SIMS

FY21

Site Improvement through Monitoring System (SIMS)

Implementation Guide

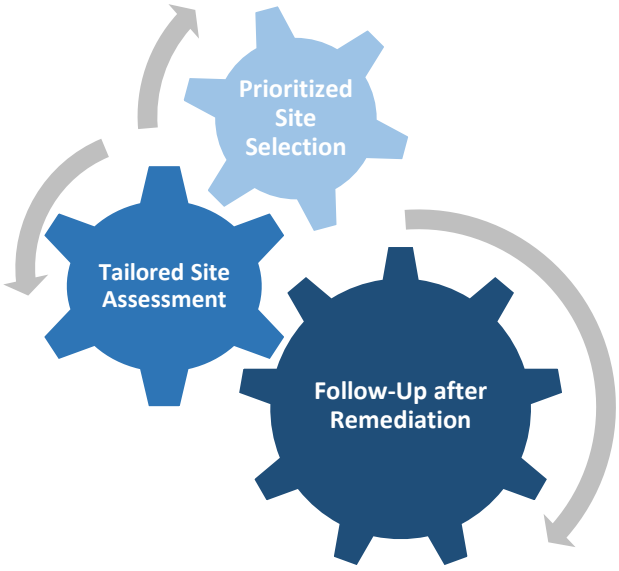
Version 4.1

15 August 2020

SIMS

Site Improvement through Monitoring System

SIMS is a quality assurance tool used to monitor and improve program quality at PEPFAR-supported sites that guide and support service and non-service delivery functions.



Goals of SIMS 4.0

- ✓ Integrate SIMS into broader framework(s) for analysis, management and improvement
- ✓ Tailored, nimble, responsive site selection and implementation based on performance, program needs, and programmatic gaps
- ✓ Actionable to drive improvement or sustain quality

2 Assessment Tools

Site Level Tool

Site assessments are conducted at both facility and community sites (i.e. places where services are provided). Examples include clinics, hospitals, laboratories, and 'standalone' structures.

Above-Site Level Tool

Above-site assessments are conducted at PEPFAR-supported institutions that are above the service delivery point (i.e. not where services are provided or beneficiaries are reached). Examples include health offices at the national or subnational level.

2 Types of Assessments

Comprehensive Assessment is the first assessment at a site or above site location. All relevant standards (Required and Elective CEEs) should be assessed.

Follow-Up Assessment determines whether all CEEs that scored red or yellow during a prior assessment have improved (i.e. red or yellow to green).

Core Essential Elements (CEEs)

Standard: CEEs are built on program quality standards based upon World Health Organization supported evidence or guidelines and/or documentation of best practices.

Assessment Questions: Each CEE is composed of a series of questions that progressively assess the site against the standard.

Final Score: The final score is red, yellow, green or N/A. CEE scores are designed to highlight whether a problem exists.

Organization of SIMS Site Assessment Tool

Set #	Set Name
SET 1A	General
SET 1B	Commodities Management
SET 1C	Data Quality
SET 2A	Care And Treatment-General Population
SET 2B	Care And Treatment For HIV Infected Children
SET 3A	Key Populations-General
SET 3B	Care And Treatment – Key Populations
SET 4A	Preventing Mother to Child Transmission, Antenatal Care, Postnatal, and Labor and Delivery
SET 4B	HIV Exposed Infants
SET 5	Voluntary Medical Male Circumcision
SET 6	Adolescent Girls and Young Women and Gender-based Violence
SET 7	HIV Testing Services
SET 8	Tuberculosis Treatment Service Point
SET 9	Methadone or Buprenorphine Medication Assisted Treatment
SET 10A	Laboratory
SET 10B	Blood Safety

Organization of SIMS Above-Site Assessment Tool

Set #	Set Name
SET 1	HIV Planning, Coordination and Management
SET 2	Orphans and Vulnerable Children/Social Services
SET 3	Guidelines and Policies
SET 4	Private Sector Engagement and Advocacy
SET 5	Human Resources for Health
SET 6	Commodities
SET 7	Quality Management
SET 8	Laboratory and Blood Transfusion Support
SET 9	Strategic Information, Surveys, Surveillance and Evaluation
SET 10	Protecting Life in Global Health Assistance

