / M M / Y Y Y Y

**CG File Ref. No.** | | | | | | | | | | | | | | | | | | | | |

*Caregiver Details*

**First Name** | | | | | | | | | | | | | | | | | | | | |

**Surname** | | | | | | | | | | | | | | | | | | | | |

**Known as** | | | | | | | | | | | | | | | | | | | | |

**Date of Birth** D D / M M / Y Y Y Y

**ID Type** ☐ SA ID Number ☐ Passport Number ☐ Permit

**ID Number** | | | | | | | | | | | | | |

**Sex** ☐ Male ☐ Female

**Race** ☐ African ☐ Indian ☐ White ☐ Coloured ☐ Asian

**Disability** ☐ None ☐ Sight/Vision ☐ Hearing ☐ Communication/Speech ☐ Physical ☐ Cognitive ☐ Neurological ☐ Other, Specify:

**Cell Phone** | | | - | | | | - | | | | |

**Alternative Cell** | | | - | | | | - | | | | |

| | | | |
|---|---|---|---|
| Personnel Initials: | Date: | Data Capture Initials: | Date: |
| Supervisor Initials: | Date: | Data Verification/validation Initials: | Date: |

Version Date: December 2024

## OVCY Comprehensive Case Management Programme Enrolment Form: Children or youth (age 0-20)

*Child Caregiver Details*

| | |
|---|---|
| Org Caregiver ID | |
| First Name | |
| Surname | |

*Child Programme Details*

| | |
|---|---|
| Enrolment Date | D D / M M / Y Y Y Y |
| Child File Ref. No. | |

*Child Details*

| | |
|---|---|
| First Name | |
| Surname | |
| Known as | |
| Date of Birth | D D / M M / Y Y Y Y |
| ID Type | ☐ SA ID Number ☐ Passport Number ☐ Other |
| ID Number | |
| Sex | ☐ Male ☐ Female |
| Race (DSD) | ☐ African ☐ Indian ☐ White ☐ Coloured ☐ Asian |
| Disability Type | ☐ None ☐ Sight/Vision ☐ Hearing ☐ Communication/Speech ☐ Physical ☐ Cognitive ☐ Neurological ☐ Other, Specify: |
| Cell Phone | - - ☐ Tick if same number as caregiver |

*Child Background*

| | |
|---|---|
| Caregiver's relationship to child | ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Cousin ☐ Non-relative ☐ Self |
| Orphan status | ☐Mother passed ☐Unknown if mother alive ☐Mother present ☐Father passed ☐Unknown if father alive ☐Father present |
| School status | ☐Not enrolled ☐Enrolled, School Name: _____ |

*Using records, forms & disclosure, mark EVERY category that the child falls within. (Multiple responses allowed).*

| Subpopulation | Description |
|---|---|
| ☐ Child living with HIV | *Child/Youth tested positive for HIV* |
| ☐ HIV-exposed infant | *Child under 2 years of age whose mother is HIV positive or whose status is unknown* |
| ☐ HIV+ caregiver | *Child/Youth lives with caregiver who has HIV* |
| ☐ Child is double orphaned | *The mother and father of the child/youth are deceased or unknown if they are alive* |
| ☐ Child is single orphaned | *The mother or father of the child/youth is deceased or unknown whether he/she is alive* |
| ☐ Teen mother or their child | *Adolescent girl under 18 who is pregnant or has a child, or her child* |
| ☐ Child/Youth at risk for HIV | *Adolescent girls/boys and young women/men ages 10- at risk for HIV; additional project specific criteria may also apply.* |
| ☐ Child survivor | *Child/youth exposed to gender-based violence* |
| ☐ Key population caregiver | *The child/youth's mother or female caregiver is a key population member* |
| ☐ Household eligibility | *Child does not meet any of the categories above but lives with a child who does.* |

| | | | |
|---|---|---|---|
| Personnel Initials: | Date: | Data Capture Initials: | Date: |
| Supervisor Initials: | Date: | Data Verification/validation Initials: | Date: |

Version Date: December 2024

## WHAT IS THE PURPOSE OF THIS FORM?

**The Enrolment & Subpopulation Determination form records participants' demographic and household information.** The use of the form aligns with PEPFAR SIMS OVC Case Management Services guidance directing programmes to enact standard procedures for identifying, assessing, and enrolling the most vulnerable children in the community.[14] While participants may be identified through various channels and processes, the enrolment tool serves as a formal eligibility determination record.

## WHEN SHOULD THIS FORM BE COMPLETED?

Upon enrolment in USAID OVC Comprehensive programming, the case manager should complete this form for every child/youth and their primary caregiver. The data from the form is used to generate the child's and household's records in CBIMS.

## HOW SHOULD THIS FORM BE COMPLETED?

Information for completing this form should be compiled from multiple sources as appropriate, including case manager observation, records from referral agencies, and interactions with participants and referring staff. There are different enrolment forms for the Primary Caregiver (18+) and Child/Youth participants (through age 20 for eligible OVC Child participants) in their care.

<u>Household and Caregiver Details</u>

- Information from the *Caregiver form* is the basis for the household record in CBIMS, and project and household details are automatically linked to each child or youth under the caregiver's care.
- The form is designed to accommodate a range of caregiving arrangements:
    - Where multiple children have the same caregiver, only one *Caregiver form* is needed.
    - Where a child has more than one caregiver, only one person should be enrolled as the primary caregiver.[15]
    - For situations in which a child/youth participant does not have a caregiver (e.g. youth or child-headed household), the 'Project details', 'Household details' and 'Household Background' sections of the *Caregiver form* should be collected for that child/youth participant in addition to all sections from the *Child/Youth form*.
    - Under-eighteen-year-old caregivers, such as teenage mothers, are enrolled as 'child/youth' participants alongside the children in their care.
- A case manager should be assigned and listed under the personnel first and surname fields on the *Caregiver form*, along with the relevant project name.
    - In CBIMS, personnel are linked to participant households, and the assigned personnel should be updated whenever the case manager changes.

<u>Child Details & Subpopulation Determination</u>

- Child participants qualify for enrolment if they meet the criteria for one or more priority subpopulations; See Table 2 for details. A box at the bottom of the Child/Youth form captures the subpopulation category/is specific to each child. **If a potential participant does**

[14] SIMS 4.2 Site Level Master CEE LIBRARY Version 4.2, August 15, 2022 (p. 145); Risiha Services Implementation Manual 2nd Edition July 2024; and Risiha Tools and Enablers 2nd Edition July 2024: SOP2 (Intake) (p. 10-12) and SOP3 (Screening & Assessment) (p. 12-13)

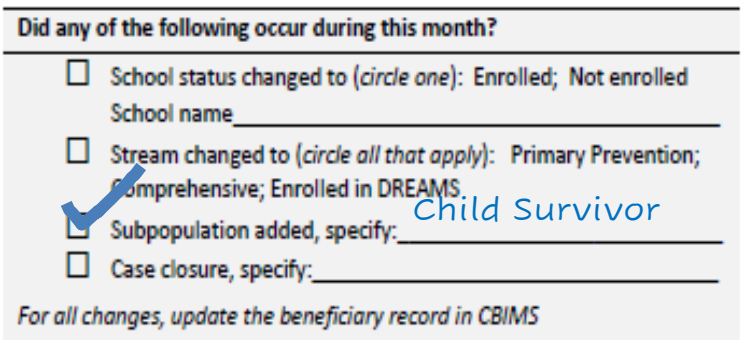
[15] PEPFAR global guidance allows up to two caregivers enrolled in OVC programming to count towards OVC_SERV; however, USAID Southern African has elected to limit reporting to one caregiver to ensure services are appropriately focused on OVC beneficiaries.

**not fall into any of the ten categories on the *Child/Youth form*, they should not be enrolled in USAID OVC programming.**

- Most subpopulations are not mutually exclusive, so children may fall within more than one subpopulation. There are a few exceptions:
    - A participant should not be listed as both 'Child/youth at risk for HIV' and 'Child living with HIV' since the primary goal of programming for those listed as "at risk" is HIV prevention.
    - A participant listed under 'Household eligibility' should not have any other subpopulations listed since it's only used for those who do not otherwise qualify for enrolment.

- In addition to basic demographic information, the Child/Youth form collects details that help to identify priority needs and determine which subpopulation(s) the child falls within. Key considerations for determining the child's sub-population(s) include:
    - **Project specific age-eligibility**. Most partners serve children ages 0-17 or those up to 20 still in school or living with HIV. The IP ensures that case managers appropriately apply age criteria in recruitment efforts.
    - **Sourcing sensitive data**. Projects should carefully consider how to obtain responses to sensitive questions based on case manager capacity and community linkages.
        - For example, qualification as a 'Key population caregiver' should typically be based on referral records obtained via strategic partnerships with agencies that serve key populations (i.e. female sex workers), *not* by asking caregivers if they are involved in sex work.
        - 'Child survivor' status should likewise be based on referral records obtained via strategic partnerships with agencies that serve survivors of sexual violence or voluntary disclosures by participants. However, if screening for gender-based violence is a usual part of the partner's work and appropriate first-line support can be offered, it may be acceptable to inquire directly with potential participants about exposure to sexual violence.

- **Subpopulation updates are limited to additions or logical corrections.**
    - Subpopulation affiliations recorded previously should remain on the child's CBIMS record. For example, children aged out of the 0-2 age group should not have the HEI subpopulation removed from the record.
    - Subpopulation data should be updated after enrolment if the case manager becomes aware of a new subpopulation affiliation, for example, if the child experiences sexual violence.
    - Subpopulation data should be checked for consistency and updated if errors occur. For example, a 'Child/youth at risk for HIV' should not also be enrolled as 'CLHIV' since HIV-positive status would preclude the child from receiving primary HIV prevention interventions.
    - Space to note additions is available in the Monthly Activity Form (discussed later in this document):



| **Table 2. Subpopulation affiliations and descriptions** | | |
|---|---|---|
| Subpopulation category | Description | Additional details |
| Child living with HIV | *Child/youth tested positive for HIV.* | 'Child living with HIV', 'HIV-exposed infant' and 'HIV+ caregiver' subpopulation determinations are sourced from the HIV and ART Status Tracking form, which is also administered at enrolment. This form involves sensitive data and may be completed using a combination of participant inquiry, voluntary disclosure, and referral records. |
| HIV-exposed infant | *Child under 2 years of age whose mother is living with HIV or whose status is unknown* | |
| HIV+ Caregiver | *Child/youth live with caregiver who has HIV* | |
| Child is double orphaned | *The mother <u>and</u> father of the child/youth are deceased or the survival status of both parents is unknown* | 'Child is double orphaned' and 'Child is single orphaned' are based on demographic data collected during enrolment. CBIMS will automatically select the correct category based on data collected in the enrolment form. |
| Child is single orphaned | *The mother <u>or</u> father of the child/youth is deceased or the survival status of one parent is unknown* | |
| Teen mother or their child | *Adolescent girl under 18 who is pregnant or has a child, or her child* | This new subpopulation was added in September 2020 to include teen mothers (<18 years). This category also consists of the teen mother's child/ren who may not otherwise fall into an eligible sub-population. |
| Child/Youth at risk for HIV | *Children and youth (aged 10-20) at risk for HIV; additional project-specific criteria may also apply* | 'Child/Youth at risk for HIV' includes girls and boys aged 10-20 living within priority PEPFAR districts. Projects may apply additional criteria for enrolment in this group to ensure they serve the most vulnerable AGYW. |
| Child Survivor | *Child/youth is a survivor of gender-based violence* | 'Survivor' refers to a child who has experienced sexual violence. The enrolment form does not explicitly refer to sexual violence to avoid stigmatising labels. |
| Key population caregiver | *The child/youth's mother or female primary caregiver is a key population member* | "Key population caregiver' refers to the child of a Female Sex Worker (FSW). The enrolment form does not explicitly refer to sex work to avoid stigmatising labels. |
| Household eligibility | *Child does not meet any of the categories above but lives with a child who does; eligibility for these children is project-specific* | This category refers to children aged 0-17 who do not fall into a priority subpopulation but live with a child who does. In this case, status is determined using enrolment data collected about other enrolees in the household; if one child is a member of a qualifying sub-population, then all children in the household become eligible to receive services. However, eligibility may be project- and model-specific. For example, some projects have strict age targeting (e.g. early child development-focused programmes) that would prohibit enrolment of children over age 5. |
| | | |

## HOW SHOULD THESE FORMS BE CAPTURED IN CBIMS?

- **All items on this form are mandatory data entry fields**. This form is designed to be used with the 'Add New Household' and 'Add New Participant' data entry forms in CBIMS. Electronic data entry fields and response options match those on the corresponding paper forms.
- The enrolment forms have a blank back side where partners can include other details related to their enrolment processes. However, because these forms will be sent for data capture, partners should carefully consider how best to maintain a record of key enrolment details on-site and accessible to case managers (such as making a paper or electronic copy of the form for the case file or ensuring forms' return delivery and filing).
- Once a child is enrolled in the OVC programme, partners should use a standard ID generation procedure to assign unique, partner-level Household, Caregiver, and Child IDs. Each partner should clearly state the procedures for ID generation in their own internal operational guidance. IDs should be captured in CBIMS as well as paper forms/files.
- The final step for case managers is to sign and date the bottom of the form before turning it in to their supervisor. Supervisors should review the form for completeness and accuracy and sign and date it. The form should then be transferred to the data entry team. The final step for the data capture team is to sign and date the bottom of the form. A space has been provided for data verification purposes (procedures may vary by partner).

## WHAT INDICATORS RESULT FROM THIS DATA?

OVC_SERV (disaggregated by Comprehensive, Preventive & DREAMS Family Strengthening), OVC_SERV_SUBPOP, OVC_SUBPOP_PRIORITY, and OVC_ENROLL are generated using data on the programme model from the enrolment forms combined with referral and service provision data from the monthly activity form.

OVC_SERV indicator reference information reflects programme participation disaggregates for the numerator: OVC Comprehensive, OVC Preventive, and DREAMS. A participant's inclusion in one of these disaggregates depends on disaggregate-specific demographic, programme model, and service participation factors. See the table below for more information. USAID OVC custom indicators are typically limited to individuals in the OVC Comprehensive disaggregate.

**Table 3. OVC_SERV details**

| Programme: | Demographic requirements | Service participation requirements |
|---|---|---|
| OVC Comp. | Age 0-20 years and enrolled as Child/Youth participant*, or Age 18 or older and enrolled as a Caregiver participant in Comprehensive stream<br>*Participants aged 18-20 must be attending secondary school or living with HIV to enrol as Child/Youth participants | Graduated from the programme or received an OVC-approved service* in each quarter or the last quarter if enrolled during the reporting period<br>*Including any single session of an approved multi-session structured intervention |
| OVC Prev. | Aged 10-14 years and enrolled as a Child/Youth participant in the Prevention stream | Met the session attendance threshold for completing an approved primary prevention intervention (i.e., ChommY, SKILLZ or No Means No) in the previous two quarters at Q2 reporting or in the past four quarters at Q4 reporting. |
| OVC DREAMS FS | Females aged 10-17 and enrolled as Child/Youth participant in the DREAMS stream | Met the session attendance threshold for completing an approved DREAMS family strengthening intervention (i.e., Let's Talk or PFLH/Sinovuyo) in the previous two quarters at Q2 reporting or the past four quarters at Q4 reporting. |

## FORM 2. HIV & ART STATUS TRACKING

**OVC Programme HIV and ART Status Tracking (HIVSTAT) Form**

*Project Details*

**Personnel First & Surname**

**Date of form completion** D D / M M / Y Y Y Y

*Beneficiary Details*

**First Name**

**Surname**

**Date of Birth** D D / M M / Y Y Y Y Age:_____ **Sex:** ☐ Male ☐ Female

**ID Number**

**Org Beneficiary ID**

*CONFIDENTIAL INFORMATION – STORE AND HANDLE THIS FORM SECURELY AT ALL TIMES!*

Why is this form being completed? (Tick one)
☐ Enrolment ☐ New test results or ART info reported ☐ New risk assessment is needed

Is this person currently pregnant or breastfeeding? ☐ Pregnant ☐ Breastfeeding ☐ Neither ☐ Don't know ☐ N/A (male)

Has this person ever been tested for HIV? ☐ Yes ☐ No ☐ Don't know

When was their last test (if known)? Month _____ Year _____

What was this person's last HIV test result? (Tick one and complete questions below it)

☐ **Positive**

Is this person on ART?
☐ Yes (Actively on ART)
☐ No (Defaulted or Awaiting on ART)→ ***Refer for ART***

Clinical information below was…
☐ Confirmed by facility
☐ Self-reported by participant

Main ART Facility: _____

Date of most recent ART initiation?
Month _____ Year _____

Have they ever had a viral load test?
☐ Yes ☐ No → ***Refer for viral load testing***

If yes, date of last viral load test?
Month _____ Year _____

What was their viral load?
☐ ≥1000 (Unsuppressed)
☐ ≥50 and <1000 (Low grade viraemia)
☐ <50 (Suppressed, undetectable/LDL)

Is their ART regimen dolutegravir (DTG)-based?
☐ Yes ☐ No ☐ Don't Know
ART Regimen: _____

What is their ART dispensing cycle?
☐ 1 mo/dc ☐ 3 mo/dc ☐ 6 mo/dc ☐ Other:_____

Has this person been decanted?
☐ Yes ☐ No
ART Pick-up Point: _____

☐ **Negative** ☐ **Unknown or never tested**

→ *STOP if form is being completed due to new HIV test results reported.*
→ *All others continue to answer all questions below.*

Which type of risk assessment did you conduct?
☐ USAID standardized risk assessment (below)
☐ DSD risk assessment → Result was: ☐ At risk ☐ Not at risk

**USAID Standardized Risk Assessment**: Which, if any, risk factors are present? (Tick all that apply):
☐ No risk factors identified
☐ Most recent HIV test result is unknown or never tested
☐ Experienced sexual violence since last test
☐ Pregnant since last test
☐ Sexually active and not tested for HIV in past 12 months
☐ Age 15+ and not tested for HIV in past 12 months
☐ Age < 2, at risk due to mother's status, and has not completed clinically recommended testing protocols
☐ Other risk factor (Specify _____)

→ ***Refer for HIV Testing if any risk factor is ticked (unless DSD risk assessment result was 'Not at risk')***

Did you refer this person for an HIV test?
☐ No
☐ Yes → Test is: ☐ Not yet completed
☐ Completed → ***Record test result on new form***

| Personnel Signature | Date | Data Capture Signature | Date |
|---|---|---|---|
| Supervisor Signature | Date | Data Verification/validation Initials: | Date |

**Version Date: Dec 2024**

**Monitoring ART adherence and interruptions in treatmentN**

When was their last appointment date (if known)? Month _____ Year _____

Was this client referred to you for support to address treatment interruptions? ☐ Yes ☐ No

If yes, complete fields below

Referral ART Facility: _____

Referral date: Month _____ Year _____

What is/are the reason/s for the treatment interruption? (Tick all that apply.)

☐ Medical ineligibility/deferral
☐ Healthcare access and equity barriers
☐ Client/Caregiver refusal
☐ Adherence challenges
☐ Relocation
☐ Other (Specify: _____)

| Reason client is not on ART | Examples |
|---|---|
| **Medical ineligibility or deferral** | **Client has a medical reason that unable to take ART**<br>• Contraindication (e.g., severe allergies to ART medications).<br>• Co-existing medical conditions affecting ART initiation.<br>• ART deferred for treatment of TB, meningitis or other OIs |
| **Healthcare access and equity barriers** | **Client has structural barriers that prevent access to ART**<br>• Geographic barriers (e.g., no nearby clinic)<br>• Financial barriers (e.g., lack of transport or money for transport, cannot afford loss of income to attend appointments or cost of paying another person to take on social care responsibilities, shortage of food)<br>• Healthcare facility-related (e.g., long wait times, limited hours, provider shortage, medication supply and stockouts.)<br>• Provider-related barriers (e.g., mistreatment by clinic staff, or concerns about privacy and confidentiality)<br>• Administrative barriers (e.g., missing or incomplete medical records, administrative issues with enrollment or eligibility, problems with identification documents.) |
| **Client refusal/CG refusal** | **Client or client's caregiver chooses not to start or continue ART**<br>• Client refuses ART based on personal, cultural or religious beliefs<br>• Client denies that HIV exists and refuses medicine.<br>• Client prefers alternative treatments (e.g., traditional medicine, prayer, etc.)<br>• Client has misconceptions about ART's effectiveness or side effects<br>• Treatment fatigue/treatment break |
| **Adherence challenges:** | **Client chooses to take ART but has a history of poor medication adherence. Potential reasons include:**<br>• Drug side effects or concerns about side effects<br>• Unpalatable medications (e.g., the child refuses to swallow the medicine or spits, or vomits the medicine out)<br>• Depression or other mental health conditions<br>• Alcohol or substance abuse issues<br>• Lack of support from family or caregivers.<br>• Poor social support and/or GBV<br>• Non-disclosure challenges<br>• Difficulty understanding directions<br>• Forgets to take treatment |
| **Relocation** | **The client's ART is interrupted due to relocation, such as:**<br>• Trouble transferring medical records or finding a new provider can delay treatment.<br>• Clients may struggle to get ART in a new place due to unstable conditions or lack of healthcare facilities.<br>• Short-term moves (e.g., for seasonal work or visiting family) can disrupt ART if they don't plan ahead for refills or access. |

| | | | |
|---|---|---|---|
| Personnel Signature | Date | Data Capture Signature | Date |
| Supervisor Signature | Date | Data Verification/validation Initials: | Date |

**Version Date: Dec 2024**

## WHAT IS THE PURPOSE OF THIS FORM?

HIV and ART status monitoring are essential components of comprehensive OVC programming contributing to case finding and treatment support. This form provides data for indicators related to the HIV service cascade and data quality indicators developed for use in South Africa, such as the percentage of children on ART who have an ART initiation date recorded in CBIMS.

The HIVSTAT form is aligned with PEPFAR SIMS OVC Services to Support HIV testing for OVC guidance, which requires that the programme's case management process capture pertinent information related to HIV status for children and their caregivers and use a standard process to assess HIV risk and facilitate linkages to HIV testing if indicated.[16] The form is also used to track important HIV service details such as ART initiation date, viral load testing dates and results, and the facility where a participant diagnosed with HIV normally receives treatment support.

## IS THIS FORM REQUIRED?

HIVSTAT form completion and capture are required for children and youth ages 0-20 enrolled in the OVC Comprehensive programme. It is strongly suggested, but not required, for Comprehensive programme caregivers aged 18+. The form is *not* required for participants enrolled *only* in the OVC Preventive or DREAMS family strengthening programs.

## WHEN SHOULD THIS FORM BE COMPLETED?

For all OVC Comprehensive programme children/youth, this form should be completed during the following times:

- Enrolment in the Comprehensive program
- Whenever new HIV test results are reported to the case manager
- Anytime the case manager becomes aware of a change in the participant's risk profile indicating an HIV test may be needed.

For children/youth living with HIV, this form should additionally be completed at the following times:

- At least every six months to ensure ART status information is current.
- Whenever ART status changes or new clinical information is available (e.g., viral load results are reported).
- Upon referral from a DSP for treatment interruption

### *1. ENROLMENT*

Complete the form for participants upon enrolment in OVC comprehensive case management programming. Note that at enrolment, HIV testing services are generally indicated for:

- Participants aged 15-20 not previously diagnosed with HIV whose most recent test result was more than 12 months ago
- Participants not previously diagnosed with HIV who are sexually active and whose most recent test result was 12 or more months ago
- Participants not previously diagnosed with HIV who have been pregnant or experienced sexual violence since their most recent test
- Participants under two years old at risk due to maternal HIV status (HIV positive or unknown) who have not completed clinically recommended infant diagnostic protocols

[16] SIMS Site Assessment Tool v4.0, Nov 30, 2018; pg. 148

- Participants who have never been tested for HIV or whose status is unknown to the partner for other reasons.

### 2. HIV TEST RESULTS OR ART STATUS UPDATE

- A new copy of the form must be completed whenever the case manager becomes aware of new HIV test results for a participant – even if the previous test result was negative and the current one is negative. This ensures that the most recent test results are on file.
- A new copy of the form must also be completed at least semi-annually for children living with HIV to track current ART status and treatment monitoring results—again, even if the previous and current ART status or treatment monitoring results are the same.
    - Treatment monitoring results include clinical facility name, ART initiation date, viral load testing dates and results, ART regimen and dispensing details.
    - **All ART treatment details should be verified through clinical records** (i.e., clinic files or TIER.net) but may be self-reported by the participant if no other option is available.
- Every form denoting that an HIV test is indicated should be followed up by one that shows the outcome of that test, to the extent possible.
    - Likewise, every tracking form reflecting a child or adolescent with HIV who is *not* on ART should ideally be followed by one that reflects the linkage to this essential service.
    - Further, post-enrolment, every completed referral for HTS or participant report of testing uptake should be followed by a new form indicating the test date and results, even if the participant's HIV status has not changed.
- This process will help case managers monitor adherence to testing protocols for groups at high risk, ensure that HIV and ART status records are current, and ultimately facilitate partners' progress towards reaching HIV service cascade targets.

### 3. NEW RISK ASSESSMENT IS NEEDED (I.E. POTENTIAL CHANGE IN RISK PROFILE)

- A new copy of the form must be completed anytime the case manager becomes aware of (or suspects) a change in the participant's risk profile.
- A change in risk profile is anything suggesting potentially elevated risk in someone not already known to be living with HIV who is an established participant (e.g., the form is not being completed because of programme enrolment).
- The known or suspected change in risk profile prompts a risk assessment to determine if risk factors exist, necessitating HIV testing. Both the risk assessment and its results are recorded on the form.

#### WHAT IS A RISK ASSESSMENT?

An HIV risk assessment is a structured tool used to identify individuals at risk of HIV infection so they may be linked to testing and treatment services. Using a standardised tool ensures consistency, accuracy, and equity in identifying individuals at risk, facilitates appropriate linkage to care and testing services, and enables reliable data collection for monitoring and reporting across programs.

IPs can use the *DSD Risk Assessment* or the *USAID OVC Risk Assessment*. All case managers within the IP should use the same approach.

### WHAT IS THE DSD RISK ASSESSMENT?

The DSD SSP guidance recommends that all children receiving services from an SSP are risk assessed, and the risk assessment outcome is discussed with the child and primary caregiver. The DSD SSP guidelines include a standardised *Enabler 1. HIV Risk Assessment form*[17] which provides a structured approach to identify children and adolescents at risk of HIV based on their previous testing history, circumstantial, health, and behavioural factors and link them to testing.