Description of Final CEE Scores

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

SIMS *Site Improvement through Monitoring System*

Programmatic Clusters of SIMS Core Essential Elements Sets

General

Set 1A: All Sites- General
Set 1B: All Sites- Commodities Management
Set 1C: All Site- Data Quality
AS Set 1: HIV Planning, Coordination and Management
AS Set 3: Guidelines and Policies
AS Set 4: Private Sector Engagement and Advocacy
AS Set 7: Quality Management
AS Set 9: Strategic Information, Surveys, Surveillance and Evaluation
AS Set 10: Protecting Life in Global Health Assistance

Resources

Set 1B: All Sites- Commodities Management
AS Set 5: Human Resources for Health
AS Set 6: Commodities

Prevention and Testing

Set 1B: All Sites- Commodities Management
Set 4A: Preventing Mother to Child Transmission (PMTCT), Antenatal Care (ANC), Postnatal and Labor and Delivery
Set 4B: HIV Exposed Infants
Set 5: Voluntary Medical Male Circumcision
Set 6: Adolescent Girls and Young Women and GBV
Set 7: HIV Testing Services
Set 10A: Laboratory
AS Set 2: Orphans and Vulnerable Children/Social Services

Care and Treatment

Set 1B: All Sites- Commodities Management
Set 2A: Care and Treatment – General Population
Set 2B: Care and Treatment for HIV Infected Children
Set 3B: Care and Treatment – Key Populations
Set 4A: Preventing Mother to Child Transmission (PMTCT), Antenatal Care (ANC), Postnatal and Labor and Delivery
Set 4B: HIV Exposed Infants
Set 8: Tuberculosis Treatment Service Point
Set 10A: Laboratory
AS Set 2: Orphans and Vulnerable Children/Social Services

Laboratory Services

Set 10A: Laboratory
Set 10B: Blood Safety
AS Set 8: Laboratory and Blood Transfusion Support

Key Populations

Set 3A: Key Populations- General
Set 3B: Care and Treatment – Key Populations
Set 9: Methadone or Buprenorphrine Medication Assisted Treatment

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

AS *indicates that the Set is part of the Above-Site Tool, if not indicated then the Set is part of the Site Tool*
Underline indicates that the Set falls within more than one of the clusters

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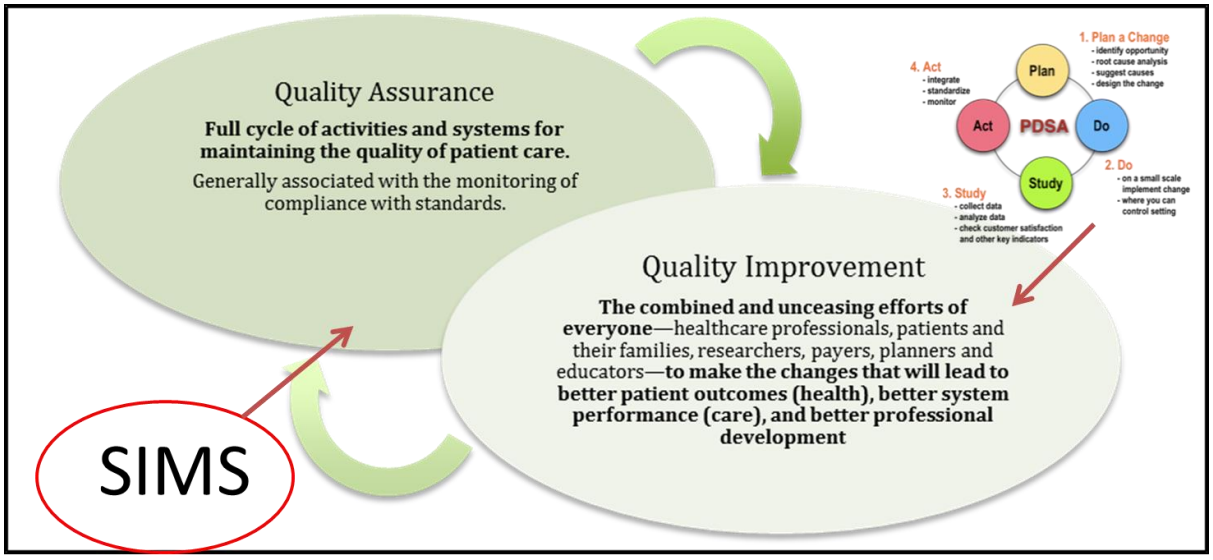
1.0 INTRODUCTION

1.1 PURPOSE AND STRUCTURE OF SIMS

In June 2014, Ambassador Deborah L. Birx, MD, the U.S. Global AIDS Coordinator, announced the launch of the Site Improvement through Monitoring System (SIMS) as a new initiative to respond to PEPFAR priorities of transparency, accountability, and maximizing impact on the HIV epidemic. At its core, SIMS is a quality assurance methodology used to increase the impact of PEPFAR programs on the HIV epidemic through standardized monitoring of the quality of services at the site- and above-site levels. SIMS is a PEPFAR-wide requirement for all Operating Units (OUs).

SIMS is grounded in quality standards against which performance can be assessed, and areas for improvement can be identified (Figure 1). Importantly, Quality Improvement (QI) and Quality Assurance (QA) are distinct but intersecting components; QI and QA are not mutually exclusive terms, and neither can be successful without the other (Figure 1). As such, SIMS should be action-oriented and used to drive change and improvement.

Figure 1. SIMS within the Context of Quality Assurance and Quality Improvement

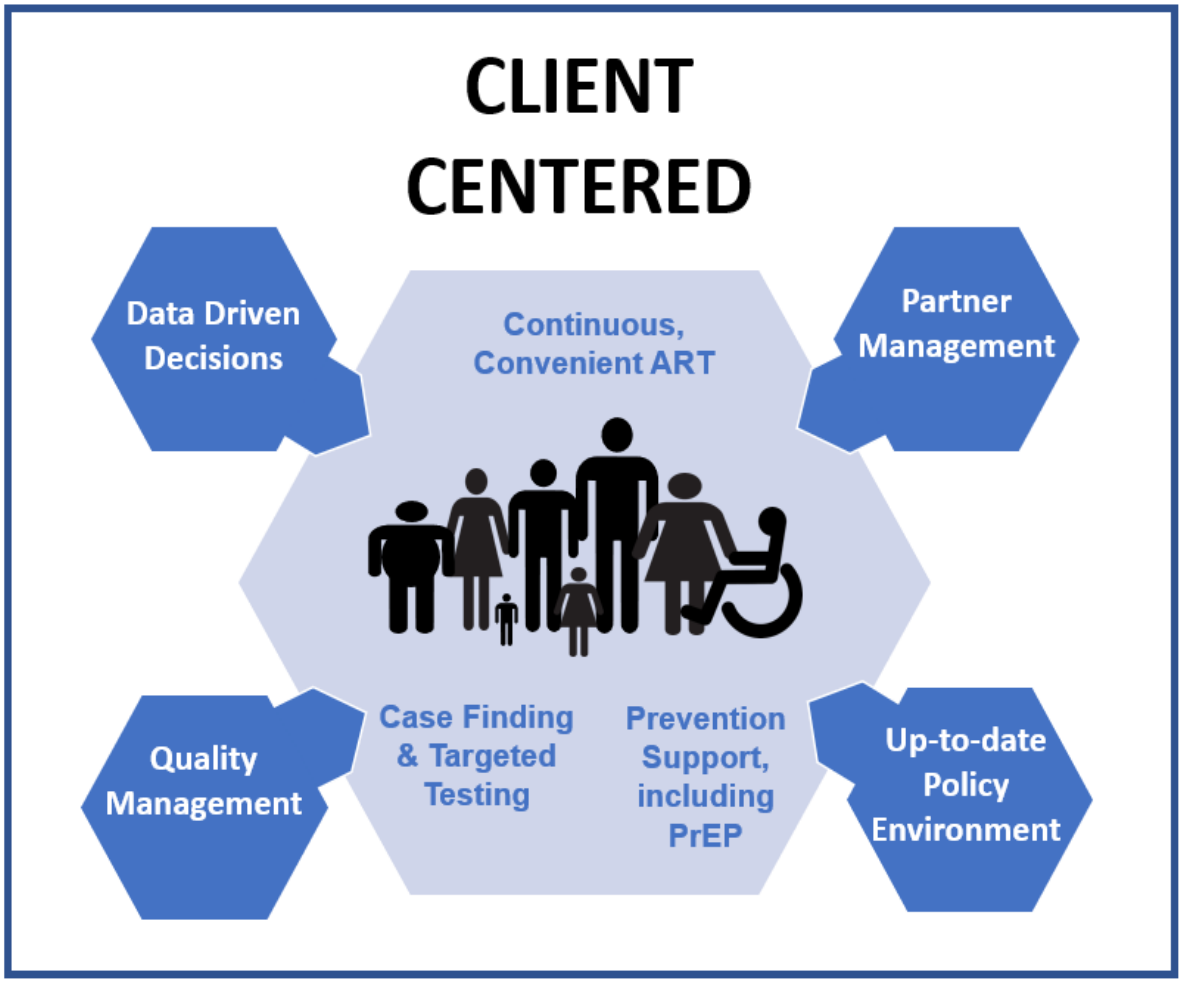


The purpose of SIMS is to provide a standardized approach to, and set of tools for, monitoring program quality at PEPFAR-supported sites that guide and support service- and non-service delivery functions. SIMS assessment results are used to strengthen alignment with global and national standards and facilitate program improvement and performance as an integrated component of overall quality-management and/or -improvement strategies.

1.2 HIV EPIDEMIC CONTROL AND QUALITY

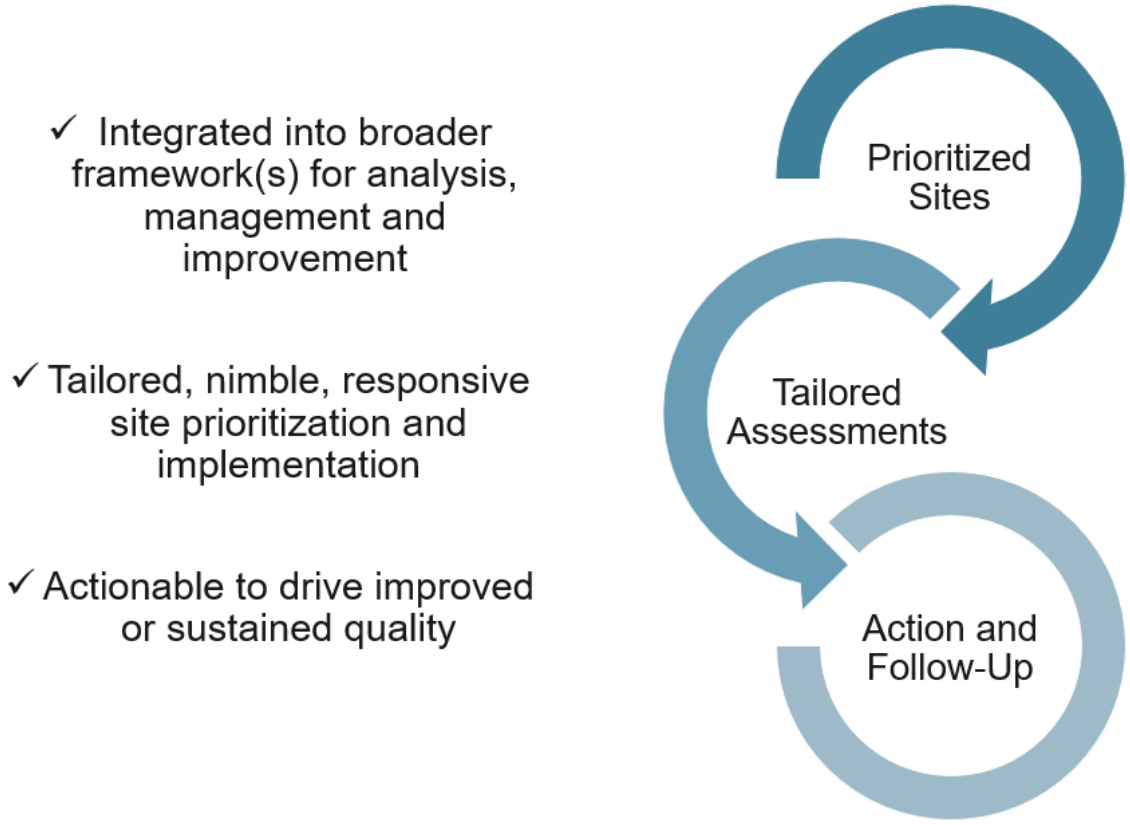
As HIV programs strive to reach and sustain HIV epidemic control, the quality of person-centered programs and services at the site and above site level is critical (Figure 2). This emphasis on improving outcomes and increasing impact, while keeping the person at the center, is reflected in PEPFAR updates to the Monitoring Evaluation and Reporting indicators (MER), inclusion of beneficiaries of services in Expenditure Reporting (ER), focus on minimum program requirements as articulated in the COP20 Guidance.