## Enabler 1: HIV Risk Assessment Form

| | | | |
|---|---|---|---|
| District | | Risk Assessment completed by: (Full Name) | |
| Organisation | | Date | |
| Service Point | | Job Title | |
| Parent's/Legal Guardian/ Caregiver Full Name | | Parent's/Legal Guardian Contact Details | |
| Child's Full Name | | Child's Contact Details | |
| Child's ID Number | | Child's Date of Birth | |

| **PART 1: HIV SCREENING** | | | |
|---|---|---|---|
| **Has the child previously been tested for HIV?** | | Yes | No |
| **UNKNOWN** | **If UNKNOWN**: Continue to PART 2, Risk Indicator questions. | | |
| **NO** | If **NO**: Continue to PART 2 Risk Indicator questions | | |
| **YES** | If **YES**, please determine whether the test results were: | | |
| | POSITIVE | | |
| | NEGATIVE | | |
| | UNKNOWN | | |
| | **If POSITIVE: STOP**<br>Ensure that the child is enrolled in a treatment and care programme and support them with adherence and retention. | | |
| | **If NEGATIVE: First determine when the test was conducted – if more than 6 months ago and child is over 13 years of age**: Proceed to risk assessment questions | | |
| | **If WITHIN PAST 6 MONTHS: HIV test not needed.** ***(as per HTS Policy)***<br>**STOP screening and refer to social and behaviour change programme.**<br>If possible confirm documentation of the test results. | | |

| **PART 2: RISK INDICATORS** | | |
|---|---|---|
| **Circumstantial Indicators (Parental/Family)** | Yes | No |
| **Are either of the child's biological parents reported to be HIV positive** | | |
| **Are one or both of his/her parents deceased due to a known AIDS related illness?** | | |
| **Does the child have one or more siblings that are deceased?** Siblings of the child are deceased *(ask probing questions on the cause of the death, especially if the cause is HIV, TB)* | | |
| **Does any member of the household have concerns about addictive substances?** | | |
| **Has there been incidents of domestic violence in the family?** | | |
| If YES to any of the above the CHILD IS AT RISK of HIV and supportive referral for TESTING IS ADVISED (referral to local | | |

[17] Department of Social Development. Guidelines for Social Service Practitioners: Enabling Access to HIV Testing Services for children, adolescents and youth. First edition October 2019: Enabler 1: HIV Risk Assessment Form (pg. 49)

| **Health Indicators** | | Yes | No |
|---|---|---|---|
| Has the child been sick for more than three weeks at a time? | Including ANY of the following:<br>• Fever, a cough, shortness of breath, rapid shallow breathing<br>• Runny stomach – continues for 3 – 5 days and happens often e.g., every month<br>• Ear infection (pus (yellow substance) leaking from ear, may have been leaking for a long time and is not responding to treatment or stops when on treatment only to restart again<br>• Skin problems (itchy, spotty skin)<br>• Thrush (rash in the child's mount) | | |
| Is the child small and/or underweight for his/her age? | If available - review the child's road to health card. Does the child not gain weight even if they are receiving regular nutritional meals? | | |
| Has the child been diagnosed with TB? | Check road to health card if available | | |
| Has the child been admitted to hospital in the past six months? | Check road to health card if available | | |
| If YES to any of the above the CHILD IS AT RISK of HIV and supportive referral for TESTING IS ADVISED (referral to local hospital, clinic or health funded NPO) | | | |
| **Behavioral Indicators** | | | |
| FOR YOUNGER CHILD | | Yes | No |
| **Do you know if the child has been sexually abused?** | | | |
| **Do you suspect that the child may have been exposed to sexual violence?**<br>Child has been exposed to sexual abuse (There is a suspicion that the child may have been abused/or it has been reported to you or the police or a social worker)<br>*Please note that all suspicion of abuse **MUST** be reported to a social worker* | | | |
| ADOLESCENT/YOUTH INTERVIEW | | Yes | No |
| **Do you have an intimate partner?** | | | |
| **Are you sexually active?** | | | |
| **Have you ever engaged in sexual activities with anyone other than your intimate partner?** | | | |
| **Have you been sexually and/or physically abused***? (There is a suspicion that the adolescent may have been, abused/or it has been reported to you or the police or a social worker)* | | | |
| **Have you been drunk or high on substance and had sex?** Adolescent is abusing alcohol or drugs and engaged in sexual activity. | | | |
| If YES to any of the above the CHILD IS AT RISK of HIV and supportive referral for TESTING IS ADVISED (referral to local hospital, clinic or health funded NPO) | | | |

| **PART 3: ASSESSMENT RESULT AND ACTION** | |
|---|---|
| Date of assessment: | |
| Test Required | |
| Routine testing every six months required | |
| Test Not Required | |
| Child Referred for HIV Testing<br>(indicate where OVCAY is referred to) | |
| Date for Follow- up: | |
| Confirmation of testing received: | |
| Ensure that all Referrals are Entered on the Referral Log and the Referral is noted on the individual child's file | |
| Social Service Practitioners Comments:<br><br>Action Required: 1.<br>2. | |

## WHAT IS THE USAID RISK ASSESSMENT?

The USAID Risk Assessment is built into the HIVSTAT form and designed to provide clear testing criteria tied to timeframes and events. It shares many similarities to the DSD Risk assessment, except for the following:

- The testing protocol prioritises testing for children with an unknown HIV status, especially those who report they have never been tested, to identify **asymptomatic children** who lack obvious risk indicators. For example, children infected perinatally might not display or disclose any obvious risk factors but could still be living with HIV.
- The risk assessment does not rely on self-reported sexual activity, which is often under-reported due to stigma, fear or social taboos. Instead, it recommends annual HIV testing for all adolescents who have reached the **average age of sexual debut** in South Africa (15 years), recognising their heightened risk of HIV acquisition during adolescence and young adulthood.
- The protocol explicitly prioritises **HIV-exposed infants** (<25 years) who require testing through Early Infant Diagnosis (EID) protocols, and addresses **pregnancy**, both as an indication of unprotected sex and due to the need for testing throughout pregnancy.

Case managers can rely on information gathered during day-to-day case management to complete the assessment, including discussions with caregivers and/or the child/youth as appropriate. The first indication for testing is universal in approach and includes anyone who has never tested for HIV or whose testing history is unknown, regardless of the absence of other reported risk factors. The remaining indications for testing are risk-based and include: Participant experienced sexual violence or pregnancy since their last test; Participant is sexually active or 15 years or older and has not been tested in the past 12 months; Participant is under two years of age, at risk due to maternal HIV status (positive or unknown), and has not yet completed clinically recommended infant diagnostic protocols; and other risk factor/s based on programmatic guidelines (e.g., failure to thrive, intravenous drug use.)

**USAID Standardized Risk Assessment**: Which, if any, risk factors are present? (Tick all that apply):

☐ No risk factors identified
☐ Most recent HIV test result is unknown or never tested
☐ Experienced sexual violence since last test
☐ Pregnant since last test
☐ Sexually active and not tested for HIV in past 12 months
☐ Age 15+ and not tested for HIV in past 12 months
☐ Age < 2, at risk due to mother's status, and has not completed clinically recommended testing protocols
☐ Other risk factor (Specify _____)

→ ***Refer for HIV Testing if any risk factor is ticked (unless DSD risk assessment result was 'Not at risk')***

## HOW SHOULD THIS FORM BE COMPLETED?

- Enter project and participant details at the top so data from the form can be linked to the individual's file in CBIMS.
- Indicate why the form is being completed: at enrolment to establish HIV testing history/ status, later to report new test results or ART information, or because the case manager believes the participant's risk profile may have changed and conducted a structured risk

assessment to determine if testing is necessary. (This is only used for participants not already known to be living with HIV).

- Indicate whether the participant is pregnant or breastfeeding when the form is completed. Mark N/A for males.
- Indicate whether the participant has ever been tested for HIV, and if so, the date of the most recent test.
- In the next section of the form, record the participant's *most recent* HIV test result. If a participant has never had an HIV test, or it is unknown whether they have ever been tested (for example, because testing history was not disclosed), tick "Unknown" for the most recent test result.
- Answer the questions in the column that includes the participant's most recent HIV test result.

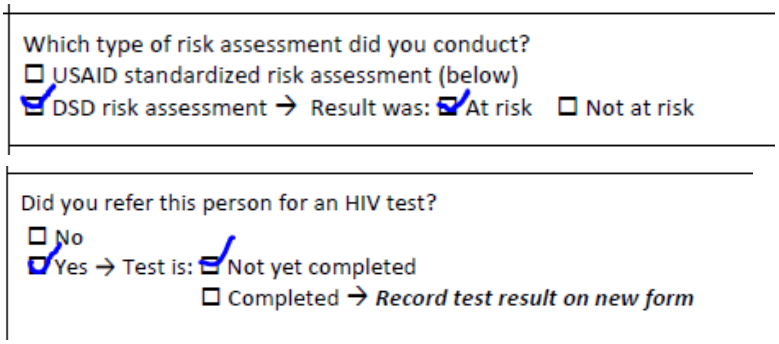
## 1. POSITIVE

- If the most recent test result was positive, indicate whether the participant is on ART
- Indicate whether clinical information related to ART status was verified by the facility or based on participant self-report. This is critical as data based on self-reports will not be counted towards OVC_HIVSTAT_POS_ON ART and related indicators (OVC_VL_Eligible, OVC VLR and OVC_VLS).
- For those on ART, record the facility where ART services are usually received, the date they most recently initiated ART, and their most recent viral load test date and results (if a participant has ever had a viral load test done).
    - Note that if a participant stopped taking ART for at least one month and then started again, the date they started taking it again should be recorded as the most recent ART initiation.
- New fields have been added for enhanced monitoring of children and youth living with HIV, including the type of ART regimen and whether it is Dolutegravir (DTG) based, the ART dispensing cycle, whether the person is decanted, and their ART pick-up point. The back of the form includes optional data collection fields for interruptions in treatment, including any referral details and reasons the participant is not on ART.
- **All ART monitoring details should be recorded and captured in CBIMS each time the form is completed, even if nothing has changed**. The HIVSTAT form's completion date is reviewed to ensure that all participants have their ART details monitored at least every six months.

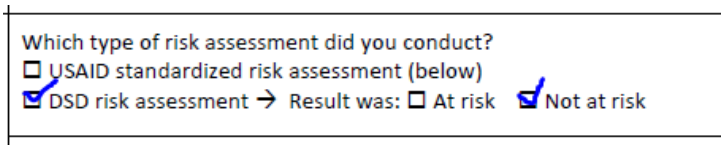
## 2. NEGATIVE OR UNKNOWN

- If the most recent test result was negative or unknown, and the form is being completed to record that test result, tick the appropriate result, sign it, and submit it for data entry. No additional fields should be completed.
- If the form is being completed *at enrolment* or *due to a change in risk profile*, participants whose last HIV test was negative or unknown (including those who have never been tested) proceed to the risk assessment questions.
- The first item asks which risk assessment was used (DSD or USAID) and
- The last item in the negative/unknown column asks if the participant was referred for an HIV test (following the risk assessment) and, if so, whether that test has been completed. The test results should be reported on a new copy of the form with 'New test results or ART info reported' ticked as the reason for form completion.
- For partners using the *DSD Risk assessment,* select 'DSD Risk Assessment' and record whether the result was 'at risk' or 'not at risk'. The details of the DSD risk assessment form are otherwise not captured in CBIMS but should be kept in the case file.

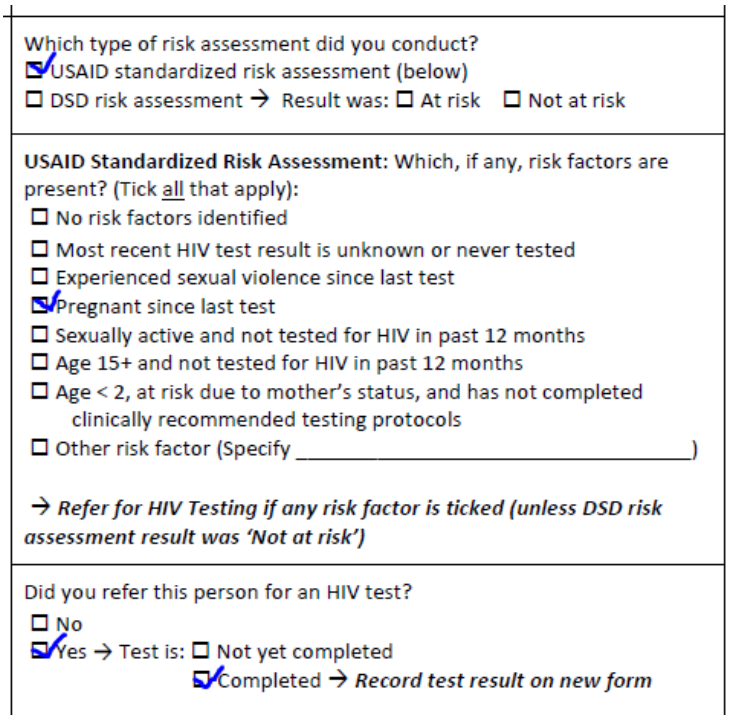
- Participants assessed as 'At risk' should be referred for HIV testing, and details should be recorded at the bottom of the HIVSTAT form.




- Participants assessed as 'not at risk' are categorised as a 'Test not required' in OVC_HIVSTAT reporting and a testing referral is unnecessary.




- For IPs using the *USAID Risk Assessment*, select 'USAID standardised risk assessment' and tick each relevant risk factor that is applicable. Note that Case managers should rely on risk factor information gathered during normal case management rather than instituting new screening for pregnancy, violence, or sexual activity.
  - Testing is indicated if any risk factors are ticked. IPs should carefully review HIVSTAT data each month to ensure that there are no 'test not required' HIVSTAT results, as this is result is only allowed under the DSD risk assessment protocol



## HOW DOES THIS FORM ALIGN WITH SERVICE PROVISION & TRACKING?

IPs should ensure that any activities or services provided to individual beneficiaries to address issues identified under the **"Monitoring Interruptions for Treatment"** section are appropriately marked and reported in the Monthly Activity Form as applicable (e.g., ART adherence counselling/treatment literacy; support for family-centred disclosure of HIV status, etc).

For guidance on service standards and assessment criteria, The SIMS Site Level CEE narratives also provide a helpful overview, including post-violence care services, HIV prevention programs for AGYW, and gender norms and OVC programs at PEPFAR-supported sites.[18] The Risiha manual and the DSD SPP guidelines, including defaulter tracing, provide further details about services and activities.[19]

## HOW SHOULD THIS FORM BE CAPTURED IN CBIMS?

This form is designed to be used with the 'HIVSTAT' data entry form in CBIMs. Upon receipt of a completed paper form, data entry personnel should look up the participant record in CBIMS and select 'Add new assessment' on the 'HIVSTAT' tab. A new HIV and ART form will open, showing the participant's last reported details, which should be updated with data from the latest paper form.

## WHAT INDICATORS RESULT FROM THIS DATA?

This form provides data for OVC_HIVSTAT and USAID OVC custom indicators including OVC_TST_ASSESS, OVC_TST_RISK, OVC_HIVSTAT_UNKNOWN, OVC_HIVSTAT_18+, OVC_VL_ELIGIBLE, OVC_VLR, OVC_VLS and OVC_DSP.

[18] SIMS v4.2 Site Level CEE Narratives: CEEs S_06_01 and S_06_02 assess sites capacity to provide post-violence clinical care to children, AGYW, and adults and availability of the minimum package of PEPFAR post-violence care services. These two CEEs should only be administered at facilities that provide post-violence clinical care. CEE S_06_03 should only be administered at sites that have received funding to provide gender norms interventions. CEE S_06_06 should only be administered at sites (community and facility) that provide HIV prevention programs to AGYW. CEEs S_06_04, S_06_05, S_06_07, and S_06_08 assess case management, HIV testing and treatment, and viral suppression for OVCs. All these CEEs require case files/chart reviews.

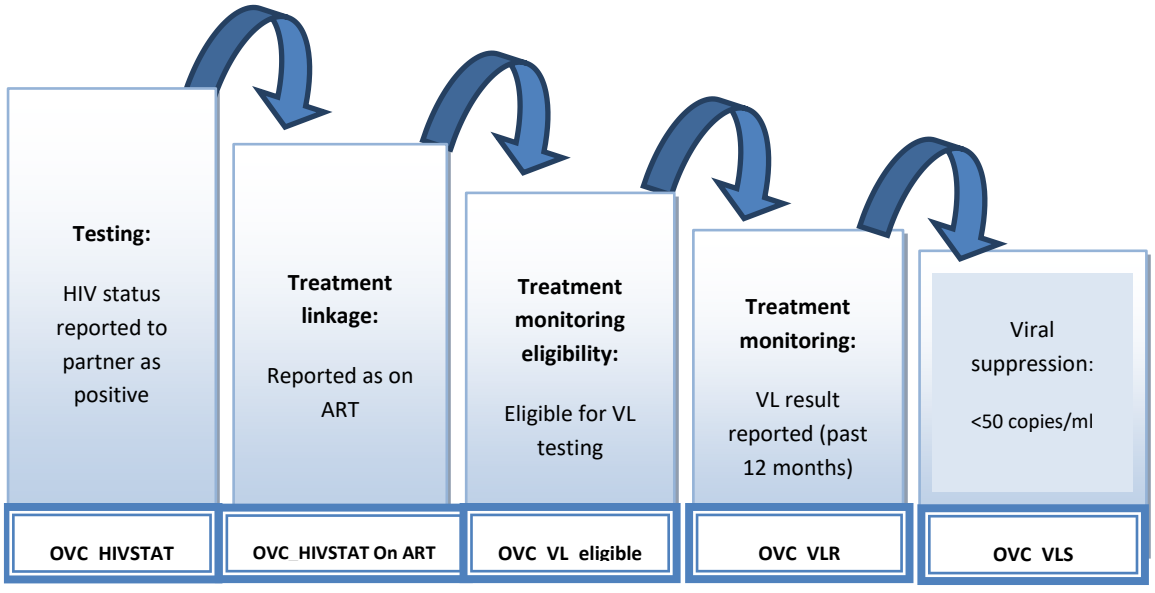
[19] The DSD SPP guidelines p 53-54 includes a 10-step guide to facilitate defaulter tracking.

OVC_TST_ASSESS & OVC_TST_RISK

- Responses to '*Why is this status being collected?*' and '*What was this person's most recent HIV test result?*' together determine who undergoes risk assessment.
    - Participants whose most recent HIV test was negative undergo risk assessment at enrolment and when the form is completed because of a change in risk profile: both instances count toward OVC_TST_ASSESS.
    - Participants with unknown status who do not undergo DSD risk assessment are automatically considered in need of HTS; this also counts as a risk assessment.
    - Those who undergo DSD risk assessment are also counted in OVC_TST_ASSESS.
    - Risk assessment does not need to be done when new negative test results are reported after enrolment – and these forms do not count toward OVC_TST_ASSESS.
- Unknown status marked on the tracking form denotes 'at risk' (for OVC_TST_RISK) unless a DSD risk assessment showed otherwise. Participants with negative HIV status recorded at enrolment or upon a change in risk profile, and 'Yes' to 'Are any of the following true?' also count as 'at risk.'

Viral load cascade

- OVC_VL_ELIGIBLE, OVC_VLR, and OVC_VLS require partners to be vigilant about recording participants' ART status, ART initiation date(s), and viral load test results in CBIMS, to ensure that these results accurately reflect performance instead of gaps in data collection.
- See the figure below for a visualization of relationships between indicators in the treatment and viral load suppression cascade. More information on the custom indicators (including reporting templates) can be found at the PEPFAR OVC Support website.



Refer to the tables below for more information on how source variables from the HIV & ART Status Tracking form are used to count Active and Graduated participants in the comprehensive programme under OVC_HIVSTAT, OVC_HIVSTAT_18+ and OVC_HIVSTAT_unknown. An HIV & ART Status Tracking form containing the value or combination of values shown as shaded for a given row **always** generates that result for the indicator listed.

**Table 4. OVC_HIVSTAT Status, last test result, and DSD risk assessment.**

| | Last test was: | | | DSD risk assessment showed: | |
|---|---|---|---|---|---|
| OVC_HIVSTAT Status | Negative | Positive | Unknown/ never tested | At risk or no assessment | Not at risk |
| Negative | | | | | |
| Positive | | | | | |
| Unknown | | | | | |
| Test not required | | | | | |

**Table 5. OVC_HIVSTAT_UNKNOWN Status, whether referred, and test referral status.**

| | OVC_HIVSTAT | Referred for HIV test? | | Test referred for is: | |
|---|---|---|---|---|---|
| OVC_HIVSTAT_UNKNOWN* | Unknown | Yes | No | Completed | Not yet completed |
| At risk, not referred | | | | | |
| Referred, test not done | | | | | |
| Tested, result not reported | | | | | |

*The 'Not assessed for HIV risk' result total (not shown in the table) will be 0 since children with unknown status are considered at risk. Children with unknown status who are missing data on the most recent HTS referral are counted under 'Missing information' (not shown).

# FORM 3. MONTHLY ACTIVITY FORM

**OVC Comprehensive Programme Monthly Activity Form**

*Project Details*

**Project Name**

**Personnel First & Surname**

**Reporting Period** Month Year:

*Participant Details*

**First Name**

**Surname**

**Date of Birth** D D / M M / Y Y Y Y Sex ☐ Male ☐ Female

**Cell phone #** - -

**Did any of the following occur during this month?**

- ☐ School status changed to (*circle one*): Enrolled; Not enrolled
  School name_____
- ☐ Stream changed to (*circle all that apply*): Primary Prevention; Comprehensive; Enrolled in DREAMS
- ☐ Subpopulation added, specify:_____
- ☐ Case closure, specify:_____

*For all changes, update the beneficiary record in CBIMS*

| | | Service or Referral Details | | | Service Received |
|---|---|---|---|---|---|
| **Risiha Domain** | **High Impact Referral Services** | **Tick if remote** | **Referral Agency/Service Provider Name** | **Referral Date (DD/MM/YY)** | **Service Date (DD/MM/YY)** |
| Domain 1: Childcare & Protection | Filed report of suspected abuse to relevant local authority | | | | |
| | Placement for child without family care (Foster Care) | | | | |
| | Emergency removal from abusive/unsafe environment | | | | |
| | Designated Child Protection Organisations (DCPO) referral | | | | |
| | Thuthuzela Care Centre Referrals | | | | |
| | Post-gender-based violence clinical care (minimum package) | | | | |
| | Post exposure prophylaxis – 28-day completion | | | | |
| | GBV-related medical, legal, or counselling referral | | | | |
| Domain 2: Psychosocial Support | Professional mental health care services | | | | |
| | Drug or alcohol abuse counselling/treatment services | | | | |
| Domain 3: HIV/AIDS | HIV Counselling & Testing | | | | |
| | ***Circle HIV Test Result once referral result received:*** | POSITIVE NEGATIVE UNKNOWN *(For all results, complete a new HIVSTAT form!)* | | | |
| | ART initiation | | | | |
| | ***Circle ART status once status confirmed:*** | INITIATED ON ART FOR THE FIRST TIME RE-INITIATED ON ART AFTER INTERRUPTION *(For all results, complete a new HIVSTAT form!)* | | | |
| | CD4 Count/Viral Load Testing and/or case conferencing | | | | |
| | Adherence support groups (facility or mobile based) | | | | |
| | TB screening (5-item questionnaire) *Circle screening results:* | PRESUMPTIVE TB (Yes to at least one screening question) NO PRESUMPTIVE TB | | | |
| | TB diagnosis & treatment services | | | | |
| | ***Circle TB diagnosis/TX status once referral result received:*** | POSITIVE & ON TB TX POSITIVE & NOT ON TB TX NEGATIVE & ON PREVENTIVE TX NEGATIVE & NOT ON PREVENTIVE TX | | | |
| | Prevention of Mother to Child Transmission (PMTCT) | | | | |
| | Early Infant Diagnosis (EID) services | | | | |
| Domain 4: Health Promotion | Childhood illness & immunisation services (<5 years) | | | | |
| | Disability support | | | | |
| | PrEP Initiation | | | | |
| | Family Planning: | | | | |
| | STI screening, diagnosis & treatment: | | | | |
| | Voluntary Male Medical Circumcision (VMMC) | | | | |

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Version Date: December 2024

| | | | | | |
|---|---|---|---|---|---|
| Domain 5: Nutrition | Nutrition/food referrals (e.g., clinical nutritional support) | | | | |
| Domain 6: Economic Strengthening | SASSA Social Grant Access Foster Care Grant | | | | |
| | Child Support Grant | | | | |
| | Care & Dependency Grant | | | | |
| | Disability Grant | | | | |
| | Social Relief of Distress Grant | | | | |
| | Youth Development Agency (YDA) - Entrepreneurial training | | | | |
| Domain 7: Education Support | Birth certificate/Birth registration | | | | |
| | S.A. ID | | | | |
| **Family Centred Services (direct services to the child, caregiver, or family)** | | **Remote?** | **Service Provider** | **Referral Date (DD/MM/YY)** | **Service Date (DD/MM/YY)** |
| Admin. processes | Case plan monitoring ***Circle if case plan was:*** UPDATED NOT UPDATED | | | | |
| | Graduation readiness assessment *(complete a new GRA Record)* | | | | |
| Psychosocial | Motivational Counseling (Risiha Enablers) | | | | |
| Healthy | Monitor/support developmental milestones in infants/CLHIV | | | | |
| | Monitor/support HIV testing service completion for HIV-exposed infants/toddlers (<2 years) | | | | |
| | Support for family-centred disclosure of HIV status | | | | |
| | ART adherence assessment & counselling/treatment literacy | | | | |
| | TB treatment adherence support | | | | |
| | PREP adherence assessment & counselling support | | | | |
| | Provide ARVs | | | | |
| | Provide Condoms | | | | |
| | Provide Dignity Packs/Hygiene Support | | | | |
| Stable | Economic (savings group, microfinance, income generation) | | | | |
| | Linkages to vocational training/opportunities | | | | |
| Safe | Early childhood household interventions (<7 years) | | | | |
| Schooled | Primary or secondary school enrolment or re-enrolment | | | | |
| | Individual tutoring/homework assistance (weekly) | | | | |
| | School visit to monitor attendance and progression | | | | |
| | Final high school exam study support/matric completion | | | | |
| | Individual support to access tertiary education | | | | |

Back Page

| **Structured Interventions & Social Behavioural Change (SBC) Groups** | | **# Sessions this month** | | | **# Sessions this month** | | | **# Sessions this month** |
|---|---|---|---|---|---|---|---|---|
| HIV Prevention/ Community Norms | ChommY | | Economic Strengthening | Financial literacy/Impumelelo | | Psychosocial Support | Ke Moja (substance abuse) | |
| | YOLO | | | Entrepreneurship Skills | | | Therapeutic Counselling (TF-CBT) | |
| | Let's Talk Teens | | | Employability Skills Training | | | Residential Therapy | |
| | Boys Championing Change | | | Intro to Financial Capabilities | | | Abangane Grief Support | |
| | Men Championing Change | | Family Strengthening | Families Matter! | | Support for people living with HIV (PLHIV) | Vhutshilo 3 | |
| | Zazi | | | Let's Talk | | | Kidz Alive | |
| | Brothers for Life | | | Let's Talk Digital | | | STARS (adherence support group) | |
| | | | | PFLH/Sinovuyo | | Other (Specify): | | |

| | | | |
|---|---|---|---|
| Personnel Signature | Date | Data Capture Signature | Date |
| Supervisor Signature | Date | Data Verification/validation Initials: | Date |

## WHAT IS THE PURPOSE OF THIS FORM?

This form tracks case management decision-making about which services are offered to participants and when. It also sources OVC_SERV and custom indicator report data in CBIMS. Case managers completing the form record referrals initiated and completed and services provided directly to participants during the month.