Figure 2. Importance of Quality in PEPFAR's client-centered approach



To improve implementation fidelity, quality, and scale of HIV programs, and both improve and sustain performance at the site- and above- site levels, SIMS technical content, planning and implementation was updated starting in FY19 Q2 to make it streamlined, utilitarian, integrated into core PEPFAR processes and actionable (Figure 3).

Figure 3: Goals of SIMS



1.3 WHAT'S NEW IN FY21 SIMS 4.1?

There are limited updates from SIMS 4.0 to SIMS 4.1. These updates are:

- **Typos, mislabeling, and some scoring logic errors were corrected** for several CEEs. These changes did not alter the definition or rationale for scoring for any SIMS Core Essential Elements (CEEs) or Standards. That is, all SIMS 4.0 CEEs apply even in SIMS 4.1.
- **Five new Elective CEEs were introduced**. Four are at the Site level while one CEE is at the Above Site level. These CEEs are part of PEPFAR's Guidance on Implementing Safe and Ethical Index testing. Moreover, these CEEs should be used for on-going monitoring of minimum standards related to Safe and Ethical Index testing, along with several existing SIMS 4.0 CEEs. These CEEs are:
    - Index Testing in HTS National Guidelines
    - Index Testing Training and Supportive Supervision
    - Monitoring Adverse Events from Index Testing
    - Secure Handling and Storage of Index Testing Data
    - Intimate Partner Violence Risk Assessment and
- **Due to the COVID-19 pandemic, virtual assessments under certain conditions and parameters will be permitted**. See Section 5.1 for details on requirements.

1.3 SIMS SUPPORTING MATERIALS

The SIMS Assessment Implementation Guide (this document) provides instructions for United States Government (USG) staff on the operationalization and implementation of SIMS in PEPFAR-supported OUs. Use of this guide should promote best practices and ensure alignment of SIMS operating procedures with applicable national and institutional policies and guidelines. Other SIMS supporting materials include the SIMS Assessment Tools. All documents will be maintained by the Office of the U.S Global AIDS Coordinator and Health Diplomacy (S/GAC), in coordination with HQ Implementing Agencies. The most recent approved version is posted on DATIM Support under Guidance.

2.0 SIMS REQUIREMENTS

All OUs must meet SIMS requirements. This section includes expectations for (1) prioritization of SIMS Assessments site and above-site, (2) conducting SIMS assessments and (3) integrated data analysis to improve or sustain performance and quality.

2.1 PRIORITIZATION OF SIMS ASSESSMENTS

Requirements for selecting or prioritizing sites and above site locations for SIMS assessments were updated to allow for the following:

- **Use of performance** data (site, SNU or IP-level), program **needs** and program **gaps** as key drivers of site and above-site prioritization for SIMS.
- **Flexibility** in weighting of criteria to use in SIMS site and above site prioritization given differing country contexts. These criteria may include site/PSNU or IP level performance data ('under-performing' or 'high performing' sites as defined by the OU), new partner(s) supporting a given site, incorporation of new sites into the PEPFAR portfolio, scaling an existing activity at a given site, or starting a new activity at a site.
- **Timely response** to any new bottlenecks or performance challenges that may have arisen. As such, SIMS Prioritization lists can be **revisited** quarterly to facilitate timely USG response.

Note: See Section 2.2 SIMS Assessments at Site and Above-site Levels for definitions of site and above-site.

To aide in the prioritization process, OUs should review and characterize their PEPFAR-supported sites based on performance (site, SNU or IP), program needs and program gaps.

The following questions may help inform discussions and decision-making on which sites and above-site locations to prioritize based on performance, program needs and program gaps.

1. What are the main program priorities based on epidemiologic and program data (geographic and IP-level), program needs and program gaps?
2. Are there geographic areas of focus based on epidemiologic or program data?
3. Are any sites consistently 'underperforming' (as defined by the OU) across certain technical areas?
4. Are any sites consistently 'performing well' (as defined by the OU) across certain technical areas? Does the team need to assess the fidelity of interventions at these sites?
5. Are there sites where new and/or priority activities are being scaled up?

6. Are there sites supported by a new partner (indigenous or otherwise)?
7. Do you have an appropriate (as defined by the OU) mix of facility and community sites?
8. What is the capacity of USG staff to support SIMS assessments, including completion of remediation activities to improve performance?
9. Were SIMS assessments conducted recently at sites on the 'shortlist' for SIMS assessments? What were the SIMS scores and question-level results at those sites?
10. What other evidence can be leveraged to help understand site level performance, needs and gaps? This could include MER data (quarterly or, in some cases, collected monthly), MOH data, ER, epidemiologic studies, surveys, evaluations etc.
11. For above-site, are there priority above site considerations that may be directly or indirectly affecting service delivery at certain sites (for example, supply chain considerations, adoption of key policies)?
12. For Above-site, are there any Table 6 (or above-site investments) benchmarks that could benefit from a SIMS assessment?

2.1.2 REQUIREMENTS FOR SUBMISSION OF SIMS PRIORITIZATION LISTS

OUs must submit a single completed SIMS Site and Above Site Prioritization list for each fiscal year to SGAC_SIMS@state.gov by October 1,2020. Importantly, this is just a planning tool and can be modified quarterly. The SIMS Site and Above Site Prioritization list template is posted on the SIMS page on the PEPFAR SharePoint site. Please note:

- OUs must include provide a justification/rationale for sites and above site locations included in the completed SIMS Prioritization list.
- For FY21, the SIMS Prioritization list will cover FY 21 Q1 – Q4.
- Military sites should NOT be included in the OU's SIMS Prioritization list. Instead, a list of Department of Defense (DoD) military sites to be visited should be submitted to agency HQ.
- There is no preset minimum or maximum number of sites or above site locations to be assessed in each FY.
- SIMS Prioritization lists will be posted on the SIMS page on PEPFAR SharePoint to inform TA and/or cross-learning.

2.2 SIMS ASSESSMENTS AT SITE AND ABOVE-SITE LEVELS

To improve or maintain compliance with quality standards across areas of PEPFAR support, SIMS assessments are conducted at the site and above-site levels.

Note: definitions below are aligned with MER and ER where feasible and applicable

1. **Site Assessments** are conducted at both facility and community sites (i.e. places where services are provided). Definition of facility and community site aligns with MER and are taken from the DATIM Site list. Examples of facility sites include clinics, hospitals, laboratories, and other 'brick and mortar' structures where services are provided. Community sites include 'assessment points' that are providing services directly to the community. Site level programs include activities at the point of service delivery and may or may not involve direct interaction with a beneficiary, as per ER. Site level programs may support Direct Service Delivery (DSD) or Technical Assistance-Service Delivery Improvement (TA-SDI) as per MER.

2. **Above-Site Assessments** are conducted at PEPFAR-supported institutions that are above the service delivery point (i.e. not a facility or community site where services are provided, or beneficiaries are reached). A PEPFAR-supported institution can either be PEPFAR-funded or a recipient of PEPFAR-funded technical assistance, and the SIMS assessment can occur at either the Subnational or National level. In either case, above-site programs often execute health system strengthening (HSS) activities and/or non-service delivery functions considered essential to the successful implementation of HIV programs. As per ER, above site programs are non-service delivery by definition (i.e. no interaction with a beneficiary) by virtue of their above-site location.