There are clear similarities between the services listed on the Monthly Activity Form and the referral, direct and SBC services detailed in the Risiha Implementation Manual[20] particularly in the prevention, early intervention, and linkage roles expected of SSPs.[21] The service area headings also align with the support and direct services in the SIMS Site Level Master Core Essential Elements (CEE) library[22] and to the Children's Act[23]. Programs are encouraged to:

- Base all service provision on case planning, as guided by the Risiha Implementation Manual[24] and DSD SSP guidelines.
- Use the Risiha tools and enablers and the DSD SSP guidelines to facilitate effective referrals and deliver family-centred case management services.
- Report services using the OVC Programme Monthly Activity Form, ensuring alignment with the USAID-funded OVC_SERV indicator definition.

## WHEN SHOULD THIS FORM BE COMPLETED?

- The case manager should complete this form monthly for every child and caregiver on their caseload enrolled in USAID-supported OVC programming. Collecting data at least monthly allows partners to identify whether they are on track to meet established performance targets and to focus service provision efforts in response to identified needs.
- Case managers may choose to add data to the form throughout the month as referrals/services occur, or they may complete it at the end of the month using case notes and other documents in the family's file as a reference. Case managers may also submit this form more frequently to avoid large monthly data entry burdens.
- Before this form is sent for data capture, partners should carefully consider how best to maintain a record of assessment, referral[25] & service delivery details are on-site and accessible to the case manager. This may include making a paper or electronic copy of the form for the case file or facilitating the timely return of the original form for filing.

## HOW DO I COMPLETE THIS FORM?

- Enter project and participant details at the top so that data from the form can be linked to the appropriate record in CBIMS.
- A separate form should be completed for each participant. Services provided to an individual should only be recorded on that individual's Monthly Activity Form and not

[20] The seven domains of the core package of services outlined in the Risiha Services Implementation Manual are: 1. Childcare and Protection, 2. Psychosocial Support, 3. HIV/AIDS, 4. Health Promotion, 5. Food and Nutrition, 6. Economic Strengthening and 7. Education Support.

[21] Guideline for Social Service Practitioners: First Edition, October 2019 - Roles & Responsibilities (p. 16 -18)

[22] Site Level Master CEE Library Version 4.2, August 15, 2022 (client tracking in sets 2,3,4 and all standards listed in set 6)

[23] Children's Act 38 of 2005 introduces intervention services under Objects of the Act in (p.19)

[24] Risiha Tools and Enablers 2nd Edition July 2024 SOP 4-6 (p. 16-22) and six-month care plan templates (p.177-179)

[25] In maintaining a record of the referrals, case managers may decide to use referral forms contained in DSD guidelines and Risiha. These include referral forms, consent forms, referral trackers, referral logs and enablers.

repeated on the forms for other household members (unless they were also provided with the same service).
    - For example, services such as structured parenting interventions for caregivers should only be placed on a Monthly Activity Form with the caregiver's name indicated, not added to the forms for children under their care, even if children are expected to benefit indirectly.
    - CBIMS will link relevant information from the Caregiver form (for example, services that count both towards the caregiver and the child) to the record for each child or youth under their care for proxy service counting as applicable.
- In the box on the top right of the form, under "Did any of the following occur this month?" tick any relevant changes to the participant status.
    - This includes changing the programme enrolment model or school status, identifying additional priority subpopulations, and ensuring case closure.
    - During data capture, the participant record should be updated accordingly. A move from the Preventive, DREAMS or Comprehensive programming should be documented in the case plan.
    - A case closure form, and other tools as relevant, should still be used to document graduation/case plan achievement among Comprehensive programme participants, or transition planning for those who permanently exited the programme for reasons other than graduation. See Section X for more information on graduation monitoring and related resources.
- Next, provide information on services delivered. Services are grouped into three types: (1) High-impact referrals, (2) Family-centred services, and (3) Structured interventions. See the next section for additional information.
- Not all partners will offer all services listed, and some partners may provide direct services, whereas others rely on referrals. The form is flexible enough to accommodate these variations.
- If a participant has graduated, transferred, or otherwise exited the programme, the monthly activity form should still be completed in full if the participant received at least one service that month.
- **Only the services on the Monthly Activity form will count towards OVC_SERV.** USAID may consider requests to add additional services to the form/CBIMS on a case-by-case basis. In general, however, partners' qualifying services from the Risiha care plan builder should be matched to items already listed, which are aligned with PEPFAR's illustrative eligible services for active OVC participants. The 'Other preapproved interventions' space is provided for partners to record services not listed on this form that might eventually qualify under OVC_SERV or are being recorded by partners for other reasons.
- **The OVC program model participants are enrolled under determines which services count towards OVC_SERV.** See Appendix 4 for a list of services that count towards the relevant OVC_SERV disaggregate under each program model. The OVC Monthly Activity form primarily focuses on comprehensive case management services in line with Risiha.
- The final step for case managers is to sign and date the bottom of the form before turning it in to their supervisor. Supervisors should review the form, sign it, and date it after ensuring it was correctly filled out. The form should then be transferred to the data entry team.

### *SERVICE DETAILS & SERVICE RECEIVED*

- For services and referrals provided, case managers should record Service Details (referral agency/service provider and referral date if applicable) and Service Received (affirmed by entering the service delivery or completed referral date). A column has also been added to track whether the service was provided remotely (typically by phone).

- If the same service is provided more than once in the month, the case manager should indicate the additional service dates in the margin of the form on the same line as the service.
    - A service or intervention provided multiple times to the same individual during a calendar month, but captured on a single form, should use the earliest date the service or intervention was provided (during that month) for CBIMS entry. For multiple sessions of a single structured intervention, the first day of the month may be entered as the service date.
- Referral dates and referral agency details (name of referral site and/or service provider name) should also be recorded as applicable. **Only *completed* referrals are counted as services under OVC_SERV so the case manager must follow up to ensure successful completion. If no service date is provided for a referral, the referral will be captured as pending**.
- For several service types, additional details are required to inform selected custom indicator results and case management reports:
    - *HIV Testing & Counselling*: Case managers should record the participant's results after the completed HIV test. This should also prompt the submission of a new HIV and ART Status Tracking Form (even if there is no change in HIV status).
    - *ART Initiation/Enrolment*: Case managers should indicate ART status upon the participant's successful linkage to ART services (Initiated ON ART for the first time or Re-initiated ON ART after an interruption in treatment). This should also prompt the submission of a new HIV and ART Status Tracking Form.
    - *TB screening, diagnosis and treatment:* Case managers should record the result of TB screening (Presumptive TB/No Presumptive TB). Thereafter, case managers can note the relevant TB diagnosis and Treatment services once the referral results are received (Positive & On Tb Tx/Positive & Not On Tb Tx/Negative & On Preventive Tx/Negative & Not On Preventive Tx/Unknown)
    - *Post-violence care*: Completion of post-gender-based violence (GBV) clinical care based on the minimum package' refers to a specific set of services provided on-site to sexual violence survivors.
    - *Administrative process*: When case plan monitoring occurs, the outcome should be recorded as either 'updated' or 'not updated'. Per MER guidance, case plans should be monitored quarterly and updated at least annually. Similarly, graduation readiness should be tracked using the Graduation Readiness Assessment (GRA) form on at least an annual basis.
- Structured interventions and Social Behavioural Change (SBC) Groups follow a curriculum and are delivered across a designated number of sessions, typically to multiple participants in small established groups.
    - The intervention facilitator (who may in some cases also act as the case manager) should indicate the number of intervention sessions attended by the child in that month by relying on signed attendance registries (not child self-report).
    - It is important that the facilitators of these interventions maintain attendance registers with attendee names and session dates so that the facilitator can easily count and verify attendance.
    - For condensed or alternative intervention offerings (e.g., holiday camps where multiple sessions are provided daily), IPs should understand how any alternative implementation aligns with the standardised session count to avoid under-counting attendance. Please refer to the intervention thresholds on the next page for (1) the standard number of total sessions programmed in CBIMS, and (2) how many standard sessions must be attended to count as 'completed.'

| Table 6. Structured Interventions and their threshold for total completion of intervention. | | |
|---|---|---|
| **Interventions** | | **Threshold/Total # Sessions** |
| HIV Prevention/ Community Norms | Let's Talk Teens | 10/12 (83%) |
| | You Only Live Once (YOLO) | 10/12 (83%) |
| | Boys Championing Change | 8/10 (80%) |
| | Men Championing Change | TBD |
| | ZAZI | TBD |
| | Brothers for Life | TBD |
| PLHIV | Vhutshilo 3 | 8/10 (80%) |
| | Kidz Alive | 4/5 (80%) Children<br>4/4 (100%) Caregivers |
| | STARS adherence curriculum | TBD |
| Psychosocial | Abangane Grief Support | 7/8 (88%) |
| | Residential Therapy | TBD |
| | Therapeutic Counselling (TF-CBT) | TBD |
| | Ke Moja (substance abuse) | TBD |
| Economic Strengthening | Financial literacy (Impumelelo) | 13/16 (81%) |
| | Entrepreneurship Skills Training | 8/10 (80%) |
| | Employability Skills Training | 10/12 (83%) |
| | Introduction to Financial Capabilities | 4/4 (100%) |
| Family Strengthening | Let's Talk | 8/10 (80%) Adolescents<br>8/10 (80) Caregivers |
| | Let's Talk Digital | 5/7 (71%) |
| | Sinovuyo/Parenting for Lifelong Health (PFLH) | 10/12 (86%) Adolescents<br>10/12 (86%) Caregiver |
| | Families Matter! | TBD |
| Primary Prevention | ChommY | 8/11 (73%) |
| | SKILLZ (9 session) | 7/9 (78%) |
| | No Means No | 4/4 (100%) |
| | No Means No Boys (10 Session) | 8/10 (80%) |

Administrative Services

- "Graduation readiness assessment" and "Case plan monitoring" are captured in the Monthly Activity form under "Family Centred Services" in a category labelled Administrative Processes. While these critical administrative processes should be captured in CBIMS to support compliance with USAID monitoring requirements, they do not count towards OVC_SERV Active status.
- Graduation readiness assessment may involve assessing progress toward only a subset of benchmarks (for example, only those applicable to the participant named on the monthly form in question) and should be captured in CBIMS regardless of the assessment results (e.g., even if no benchmarks have been met). This data will inform monthly reporting requirements regarding the number of participants assessed for graduation readiness.

## HOW SHOULD THIS FORM BE CAPTURED IN CBIMS?

- This form is designed to be used with the 'Participant Interventions' data entry form in CBIMS. Upon receipt of a completed Monthly Activity Form, check to see if a new telephone number is reported, and if so, ensure that the participant's contact details are updated in

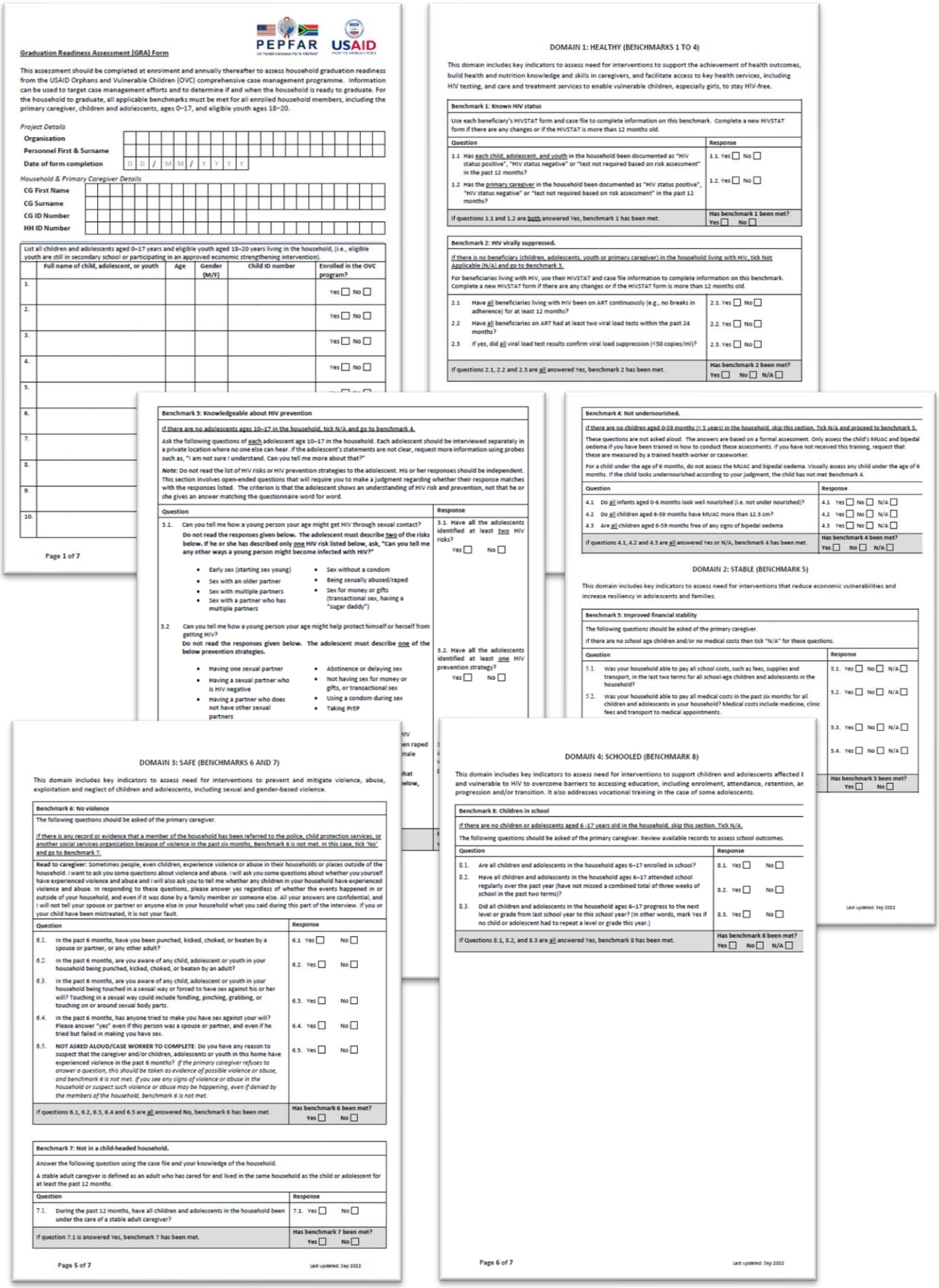
the participant record. Also, check for and capture any changes to participation status in the participant record.

- After making necessary updates to the participant record, select the 'Participant Intervention' button. Select the partner, participant type, year, month and personnel corresponding to the 'Project details' at the top of the form. Use the 'Participant details' fields to find the correct participant. Cell phone number and Participant ID have been included on the form as additional filters to help identify the correct participant.
- Once the correct participant has been selected, ensure that all referrals and services received on the Monthly Activity Form are entered into the database by selecting one service at a time. Several drop-down filters with service categories are provided to narrow down the range of services. The 'Description' box should be used to select the intervention/service of interest.
- If only a service date is recorded on the form, select "Direct Service." Select ' Incomplete Referral ' if a referral date is recorded but no service is received. Select ' Completed Referral ' if a referral date and a service date are recorded on the form. Be sure to capture the service again as a "Completed Referral" once a service date is provided.
- Once a service has been selected, select the date and type in the count of services.
    - For high-impact referrals and family-centred services, the count of services will usually be '1' (unless more than one service of the same type was received during that month).
    - For structured interventions, the count may be more than one, as each intervention session attended during the month is counted as a separate service. Again, the earliest service date may be captured for services delivered more than once to the same participant in the same month if multiple service dates are recorded on the form. The first day of the month should be used for structured interventions since session dates are not generally recorded on the form.
- The final step for the data capture team is to sign and date the bottom of the form. A space has been provided for data verification; however, the procedures will vary by partner.

## WHAT INDICATORS RESULT FROM THIS DATA?

Combined with data on the programme model from the enrolment form, OVC_SERV and its downstream indicators (e.g. OVC_SERV_SUBPOP) result from service data. In addition, OVC_TST_REFER, OVC_TST_REPORT, OVC_GBI, PREP_LINK, and CHILD_LINK_FACILITY also rely on data about referrals and services received by OVC participants and recorded here. OVC Service data under the DREAMS family strengthening model is also used to report AGYW_PREV and related DREAMS custom indicators.

# FORM 4. GRADUATION READINESS ASSESSMENT



**Graduation Readiness Assessment (GRA) Form**

This assessment should be completed at enrolment and annually thereafter to assess household graduation readiness from the USAID Orphans and Vulnerable Children (OVC) comprehensive case management programme. Information can be used to target case management efforts and to determine if and when the household is ready to graduate. For the household to graduate, all applicable benchmarks must be met for all enrolled household members, including the primary caregiver, children and adolescents, ages 0–17, and eligible youth ages 18–20.

*Project Details*

Organisation
Personnel First & Surname
Date of form completion D D / M M / Y Y Y Y

*Household & Primary Caregiver Details*

CG First Name
CG Surname
CG ID Number
HH ID Number

List all children and adolescents aged 0–17 years and eligible youth aged 18–20 years living in the household, (i.e., eligible youth are still in secondary school or participating in an approved economic strengthening intervention)

| | Full name of child, adolescent, or youth | Age | Gender (M/F) | Child ID number | Enrolled in the OVC program? |
|---|---|---|---|---|---|
| 1. | | | | | Yes ☐ No ☐ |
| 2. | | | | | Yes ☐ No ☐ |
| 3. | | | | | Yes ☐ No ☐ |
| 4. | | | | | Yes ☐ No ☐ |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |

Page 1 of 7

**DOMAIN 1: HEALTHY (BENCHMARKS 1 TO 4)**

This domain includes key indicators to assess need for interventions to support the achievement of health outcomes, build health and nutrition knowledge and skills in caregivers, and facilitate access to key health services, including HIV testing, and care and treatment services to enable vulnerable children, especially girls, to stay HIV-free.

**Benchmark 1: Known HIV status**

Use each beneficiary's HIVSTAT form and case file to complete information on this benchmark. Complete a new HIVSTAT form if there are any changes or if the HIVSTAT is more than 12 months old.

| Question | Response |
|---|---|
| 1.1 Has each child, adolescent, and youth in the household been documented as "HIV status positive", "HIV status negative" or "test not required based on risk assessment" in the past 12 months? | 1.1. Yes ☐ No ☐ |
| 1.2 Has the primary caregiver in the household been documented as "HIV status positive", "HIV status negative" or "test not required based on risk assessment" in the past 12 months? | 1.2. Yes ☐ No ☐ |
| If questions 1.1 and 1.2 are both answered Yes, benchmark 1 has been met. | Has benchmark 1 been met? Yes ☐ No ☐ |

**Benchmark 2: HIV virally suppressed.**

If there is no beneficiary (children, adolescents, youth or primary caregiver) in the household living with HIV, tick Not Applicable (N/A) and go to Benchmark 3.

For beneficiaries living with HIV, use their HIVSTAT and case file information to complete information on this benchmark. Complete a new HIVSTAT form if there are any changes or if the HIVSTAT form is more than 12 months old.

| | |
|---|---|
| 2.1 Have all beneficiaries living with HIV been on ART continuously (e.g., no breaks in adherence) for at least 12 months? | 2.1. Yes ☐ No ☐ |
| 2.2 Have all beneficiaries on ART had at least two viral load tests within the past 24 months? | 2.2. Yes ☐ No ☐ |
| 2.3 If yes, did all viral load test results confirm viral load suppression (<50 copies/ml)? | 2.3. Yes ☐ No ☐ |
| If questions 2.1, 2.2 and 2.3 are all answered Yes, benchmark 2 has been met. | Has benchmark 2 been met? Yes ☐ No ☐ N/A ☐ |

**Benchmark 3: Knowledgeable about HIV prevention**

If there are no adolescents ages 10–17 in the household, tick N/A and go to benchmark 4.

Ask the following questions of each adolescent age 10–17 in the household. Each adolescent should be interviewed separately in a private location where no one else can hear. If the adolescent's statements are not clear, request more information using probes such as, "I am not sure I understand. Can you tell me more about that?"

*Note:* Do not read the list of HIV risks or HIV prevention strategies to the adolescent. His or her responses should be independent. This section involves open-ended questions that will require you to make a judgment regarding whether their response matches with the responses listed. The criterion is that the adolescent shows an understanding of HIV risk and prevention, not that he or she gives an answer matching the questionnaire word for word.

| Question | Response |
|---|---|
| 3.1. Can you tell me how a young person your age might get HIV through sexual contact? **Do not read the responses given below. The adolescent must describe two of the risks below. If he or she has described only one HIV risk listed below, ask, "Can you tell me any other ways a young person might become infected with HIV?"**<br>• Early sex (starting sex young)<br>• Sex with an older partner<br>• Sex with multiple partners<br>• Sex with a partner who has multiple partners<br>• Sex without a condom<br>• Being sexually abused/raped<br>• Sex for money or gifts (transactional sex, having a "sugar daddy") | 3.1. Have all the adolescents identified at least two HIV risks? Yes ☐ No ☐ |
| 3.2 Can you tell me how a young person your age might help protect himself or herself from getting HIV? **Do not read the responses given below. The adolescent must describe one of the below prevention strategies.**<br>• Having one sexual partner<br>• Having a sexual partner who is HIV negative<br>• Having a partner who does not have other sexual partners<br>• Abstinence or delaying sex<br>• Not having sex for money or gifts, or transactional sex<br>• Using a condom during sex<br>• Taking PrEP | 3.2. Have all the adolescents identified at least one HIV prevention strategy? Yes ☐ No ☐ |

**Benchmark 4: Not undernourished.**

If there are no children aged 0-59 months (< 5 years) in the household, skip this section. Tick N/A and proceed to benchmark 5.

These questions are not asked aloud. The answers are based on a formal assessment. Only assess the child's MUAC and bipedal oedema if you have been trained in how to conduct these assessments. If you have not received this training, request that these are measured by a trained health worker or caseworker.

For a child under the age of 6 months, do not assess the MUAC and bipedal oedema. Visually assess any child under the age of 6 months. If the child looks undernourished according to your judgment, the child has not met Benchmark 4.

| Question | Response |
|---|---|
| 4.1 Do all infants aged 0-6 months look well nourished (i.e. not under nourished)? | 4.1 Yes ☐ No ☐ N/A ☐ |
| 4.2 Do all children aged 6-59 months have MUAC more than 12.5 cm? | 4.2 Yes ☐ No ☐ N/A ☐ |
| 4.3 Are all children aged 6-59 months free of any signs of bipedal oedema | 4.3 Yes ☐ No ☐ N/A ☐ |
| If questions 4.1, 4.2 and 4.3 are all answered Yes or N/A, benchmark 4 has been met. | Has benchmark 4 been met? Yes ☐ No ☐ N/A ☐ |

**DOMAIN 2: STABLE (BENCHMARK 5)**

This domain includes key indicators to assess need for interventions that reduce economic vulnerabilities and increase resiliency in adolescents and families.

**Benchmark 5: Improved financial stability**

The following questions should be asked of the primary caregiver.

If there are no school age children and/or no medical costs then tick "N/A" for these questions.

| Question | Response |
|---|---|
| 5.1. Was your household able to pay all school costs, such as fees, supplies and transport, in the last two terms for all school-age children and adolescents in the household? | 5.1. Yes ☐ No ☐ N/A ☐ |
| 5.2. Was your household able to pay all medical costs in the past six months for all children and adolescents in your household? Medical costs include medicine, clinic fees and transport to medical appointments. | 5.2. Yes ☐ No ☐ N/A ☐ |
| | 5.3. Yes ☐ No ☐ N/A ☐ |
| | 5.4. Yes ☐ No ☐ N/A ☐ |
| | Has benchmark 5 been met? Yes ☐ No ☐ |

**DOMAIN 3: SAFE (BENCHMARKS 6 AND 7)**

This domain includes key indicators to assess need for interventions to prevent and mitigate violence, abuse, exploitation and neglect of children and adolescents, including sexual and gender-based violence.

**Benchmark 6: No violence**

The following questions should be asked of the primary caregiver.

If there is any record or evidence that a member of the household has been referred to the police, child protection services, or another social services organization because of violence in the past six months, Benchmark 6 is not met. In this case, tick 'No' and go to Benchmark 7.

**Read to caregiver:** Sometimes people, even children, experience violence or abuse in their households or places outside of the household. I want to ask you some questions about violence and abuse. I will ask you some questions about whether you yourself have experienced violence and abuse and I will also ask you to tell me whether any children in your household have experienced violence and abuse. In responding to these questions, please answer yes regardless of whether the events happened in or outside of your household, and even if it was done by a family member or someone else. All your answers are confidential, and I will not tell your spouse or partner or anyone else in your household what you said during this part of the interview. If you or your child have been mistreated, it is not your fault.

| Question | Response |
|---|---|
| 6.1. In the past 6 months, have you been punched, kicked, choked, or beaten by a spouse or partner, or any other adult? | 6.1 Yes ☐ No ☐ |
| 6.2. In the past 6 months, are you aware of any child, adolescent or youth in your household being punched, kicked, choked, or beaten by an adult? | 6.2. Yes ☐ No ☐ |
| 6.3. In the past 6 months, are you aware of any child, adolescent or youth in your household being touched in a sexual way or forced to have sex against his or her will? Touching in a sexual way could include fondling, pinching, grabbing, or touching on or around sexual body parts. | 6.3. Yes ☐ No ☐ |
| 6.4. In the past 6 months, has anyone tried to make you have sex against your will? Please answer "yes" even if this person was a spouse or partner, and even if he tried but failed in making you have sex. | 6.4. Yes ☐ No ☐ |
| 6.5. **NOT ASKED ALOUD/CASE WORKER TO COMPLETE**: Do you have any reason to suspect that the caregiver and/or children, adolescents or youth in this home have experienced violence in the past 6 months? *If the primary caregiver refuses to answer a question, this should be taken as evidence of possible violence or abuse, and benchmark 6 is not met. If you see any signs of violence or abuse in the household or suspect such violence or abuse may be happening, even if denied by the members of the household, benchmark 6 is not met.* | 6.5. Yes ☐ No ☐ |
| If questions 6.1, 6.2, 6.3, 6.4 and 6.5 are all answered No, benchmark 6 has been met. | Has benchmark 6 been met? Yes ☐ No ☐ |

**Benchmark 7: Not in a child-headed household.**

Answer the following question using the case file and your knowledge of the household.

A stable adult caregiver is defined as an adult who has cared for and lived in the same household as the child or adolescent for at least the past 12 months.

| Question | Response |
|---|---|
| 7.1. During the past 12 months, have all children and adolescents in the household been under the care of a stable adult caregiver? | 7.1. Yes ☐ No ☐ |
| If question 7.1 is answered Yes, benchmark 7 has been met. | Has benchmark 7 been met? Yes ☐ No ☐ |

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**DOMAIN 4: SCHOOLED (BENCHMARK 8)**

This domain includes key indicators to assess need for interventions to support children and adolescents affected by and vulnerable to HIV to overcome barriers to accessing education, including enrolment, attendance, retention, and progression and/or transition. It also addresses vocational training in the case of some adolescents.

**Benchmark 8: Children in school**

If there are no children or adolescents aged 6 -17 years old in the household, skip this section. Tick N/A.

The following questions should be asked of the primary caregiver. Review available records to assess school outcomes.

| Question | Response |
|---|---|
| 8.1. Are all children and adolescents in the household ages 6–17 enrolled in school? | 8.1. Yes ☐ No ☐ |
| 8.2. Have all children and adolescents in the household ages 6–17 attended school regularly over the past year (have not missed a combined total of three weeks of school in the past two terms)? | 8.2. Yes ☐ No ☐ |
| 8.3. Did all children and adolescents in the household ages 6–17 progress to the next level or grade from last school year to this school year? (in other words, mark Yes if no child or adolescent had to repeat a level or grade this year.) | 8.3. Yes ☐ No ☐ |
| If Questions 8.1, 8.2, and 8.3 are all answered Yes, benchmark 8 has been met. | Has benchmark 8 been met? Yes ☐ No ☐ N/A ☐ |

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**Final Assessment: Is the household ready to graduate?** Once all questions have been completed, record the outcome of each benchmark below. If all applicable benchmarks have been met, congratulate the household. They are ready to graduate!

| Graduation Readiness Assessment Summary | | |
|---|---|---|
| **Benchmark** | **Applies to** | **Benchmark is met?** |
| 1. Known HIV status | All ages | Yes ☐ No ☐ |
| 2. Adherent/virally suppressed | HIV+ | Yes ☐ No ☐ N/A ☐ |
| 3. Knowledgeable about HIV prevention | 10-17 years | Yes ☐ No ☐ N/A ☐ |
| 4. Not undernourished | <5 years | Yes ☐ No ☐ N/A ☐ |
| 5. Financially stable | Household | Yes ☐ No ☐ |
| 6. No violence reported | Household | Yes ☐ No ☐ |
| 7. Not in a child-headed household | Household | Yes ☐ No ☐ |
| 8. Children in school | 6-17 years | Yes ☐ No ☐ N/A ☐ |
| **Have all applicable benchmarks been met? (Benchmarks 1-8 ticked Yes or N/A)** | | Yes ☐ No ☐ |

**Notes:**

| |
|---|
| |
| |
| |
| |
| |
| |
| |
| |

## WHAT IS THE PURPOSE OF THIS FORM?

Risiha guidance recommends that a case is graduated when there is no risk to the child for three consecutive measurements and the child and their family meet the graduation criteria of the organisation.[26] This form is designed to track PEPFAR's established global graduation benchmarks[27] for households, including:

1. All participants have known HIV status (or test is not required)
2. All participants living with HIV who have documented viral load results have been virally suppressed for the last 12 months
3. All adolescents aged 10-17 have key knowledge about HIV prevention
4. No children < 5 are undernourished
5. Caregivers can access money without selling productive assets to pay school fees and medical costs for children 0-17
6. No participants report experiences of violence in the last six months
7. All children are under the care of a stable adult caregiver
8. All school-age children regularly attended school and progressed during the last year

Information can also be used to target case management efforts and to determine when the household is ready to graduate.[28] Participants in a household graduate together once the case manager determines that all applicable benchmarks have been met for all enrolled household members, including the primary caregiver, children and adolescents, ages 0–17, and eligible youth ages 18–20.

The Risiha guidance recommends that cases may be closed (exited) without graduation when:

- The child and family are untraceable or lost to follow-up (after attempts were made to trace them).
- The child or family have moved out of your service area.
- The child does not meet the organisation's service criteria (e.g., they are too old or no longer attending school).
- The case has been transferred to another organisation.
- The child has died.

## WHEN SHOULD THIS FORM BE COMPLETED?

- The Graduation Readiness Assessment (GRA) form is optional for IPs who wish to capture benchmark assessment results.
- It is recommended that the assessment is completed at enrolment and annually thereafter to assess household graduation readiness from the OVC comprehensive programme.

## HOW DO I COMPLETE THIS FORM?

A benchmark can only be considered met when all applicable members of the participant's household have achieved the requisite status (or the household overall, in the case of household-level benchmarks like "financially stable"). In other words, the assessment process requires

[26] Risiha Services Implementation Manual 2nd Edition July 2024 (p.15);
[27] See FY25 MER 2.8 indicator reference guide, Appendix E., page 208.
[28] SIMS S_06_04 also includes a review of household case files for compliance to standard procedures for supporting case plan achievement/graduation.

participant-level information, but, like graduation itself, benchmark achievement is captured against the household and applies to all members.

IPs should reference the MER reference guide and other global and local USAID-approved resources related to OVC program graduation to ensure they correctly apply specific criteria under each graduation benchmark.

## HOW SHOULD THIS FORM BE CAPTURED IN CBIMS?

This form is designed to be used with the 'GRA' data entry form in CBIMS. Upon receipt of a completed GRA Form, data capturers should record the 'final assessment' portion, indicating whether each applicable benchmark is met.

The form is accessible from the household record, and multiple entries can be made and saved over time, as with the HIVSTAT form.

When a new GRA record is opened, CBIMS will auto-tick the relevant boxes if:

- All participants in the household are HIVSTAT positive or negative
- all participants who are HIVSTAT positive show viral load suppression
- all children aged 6-17 are reported to be enrolled in school

Data capturers should confirm the accuracy of data added automatically to these fields before saving the GRA Record. CBIMS will also check to ensure that "Graduation Readiness Assessment" was captured as a service delivered during the calendar month corresponding to the date of any GRA Record entry and will prompt the user to add the service if not.

Similarly, if the user tries to save a GRA record with one or more of these three benchmarks NOT ticked, but HIVSTAT, VLS, or school status data for relevant members of the participant's household in CBIMS suggest that the benchmark has been met, an error message will appear prompting the user to confirm or update the GRA results and/or correct affiliated data in CBIMS (HIVSTAT, VLS, school status).

## WHAT INDICATORS RESULT FROM THIS DATA?

Data from Graduation Readiness Assessment Record entries source a case management report listing households with graduation benchmarks that likely apply to them but remain unmet to facilitate appropriate follow-up (targeted service provision and/or Graduation Readiness Assessment Record data entry).

A second case management report lists households recorded as meeting all apparently applicable benchmarks but not marked as graduated in CBIMS; these households are at risk of being counted as EWG or continuing too long as Active. Case managers should take appropriate action to either designate these households as Graduated in CBIMS or confirm they are eligible to graduate and expedite the process.

## SECTION 2. OVC PREVENTIVE AND OVC DREAMS FORMS & GUIDANCE

Program-specific enrolment forms have been designed for OVC Preventive and DREAMS program participants.

PEPFAR

*[Partner Logos]*

USAID
FROM THE AMERICAN PEOPLE

**OVCY Programme Enrolment & Subpopulation Determination Form:**
**Primary Prevention ages 10-14**

*Project Details*

**Organisation:** _____

**Personnel** *(First & Surname)* _____

*Programme Site Location Details*

**Province** _____ **District** _____

**Sub-District** _____ **Ward** _____

**Site Type** ☐ School ☐ Other **School/Site Name** _____

**Intervention** ☐ Vhutshilo 1 ☐ ChommY ☐ SKILLZ ☐ No Means No

**Group Name** _____

*Child Programme Details*

**Enrolment Date** D D / M M / Y Y Y Y

**File Reference No**

*Child Personal Details*

**First Name**

**Surname**

**Known as**

**Date of Birth** D D / M M / Y Y Y Y

**ID Type** ☐ SA ID Number ☐ Passport Number ☐ Other

**ID Number**

**Sex** ☐ Male ☐ Female

**Race (DSD)** ☐ African ☐ Indian ☐ White ☐ Coloured ☐ Asian

**Disability Type** ☐ None ☐ Sight/Vision ☐ Hearing ☐ Communication/Speech ☐ Physical ☐ Cognitive ☐ Neurological ☐ Other, Specify:

**School Status** ☐Not enrolled ☐Enrolled

*Using records, forms & disclosure, mark EVERY category that the child falls within. (Multiple responses allowed).*

| Subpopulation | Description |
|---|---|
| ☐ Child living with HIV | *Child/Youth tested positive for HIV* |
| ☐ HIV-exposed infant | *Child under 2 years of age whose mother is HIV positive or whose status is unknown* |
| ☐ HIV+ caregiver | *Child/Youth lives with caregiver who has HIV* |
| ☐ Child is double orphaned | *The mother and father of the child/youth are deceased or unknown if they are alive* |
| ☐ Child is single orphaned | *The mother or father of the child/youth is deceased or unknown whether he/she is alive* |
| ☐ Teen mother or their child | *Adolescent girl under 18 who is pregnant or has a child, or her child* |
| ☐ Child/Youth at risk for HIV | *Adolescent girls/boys and young women/men ages 10-20 at risk for HIV; additional project specific criteria may also apply.* |
| ☐ Child survivor | *Child/youth exposed to gender-based violence* |
| ☐ Key population caregiver | *The child/youth's mother or female caregiver is a key population member* |
| ☐ Household eligibility | *Child does not meet any of the categories above but lives with a child who does.* |

| | | | |
|---|---|---|---|
| Personnel Initials: | Date: | Data Capture Initials: | Date: |
| Supervisor Initials: | Date: | Data Validation Initials: | Date: |

Version Date: 15 November 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

## DREAMS Programme Enrolment & Vulnerability Determination Form

*Project Details*

**Organisation** _____

**Personnel** *(First & Surname)* _____

*Programme Site Location Details*

**Province** _____ **District** _____

**Sub-District** _____ **Ward** _____

**Site Type** ☐ School ☐ Other **Site Name** _____

**Group Name** _____

*Beneficiary Programme Details*

**Enrolment Date** D D / M M / Y Y Y Y

**File reference no.**

**Referral agency** _____

*Beneficiary Personal Details*

**First Name**

**Surname**

**Known as**

**Date of Birth** D D / M M / Y Y Y Y

**ID Type** ☐ SA ID Number ☐ Passport Number

**ID Number**

**Reason for missing SA ID?** ☐ Non-citizen ☐ Citizen, but does not have SA ID ☐ Refused to share SA ID ☐ invalid SA ID/Capture error

**Sex** ☐ Male ☐ Female

**School Status** ☐Not enrolled ☐Enrolled

**School Name** _____

**School Grade**

**School Learner ID**

***CONFIDENTIAL INFORMATION – STORE AND HANDLE THIS FORM SECURELY AT ALL TIMES!***

*Using records, forms & disclosure, mark EVERY category the AGYW enrollee falls within. (Multiple responses allowed).*

| | **Vulnerability criteria for enrolment** |
|---|---|
| ☐ | *Ever had sex* |
| ☐ | *History of pregnancy* |
| ☐ | *Experience of sexual violence (lifetime)* |
| ☐ | *Experience of physical or emotional violence (within the last year)* |
| ☐ | *Alcohol or other substance use* |
| ☐ | *Out-of-school* |
| ☐ | *Orphanhood* |
| ☐ | *Multiple sex partners* |
| ☐ | *STI diagnosed or treated* |
| ☐ | *No or irregular condom use* |
| ☐ | *Transactional sex (including staying in a relationship for material/financial support)* |
| ☐ | *Other, specify:* |

| | | | |
|---|---|---|---|
| Personnel Initials: | Date: | Data Capture Initials: | Date: |
| Supervisor Initials: | Date: | Data Validation Initials: | Date: |

Version Date: 03 November 2023

These forms collect additional information needed for programme-model-specific enrolment in the OVC DREAMS Family Strengthening or OVC Preventive programme models.

Unlike the Comprehensive program, the OVC Preventive and OVC DREAMS Family Strengthening programs are not household-based. Instead, it is assumed that participants will be enrolled at school or community sites as part of group-based interventions. Subsequently, the forms do not require household location details. However, these fields have been added to the forms for organisations to track participants for additional service provision, programmatic transfers, or data quality assessments.

The forms also collect the minimum amount of information needed to de-duplicate the participant and to report on the OVC_SERV Prevention or DREAMS disaggregates (name, birth date, ID type, ID number, sex).

### OVC PREVENTIVE PROGRAMME

This form includes DSD demographic fields (race, disability, school status) in addition to the previously described fields. Child participants qualify for enrolment if they are aged 10-14 and meet the criteria for one or more priority subpopulations (like the OVC Comprehensive program). A box at the bottom of the form captures each child's subpopulation category/ies.

The G2G National program provides group-based HIV prevention education (YOLO) to older adolescents (ages 15 and older). While YOLO participants are technically not part of the OVC Preventive programme due to their age, it makes sense to track them on this form given the programmatic similarities. Rather than count towards OVC_SERV Preventive, completion of YOLO will count towards PP_PREV. **No other OVC partners should use this form to report on YOLO enrolment; it is for G2G National use only unless USAID approves otherwise.**

### OVC DREAMS FAMILY STRENGTHENING PROGRAMME

The DREAMS enrolment form collects the enrolment date and the age-specific vulnerability criteria that qualify the AGYW for the DREAMS programme.

Eligibility screening for DREAMS is based on global DREAMS programming guidance.[29] The DREAMS program enrolment form is not designed to act as a DREAMS Risk and vulnerability assessment but rather to provide a place to record the final determination of eligibility systematically. See the box below for screening considerations.

*Excerpt from PEPFAR DREAMS Guidance document (pg. 28-29)*

To ensure screenings are administered appropriately, all individuals who provide eligibility screening must be trained in building rapport, how to ask about experiences of violence, the provision of first line-support in response to disclosure of violence, local mandatory reporting laws, and their partner's SOP to complete active linkages to necessary services (including GBV response). Active linkages to services such as GBV response and HIV care and treatment must be completed when indicated, regardless of an individual's DREAMS eligibility or enrollment status. The AGYW's confidentiality and informed consent must be ensured throughout the screening process. Screening questions should be age appropriate and tailored to elicit candid responses, while allowing an AGYW to easily refuse to answer.

[29] See Appendix A. DREAMS Risk and Vulnerability Assessment (pg. 27) of the PEPFAR DREAMS Guidance document (updated March 2021)

While ideally, enrolled AGYW meet at least one of the age-specific vulnerability criteria below, it is recognised that OVC partners are not the program entry point for DREAMS AGYW. Rather, they serve AGYW referred by primary partners who may have identified and engaged AGYW using different criteria (e.g. school-based programming, which engages all participants in a classroom).

**Table 7. Vulnerability criteria for enrolment and their applicable age groups**

| Vulnerability criteria for enrolment | Applicable age group | | |
|---|---|---|---|
| | 10-14 | 15-19 | 20-24 |
| Out-of-school | x | x | |
| Orphanhood | x | x | |
| Experience of physical or emotional violence (within the last year) | x | | |
| Experience of sexual violence (lifetime) | x | x | x |
| Alcohol or other substance use | x | x | x |
| Ever had sex | x | | |
| History of pregnancy | x | x | |
| Multiple sex partners | | x | x |
| STI diagnosed or treated | | x | x |
| No or irregular condom use | | x | x |
| Transactional sex (including staying in a relationship for material or financial support) | | x | x |

# APPENDIX 1. REPORTS AVAILABLE IN CBIMS.NET

## De-identified Summary Reports

| Name | Description | Indicators Available |
|---|---|---|
| **PEPFAR MER Indicator Reports** | | |
| PEPFAR MER OVC_SERV Report | PEPFAR OVC_SERV (MER 2.8) indicator data for OVC partners to report in DATIM. (Semi-annual and annual basis). Additional data to help understand progress and gaps towards OVC_SERV. | • OVC_SERV<br>• OVC_SERV disaggregates<br>• OVC_SERV_SUBPOP<br>• OVC_SERV_PRIMARY_SUBPOP<br>• EWG_REPORT |
| PEPFAR MER OVC_HIVSTAT Report | PEPFAR OVC_HIVSTAT (MER 2.8) indicator data for OVC partners to report in DATIM. (Semi-annual and annual basis). Additional data to help understand progress and gaps towards known status & the HIV treatment cascade. | • OVC_HIVSTAT<br>• OVC_HIVSTAT_18+<br>• OVC_HIVSTAT_UNKNOWN<br>• OVC_VL_ELIGIBLE<br>• OVC_VLR<br>• OVC_VLS<br>• OVC_ENROLL<br>• OVC_DSP<br>• DTG, MMD, & IIT |
| PEPFAR PP_PREV | PEPFAR PP_PREV (MER 2.7) indicator data for G2G National to report in DATIM (Semi-annual and annual basis). PP_PREV is the number of priority populations (PP) reached with the standardized, evidence-based intervention(s) required that are designed to promote the adoption of HIV prevention behaviors and service uptake | • PP_PREV |
| **OVC Custom Indicator Reports** | | |
| OVC Monthly Reporting Tool | The USAID SI team designed a monthly report to report OVC_HIVSTAT disaggregation, OVC_SERV service lapses, and other important metrics. | • OVC_HIVSTAT_Negative<br>• OVC_HIVSTAT_Positive_Not Receiving ART<br>• OVC_HIVSTAT_Positive_Receiving ART<br>• OVC_HIVSTAT_Test Not Required<br>• OVC_HIVSTAT_Unknown_No HIV Status<br>• OVC_SERV Active Graduation readiness<br>• OVC_SERV Active referred for family planning<br>• OVC_SERV Active referred for TB_Screening<br>• OVC_SERV_Comprehensive<br>• OVC_SERV_DREAMS<br>• OVC_SERV_EWG_Service Lapse<br>• OVC_SERV_Potentially Active<br>• OVC_SERV_Preventive<br>• OVC_VL_ELIGIBLE<br>• OVC_VLR<br>• OVC_VLS |

| Name | Description | Indicators Available |
|---|---|---|
| OVC Custom HIV Testing Assessment Cascade Report | Four required semi-annual indicators: OVC_TST_ASSESS, OVC_TST_RISK, OVC_TST_REFER, OVC_TST_REPORT<br>Limited to active and graduated participants in the OVC comprehensive programme. | • OVC_TST_ASSESS<br>• OVC_TST_RISK<br>• OVC_TST_REFER<br>• OVC_TST_REPORT |
| OVC DQA & SQA Report | The data quality assessments (DQA) and service quality assessments (SQA) are indicators which measure the completeness of data capture, particularly regarding HIVSTAT and the quality of service packages to participants. | • Multiple, unnamed |
| NSP SANAC Report | Selected DSD NSP indicators for SANAC reporting | • NSP 1, 2, 6 & 8 |
| **Other Reports** | | |
| Completion rate for group-based interventions | Number of children and adults completing threshold number of structured group-based intervention sessions (As needed basis) | |
| Participant Service count report | Number of beneficiaries served per service by each partner, de-duplicated within the reporting period and excluding incomplete referrals | |
| Pre/Post Survey Indicators Report | Report on the results of indicator scores of the pre and post-surveys | |
| Pre/Post Groups Report | Report on the counts of respondents from the pre and post-survey groups | |
| Pre/Post Survey Questions Report | Report on the individual question scores from the pre and post-survey results. | |
| GRA Summary Report | Cross-sectional graduation readiness assessment summary | |

## Case Management Reports (Confidential)

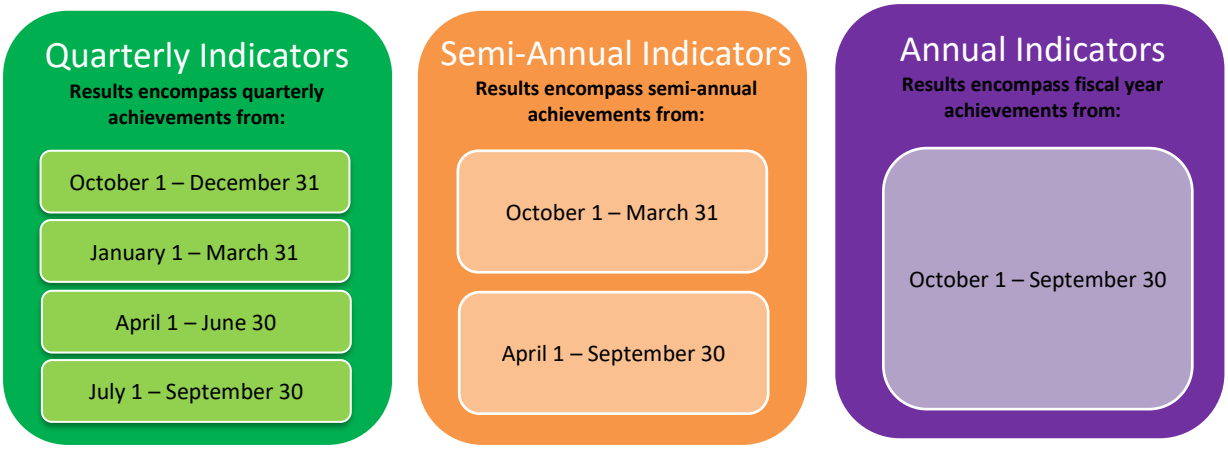
| Name | Description |
|---|---|
| OVC Active Participant Case Management Report | This report lists all active and inactive participants, grouped by worker, to identify kids who must be served to count towards OVC_SERV. It should be shared with case managers for follow-up (As needed basis) (CONFIDENTIAL) |
| Intervention report (Identified) | List all interventions per person over a user-defined period. Please note that workshop dates are stored as the first day of the month in which the sessions were captured (CONFIDENTIAL) |
| Data Capture Report | Lists households, participants, and services captured between a start and end date. Use this report to see what each data capturer has captured in a specific period. |
| ART Monitoring Case Management Report | Lists key treatment details for participants living with HIV in the OVC Comprehensive program and flags related data and service needs |
| HIV Testing Case Management Report | Lists key testing details for participants in the OVC Comprehensive program and flags related data and service needs. |
| Graduation readiness tracking - unmet benchmarks | Lists households with unmet graduation benchmarks. |
| Graduation readiness tracking - met benchmarks. | Lists households with all applicable graduation benchmarks met to prompt the case manager to graduate the family and/or update their record. |
| DSD Case Management Report | Lists individuals who have received DSD structured interventions and other relevant services, categorised by DSD Risiha domains |
| OVC Active Beneficiary CSV raw data file | CSV file of raw data underlying the Active Beneficiary Report. Use this file for further data analysis. |

## APPENDIX 2. INDICATOR REFERENCE SHEETS

Reference sheets are included below for PEPFAR MER and custom indicators used by the USAID OVC programme implementing partners.

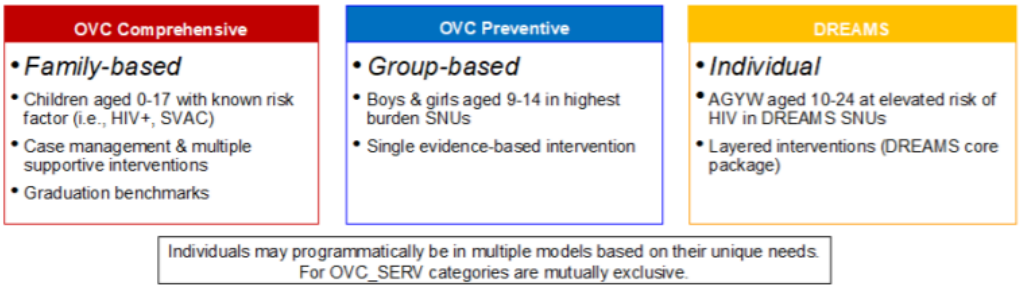
PEPFAR MER indicator reference information reflects global guidance and may be adapted in South Africa. Where discrepancies occur, local guidance should be prioritised. Partners may be required to report additional indicators based on other programme affiliations and their specific services. Reference sheet details are subject to change (partners will be notified of any substantive changes).

The figure below indicates the reporting frequency and time periods for PEPFAR indicators.



# OVC_SERV

**Source: PEPFAR MER 2.0 (Version 2.8) September 2024**

| | | |
|---|---|---|
| **Description:** | Number of participants served by PEPFAR OVC programs for children and families affected by HIV | |
| **Numerator:** | Number of participants served by PEPFAR OVC programs for children and families affected by HIV | The numerator is the sum of the following Program Participation Status disaggregates:<br>• OVC Comprehensive Active and Graduated participants (children and caregivers)<br>• DREAMS Family Strengthening participants<br>• OVC Preventive participants |
| **Denominator:** | N/A | |
| **Indicator changes (MER v2.7 to v2.8):** | None | |
| **Reporting Level** | Facility & Community | |
| **Reporting Frequency** | Semi-annually | |
| **How to use:** | One of PEPFAR's mandates is to care for "children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects" (PEPFAR authorization). To meet this mandate, PEPFAR's Orphans and Vulnerable Children (OVC) programming serves the dual purposes of mitigating the impact of HIV/AIDS on children and adolescents and their families, as well as preventing HIV/AIDS-related morbidity and mortality.<br><br>COP Guidance details an approach to risk and resilience for the OVC portfolio that responds to the current stage of the HIV/AIDS pandemic and the child's needs. To implement this framework, three distinct but complementary models are required to address children's vulnerabilities and provide appropriate support services: OVC Comprehensive, OVC Preventive, and DREAMS (Figure 1). OVC_SERV is a direct (output) measure of the number of individuals receiving PEPFAR OVC program services for children and families affected by HIV/AIDS across these three models.<br><br>**Figure 1: Three Distinct but Complementary OVC_SERV Program Models**<br>  <br><br><br>The OVC_SERV indicator can be used to:<br>• Determine the number of individuals (by age/sex and program status) that were served by the OVC Comprehensive Program.<br>• Understand the program participation status (i.e. active, graduated) or transferred/exited status of participants in the OVC Comprehensive Program.<br>• Assess the ratio of caregivers to children or adolescent participants within the OVC Comprehensive Program. | |

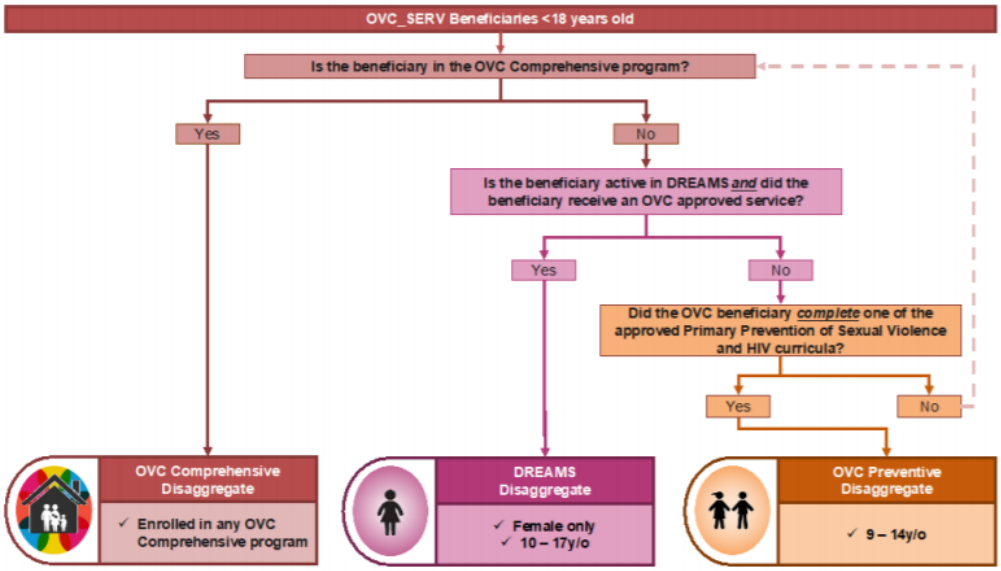
• Identify the number of children aged 10-14 years that exclusively received an approved primary prevention of HIV and sexual violence intervention (i.e., primary prevention of both HIV and sexual violence) through the OVC Preventive Program.
• Gain an understanding of the number of AGYW enrolled in DREAMS that received one or more eligible OVC services as part of their DREAMS core package of services/interventions.
• Ensure that the program implementation is matching community needs.