2.3 SIMS ASSESSMENT TYPES

To ensure SIMS is action-oriented and results in remediation and improvement, PEPFAR requires two types of SIMS assessments - comprehensive and follow-up:

1. **Comprehensive Assessment** is the first assessment conducted at a specific site or above site location for the implementing mechanism (IM) in each FY. All relevant standards (Required and Elective Core Essential Elements) should be assessed. [*Note: See Section 2.4.2 Required vs Elective CEEs for definitions of Required vs Elective Core Essential Elements (CEEs).]* **Only** USG staff may conduct Comprehensive assessments at both the site- and above-site levels.

2. **Follow-Up Assessment** is conducted to determine whether all CEEs that scored red or yellow during a prior assessment have improved (i.e. red or yellow to green). As such, only CEEs that scored red or yellow in a previous assessment are re-scored during a follow-up assessment. *[Note: See Section 2.4.1 Organization of SIMS Assessment Tools for explanation of color-based scoring.]* Follow-up assessments should be conducted within 6 months of the prior assessment. It is expected that remediation activities will have occurred in the intervening months to address the challenges and bottlenecks previously identified. OUs are responsible for determining whether the Implementing Partner (IP) or USG staff will conduct the follow-up assessment based upon a review of the findings from the prior visit. If the IP conducts the follow-up assessment, the IP should coordinate with the USG Activity Manager to review and agree on scores from reassessed CEEs. As a best practice, IPs should ensure that low scoring areas are also reviewed at other sites supported by the IP so that all sites benefit from lessons learned and implement best practices. USG staff are responsible for entering the results from the rescored CEEs for both USG and IP led follow-up assessments. Follow-up assessments are only conducted at the site-level.

By conducting both comprehensive and more tailored follow-up assessments, OUs are better able to determine the evolution of quality at PEPFAR-supported sites and above-site locations. This approach helps ensure that any quality standards, related to service delivery or non-service delivery, that are not met during an initial or comprehensive assessment are remediated before the subsequent or follow-up assessment.

Note: Above-Site assessments do not receive 6 month follow-up assessments. However, remediation activities should occur between annually scheduled visits. Issues identified during the comprehensive assessment for Above-Site should be reassessed as part of the comprehensive assessment in the next fiscal year.

2.4 SIMS ASSESSMENT TOOLS

SIMS assessments conducted at the site level should utilize the SIMS Site Assessment Tool, while above-site assessments should utilize the Above Site Assessment Tool. As mentioned above, both site and above-site locations included in the SIMS Prioritization List will receive a Comprehensive Assessment. While only sites (not above-site locations) will receive a Follow-up assessment, if any CEEs score Red or Yellow during the previous assessment.

2.4.1 ORGANIZATION OF SIMS ASSESSMENT TOOLS

SIMS Assessment Tools are divided into Sets. Each Set aligns with one or more- programmatic area(s), beneficiary type(s), or national/subnational level(s) (Tables 1 and 2 below). Each Set consists of Core Essential Elements (CEEs) that align with established standards of program quality for a given Set. Adherence or compliance with a CEE standard is measured through a series of questions that progressively assess the site or above-site location against that standard. Therefore, as an assessor advances through CEEs, they are provided with answers to whether or not that site or above-site location 'meets' the standard.