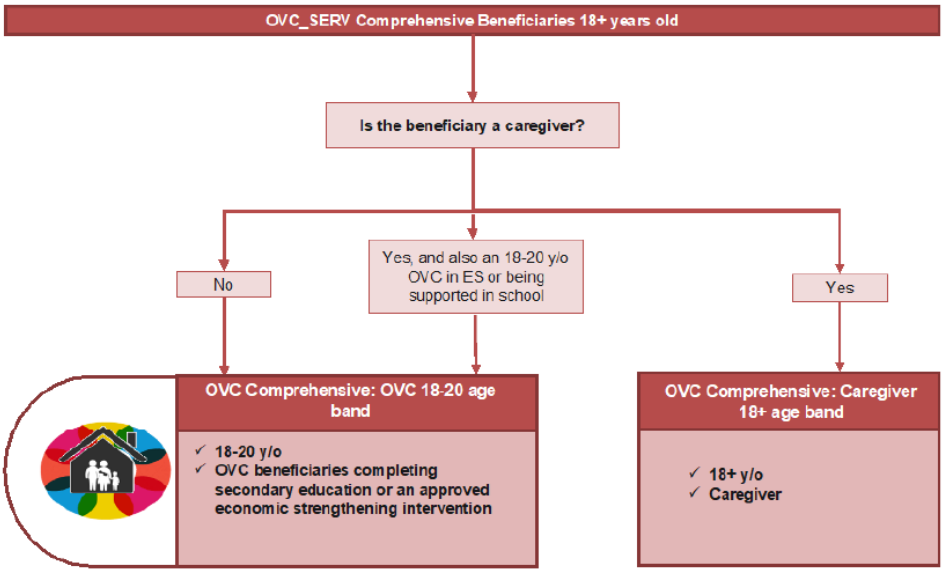
**Determining Which Model(s) to Report Under**

To ensure that individual children and adolescents are not double counted under this indicator, the following hierarchy of the OVC_SERV program models must be followed when reporting on OVC_SERV (Figures 2 & 3). Example scenarios are below:

• A 14-year-old girl is enrolled in the OVC Comprehensive Program, is an active DREAMS participant, and has completed an approved primary prevention of HIV and sexual violence intervention. She should be reported exclusively in the "OVC Comprehensive" disaggregate.
• A 10-year-old boy is enrolled in the OVC Comprehensive Program and completes an approved primary prevention of HIV and sexual violence intervention. He should be reported exclusively under the "OVC Comprehensive" disaggregate.
• A 13-year-old girl is an active DREAMS participant, completes an approved primary prevention of HIV and sexual violence intervention, and is NOT enrolled in the OVC Comprehensive Program. She should be reported exclusively under the "DREAMS" disaggregate.
• A 12-year-old boy completes an approved primary prevention of HIV and sexual violence intervention and is not enrolled in the OVC Comprehensive program. He should be reported exclusively under the "OVC Preventive" disaggregate.
• A 19-year-old female is completing secondary education with OVC program support and is the caregiver of a child in the OVC Comprehensive program. Both her and her child should be reported as "OVC" under the "OVC Comprehensive" disaggregate. The caregiver will not be counted under the "Caregiver" disaggregate because she is already being counted under the OVC Comprehensive 18-20 years of age disaggregate.

**Figure 2: Hierarchy of OVC_SERV Program Models for Beneficiaries <18**



| | |
|---|---|
| | Figure 3: Hierarchy of OVC_SERV Comprehensive OVC & Caregiver Categories for Beneficiaries 18+<br>  <br> |
| **How to collect:** | Data sources include PEPFAR OVC program registers and other records of program data generated by implementing partners (IPs). Implementing partners' registers need to record sex and ages of children and caregivers who meet the criteria for the disaggregates included in this indicator (e.g., participation status, program model). Use of a unique ID system is recommended. All agencies and IPs serving individuals that meet the definition of OVC_SERV across program models are required to report on this indicator (e.g., OVC partners, DREAMS partners serving AGYW 10-17 years of age with eligible OVC services). Additionally, agencies and IPs implementing approved primary prevention of HIV and sexual violence interventions (e.g., OVC Preventive) are required to report on this indicator regardless of funding source.<br><br>**Each individual should be counted only once under OVC_SERV in the reporting period.** Please follow the hierarchy detailed in Figures 2 & 3 to ensure that everyone is reported under only one program model (i.e., OVC Comprehensive, DREAMS, or OVC Preventive). Efforts will need to be made to de-duplicate OVC_SERV data in SNUs with multiple IPs implementing the various program models. An IP implementing the OVC Preventive program model may end up reporting significantly fewer individuals than they are actually serving, because the Preventive model falls lowest on the hierarchy in Figure 2, and individuals may already be counted in a different program model disaggregate. When targets are set by program model, this should also be taken into consideration. The only individuals who should be reported in the Preventive model are those who are not receiving services in the Comprehensive model or in DREAMS. Correct reporting of OVC_SERV will require comparing program records with IPs implementing the other program models in the same SNU to determine how many program models an individual is participating in and where to count them. Similarly, the only individuals who should be reported in the DREAMS model are those not receiving services in the Comprehensive model. All individuals receiving services in the Comprehensive model should be counted there.<br><br>For those reported under OVC Comprehensive, IPs must record the participation status of children and caregivers (i.e., active or graduated) or if they are transferred out to a PEPFAR-supported partner, transferred out to a non-PEPFAR supported partner, or exited without graduation. The program participation status and transfer/exit disaggregate categories are mutually exclusive. |
| **How to review for data quality:** | Review PEPFAR OVC implementing partners' results to ensure that there is no double counting between program models (e.g., OVC Comprehensive, DREAMS, OVC Preventive) and between program participation status and transfer/exit disaggregate categories within OVC Comprehensive. |

<table>
<tr><td></td><td>Review IP and site results for deviations from one period to the next which may indicate rapid exit and entry of participants or high sudden graduation rate in one, versus another period.</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator. Individuals should only be counted once by each partner at Q4 reporting. Individuals should only be counted under one OVC program model at Q4 reporting (see Figures 2 & 3).<br><br>Q4 OVC_SERV = (OVC Comprehensive Active Q4 + Graduated Q4) + (DREAMS Q4) + (OVC Preventive Q4)<br><br>All disaggregates except for “active” under OVC Comprehensive are a snapshot for the entire fiscal year at the time of reporting. This includes graduated, exited, and transferred disaggregates under OVC Comprehensive; DREAMS; and OVC Preventive.<br><br>Under OVC Comprehensive, program participation status at the end of Q4 should take precedence for where to count an individual (i.e., if a participant was counted as exited without graduation at Q2 but had met the criteria to be counted as active at Q4, then they should be reported at Q4 only under the active category and not in the total reported for exited without graduation).</td></tr>
<tr><td>`Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>OVC Comprehensive [Required]</td><td>• Program Participation Status<br>○ Active<br>▪ OVC, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M<br>▪ Caregiver, by 18+ F/M<br>○ Graduated<br>▪ OVC, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M<br>▪ Caregiver, by: 18+ F/M</td></tr>
<tr><td>OVC Exited or Transferred [Required]</td><td>• Transferred out to a PEPFAR-supported partner<br>• Transferred out to a non-PEPFAR supported partner<br>• Exited without graduation</td></tr>
<tr><td>DREAMS [Required]</td><td>• Age/Sex: Unknown age F/M, 10-14 F/M, 15-17 F/M</td></tr>
<tr><td>OVC Preventative [Required]</td><td>• Age/Sex: Unknown age F/M, 5-9 F/M, 10-14 F/M</td></tr>
<tr><th colspan="2">Denominator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Please see Figures 2 & 3 to help determine which disaggregate category to report individual participants under. Remember that for the purposes of OVC_SERV reporting these categories are mutually exclusive.<br><br>OVC COMPREHENSIVE<br>Active: A child or caregiver who has received at least one eligible PEPFAR OVC program service in each of the preceding two quarters. New participants enrolled during the reporting period can be counted as active only if they have received at least one service in the preceding quarter.<br>• Child program participants (“OVC”) are defined as children and adolescents aged 0-17 years. Individuals aged 18-20 years are also included as “OVC” if they are completing secondary education or are living with HIV (modified per South Africa specific guidelines).</td></tr>
</table>

- OVC aged 18-20 should be counted in the OVC 18-20 age/sex disaggregate, rather than the Caregiver 18+ age/sex disaggregate, even if they are caregivers themselves (see Figure 3).

- **Caregivers** fulfill the role of parent or guardian to a child participant. For OVC_SERV, there should be no more than one primary caregiver per household (*modified per South Africa specific guidelines*). In most cases, given the vulnerability status of the households PEPFAR serves, there is likely to be only one primary caregiver. While adults or household members who are not caregivers fulfilling the role of parent or guardian may indirectly benefit from program support or access a one-time service, they should not be counted, as that does not meet the intention of increasing primary caregivers' access to critical services and support.
- **All active OVC Comprehensive participants (both children and caregivers) must:**
  - Have a case plan that has been developed or updated in the last 12 months that monitors their progress towards the graduation benchmarks (see details on the benchmarks below).
  - Have received directly from the project, was facilitated to obtain, or has a completed referral for at least one intervention in each of the preceding two quarters (see Appendix E for illustrative eligible interventions; if a service is not included on this list, the partner must seek and receive approval from local USG funding agency and note this in the OVC_SERV narrative).
    - Intake assessment, enrollment, subsequent assessments including HIV risk assessment, case plan development, and case plan monitoring are considered critical administrative processes rather than services but remain critical to ensuring provision of needs-based services in a timely manner.
- I**n addition, child participants ("OVC") aged 0-17 years and OVC aged 18-20 years completing secondary education or living with HIV must:**
  - Be monitored at least quarterly, but as often as is necessary according to the child's safety, schooling, stability, and health status. Monitoring includes establishing contact in person, or virtually where needed, to ensure that the case plan is progressing, and documentation of this contact is recorded in the case plan.

**Graduated**: The point at which a household enrolled in a PEPFAR OVC Comprehensive Program is deemed to have become more resilient and is no longer in need of PEPFAR OVC project-provided services. For caregivers and child participants to be counted as an individual graduated in DATIM, all child and all caregiver participants in a household must meet all applicable (age and HIV status specific) graduation benchmarks established by PEPFAR for improving resiliency in the household.

- At Q2: Report the number of children and caregivers that graduated from the OVC program in previous two quarters. At Q4: Report the number of children and caregivers that graduated from the OVC program in the past four quarters.
- For the purposes of graduation, a household is defined as all children in the household/family unit less than age 18 years who based on risk assessment are enrolled in the OVC project and their caregiver.
- PEPFAR guidance for graduation from an OVC project includes the following eight benchmarks (Figure 4) which align with the illustrative services in Appendix E. Please see Appendix F for additional details, definitions, and data sources for each minimum required benchmark. Countries may include additional benchmarks based on local criteria for achieving stability, but the eight global benchmarks are a minimum requirement.

| Benchmarks | Beneficiaries | | | | | House-hold |
|---|---|---|---|---|---|---|
| | All ages | HIV+ | 10–17 years | 0–4 years | School age | |
| 1. Known HIV status (or test not required) | ✓ | | | | | |
| 2. Virally suppressed | | ✓ | | | | |
| 3. Knowledgeable about HIV prevention | | | ✓ | | | |
| 4. Not malnourished | | | | ✓ | | |
| 5. Improved financial stability | | | | | | ✓ |
| 6. No violence | | | | | | ✓ |
| 7. Not in a child-headed household | | | | | | ✓ |
| 8. Children in school | | | | | ✓ | |

- Please note: CLHIV enrolled in the comprehensive program should follow the same graduation protocols as other enrolled children. When they and their families meet all their applicable required graduation benchmarks (including viral suppression which is only applicable to CLHIV and Caregivers living with HIV), they should be graduated from the program and counted under the OVC_SERV Comprehensive Graduated disaggregate and removed from the Active disaggregate. Because this may cause the associated indicator OVC_HIVSTAT_POS to decrease, please explain any graduations of CLHIV in the narrative section to account for it. As with all children and families enrolled in the comprehensive program, it is critical to remind graduating C/ALHIV and their caregivers that they can re-enroll at any time that they are not meeting the benchmarks.

**Exited or Transferred:**

- Data reported into the Exited or Transferred disaggregate should only include participants exiting or transferring from the OVC Comprehensive program. However, the Exited or Transferred disaggregate will not be included in the OVC Comprehensive total. The OVC Comprehensive total includes only active and graduated participants.
- At Q2: Report the number of children and caregivers that exited or transferred from the OVC program in previous two quarters. At Q4: Report the number of children and caregivers that exited or transferred from the OVC program in the past four quarters.
- **"Transferred out to a non-PEPFAR-supported partner"** is defined as when a child or caregiver participant has transitioned to programs that are not PEPFAR funded. These could include country-led services or other donor-funded programs.
- **"Transferred out to a PEPFAR-supported partner"** is defined as when a child or caregiver participant has transitioned from the support of one PEPFAR partner to another PEPFAR partner.
- **"Exited without graduation"** is defined as when a child or caregiver has not received program services in each of the past two preceding quarters or is lost-to-follow up, re-located, died, or the child has aged-out of the program without the household meeting graduation benchmarks from the PEPFAR OVC program.

**DREAMS**

- **Active DREAMS participants aged 10-17**
  - To be counted under this disaggregate, an active DREAMS participant who is not otherwise actively enrolled in the OVC Comprehensive Program must receive a DREAMS service/intervention that is also included in the list of OVC_SERV illustrative services (Appendix E).

| | |
|---|---|
| | ▪ At Q2: Report those that received an eligible OVC intervention in the previous two quarters. At Q4: Report those that received an eligible OVC intervention in the past four quarters.<br>o These individuals are <u>not</u> required to have an OVC case plan or to be monitored using the OVC graduation benchmarks. Active DREAMS participants should also be counted under the AGYW_PREV indicator according to their layering status.<br>o Active DREAMS participants aged 10-17 should be counted under both AGYW_PREV and the OVC_SERV DREAMS disaggregate, per each indicator's definition. Intervention completion definitions should be consistent across indicators and should be documented in each OU's DREAMS layering table (see AG W_PREV reference sheet). Note that it is possible for some individuals to be counted under AGYW_PREV but not the OVC_SERV DREAMS disaggregate. Only DREAMS AGYW who meet the definition above should be counted under OVC_SERV, whereas all DREAMS participants are counted under AGYW_PREV according to their layering status<br>o Active DREAMS participants aged 18+ who are not otherwise actively enrolled in the OVC Comprehensive Program should NOT be counted under OVC_SERV.<br><br>**<u>OVC PREVENTIVE</u>**<br>Prevention of HIV and sexual violence are important services that fit under the core components of the OVC program. Delivery of these services may differ from the OVC Comprehensive model. Individuals counted in this disaggregate are:<br>• **Children aged 10-14 who have completed only a primary prevention of HIV & sexual violence intervention**<br>o These individuals are not otherwise actively receiving services in the OVC Comprehensive program and are not active DREAMS participants. Therefore, they are <u>not</u> required to have an OVC case plan or to be monitored using the OVC graduation benchmarks.<br>o At Q2: Report the number of children that have completed an approved primary prevention intervention in the past two quarters. At Q4: Report the number of children that have completed an approved primary prevention intervention in the past 4 quarters.<br>o Approved primary prevention of sexual violence and HIV interventions are as follows: Families Matter Program, Parenting for Lifelong Health (also known as Sinovuyo), Coaching Boys into Men, and No Means No Worldwide . Countries are strongly encouraged to implement one of these four pre-approved curricula. All other curricula used for 10-14 primary prevention must be approved by S/GAC and the relevant agency HQ and must include the three S/GAC evidence-informed modules on healthy and unhealthy relationships, healthy choices about sex, and understanding consent. |

**Figure 5: OVC_SERV Numerator Beneficiary Categories**

| Program Model | Who | What | When Reported |
|---|---|---|---|
| OVC Comprehensive | **Active Children**<br>- Children (ages 0-17)<br>- Youth 18-20 completing secondary school or an approved economic intervention | - Have received 1+ eligible program services<br>- Have a current case plan (updated within last year)<br>- Are monitored at least quarterly<br>- Are monitored against the graduation benchmarks | - At Q2 & Q4: Meets definition in each of the past two quarters, *or* in past quarter if beneficiary was newly enrolled |
| | **Active Caregivers**<br>- Ages 18+<br>- Fulfill role of parent/guardian<br>- ≤ 2 per household | - Have received 1+ eligible program services<br>- Are monitored against the graduation benchmarks | |
| | **Graduated Children & Caregivers**<br>- See respective definitions above | - All children and caregivers in a household have met all applicable graduation benchmarks | - At Q2: graduated in past 2 quarters<br>- At Q4: graduated in past 4 quarters |
| DREAMS | - **Active DREAMS beneficiary ages 10-17**<br>- NOT enrolled in OVC Comprehensive Program | - Have received 1+ DREAMS services that are also an eligible OVC_SERV service<br>- Do not need an OVC case plan or to be monitored using the graduation benchmarks | - At Q2: received eligible service in past 2 quarters<br>- At Q4: received eligible service in past 4 quarters |
| OVC Preventive | - **Children ages 9-14**<br>- NOT enrolled in OVC Comprehensive Program or in DREAMS | - Have completed an approved primary prevention of HIV & sexual violence intervention<br>- Do not need an OVC case plan or to be monitored using the graduation benchmarks | - At Q2: completed intervention in past 2 quarters<br>- At Q4: completed intervention in past 4 quarters |

**PEPFAR-support definition:**

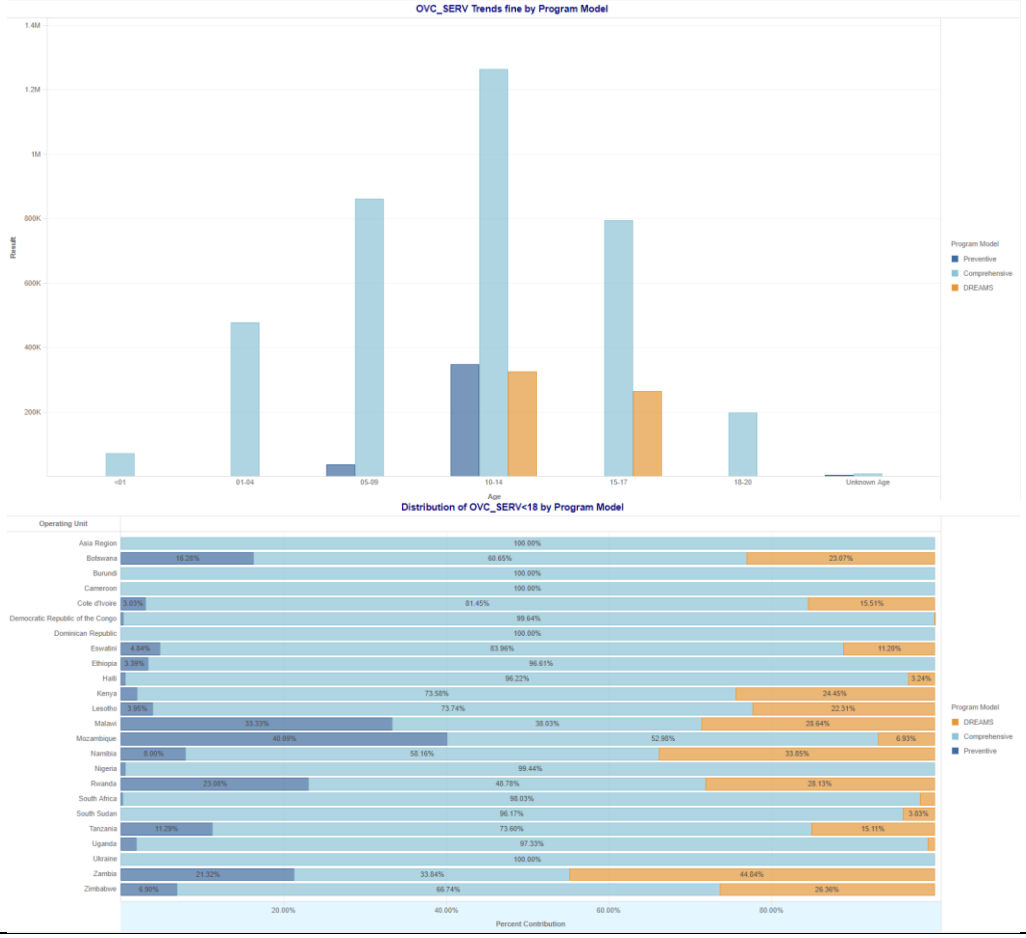
Modifications to standard definition of DSD and TA-SDI related to eligible goods and services:

<u>Provision of key staff or eligible goods/services for OVC participants receiving care and support services in the community includes</u>: For participants of OVC services, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group, or community level activity (e.g., psychosocial support, child protection services, education, etc.). Partial salary support may include stipends or incentives for volunteers/para-social workers or paying for transportation of those staff to the point of service delivery. For goods or services to be eligible, goods or services (e.g., bursaries, cash transfers, uniforms) can either be paid for out of the implementing partner's budget or be provided as a result of the IPs efforts to leverage and mobilize non-project resources. For example, an IP may help participants fill out and file forms necessary for the receipt of government provided cash transfers, social grants, or bursaries for which they are eligible. Given the focus on long-term local ownership, IPs are encouraged to mobilize goods and services whenever possible.

<u>For care and support services, ongoing support for OVC service delivery for improvement includes</u>: the development of activity-related curricula, education materials, etc., supportive supervision of volunteers, support for setting quality standards and/or ethical guidelines, and monitoring visits to assess the quality of the activity, including a home visit, a visit to a school to verify a child's attendance and progress in school or observation of a child's participation in kids' clubs.

**Guiding narrative questions:**

1. Please explain reasons and context for highest/lowest performing partners' performance (i.e., results/target) for OVC_SERV total numerator and OVC_SERV <18, including any programmatic shifts or monitoring updates.
2. For OVC Comprehensive, please explain results by Program Participation Status:
    a. For active participants, were there any interventions that were provided and approved by local USG funding agency that were not included in the illustrative examples (Appendix 3)?
    b. For graduation, were any of the benchmarks especially challenging to achieve or monitor? If so, which ones and why?
    c. For graduation, please note how many of the total graduated results were CLHIV graduations

| | |
|---|---|
| | 3. For OVC Comprehensive, please explain results by exited/transferred:<br>a. How many individuals exited without graduation? Please explain the reasons for exiting without graduation and try to quantify with percentages if possible. Are there certain partners with higher rates of exiting without graduation? How are you managing this with the partner(s)?<br>b. How many participants were transferred? To whom (e.g., other NGOs, government support, etc.) were they transferred? Where were participants transferred? Please provide disaggregates for participants transferred to specific sources of support.<br>4. For the OVC Preventive disaggregate, which approved primary prevention of HIV and sexual violence intervention(s) were implemented during the reporting period? Were there any implementation challenges that affected results?<br>5. For the DREAMS disaggregate, what were the most common interventions that DREAMS participants received? Were there any implementation challenges that affected results?<br>6. Please explain the steps taken by partners working in the same district to ensure that individuals were counted in the correct program model disaggregate and were not counted more than once. |
| **Data Visualization & Use Examples:** |  |

# Structured Intervention Completion (OVC-GBI)

| | | |
|---|---|---|
| **Description:** | Number of adults and children who completed group-based and/or structured interventions (by intervention type and by specific intervention) | |
| **Numerator:** | Number of adults and children who completed structured interventions | 'Completing' a structured intervention means attending a predetermined number of sessions – typically around 80% of the total number but sometimes 100% for interventions with a smaller number of total sessions (see table at the end of this reference sheet for specific completion thresholds). Participants are counted in the reporting period in which they reach the attendance threshold (e.g., attend their 8th session of a 10-session intervention). Sessions attended need not be consecutive; a participant attending sessions 1-7 and session 10 of a ten-session intervention would be counted in the numerator for OVC_GBI during the reporting period in which s/he attended session 10. If the sessions in an intervention span two or more reporting periods and the participant reaches 80% attendance in one reporting period and exceeds it in the next, s/he is counted only in the first period. Participants should be reported in the age group disaggregate reflecting their age at the start of the reporting period in which they are counted. Participants do not need to have 'active' participation status (per OVC_SERV) to be counted under this indicator. |
| **Denominator:** | N/A | |
| **How to use:** | Structured, group-based interventions are an important modality for sharing knowledge and skills related to preventing and managing HIV, receiving psychological support, acquiring and strengthening skills for parenting/caregiving, improving one's economic status and more. Several GBIs implemented by OVC program partners in South Africa are also backed by evidence of effectiveness, especially for behavioural and knowledge precursors to adolescent HIV prevention. This indicator provides a count of the number of participants completing at least one group-based intervention in a given reporting period. Disaggregates provide a count of the number of participants that completed each specific intervention in a given reporting period, as well as by intervention type, and the number that completed at least one intervention by age group and gender. Because some participants may complete more than one intervention, the disaggregates by intervention and type will not necessarily sum to the numerator. | |
| **How to collect:** | The data sources for this indicator are the PEPFAR OVC program service delivery data generated by implementing partners. The *OVC Programme Monthly Activity* form has been designed to collect monthly session attendance details under the 'Structured Interventions' section. These details once entered into CBIMS will be used to generate this indicator and disaggregates. | |
| **How often to report:** | Semi-annual | |
| **How to review for data quality:** | In general, the use of CBIMS makes manual data quality checking (e.g. ensuring no double counting, verifying that the numerator equals the sum of disaggregates) unnecessary. For this indicator, CBIMS will automatically recognize when a participant has met the intervention-specific threshold(s) for completion of one or more GBIs; partners only need to enter accurate data from the activity tracking form on the number of sessions that were attended each month. To ensure data quality, partners should establish internal procedures for auditing the completeness and accuracy of data entry into CBIMS from paper monitoring forms. | |

| | | | |
|---|---|---|---|
| **How to calculate annual total:** | CBIMS will calculate sum of de-duplicated results reported at Q2 and at Q4 of the fiscal year. De-duplicated results may also be obtained for any user-specified reporting period, not limited to fiscal years. | | |
| **Data elements (components of indicator):** | Numerator: Number of adults and children who completed group-based interventions during the reporting period | Disaggregate Groups | Disaggregates |
| | | Intervention and intervention type [Required] (list subject to change per USAID directive) | • **See 'structured intervention' list in the appendix for current interventions** |
| | | Age/Gender [Required] | 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M, 21+ F/M |

# OVC_SUBPOP

| Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021) | |
|---|---|
| **Description:** | Percentage of participants <18 years (active or graduated) who are served by an OVC comprehensive program who are a member of a priority sub-population |
| **Numerator:** | Number of participants <18 years (active or graduated) who are served by the OVC comprehensive program, disaggregated by priority sub-population |
| **Denominator:** | Number of participants <18 years (active or graduated) who are served by the OVC comprehensive program |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | This indicator counts all participants under 18 years old served by the OVC comprehensive program and disaggregates by "priority sub-population" as defined by PEPFAR. This includes those who are "active" and "graduated."<br>Priority sub-populations are generally defined as the following (or as otherwise defined by the in-country PEPFAR team):<br>● Children/adolescents living with HIV<br>● HIV-exposed infants (HEI)<br>● Children of an HIV-positive caregiver<br>● Children of female sex workers<br>● Sexual violence against children (SVAC)/gender-based violence (GBV) survivors<br>● Adolescent mothers<br>● Other priority sub-population groups, as defined by country programs/Operating Units<br>● Non-priority groups (none of the above categories apply)<br><br>This indicator captures participants' demographic data per the PEPFAR priority sub-population groups. It is possible that, over time, participants will experience or disclose to the program circumstances that change which priority sub-population(s) under which they would be counted. All relevant sub-population categories should be collected for each participant. For example, if, at enrolment, a child is known to be HIV positive, but six months after enrolment, is a victim of sexual violence, the participant would first be counted only under "CLHIV," and then later be counted under both "CLHIV" and "SVAC." Programs should monitor any changes in circumstances and/or disclosure of circumstances and track them on a semiannual basis. |

<table>
<tr><td>How to collect:</td><td>Sub-population data should be collected through program enrollment forms/tools, registers, participant case files, and/or other program monitoring tools. Note that implementing partners should also consider collecting data about these priority sub-populations during baseline evaluations, midline evaluations, and/or vulnerability assessments.<br>These key sub-populations are not mutually exclusive. In other words, a child can meet the definition for multiple sub-population categories. For example, a child may be HIV positive and also a GBV survivor. As such, because participants may be counted in multiple categories, these sub-population categories may not be summed together because it would likely be >100%. The only exceptions to this rule are the “Other sub-population groups” and “non-priority groups”, whereas a participant should only be counted under one of these two categories if they do not fall into one of the designated priority subpopulations.<br>All participants enrolled in the OVC comprehensive program should be counted under this indicator. During enrollment, or otherwise part of the CM process, programs should indicate which sub-population categories apply to the participant. Changes to sub-population demographic information should be collected and calculated in the semiannual performance report (SAPR) and annual performance report (APR). More than one category can be selected, if applicable.</td></tr>
<tr><td>How to review for data quality:</td><td>Through routine data quality audits or assessments conducted by the program or externally.</td></tr>
<tr><td>How to calculate annual totals:</td><td>This indicator calculates all sub-population categories that are relevant to each participant that is active or graduated from an OVC comprehensive program at the time of reporting.</td></tr>
<tr><td>Disaggregations</td><td colspan="2">Numerator disaggregations<table><tr><th>Disaggregate groups</th><th>Disaggregates</th></tr><tr><td>Sub-population types (modified per South Africa guidelines)</td><td>• Children living with HIV<br>• HIV-exposed infants (HEI)<br>• Children of an HIV-positive caregiver<br>• Children of female sex workers (i.e., Key population caregiver)<br>• Child survivor (i.e., Sexual violence against children (SVAC)/ gender-based violence (GBV) victims)<br>• Teen mother or their child<br>• Child is double-orphaned<br>• Child is single-oprhaned<br>• Child/youth at risk for HIV<br>• Non-priority groups (none of the above categories apply)</td></tr></table></td></tr>
</table>

# OVC_SERV_Primary_Subpop

| **USAID South Africa custom indicator** | |
|---|---|
| **Description:** | Percentage of participants <18 years (active or graduated) who are served by an OVC comprehensive program who are a member of a priority sub-population |
| **Numerator:** | Number of participants <18 years (active or graduated) who are served by the OVC comprehensive program, disaggregated by priority sub-population |
| **Denominator:** | Number of participants <18 years (active or graduated) who are served by the OVC comprehensive program |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |

<table>
<tr>
<td>How to use</td>
<td>Data on subpopulations can help partners understand the vulnerability profile of the children they are serving. These results generally reflect information obtained at the time of program enrolment, except for the children living with HIV (CLHIV) category, which is classified using the most recent HIV & antiretroviral therapy (ART) Status Tracking data in CBIMS. All participants in the South Africa OVC program fall within one or more priority subpopulations. While understanding what proportion of participants fall within each of the distinct subpopulations is helpful, it also benefits IPs to identify children according to their primary subpopulation. To this end, USAID South Africa developed a hierarchy for identifying a participant's 'primary' or 'priority' subpopulation (See Table 1 for the subpopulation prioritization). Using this hierarchy, children who fall within multiple subpopulations are only counted in their most vulnerable subpopulation, such that each child is assigned one primary subpopulation.<br><br>Table 1. Primary subpopulation
<table>
<tr><th>Priority</th><th>Subpopulation</th></tr>
<tr><td>1</td><td>Child Living With HIV</td></tr>
<tr><td>2</td><td>HIV-Exposed Infant</td></tr>
<tr><td>3</td><td>HIV Positive CG</td></tr>
<tr><td>4</td><td>KPCG</td></tr>
<tr><td>5</td><td>Child Survivor</td></tr>
<tr><td>6</td><td>Teen mother</td></tr>
<tr><td>7</td><td>Double Orphan</td></tr>
<tr><td>8</td><td>Single Orphan</td></tr>
<tr><td>9</td><td>Child/Youth at Risk</td></tr>
<tr><td>10</td><td>Household Eligibility</td></tr>
</table>
</td>
</tr>
</table>

# OVC_OFFER*

| Source: USAID PEPFAR Central Custom Indicators Guidance (Version 1: January 15, 2021) | |
|---|---|
| **Description:** | Percentage of children and adolescents on ART in PEPFAR clinical settings offered enrollment in the OVC program, as counted through family-based enrollment as the number of children and adolescents on ART who are in enrolled households. |
| **Numerator:** | Number of children and adolescents on ART in PEPFAR clinical settings whose households are offered enrollment in the OVC program PLUS the number of children and adolescents already in the OVC Program who are HIV+ and on ART. |
| **Denominator:** | (TX_CURR <20) |
| **Reporting level:** | Facility & Community |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | This indicator is a measure of the number and percentage of children and adolescents who are on ART in a PEPFAR clinical setting whose households are offered enrollment in a PEPFAR OVC program. This measures the process of offering facility-based client enrollment in community-based OVC programs, which can be monitored over time and across age and sex of participants through this indicator. Through a memorandum of understanding (MOU, or equivalent), PEPFAR OVC implementing partners should monitor clinical clients for enrollment in the OVC program. Giving HIV-positive clients support through OVC programs provides critical support to families for ART adherence, psychosocial support, economic strengthening, and prevention of HIV transmission. |
| **How to collect:** | The data for the numerator should be collected by PEPFAR OVC implementing partners. Data sources for this indicator include facility patient records, referral forms, or other facility monitoring tools that track those in treatment and care. OVC implementing partners who do not have a MOU (or equivalent) with PEPFAR-supported facilities that allows the OVC partner to monitor patients on ART will not be able to report under this indicator. In other words, OVC implementing partners should only report under this indicator if they are engaged in the identification and screening of prospective OVC participants at the facility. |

| OVC_ENROLL* | |
|---|---|
| **Source: USAID PEPFAR Central Custom Indicators Guidance (Version 1: January 15, 2021)** | |
| **Description:** | Percentage of HIV-positive children and adolescents on ART at a PEPFAR clinical setting whose households are enrolled in the OVC comprehensive program after having been offered enrollment. This is counted through family-based enrollment as the number of children and adolescents on ART who are in households enrolled in the OVC comprehensive program. |
| **Numerator:** | Number of HIV-positive children and adolescents on ART at a PEPFAR clinical setting whose households are enrolled in the OVC comprehensive program after having been offered enrolment. |
| **Denominator:** | Number of children and adolescents on ART in PEPFAR clinical settings whose households are offered enrollment in the OVC program (OVC_OFFER). |
| **Reporting level:** | Facility & Community |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | This indicator is a measure of the process of enrolling HIV-positive children and adolescents in an OVC program through PEPFAR-funded health facilities/clinics. This measures whether the process of offering enrollment to ART clients is effectively resulting in enrollment in an OVC program. This indicator assumes that prospective participants are screened for eligibility before being offered enrollment so that everyone offered enrollment can be enrolled in the program, if they consent/agree. Giving HIV-positive clients support through OVC programs provides critical services to families for ART adherence, psychosocial support, economic strengthening, and prevention of HIV transmission. |
| **How to collect:** | These data should be collected by PEPFAR OVC implementing partners. Data sources for this indicator include facility patient records, OVC referral forms, or other monitoring tools that track those in treatment and care. OVC implementing partners who do not have a MOU (or equivalent) with PEPFAR supported facilities that allows the OVC partner to monitor patients on ART 13 will not be able to report under this indicator. In other words, OVC implementing partners should only report under this indicator if they are engaged in the identification and screening of prospective OVC beneficiaries at the 89 facility (e.g., through an OVC staff member enrolling new beneficiaries at the facility, or equivalent). On the other hand, if facility staff are identifying, screening, and referring OVC beneficiaries, these referrals should not be counted under this indicator. |
| **How to review for data quality:** | Through routine data quality audits or assessments conducted by the program or externally. |

<table>
<tr><td>How to calculate annual totals:</td><td colspan="2">This is a cumulative indicator that calculates all children and adolescents on ART in a PEPFAR clinical setting whose households were enrolled in the OVC comprehensive program during the fiscal year. For example, during both Q2 and Q4 reporting, calculate and sum all such prospective beneficiaries offered enrolment and then enrolled at any point during that fiscal year at the time of reporting. All beneficiaries enrolled should be counted only once, regardless of the number of times they were offered enrolment during a reporting period.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>Age/Sex<br>[Required]</td><td>By <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate Groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

# CHILD_LINK_FACILITY

| | |
|---|---|
| **USAID South Africa custom indicator** | |
| **Description:** | Total number of OVC participants <20 referred to DSP facilities for HTS or ART linkage |
| **Numerator:** | Total number of children and adolescents ≤19 years referred to the facility for HTS or ART linkage |
| **Denominator:** | N/A |
| **Link to PEPFAR MER indicator** | Cases in the 'Initiated on ART' referral result disaggregate also count toward TX_NEW; cases in ART referral result disaggregates except 'Incomplete referral' also count toward HTS_TST. |
| **Reporting level:** | Facility |
| **Reporting frequency:** | Quarterly |
| **How to use:** | This indicator tracks the number of children and adolescents enrolled in the OVC programme who were referred to DSPs for HTS or ART linkage during the reporting period. Referral result disaggregates for this indicator help programme teams identify the proportion of children and adolescents referred who were successfully linked to services, and the proportion of those linked to HTS with known or positive test results. It also tracks programme integration between OVC partners and DSPs. |
| **How to collect:** | Information on HTS and ART referrals and referral results is captured on the Monthly Activity form. OVC partner staff should communicate regularly with DSPs to follow up on the status of referrals initiated. This ensures that children's needs are being met and facilitates reporting on CHILD_LINK_FACILITY.<br>Age should be calculated at the start of Q1 for reporting on this indicator. Participants may appear (once) in both the HTS referral disaggregates and the ART referral disaggregates, if referred for each service type during the reporting period.<br>Results are cumulative at each reporting period and should include children and adolescents referred for HTS or ART any time during the year:<br>At Q1: report the number of unique individuals referred in Q1.<br>At Q2: report the number of unique individuals referred in Q1 and Q2.<br>At Q3: report the number of unique individuals referred in Q1, Q2, and Q3.<br>At Q4: report the number of unique individuals referred in Q1, Q2, Q3, and Q4.<br>Participants should be counted in the referral result disaggregate that matches their last recorded result during the (cumulative) reporting period, for multiple referrals of the same type (HTS or ART). |
| **How to calculate annual total:** | This is a snapshot indicator that reflects:<br>the number of children and adolescents in need of HIV testing as identified by the OVC partner who were referred to DSPs for HTS<br>the number of children and adolescents not currently on treatment (by self-report, including caregiver report as applicable), and referred to the DSP for ART initiation/re-initiation support<br><br>Results are cumulative at each quarter and the Q4 result equals the annual total. |
| **Data quality** | Ensure data quality by doing routine data quality audits or assessments, conducted by the program or externally. |
| **Data elements** | **Disaggregate Groups** / **Disaggregates**<br>Age/Sex: <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M<br>Assessment Results: Referred for HTS: Positive result; Referred for HTS: Negative result; Referred for HTS: Unknown result; Referred for ART: Initiated on ART; Referred for ART: Re-initiated on ART; Referred for ART: Unknown result |

# PREP_LINK

| | |
|---|---|
| **Description:** | Number of individuals who have been successfully linked to PrEP services to prevent HIV infection in the reporting period |
| **Numerator:** | Number of individuals successfully linked to PrEP during the reporting period |
| **Denominator:** | N/A |
| **Link to PEPFAR MER indicator** | PrEP_NEW |
| **Reporting level:** | Community |
| **Reporting frequency:** | DREAMS partners report on this indicator monthly; however, other partners may report semi-annually |
| **How to use:** | This indicator monitors the number of HIV negative clients identified in the community and are actively linked to PrEP in the facility or a mobile. A successful linkage refers to those clients that were referred to and initiated on PrEP. 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.<br><br>Tenofovir-containing oral PrEP reduces the risk of HIV acquisition among numerous populations when taken consistently. PEPFAR supports WHO guidelines on the use of PrEP as part of a package of comprehensive structural, biomedical and behavioural prevention services. In most settings, PrEP will be integrated into existing prevention or treatment services for the target population. |
| **How to collect:** | The data sources are the PEPFAR OVC program service delivery data generated by implementing partners. The OVC Programme Monthly Activity Form has been designed to collect details on completed referrals for PrEP. These details once entered into CBIMS will be used to generate this indicator and its disaggregates. |
| **How to calculate annual total:** | CBIMS will calculate sum of de-duplicated results reported at Q2 and at Q4 of the fiscal year. De-duplicated results may also be obtained for any user-specified reporting period, not limited to fiscal years. |
| **Data quality** | In general, the use of CBIMS makes manual data quality checking (e.g. ensuring no double counting, verifying that the numerator equals the sum of disaggregates) unnecessary. However, partners should establish internal procedures for auditing the completeness and accuracy of data entry into CBIMS from paper monitoring forms.<br><br>The total number of clients successfully linked to PrEP services (numerator) should be equal to the subtotal of the age/sex disaggregate group. |
| **Data elements** | **Disaggregate Groups** / **Disaggregates**<br>Age/Sex / 15-19 F, 20-24 F |

# OVC_HIVSTAT

**Source: PEPFAR MER 2.0 (Version 2.8) September 2024**

| | | |
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| **Description:** | Percentage of orphans and vulnerable children (<18 and 18-20 years old) enrolled in the OVC Comprehensive program with HIV status reported to implementing partner. | |
| **Numerator:** | Number of orphans and vulnerable children (<18 years of age and 18-20 years of age) enrolled in the OVC Comprehensive program with HIV status reported, disaggregated by HIV status | Data sources for this indicator include HIV test results that are self-reported by OVC (or their caregivers), results of HIV Risk Assessments conducted by implementing partners, registers, referral forms, client records, or other confidential case management and program monitoring tools that track those in treatment and care. Partners are strongly encouraged to confirm HIV and ART status through clinical record confirmation. |
| **Denominator:** | Number of orphans and vulnerable children reported under the OVC_SERV "OVC Comprehensive" disaggregate (<18 years old, and 18-20 years of age, active and graduated) | Denominator is not collected again as part of this indicator, but is collected under the "OVC Comprehensive" disaggregate of OVC_SERV. |
| **Indicator changes (MER v2.7 to 2.8):** | None | |
| **Reporting level:** | Facility & Community | |
| **Reporting frequency:** | Semi-Annually | |
| **How to use:** | Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC Comprehensive participants, to assess their risk of HIV infection, and to facilitate access and continuity of treatment for those who are HIV positive. When the implementing partner determines that the child is at risk of HIV infection, the program should refer children for testing and counselling services. When the implementing partner knows the HIV status, the program should ensure that the children are linked to appropriate care and treatment services as an essential element of quality case management. OVC programs should also play an important role in family-centred disclosure, for those who are HIV positive.<br><br><u>The goal of monitoring OVC_HIVSTAT is to increase the proportion of children in the OVC Comprehensive program with a known HIV status or for whom an HIV test is not required based on a risk assessment</u>.<br><br>• While OVC partners are encouraged to work with testing and clinical partners wherever possible to confirm HIV and ART status, this indicator is NOT intended to be an indicator of HIV tests performed or receipt of testing results, as these are measured elsewhere.<br>• This indicator is NOT intended to imply that all OVC require an HIV test. OVC with known positive or negative status do not need to be tested. OVC with unknown HIV status should be assessed for risk, and if determined to be at risk, should be referred or otherwise supported, to access HTS. For younger children who are determined not to be at risk ("test not required based on risk assessment"), reassessment of risk will only be needed in cases where their risk situation changes (i.e., in cases of child sexual abuse). Older children whom the IP thinks may be sexually active should be assessed every reporting period. An HIV risk assessment should always occur prior to HIV testing to determine if a test is required.<br>• Status disclosure to the implementing partner is NOT a prerequisite for enrollment or continuation in an OVC program. OVC programs serve persons of positive, negative, and unknown HIV status appropriate to their needs and vulnerability to HIV. This indicator ensures that IPs are regularly providing outreach to caregivers to identify children's HIV status, encouraging family disclosure, and linking to care and treatment services as needed. | |

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| | • This indicator captures if implementing partners are tracking the HIV status of the OVC that they serve and enrollment in ART for those who are positive. Testing results for OVC who are referred for testing should be reported under HTS_TST based on the service delivery point where they are tested.<br>• This indicator also captures if implementing partners are tracking if the OVC that they serve who report to be living with HIV are successfully linked to and have continuity of treatment and care. ART treatment status should be recorded both at the time of enrollment as well as at regular intervals at least once during the reporting period.<br>• Since this is not a testing indicator, HIV positivity yield should NOT be calculated based on this indicator. Yield calculations should only be made by testing partners.<br>• A helpful way to assess OVC_HIVSTAT performance is to create a "known status proxy" category of known status/risk (by combining those reported positive, negative, and those who have been risk assessed and found to not require a test) and compare this with the OVC_SERV <18 years of age or 18-20 years of age "OVC Comprehensive" disaggregates. These analyses encourage programs to actively follow-up on all instances of "HIV status unknown" by targeting instances of missing data, nondisclosure, and issues with reporting timing. The primary focus remains on OVC Comprehensive program participants <18 years of age, but the inclusion of participants 18-20 years of age analysis allows implementing partners to have a comprehensive understanding of the status of ALL the OVC in their programs.<br>• This indicator is a subset of the OVC_SERV Comprehensive program. Only OVC who were reported under the OVC_SERV 0- years of age, excluding caregivers + years of age, "OVC Comprehensive" disaggregate should be reported in the numerator for this indicator.<br>• In previous MER iterations, DREAMS participants who were reported under OVC_SERV were reported under OVC_HIVSTAT where feasible. With the denominator change to include only OVC Comprehensive program participants, DO NOT count non-Comprehensive (i.e. DREAMS or OVC Preventive) participants in the OVC_HIVSTAT numerator.<br>• In FY22, the age bands were introduced and aligned this indicator with TX_CURR, allowing for a more accurate assessment of proxy coverage calculations for OVC <15. However, TX_CURR proxy coverage has been underrepresenting coverage of OVC programs due to misalignment of OVC and TX indicators. The addition of the 18-20 age band also improves an OVC program's ability to more closely calculate the requested TX_CURR proxy coverage targets. Although a misalignment remains for participants 20 years of age, participants who are 18-19 years of age who were not previously captured in this calculated proxy coverage, are now included into the metric, better demonstrating the OU's program coverage. |
| **How to collect:** | Data sources for this indicator include HIV test results that are self-reported by OVC (or their caregivers), results of HIV Risk Assessments conducted by implementing partners, registers, referral forms, client records, or other confidential case management and program monitoring tools that track those in treatment and care.<br><br>Implementation of the HIV risk assessment should be integrated into case management and on-going case monitoring, and should not be conducted separately, if possible. This will vary by partner and project. The partners should work out a timeline based on their experience of how long referral completion and status disclosure usually takes and factor that into their case management processes.<br><br>Implementing partners will record the OVC participant's self-reported HIV status semi-annually.<br><br>**Reporting Scenarios**:<br>**Q3**: *What do we do when a caregiver refuses to disclose their status and the status of their child or refuses to complete an HIV test – even when the HIV risk screening tool indicates that their child is at high risk of HIV infection?*<br><br>**A3**: A caregiver should never be forced to disclose their or their child's status, the results of an HIV test, or to complete an HIV test. HIV status and completion of an HIV test are not required for enrolment in an OVC program. If a child is believed to be at high risk of HIV and the caregiver is reluctant to disclose results or complete a test, OVC programs should attempt to facilitate a meeting with the caregiver, and persons specially trained on HIV disclosure. OVC programs may also consider enlisting the support of community members with whom the caregiver has greater trust. Until the |

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|---|---|
| | client chooses to disclose test results, status under OVC_HIVSTAT should be recorded as "No HIV Status."<br><br>**Q4**: *How do we report on HIV exposed infants who are still too young to have had their final HIV status testing?*<br><br>**A4**: Because HIV-exposed infants may be tested at multiple points prior to receiving a final HIV status, we recommend that they be counted as "no status" until such time that the clinic determines their final status as positive (infected) or negative (not infected). A note can be entered in DATIM in the narrative section indicating the number of children entered as "no status" that are HIV-exposed (i.e., infants during the reporting period who were of undetermined status). It is important for all HIV-exposed infants and their caregivers to be facilitated to make appointments deemed necessary by the clinic.<br><br>**Q5**: *Jane is an 11-year-old AGYW enrolled in DREAMS, and one of the DREAMS services she receives is also an eligible OVC service. Therefore, she is captured under the OVC_SERV disaggregate "DREAMS." If the implementing partner knows that Jane is HIV negative, should Jane's HIV status be reported under OVC_HIVSTAT?*<br><br>**A5**: No. Under the new OVC_HIVSTAT definition, only participants enrolled in the OVC comprehensive program should have their HIV status reported. Participants reported under the "DREAMS" or "OVC Preventive" OVC_SERV disaggregates should NOT be captured under OVC_HIVSTAT since the participants counted here are not enrolled in the OVC Comprehensive program.<br><br>**Q6**: *Nelson is a 14-year-old who has just successfully completed one of the approved primary preventions of HIV and sexual violence curricula. He has disclosed to the course facilitator that he is HIV+. Should his HIV status be reported under OVC_HIVSTAT?*<br><br>**A6**: No. Only those children and adolescents who are enrolled in the OVC Comprehensive program are to have their HIV status reported under OVC_HIVSTAT. The course facilitator should check to ensure that the child is linked to a health facility and referred to the OVC Comprehensive program for an assessment to determine whether or not the child and his family are in need of additional support from the OVC Program. |
| **How to review for data quality:** | The OVC_HIVSTAT Total Numerator should equal the OVC_SERV 0-20 years of age "OVC Comprehensive" age disaggregates, including active and graduated. Review any site with the following reporting issues: (1) numerator greater than 100% of OVC_SERV 0-20 years of age "OVC Comprehensive" age disaggregates, and (2) very low coverage of OVC_HIVSTAT (defined as OVC_HIVSTAT numerator, divided by OVC_SERV 0-20 years of age "OVC Comprehensive" age disaggregates) which provides data on reporting of status.<br><br>Missing data should be documented under "HIV status unknown" or "Reported HIV-positive- Not currently receiving ART or ART status unknown." Potential reasons for missing data may include: **(1)** IP was not able to collect information from all caregivers of OVC_SERV 0–20-year-old Comprehensive participants within the reporting period, or **(2)** IP was not able to locate all the caregivers of OVC_SERV 0–20-year-old Comprehensive participants (e.g., relocated, migrant work). |

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

$$\frac{\text{Reported HIV-positive} + \text{Reported HIV-negative} + \text{HIV status unknown} + \text{HIV test not required based on risk assessment}}{\text{Number of orphans and vulnerable children reported under the OVC\_SERV "OVC Comprehensive" disaggregate}} = 100\%$$

</td></tr>
<tr><td>How to calculate annual total:</td><td>This is a snapshot indicator. Results are cumulative at each reporting period.</td></tr>
<tr><td>Disaggregations</td><td>
<table>
<tr><th colspan="2">Numerator Disaggregations:</th></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>Age/Sex/Status Type [Required]</td><td>
<ul>
<li>Reported HIV-positive to implementing partner</li>
<li><u>Currently receiving ART</u>, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M</li>
<li><u>Not currently receiving ART or ART status unknown</u>, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M</li>
<li>Reported HIV-negative to implementing partner, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M</li>
<li>Test not required based on risk assessment, by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M</li>
<li>No HIV status reported to the implementing partner (HIV status unknown), by: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M</li>
</ul>
</td></tr>
<tr><th>Disaggregate Groups</th><th>Disaggregates</th></tr>
<tr><td>See OVC_SERV "OVC Comprehensive" disaggregate".</td><td>See OVC_SERV "OVC Comprehensive" disaggregate.</td></tr>
</table>
</td></tr>
<tr><td>Disaggregate descriptions & definitions:</td><td>Age/Sex/Status Type Disaggregate Definitions:<br>• All Status Type disaggregates noted below should be reported by fine age/sex band using the following options: Unknown age F/M, <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M<br>• "Reported HIV-positive to IP" includes all OVC 0-20 years of age enrolled in the OVC Comprehensive program who are either clinically confirmed to be living with HIV and/or self- report to the IP that they are living with HIV based on an HIV test conducted during or prior to the reporting period (regardless of where the test occurred). All OVC in this category should be reported as "currently receiving ART" or "not currently receiving ART or ART Status Unknown." This also includes OVC 0-20 years of age who report that they are living with HIV based on an HIV test conducted during previous project reporting periods. OVC entered in either category as "Reported HIV-positive – currently receiving ART" or "Reported HIV-positive – not currently receiving ART or ART Status Unknown" in the previous reporting period should be followed in the current reporting period and their current ART treatment status noted. To be counted as "currently receiving ART," the IP should confirm at the last visit preceding the reporting month whether the response to the following questions is "yes" to ensure that this captures more than just initial linkage to care: Are you taking your ARV pills every day?</td></tr>
</table>

| | |
|---|---|
| | • "Reported HIV-negative to IP" includes OVC 0-20 years of age enrolled in the OVC Comprehensive program who are either clinically confirmed to be HIV-negative or self-report that they are HIV-negative to the IP based on an HIV test conducted during the reporting period (regardless of where the test occurred). For a child who reports multiple tests within the current period, use the most recent test. For OVC entered as "Reported HIV-negative to IP" in a previous reporting period - if the IP believes the child's risk has not changed in the last 6 months, they should continue to report the child as HIV-negative during the current reporting period. However, if the IP believes that the child has recently been exposed to risk of HIV infection (e.g., sexual violence) or if an adolescent has become sexually active, then the IP should conduct an HIV risk assessment. Potential outcomes reported after the HIV risk assessment include (1) the child is tested and reported as HIV-positive and either currently receiving ART or not receiving ART or ART status unknown, or (2) the child is tested and reported as HIV-negative, (3) the child is reported as "No HIV Status reported to the IP", or (4) the child is reported as "Test not required based on risk assessment."<br>• "Test not required based on risk assessment" includes OVC 0-20 years of age enrolled in the OVC Comprehensive program who based on a risk assessment made by the implementing partner do not require a test during the reporting period (formerly known as test not indicated).<br>• "No HIV status reported to the IP" (HIV status unknown) includes all OVC 0-20 years of age enrolled in the OVC Comprehensive program who do not fit into the above categories and who report to the IP that they do not know their HIV status or for whom HIV status is missing. Potential scenarios for reporting a child in this category include:<br>o Final outcome not yet confirmed for HIV-exposed infants<br>o Not yet assessed: Child enrolled in program, but not yet assessed for HIV risk.<br>Refuse HIV assessment: Caregiver has been approached but did not agree to let the IP conduct a risk assessment on the child in the reporting period.<br>o at risk for HIV: Child has been assessed and is at risk for HIV, but caregiver has not yet taken child to be tested (including if they have refused testing referral or if they have accepted the referral but not yet completed the test).<br>o HIV referral completed: OVC has completed HIV test, but result is not available OR caregiver doesn't report results to IP in the reporting period.<br>o Refuse report: Caregiver has been approached by IP but has not yet agreed to disclose whether the child has been tested and his/her current HIV status in the reporting period.<br>o Missing: No available data, including because an IP did not attempt to find out about a child's status.<br>IPs should aim to move a newly enrolled OVC with HIV Status Unknown through the assessment cascade within the reporting period. A newly enrolled child would initially be considered "HIV Status Unknown" until the child is risk assessed. If the OVC is found to not be at risk at present, the child will be noted as "Test not required based on risk assessment." If the OVC is found to be at risk, the child will be referred for HIV testing and then the program will work with the guardian to disclose the results until the child can be reported as "Reported HIV-Negative", "Reported HIV-Positive – currently on ART" or "Reported HIV-Positive – not currently on ART or ART status unknown."<br>For children reported as "HIV Status Unknown" in the previous reporting period, the IP should ensure that child is risk assessed, referred for testing if needed, and supported to disclose new test results. Children reported as "Test not required based on risk assessment" with no changes in their risk situation for the past 6 months, don't need to be reassessed. If the IP believes the child's risk situation has changed in the last 6 months, then the child should be reassessed by the implementing partner to determine whether testing is indicated and the results entered as outline above, and the child should receive appropriate follow-up. |
| **PEPFAR support definition:** | Modifications to standard definition of DSD and TA-SDI related to eligible goods and services: |

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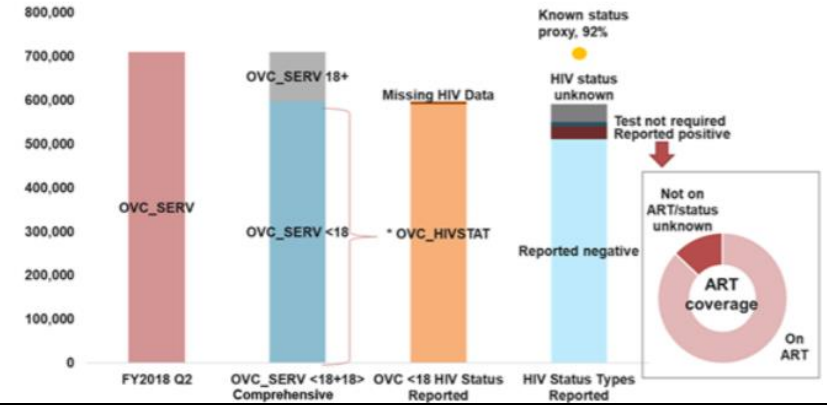
| | Provision of key staff or eligible goods/services for OVC participants receiving care and support services in the community include: For participants of OVC services, this can include funding of salaries (partial or full) for staff of the organization delivering the individual, small group or community level activity (e.g., psychosocial support, child protection services, 118 UNCLASSIFIED educations, etc.). Partial salary support may include stipends or incentives for volunteers/parasocial workers or paying for transportation of those staff to the point of service delivery. For goods or services to be eligible, goods or services (e.g., bursaries, cash transfers, uniforms) can either be paid for out of the implementing partner's budget or be provided as a result of the IP's efforts to leverage and mobilize non-project resources. For example, an IP may help participants fill out and file forms necessary for the receipt of government provided cash transfers, social grants, or bursaries for which they are eligible. Given the focus on long-term local ownership, IPs are encouraged to mobilize goods and services whenever possible.<br>For care and support services, ongoing support for OVC service delivery for improvement includes: the development of activity-related curricula, education materials, etc., supportive supervision of volunteers, support for setting quality standards and/or ethical guidelines, and monitoring visits to assess the quality of the activity, including a home visit, a visit to a school to verify a child's attendance and progress in school or observation of a child's participation in kids clubs. |
| **Guiding narrative questions:** | 1. Please report the percentage of OVC comprehensive beneficiaries 0-20 years of age who have a clinically confirmed HIV status vs. a self-reported HIV status for both OVC_HIVSTAT_POS and OVC_HIVSTAT_NEG.<br>2. Please describe how OVC and clinical IPs are working together to responsibly share this information for clinical confirmation and jointly serving OVC participants. Include any challenges and what is being done to overcome these challenges.<br>3. If the sum of reported HIV-negative and reported HIV-positive and Test not required based on risk assessment is less than 90% of OVC_SERV 0-20 years of age "OVC Comprehensive" disaggregate, please explain why such a high proportion are being reported in the category of "HIV Status Unknown" (i.e., the performance metric described in the "how to use" section). Are there certain partners that are struggling with reporting or understanding the disaggregates? How is the OU responding?<br>4. Please explain the breakdown of those reported under "HIV Status Unknown." What percentage of caregivers refused to disclose a child's HIV status? What percentage represents those who have been referred for testing but do not yet have results? What percentage represents missing data where an implementing partner failed to document the child's HIV status? What are the other reasons? Specifically, for the <1 year age band, please report the number who are HEI who have not yet received a final HIV status outcome.<br>5. For children reported as "Reported HIV-Positive - not currently on ART or ART Status Unknown," what efforts are being undertaken in response? Are there certain partners with low ART coverage, why? Is this an issue related to community case management? Or are partners unable to collect timely confirmation of treatment status (i.e., missing)? |
| **Data Visualization & Use Examples** | **OVC_HIVSTAT Cascade:**<br>  <br> |

# OVC_HIVSTAT_18+

**Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021)**

| | |
|---|---|
| **Description:** | Percentage of OVC_SERV participants 18 years old and above (active or graduated) who are served by an OVC comprehensive program with HIV status reported to the implementing partner |
| **Numerator:** | Number of children (>18 years old) and caregivers (active or graduated) who are served by an OVC comprehensive program with HIV status reported, disaggregated by HIV status |
| **Denominator:** | Number of participants 18 years old and above (active or graduated) served by the OVC comprehensive program (OVC_SERV >18 years old) |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | It is imperative for PEPFAR implementing partners to monitor HIV status among OVC participants and their caregivers, to assess their risk of HIV infection, and to facilitate access and retention in ART for those who are HIV positive.<br>OVC_HIVSTAT is a required MER 2.5 indicator. The goal of monitoring OVC_HIVSTAT is to increase the proportion of participants reported as active or graduated under OVC_SERV under age 18 with a known HIV status or for whom an HIV test is not required based on a risk assessment. OVC_HIVSTAT_18+ captures the same information as OVC_HIVSTAT per the MER 2.5 guidance, but for participants in the 18+ years old categories, who are included in OVC_SERV but excluded from OVC_HIVSTAT totals per the MER 2.5 guidance.<br>This indicator is NOT intended to be an indicator of HIV tests performed or the receipt of test results because these are measured elsewhere in MER 2.5, and confirmed test results are frequently unavailable to community organizations because of patient confidentiality.<br>This indicator is NOT intended to imply that all OVC participants require an HIV test. OVC and their caregivers with known positive or negative status do not need to be tested. OVC and caregivers with unknown HIV status should be assessed for risk, and if determined to be at risk, should be referred or otherwise supported to access HIV 13 testing services. An HIV risk assessment should always occur before HIV testing to determine whether a test is required.<br>Status disclosure to the implementing partner is NOT a prerequisite for enrolment or continuation in an OVC program. OVC programs serve persons of positive, negative, and unknown HIV status appropriate to their needs and vulnerability to HIV. This indicator ensures that implementing partners are regularly providing outreach to caregivers to identify their children's HIV status, encouraging family disclosure, and linkages to testing, care, and treatment services, as needed.<br>This indicator captures whether implementing partners are tracking the self-reported HIV status and enrolment in ART of HIV-positive OVC 18 years old and older (youth 18–20 years old) and caregivers 18+ years. Testing results for OVC and caregivers who are referred for testing should be reported under HTS_TST based on the service delivery point at which they are tested.<br>This indicator also captures whether implementing partners are tracking whether the OVC (youth 18–20 years old) and caregivers 18+ years that they serve who report being HIV positive are successfully linked to and retained in treatment. ART status should be recorded at the time of enrollment and updated at regular intervals, at least once each quarter. |

<table>
<tr><td></td><td>Because this is not a testing indicator, HIV positivity yield should NOT be calculated based on this indicator. Yield calculations should only be made by testing partners.<br>A helpful way to assess OVC_HIVSTAT_18+ performance is to create a “known status proxy” category of known status/risk (by combining those reported positive, negative, and those who have been risk assessed and found to not require a test) and compare them with OVC_SERV 18+. This analysis encourages programs to actively follow up on all instances of “HIV status unknown” by targeting instances of missing data, nondisclosure, and issues with reporting timing. This updated way of reviewing the data provides insight on OVC and caregivers with known status and identifies where additional follow-up is needed for those with unknown status.</td></tr>
<tr><td>How to collect:</td><td>Data sources for this indicator include HIV test results that are self-reported, results of HIV risk assessments conducted by implementing partners, registers, referral forms, client records, or other confidential CM and program monitoring tools that track those in treatment and care. Implementation of the HIV risk assessment should be integrated in CM and ongoing case monitoring, and should not be conducted separately, if possible. Participants reported as “test not required based on risk assessment” with no changes in their risk situation for the past six months do not need to be reassessed. If the implementing partner believes that the individual’s risk situation has changed in the last six months, the participant should be reassessed by the implementing partner to determine whether testing is indicated. The partner should work out a timeline based on its experience of how long referral completion and status disclosure usually takes, and factor that in its CM processes.<br>See OVC_HIVSTAT in the MER 2.5 guidance for example scenarios of how this indicator should be calculated.</td></tr>
<tr><td>How to review for data quality:</td><td>OVC_HIVSTAT_18+ numerator = 18+ HIV positive + 18+ HIV negative + 18+ HIV status unknown + 18+ HIV test not required based on risk assessment.<br>OVC_HIVSTAT_18+ numerator = OVC_SERV 18+ (active or graduated).<br>OVC_HIVSTAT_18+ disaggregates = OVC_SERV 18+ (active or graduated).<br>Any missing data should be documented under “HIV status unknown” or “reported HIV positive – not currently receiving ART or ART status unknown.”</td></tr>
<tr><td>How to calculate annual totals:</td><td>This indicator is a subset of OVC_SERV 18+ and, therefore, is calculated based on the calculations described in the MER 2.5 guidance.</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator disaggregations</th></tr>
<tr><th>Disaggregate groups</th><th>Disaggregates</th></tr>
<tr><td>Status type</td><td>Follow the same disaggregates for OVC_HIVSTAT <18 (see MER 2.5 Guidance for more details on each of the disaggregates):<br>● Reported HIV positive to the implementing partner; 18-20 F/M youth, 18+ F/M caregivers<br>○ Currently on ART<br>○ Not currently on ART or ART status unknown<br>● Reported HIV negative to the implementing partner; 18-20 F/M youth, 18+ F/M caregivers<br>● Test not required based on risk assessment; 18-20 F/M youth, 18+ F/M caregivers<br>● No HIV status reported to the implementing partner (HIV status unknown); 18-20 F/M youth, 18+ F/M caregivers</td></tr>
<tr><th colspan="2">Denominator disaggregations</th></tr>
<tr><th>Disaggregate groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
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# OVC_HIVSTAT_UNKNOWN

**Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021)**

| | |
|---|---|
| **Description:** | Number of <18 years old participants (active and graduated) served by an OVC comprehensive program whose HIV status is unknown to the IP, by reason for unknown HIV status |
| **Numerator:** | Number of <18 years old participants (active and graduated) served by the OVC comprehensive program whose HIV status is unknown to the IP, by reason for unknown HIV status (OVC_HIVSTAT disaggregated by reason for unknown status) |
| **Denominator:** | N/A |
| **Reporting level:** | Implementing partner |
| **Reporting frequency:** | Semi-Annually |
| **How to use:** | Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC participants, to assess their risk of HIV infection, and to facilitate access and retention in ART treatment for those who are HIV positive.<br>OVC_HIVSTAT is a required MER 2.4 indicator. The goal of monitoring OVC_HIVSTAT is to increase the proportion of participants reported as active or graduated under OVC_SERV under age 18 with a known HIV status or for whom an HIV test is not required based on a risk assessment. OVC_HIVSTAT_UNKNOWN captures the same information as OVC_HIVSTAT, but only for the participants with unknown status. In other words, this indicator is a further disaggregation of the OVC_HIVSTAT unknown disaggregate.<br>Reasons for HIV status being unknown, include the following:<br>• Not assessed for HIV risk (either the program has not yet requested the HIV status, not yet assessed for HIV risk or the caregiver refused to consent for the child to be assessed for HIV risk)<br>• Assessed, at risk but not referred (referral not made yet or caregiver refused the referral)<br>• Referred, but test not yet completed (caregiver has not yet completed the testing referral or not reported if they have completed the testing referral)<br>• Tested, but results not reported (have not yet received results of the HIV test or the caregiver refused to disclose status after testing)<br>• Missing information (all other categories)<br><br>(Note that each possible scenario described in parentheses should be considered from a program monitoring perspective but is not required for reporting. For example, an implementing partner may monitor both possible scenarios of "not assessed for HIV risk": 1) the program has not yet assessed and 2) the caregiver refused to consent for the child to be assessed. While this may be useful at the program level, it is not required for reporting purposes.) |
| **How to collect:** | Reasons for unknown HIV status data should be collected through program registers, participants case files, HIV risk assessment tool, other case management records and/or other monitoring tools.<br>Implementation of the HIV risk assessment should be integrated into case management and on-going case monitoring, and should not be conducted separately, if possible. This will vary by partner and project. The partners should work out a timeline based on their experience of how long referral completion and status disclosure usually takes and factor that into their case management processes. |

<table>
<tr><td>How to review for data quality:</td><td colspan="2">All disaggregates should add up = OVC_HIVSTAT_UNKNOWN numerator; and should equal the difference between the MER 2.4 indicators: (OVC_SERV<18) – (<18 HIV positive + <18 HIV negative + <18 HIV test not required based on risk assessment).</td></tr>
<tr><td>How to calculate annual totals:</td><td colspan="2">This indicator is a subset of OVC_HIVSTAT and therefore calculated based on the calculations described in the MER 2.4 Guidance.</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>Reason for unknown status and age and sex of participant</td><td>● Not assessed<br>● Assessed, at risk but not referred<br>● Referred, but test not yet completed<br>● Tested, but results not reported<br>● Missing information</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

# OVC_TST_ASSESS

**Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021)**

| | |
|---|---|
| **Description:** | Number of children and adolescents <18 years (active and graduated) served by an OVC comprehensive program whose HIV status was ever unknown and who were assessed for HIV risk during the reporting period. This includes reported HIV-negative children and adolescents whose risk profile may have changed and, therefore, an HIV risk assessment was needed. |
| **Numerator:** | Number of children and adolescents <18 years (active and graduated) served by an OVC comprehensive program whose HIV status was ever unknown and who were assessed for HIV risk during the reporting period. This includes reported HIV-negative children and adolescents whose risk profile may have changed and, therefore, an HIV risk assessment was needed. |
| **Denominator:** | None |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC participants, to assess their risk of HIV infection, and to facilitate access, initiation, and retention in ART for those who are HIV positive.<br>PEPFAR OVC programs should support caregivers of children to disclose to the program the HIV status of child/adolescent participants. When appropriate, (i.e., the child or adolescent has never been tested or his/her circumstances are such that a risk assessment is warranted), the program should conduct an assessment of HIV risk. This assessment will determine which participants the program should refer to HIV testing and which are deemed "test not required."<br>When the implementing partner determines that the participant is at risk of HIV infection, the program should refer him/her for HIV testing and counselling services. After the implementing partner refers "at risk" participants for testing, the partner should follow up to make sure that the test was conducted and to support the caregiver to disclose the results of the test.<br>This indicator counts the number of participants <18 years old (active in and graduated from an OVC comprehensive program) whose most recent HIV risk assessment has been conducted during the reporting period, regardless of the results of the risk assessment. Counting the most recent assessment will eliminate the possibility of double counting a participant. This does not include any HIV risk assessments administered during previous reporting periods.<br>Only HIV risk assessments of active or graduated participants in an OVC comprehensive program are reported in OVC_TST_ASSESS. Administering an HIV risk assessment alone is not a qualifying service under OVC_SERV. Refer to MER 2.5 guidance to determine how to calculate OVC_SERV.<br>The reporting periods are defined as follows for this indicator:<br>SAPR: count the most recent HIV risk assessment per participant from Q1 and Q2<br>APR: count the most recent HIV risk assessment per participant from Q1, Q2, Q3, and Q4 |
| **How to collect:** | Data sources for this indicator include client records or other confidential CM and program monitoring tools that track HIV risk assessments and assessment results. Implementation of the HIV risk assessment should be integrated in CM and ongoing case monitoring, and should not be conducted separately, if possible. Children reported as "test not required based on risk assessment" with no known or perceived changes in their risk situation for the past six months do not need to be reassessed. If |

<table>
<tr><td></td><td colspan="2">the implementing partner believes that the child's HIV risk profile has changed in the last six months, then the child should be reassessed by the implementing partner to determine whether testing is required. The appropriate follow-up should be provided to the child based on his/her HIV assessment and HIV test results, where testing is required.</td></tr>
<tr><td>How to review for data quality:</td><td colspan="2">Through routine data quality audits or assessments conducted by the program or externally. OVC_TST_ASSESS is less than or equal to (OVC_SERV <18 years served by an OVC comprehensive program)</td></tr>
<tr><td>How to calculate annual totals:</td><td colspan="2">Annual totals include children and adolescents <18 years whose most recent HIV risk assessment was conducted during the previous four quarters (Q1, Q2, Q3, and Q4).</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator Disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="2">Denominator Disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>

# OVC_TST_RISK

| Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021) | |
|---|---|
| **Description:** | Number of children and adolescents <18 years (active and graduated) served by an OVC comprehensive program who were assessed for HIV risk and determined to need an HIV test |
| **Numerator:** | Number of children and adolescents <18 years (active and graduated) served by an OVC comprehensive program who were assessed for HIV risk and determined to need an HIV test |
| **Denominator:** | None |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC participants, to assess their risk of HIV infection, and to facilitate access, initiation, and retention in ART for those who are HIV positive.<br>PEPFAR OVC programs should support caregivers of children to disclose to the program the HIV status of child/adolescent participants. When appropriate, (i.e., the child or adolescent has never been tested or his/her circumstances are such that a risk assessment is warranted), the program should conduct an assessment of HIV risk. This assessment will determine which participants the program should refer to HIV testing and which are deemed "test not required."<br>When the implementing partner determines that the participant is at risk of HIV infection, the program should refer him/her for HIV testing and counselling services. After the implementing partner refers "at risk" participants for testing, the partner should follow up to make sure that the test was conducted and to support the caregiver to disclose the results of the test.<br>This indicator tracks the number of participants <18 years old (active or graduated) in an OVC comprehensive program who were determined to be "at risk" for HIV infection based on a risk assessment administered during the current reporting period. This indicator does not include any "at risk" findings from HIV risk assessments administered during previous reporting periods. All participants assessed for risk should be counted only once, regardless of whether they were assessed multiple times during a reporting period.<br>If a participant < 18 years old is assessed for risk of HIV infection, but he or she is not counted as active or graduated in OVC_SERV, then the "at risk" finding of his/her most recent risk assessment cannot count toward this indicator. Only active and graduated participants found to be at risk can be reported in OVC_TST_RISK. Administering an HIV risk assessment alone is not a qualifying service under OVC_SERV.<br>The reporting periods are defined as follows for this indicator:<br>SAPR: count the most recent HIV risk assessment per participant from Q1 and Q2<br>APR: count the most recent HIV risk assessment per participant from Q1, Q2, Q3, and Q4 |
| **How to collect:** | Data sources for this indicator include client records or other confidential CM and program monitoring tools that track HIV risk assessments and assessment results. Implementation of the HIV risk assessment should be integrated in CM and ongoing case monitoring, and should not be conducted separately, if possible. Children reported as "test not required based on risk assessment" with no changes in their risk situation for the past six months do not need to be reassessed. If the implementing partner believes that the child's HIV risk profile has changed in the last six months, then the child should be reassessed by the implementing partner to determine |

<table>
<tr><td></td><td>whether testing is required. The appropriate follow-up should be provided to the child based on his/her HIV assessment and HIV test results, where testing is required.</td></tr>
<tr><td>How to review for data quality:</td><td>Through routine data quality audits or assessments conducted by the program or externally.<br><br>OVC_TST_RISK is less than or equal to OVC_TST_ASSESS</td></tr>
<tr><td>How to calculate annual totals:</td><td>Annual totals include children and adolescents <18 years who were ever found to be at risk based on an HIV risk assessment conducted in the previous four quarters (Q1, Q2, Q3, and Q4).</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator disaggregations</th></tr>
<tr><th>Disaggregate groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><th colspan="2">Denominator disaggregations</th></tr>
<tr><th>Disaggregate groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
</table>

# OVC_TST_REFER

| Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021) | |
|---|---|
| **Description:** | Number of children and adolescents <18 years (active and graduated) served by an OVC comprehensive program that initiated a referral for HIV testing and counselling services |
| **Numerator:** | Number of children and adolescents <18 years (active or graduated) served by an OVC comprehensive program that initiated a referral for HIV testing and counselling services |
| **Denominator:** | None |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC participants, to assess their risk of HIV infection, and to facilitate access, initiation, and retention in ART for those who are HIV positive.<br>PEPFAR OVC programs should support caregivers of children to disclose the HIV status of child/adolescent participants to the program. When appropriate, (i.e., the child or adolescent has never been tested or his/her circumstances are such that a risk assessment is warranted), the program should conduct an assessment of HIV risk. This assessment will determine which participants the program should refer to HIV testing and which are deemed "test not required."<br>When the implementing partner determines that the participant is at risk of HIV infection, the program should refer him/her for HIV testing and counselling services. After the implementing partner refers "at risk" participants for testing, the partner should follow up to make sure that the test was conducted and to support the caregiver to disclose the results of the test.<br>This indicator tracks the number of unique participants < 18 years (active or graduated) served by an OVC comprehensive program who are referred for HIV testing and counselling during the reporting period, regardless of when the participant was determined to be at risk. If the caregiver refuses the referral of the child or adolescent for any reason, the referral is not counted under this indicator because the referral could not be officially made. All participants referred for testing should be counted only once, regardless of the number of times they were referred during a reporting period.<br>This indicator is not a direct subset of OVC_TST_RISK because it is possible that participants who are "at risk" from a previous reporting period could be referred during the current reporting period. 21<br>The reporting periods are defined as follows for this indicator:<br>SAPR: count the most recent HIV testing and counselling referral per participant from Q1 and Q2<br>APR: count the most recent HIV testing and counselling referral per participant from Q1, Q2, Q3, and Q4 |
| **How to collect:** | Data sources for this indicator include client records or other confidential CM and program monitoring tools that track HIV testing and counselling referrals made. |
| **How to review for data quality:** | Through routine data quality audits or assessments conducted by the program or externally.<br>OVC_TST_REFER is less than or equal to (OVC_SERV < 18 years served by an OVC comprehensive program |

<table>
<tr><td>How to calculate annual totals:</td><td colspan="2">Annual totals include children and adolescents <18 years who initiated a referral to HIV testing and counselling in the previous four quarters (Q1, Q2, Q3, and Q4).</td></tr>
<tr><td rowspan="5">Disaggregations:</td><td colspan="2">Numerator disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="2">Denominator disaggregations</td></tr>
<tr><td>Disaggregate groups</td><td>Disaggregates</td></tr>
<tr><td></td><td>N/A</td><td>N/A</td></tr>
</table>

# OVC_TST_REPORT

| Source: Optional Custom Indicators for USAID OVC Programs: Performance Indicator Reference Sheets (February 2021) | |
|---|---|
| **Description:** | Number of children and adolescents <18 years (active and graduated)) served by an OVC comprehensive program who reported an HIV test result to the implementing partner after being referred for HIV testing and counselling |
| **Numerator:** | Number of children and adolescents <18 years (active and graduated) served by an OVC comprehensive program who reported an HIV test result to the implementing partner after being referred for HIV testing and counselling |
| **Denominator:** | None |
| **Reporting level:** | OU |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | Given the elevated risk of HIV infection among children affected by and vulnerable to HIV, it is imperative for PEPFAR implementing partners to monitor HIV status among OVC participants, to assess their risk of HIV 22 infection, and to facilitate access, initiation, and retention in ART for those who are HIV positive.<br>PEPFAR OVC programs should support caregivers of children to disclose the HIV status of child/adolescent participants to the program. When appropriate, (i.e., the child or adolescent has never been tested or their circumstances are such that a risk assessment is warranted), the program should conduct an assessment of HIV risk. This assessment will determine which participants the program should refer to HIV testing and which are deemed “test not required.”<br>When the implementing partner determines that the participant is at risk of HIV infection, the program should refer him/her for HIV testing and counselling services. After the implementing partner refers “at risk” participants for testing, the partner should follow up to make sure that the test was conducted and to support the caregiver to disclose the results of the test.<br>This indicator measures whether participants who are referred for testing are being tested and reporting the results of the test to the PEPFAR OVC implementing partner. This indicator tracks the number of participants <18 years (active or graduated) served by an OVC comprehensive program who reported an HIV test result to the implementing partner during the reporting period, regardless of when the participant was assessed for risk or referred for testing. This means that a participant could have been referred for testing during a previous reporting period but disclosed the test result to the implementing partner during the current reporting period. All participants should be counted only once, regardless of the number of times they were tested and self-reported during a reporting period.<br>As a result, this indicator is not necessarily a subset of OVC_TST_REFER because it is possible that participants who were referred during a previous reporting period report their status during the current reporting period.<br>The reporting periods are defined as follows for this indicator:<br>SAPR: count the most recent HIV test result reported to the implementing partner per participant from Q1 and Q2<br>APR: count the most recent HIV test result reported to the implementing partner per participant from Q1, Q2, Q3, and Q4 |
| **How to collect:** | Data sources for this indicator include client records or other confidential CM and program monitoring tools that track HIV risk assessments and assessment results and referrals.<br>Results of HIV tests are self-reported by the participant to the PEPFAR OVC implementing partner. This self-reported information should be tracked by the program. The aim is for 100 percent of participants who are referred for testing, receive a test result, and self-report that result to the implementing 23 partner. |

<table>
<tr><td></td><td>Programs showing less than 100 percent should explore the reasons why testing is not occurring and/or the results are not being reported to the implementing partner.</td></tr>
<tr><td>How to review for data quality:</td><td>Through routine data quality audits or assessments conducted by the program or externally.<br>OVC_TST_RESULT < (OVC_SERV < 18 years served by an OVC comprehensive program)<br>OVC_TST_RESULT <= (OVC_HIVSTAT disaggregates of Positive, Negative, or Test Not Required)</td></tr>
<tr><td>How to calculate annual totals:</td><td>Annual totals include children and adolescents <18 years who reported their HIV test result to the implementing partner in the previous four quarters (Q1, Q2, Q3, and Q4).</td></tr>
<tr><td>Disaggregations:</td><td>
<table>
<tr><th colspan="2">Numerator disaggregations</th></tr>
<tr><th>Disaggregate groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
<tr><th colspan="2">Denominator disaggregations</th></tr>
<tr><th>Disaggregate groups</th><th>Disaggregates</th></tr>
<tr><td>N/A</td><td>N/A</td></tr>
</table>
</td></tr>
</table>

# OVC_VL_ELIGIBLE (<18) *

**Source: USAID PEPFAR Central Custom Indicators Guidance (Version 1: January 15, 2021)**

| | |
|---|---|
| **Description:** | Percentage of HIV-positive OVC (required) and caregivers (optional) on ART, active or graduated, who are served by an OVC comprehensive program, who are eligible for viral load testing. (Eligible means consistently on ART for a minimum of three months or whatever the standard established in the country.) |
| **Numerator:** | Number of HIV-positive children and caregivers on ART (active or graduated) who are served by an OVC comprehensive program who are eligible to have a viral load test |
| **Denominator:** | Number of HIV-positive children and caregivers on ART (active or graduated) who are served by an OVC comprehensive program |
| **Reporting level:** | Facility & Community |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | CD4+ T-cell counts are used, together with the viral load test, to get a complete picture on how the immune system is fighting the virus. As HIV reproduces in the body, the viral load increases, HIV destroys the CD4+ T-cells, and lowers the number of T-cells present. Generally, the higher the HIV 14 viral load, the more CD4+ T-cells are being destroyed. The goals are to keep CD4+ T-cell count high and viral load low.2 OVC implementing partners should refer participants who are on ART and eligible for viral load testing. Eligibility for viral load testing should be based on in-country criteria and guidance. This indicator continues along the HIV continuum of care from OVC_HIVSTAT to ensure that HIV-positive participants are receiving appropriate treatment to reach viral suppression. Implementing partners should refer to definitions of "on ART" provided under OVC_HIVSTAT in the MER 2.4 guidance |
| **How to collect:** | Viral load testing is conducted by clinical providers, not directly by OVC programs. Viral load testing eligibility should be monitored primarily by clinical partners; however, OVC implementing partners should confirm participant reported viral load test eligibility with facility-based partners. This requires a data sharing agreement that should be articulated in a MOU (or equivalent) between the facility partner and OVC partner. Data sources for this indicator include client records or other confidential CM and program monitoring tools that track those in treatment and care. All participants should be counted only once. OVC_VL_ELIGIBLE is applicable to all HIV-positive OVC_SERV participants (active or graduated) who are served by an OVC comprehensive program, who are on ART. |
| **How to review for data quality:** | Disaggregates should add up to 100% of the numerator. |
| **How to calculate annual totals:** | Calculate by counting all OVC_SERV who are on ART, then calculate the number of those who are eligible for viral load testing. |

**Disaggregations:**

**Numerator disaggregations**

| Disaggregate groups | Disaggregates |
|---|---|
| **Age/ Sex [Required]** | By <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M |
| **Age/ Sex [Optional]** | 18+ F/M caregivers |

**Denominator disaggregations**

| Disaggregate groups | Disaggregates |
|---|---|
| **N/A** | N/A |

# OVC_VLR (<18) *

**Source: USAID PEPFAR Central Custom Indicators Guidance (Version 1: January 15, 2021)**

| | |
|---|---|
| **Description:** | Percentage of HIV-positive OVC (required) and caregivers (suggested) on ART, active or graduated, who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months |
| **Numerator:** | Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months |
| **Denominator:** | Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program who were eligible to have a viral load test in the previous 12 months |
| **Reporting level:** | Facility & Community |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | CD4+ T-cell counts are used, together with the viral load test, to get a complete picture on how the immune system is fighting the virus. As HIV reproduces in the body, the viral load increases, HIV destroys the CD4+ T-cells, and lowers the number of T-cells present. Generally, the higher the HIV viral load, the more CD4+ T-cells are being destroyed. The goals are to keep CD4+ T-cell count high and viral load low.3 OVC implementing partners should monitor participants' eligibility, the frequency of viral load testing, and refer participants who are eligible for viral load testing but have not had the test, as needed. When the implementing partner does not know the last viral load test status, the program should discuss and provide any relevant counselling support with the participant/caregiver. This indicator continues along the HIV continuum of care from OVC_HIVSTAT to ensure that HIV-positive participants are receiving appropriate treatment to reach viral suppression. Implementing partners should refer to definitions of "on ART" provided under OVC_HIVSTAT in the MER 2.4 guidance. |
| **How to collect:** | Viral load testing is conducted by clinical providers, not directly by OVC programs. Viral load testing should be monitored primarily by clinical partners; however, OVC implementing partners should confirm participant reported viral load test results with facility-based partners. This requires a data sharing agreement that should be articulated in a MOU (or equivalent) between the facility partner and OVC partner. Data sources for this indicator include client records or other confidential CM and program monitoring tools that track those in treatment and care. In the absence of an MOU, OVC partners can collect self-reported viral load test results from participants. This should be a temporary method of reporting on this indicator, while MOUs are being established. Viral load results that are self-reported should be counted as "self-report" under the disaggregates provided. All participants should be counted only once, regardless of the number of times they were tested and reported during a reporting period. OVC_VLR is applicable to all OVC_SERV who are served by an OVC comprehensive program. |
| **How to review for data quality:** | Disaggregates should add up to 100% of the numerator. |
| **How to calculate annual totals:** | Calculate by counting all OVC_SERV who are on ART, then calculate the number who are eligible for a viral load test, then calculate the number who have a documented viral load test result in the last 12 months. |
| **Disaggregations:** | **Numerator disaggregations** |
| | **Disaggregate groups** / **Disaggregates** |

| | | |
|---|---|---|
| | **Confirmed with facility (as applicable), by age and sex** | ● Confirmed <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M youth<br>● Confirmed 18+ F/M caregivers (optional) |
| | **Self-reported (as applicable), by age and sex** | ● Self-reported <1 F/M, 5-6 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M youth<br>● Self-reported 18+ F/M caregivers (optional) |
| | **Denominator disaggregations** | |
| | **Disaggregate groups** | **Disaggregates** |
| | **N/A** | N/A |

# OVC_VLS (<18) *

**Source: USAID PEPFAR Central Custom Indicators Guidance (Version1: January 15, 2021)**

| | |
|---|---|
| **Description:** | Percentage of HIV-positive OVC (required) and caregivers (optional) on ART, active or graduated, who are served by an OVC comprehensive program who are virally suppressed (<50 copies/ml) (*modified per South African guidelines*). |
| **Numerator:** | Number of HIV-positive OVC (required) and caregivers (optional) on ART (active or graduated) who are served by an OVC comprehensive program and whose most recent viral load test result in the last 12 months was virally suppressed (<50 copies/ml). |
| **Denominator:** | Number of HIV-positive OVC and caregivers on ART (active or graduated) who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months (OVC_VLR numerator) |
| **Reporting level:** | Facility & Community |
| **Reporting frequency:** | Semi-annual |
| **How to use:** | If taken as prescribed, ART reduces the amount of HIV in the body— otherwise known as the viral load, to a very low level. This keeps the body's immune system working and prevents illness. Suppressing the viral load to this point is called viral suppression and is measured as having <50 copies/ml (*modified per South African guidelines*). OVC implementing partners should monitor participants' viral suppression and refer participants who are due for a viral load test or showing signs of worsening illness. When the implementing partner does not know the last viral load test status, the program should discuss and provide any relevant counselling support with the participant/caregiver. This indicator continues along the HIV continuum of care from OVC_HIVSTAT to ensure that HIV-positive participants are receiving appropriate treatment to reach viral suppression. Implementing partners should refer to definitions of "on ART" provided under OVC_HIVSTAT in the MER 2.4 guidance. |
| **How to collect:** | Viral load testing is conducted by clinical providers, not directly by OVC programs. Viral load suppression should be monitored primarily by clinical partners; however, OVC implementing partners should confirm participant reported viral load test results with facility-based partners. This requires a data sharing agreement that should be articulated in a MOU (or equivalent) between the facility partner and OVC partner. Data sources for this indicator include client records or other confidential CM and program monitoring tools that track those in treatment and care. In the absence of an MOU, OVC partners can collect self-reported viral suppression from participants. This should be a temporary method of reporting on this indicator, while MOUs are being established. Viral suppression instances that are self-reported should be counted as "self-report" under the disaggregates provided. OVC_VLR is applicable to all OVC_SERV who are served by an OVC comprehensive program. |
| **How to review for data quality:** | Disaggregates should add up to 100% of the numerator. |
| **How to calculate annual totals:** | Calculate by counting all OVC_SERV who are on ART, then calculate the number with a known documented viral load test result in the last 12 months, then calculate the number who are virally suppressed. |
| **Disaggregations:** | **Numerator disaggregations** |

| Disaggregate groups | Disaggregates |
|---|---|

| | | |
|---|---|---|
| | **Confirmed with facility (as applicable), by age and sex** | ● Confirmed <1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M youth<br>● Confirmed 18+ F/M caregivers (optional) |
| | **Self-reported (as applicable), by age and sex** | ● Self-reported <1 F/M, 5-6 F/M, 10-14 F/M, 15-17 F/M, 18-20 F/M youth<br>● Self-reported 18+ F/M caregivers (optional) |
| | **Denominator disaggregations** | |
| | **Disaggregate groups** | **Disaggregates** |
| | **N/A** | N/A |

## APPENDIX 4. MONTHLY ACTIVITY SERVICES BY PROGRAM MODEL

| | OVC Comprehensive | OVC Preventive | OVC DREAMS FS | DSD Only |
|---|---|---|---|---|
| **Structured Interventions** | – Abangane Grief Support<br>– Boys Championing Change<br>– ChommY<br>– Families Matter!<br>– Kemoja<br>– Kidz Alive<br>– Let's Talk<br>– Let's Talk Teens<br>– Men Champion Change<br>– PFLH/Sinovuyo<br>– Residential Therapy<br>– Therapeutic Counselling/TF-CBT<br>– Vhutshilo 3<br>– YOLO | – ChommY<br>– No Means No<br>– SKILLZ | – Let's Talk<br>– PFLH/Sinovuyo | – DSD - Traditional Leader Programme<br>– DSD - Life skills |
| **Other services (completed referral or direct service)** | – Adherence support groups (facility or mobile based)<br>– ART adherence assessment & counselling/treatment literacy<br>– ART initiation<br>– Birth Certificate/Birth Registration<br>– CD4 Count/Viral Load Testing and/or case conferencing<br>– Care & Dependency Grant<br>– Child Support Grant<br>– Childhood illness & immunisation services (<5 years)<br>– Nutrition/food referrals, including clinical nutritional support<br>– Condoms<br>– Designated Child Protection organisations<br>– Disability Grant<br>– Drug or alcohol abuse counselling/treatment services<br>– Early childhood household interventions (<7 years)<br>– Early Infant Diagnosis (EID) services<br>– Economic (savings group, microfinance, income generation) | | – Condoms | – DSD - Attend drop-in centre<br>– DSD - Cooked meals<br>– DSD - Food parcels<br>– DSD - Health hygiene water and sanitation messaging<br>– DSD - Home Visits<br>– DSD - Homework Supervision<br>– DSD - Indigenous games<br>– DSD - Provision of clothes and material support<br>– DSD - Referral to shelter for victims of violence<br>– DSD - Referral to substance abuse prevention programme<br>– DSD - School holiday programmes<br>– DSD - Sports activity<br>– DSD - TB Defaulters traced |

| | OVC Comprehensive | OVC Preventive | OVC DREAMS FS | DSD Only |
|---|---|---|---|---|
| | – Emergency removal from abusive/unsafe environment<br>– Filed report of suspected abuse to relevant local authority<br>– Final high school exam study support/matric completion<br>– Foster Care Grant<br>– GBV-related medical, legal, or counselling referral<br>– HIV Counselling & Testing<br>– Individual support to access tertiary education<br>– Individual tutoring/homework assistance (weekly)<br>– Linkages to vocational training/opportunities<br>– Monitor/support developmental milestones in infants and young children living with HIV<br>– Monitoring & support to complete HIV testing services for HIV exposed infants/toddlers (<2 years)<br>– Motivational Counselling (Risiha Enablers)<br>– Placement for child without family care (Foster Care)<br>– Post exposure prophylaxis – 28-day completion<br>– Post-gender-based violence clinical care (minimum package)<br>– PREP adherence assessment & counselling support<br>– Prevention of Mother to Child Transmission (PMTCT)<br>– Primary or secondary school enrolment or re-enrolment<br>– Professional mental health care services<br>– Provide ARVs<br>– Provide Dignity Packs/Hygiene Support<br>– S.A. ID<br>– School visit to monitor attendance and progression<br>– Sexual Reproductive Health Services - STI screening, diagnosis & treatment<br>– Sexual Reproductive Health Services - Family Planning<br>– Sexual Reproductive Health Services - Initiated on PrEP<br>– Social Relief of Distress Grant<br>– Support for family-centred disclosure of HIV status<br>– TB diagnosis & treatment services<br>– TB screening<br>– TB treatment adherence support | | | |

| | OVC Comprehensive | OVC Preventive | OVC DREAMS FS | DSD Only |
|---|---|---|---|---|
| | – Thuthuzela Care Centre Referrals<br>– Voluntary Male Medical Circumcision (VMMC)<br>– Youth Development Agency (YDA) – entrepreneurial training & support | | | |

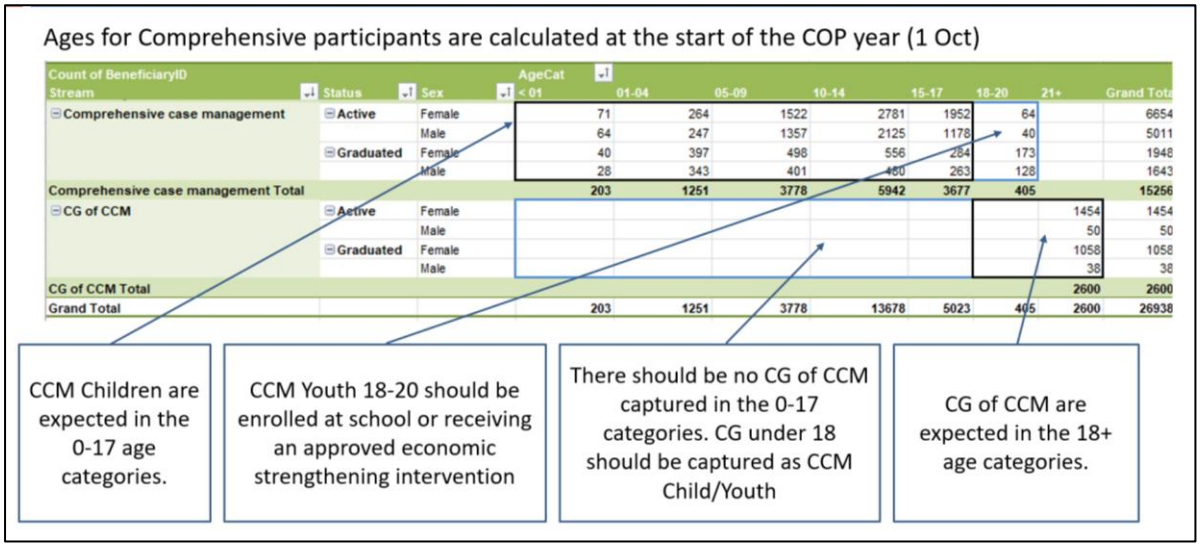
# APPENDIX 5. FAQS: OVC_SERV IN CBIMS

## QUESTION. HOW IS AGE CALCULATED IN CBIMS REPORTS?

**Answer**: Age calculations vary by program model per below guidance

OVC Comprehensive

- For OVC Comprehensive, age is calculated as at the start of the COP year (1 October).
- OVC Comprehensive Children are expected in the 0-17 age categories.
- OVC Comprehensive Youth 18-20 should be enrolled in secondary school or living with HIV. Receiving an approved economic strengthening intervention is no longer sufficient to remain enrolled after turning 18. Note that CBIMS will verify school and HIV status based on the participant record and only include eligible youth in report results.
- There should be no caregivers of OVC Comprehensive (CG of CCM) captured in the 0-17 categories. CG under 18 should be captured as OVC Comprehensive Child/Youth.
- Caregivers in the OVC comprehensive program are expected in the 18+ age categories

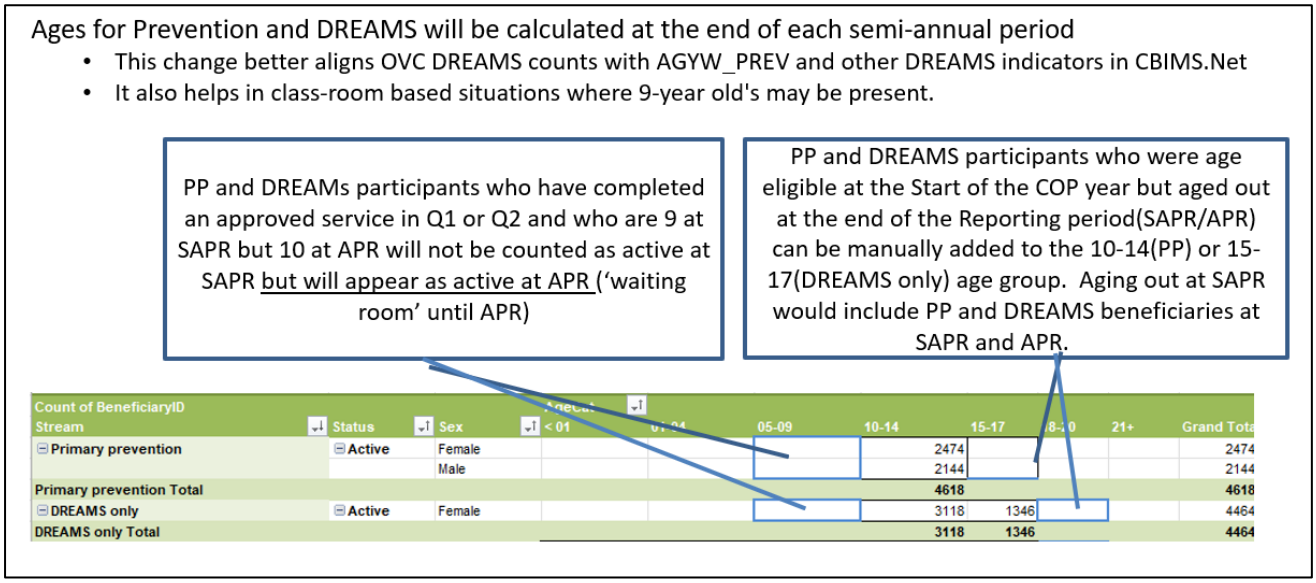



| Count of BeneficiaryID | | | AgeCat | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Stream | Status | Sex | < 01 | 01-04 | 05-09 | 10-14 | 15-17 | 18-20 | 21+ | Grand Tot |
| Comprehensive case management | Active | Female | 71 | 264 | 1522 | 2781 | 1952 | 64 | | 6654 |
| | | Male | 64 | 247 | 1357 | 2125 | 1178 | 40 | | 5011 |
| | Graduated | Female | 40 | 397 | 498 | 556 | 284 | 173 | | 1948 |
| | | Male | 28 | 343 | 401 | 460 | 263 | 128 | | 1643 |
| Comprehensive case management Total | | | 203 | 1251 | 3778 | 5942 | 3677 | 405 | | 15256 |
| CG of CCM | Active | Female | | | | | | | 1454 | 1454 |
| | | Male | | | | | | | 50 | 50 |
| | Graduated | Female | | | | | | | 1058 | 1058 |
| | | Male | | | | | | | 38 | 38 |
| CG of CCM Total | | | | | | | | | 2600 | 2600 |
| Grand Total | | | 203 | 1251 | 3778 | 13678 | 5023 | 405 | 2600 | 26938 |

OVC Preventive and OVC DREAMS Family Strengthening

- For OVC Preventive and OVC DREAMS Family Strengthening, age is calculated as at the end of the report period (i.e., 31 March for Q1 and Q2 and 30 September for Q3 and Q4). This is to align with PEPFAR MER age calculations for AGYW_PREV.
- OVC Preventive and OVC DREAMS Family Strengthening participants who have completed an approved service in Q1 or Q2 and who are 9 at SAPR but 10 at APR, are not counted as active at SAPR. However, they are counted as active at APR.
- OVC DREAMS Family Strengthening participants who were 17 at the beginning of the COP year but turned 18 before the end of the reporting period will appear in the 18-20 age category of the OVC_SERV Report and can be manually added to the 15-17 (DREAMS) age group in DATIM.
- OVC Preventive participants who were 14 at the beginning of the COP year but turned 15 before the end of the reporting period will appear in the 15-17 age category of the OVC_SERV Report and can be manually added to the 10-14 (OVC Preventive) age group in DATIM.

- CBIMS Desktop does not track the age when the service was given. It is assumed that partners will do their best to ensure that the participant is age-eligible at the time-of-service receipt.




## QUESTION. HOW ARE DIVERSE GENDER IDENTITIES CAPTURED IN CBIMS?

In CBIMS and DATIM, the "Sex" data field refers to whether someone is categorized as male or female. However, some participants may have a gender identity that is different from the sex they were assigned at birth. Here are definitions of key terms to guide data capture:

- Sex: Refers to the biological characteristics a person is born with, typically categorized as male or female. This is what is often listed on legal documents like birth certificates and national IDs.
- Gender: Refers to a person's internal sense of their identity, which may be male, female, or something else. Gender identity is how someone sees themselves and may not match the sex they were assigned at birth.
- Transgender: A person whose gender identity is different from the sex they were assigned at birth. For example, a transgender female is someone who was assigned male at birth but identifies and lives as female.

Currently, CBIMS does not have a category to record diverse gender identities, such as trans male or trans female. However, this should not prevent service delivery. Data collection and capture should never be a barrier to services. Personnel should record the sex of transgender participants based on their preferred gender identity:

- Transgender girls/women should be categorized under "female".
- Transgender boys/men should be categorized under "male".

Because the "sex" data field in CBIMS is auto-filled based on the SA ID number, it may not match the participant's preferred gender identity. You will need to manually update the "sex" field to reflect their preferred gender identity.

When intentionally capturing a transgender person, you can ignore the error message that appears when you change the sex field, as you can still save the record with the corrected information. Please Do Not ignore this error message otherwise.


## QUESTION: WHAT ARE PROXY SERVICES AND HOW DO THEY COUNT TOWARDS OVC_SERV?

**Answer**: Proxy services are services that when captured against caregivers also count towards the child because the services provide direct benefit to the child.[30]

The following services when captured against caregivers also count towards the child, and CBIMS will link relevant information from the Caregiver Monthly Activity Form to the record for each associated child or youth when generating the PEPFAR report:

- Early childhood household interventions
- Let's Talk
- Families Matter!
- Sinovuyo/PLH
- Foster Care Grant
- Child Support and other grants
- Emergency removal from abusive/unsafe environment
- Household economic strengthening (savings group, microfinance, income generation)
- Linkages to vocational training/opportunities

Other services are usually captured against the child but are obviously directed towards the caregiver. If captured against the child, these services can count towards the caregiver and other children in the household as appropriate (note that early childhood household interventions cannot count towards children aged 7 or older):

- Early childhood household interventions (limited to children <7)
- Foster Care Grant & Child Support and other grants

[30] See MER 2.8, Appendix D, pg. 205 for illustrative examples of services that count towards the child and caregiver when received by the caregiver.