Table 1. Organization of SIMS Site Assessment Tool by Sets

Set #	Set Name
SET 1A	All Sites - General
SET 1B	All Sites - Commodities Management
SET 1C	All Sites – Data Quality
SET 2A	Care and Treatment-General Population (Non-Key Populations Facilities)
SET 2B	Care and Treatment for HIV Infected Children
SET 3A	Key Populations-General
SET 3B	Care and Treatment – Key Populations (KP)
SET 4A	Preventing Mother to Child Transmission (PMTCT), Antenatal Care (ANC), Postnatal, and Labor and Delivery
SET 4B	HIV Exposed Infants (HEI)
SET 5	Voluntary Medical Male Circumcision (VMMC)
SET 6	Adolescent Girls and Young Women (AGYW) and Gender-based Violence (GBV)
SET 7	HIV Testing Services (HTS)
SET 8	Tuberculosis (TB) Treatment Service Point
SET 9	Methadone or Buprenorphine Medication Assisted Treatment (MAT)
SET 10A	Laboratory
SET 10B	Blood Safety

Table 2. Organization of SIMS Above-Site Assessment Tool by Sets

Set #	Set Name
SET 1	HIV Planning, Coordination and Management
SET 2	Orphans and Vulnerable Children/Social Services
SET 3	Guidelines and Policies
SET 4	Private Sector Engagement and Advocacy
SET 5	Human Resources for Health
SET 6	Commodities
SET 7	Quality Management
SET 8	Laboratory and Blood Transfusion Support
SET 9	Strategic Information, Surveys, Surveillance and Evaluation
SET 10	Protecting Life in Global Health Assistance

As mentioned above, each Assessment Tool follows a similar format, and is composed of Sets of CEEs. The Sets have been color-coded to aid in grouping and assignment of CEEs to a given Set. CEEs are used to score the site or above-site location's achievement against an established standard using a three-colored scoring system. Information on the layout of CEEs, along with the scoring convention, are described below:

1. **CEE Title and Unique Identification (UID) Numbers:** The CEE Title provides an abbreviated description of the activity or service delivery function being assessed. Each CEE has a UID number.

   Note: As some CEEs are repeated within a tool to enable the CEE to be assessed in different program areas, locations, beneficiary groups, or levels, each CEE also has a coded identification number that is used to link results from the assessment tools to an electronic database.

2. **Standard:** SIMS CEEs are built on program quality standards based upon World Health Organization (WHO)--supported evidence or guidelines and/or by documentation of best practices (such as, technical publications).

   Note: Prior to any modification or adaption of any SIMS standards, requests should be submitted to SGAC_SIMS@state.gov to initiate discussion and resolution with implementing agency representatives.

3. **Instructions**: Some CEEs contain specific instructions within the CEE that provide additional guidance on completion and/or scoring of the CEE. In addition, to allow flexibility and tailoring of the tool to align with services provided at a specific site or above site location, some CEEs enable the user to 'opt out' of including the CEE in the assessment tool by selecting the "NA box" within the CEE. For example, if services related to a specific Required CEE are not offered at a site or above site location, the NA box should be selected.

4. **Comment:** During the SIMS assessment, the person completing the assessment (i.e. the SIMS assessor) may need to capture comments that provide additional information or context. These comments should be written on the Comment Worksheet (Appendix 2: Dashboards) and the Comment number captured in Comment box within the CEE in the Assessment Tool. Comments collected on paper should be reviewed and entered the electronic assessment tool after the assessment if not directly recorded at the time of the assessment visit (applicable to tablet-or laptop-based electronic data collection).

5. **Assessment Questions**: Each CEE is composed of a series of questions that are used to progressively assess the site against the standard. The flow of the question is designed to build upon the previous question, progressively reaching achievement of the standard. The assessment of a specific CEE is complete for that CEE once an answer yields a color or final score, therefore all questions within the CEE do not need to be asked during the assessment if a result has already been obtained in a previous question. Once a score has been reached, assessors should enter any comments in the comment box (as appropriate) and move to the next CEE to continue the assessment. Questions that require visual inspection of documents, charts/registers, or materials, or a verbal check have been designated as such the paper-based tools (Table 3).

Table 3. Explanation of Icons in the SIMS Assessment Tools

Icon	Description of Icon	Explanation

	Eyes	Question requires visual inspection of documents, charts/registers or materials
	Pink Square	Question requires Chart or register review
	Gray Circle	Question requires Materials review
	Blue Triangle	Question requires Document review

6. **Question Score:** The assessor will score the response to the first question in the CEE and either a color-coded score (red, yellow, green) will be assigned or the assessor will proceed to the next question within the CEE. The assessment process continues until a color coded score is reached. Note that the order in CEEs flows from red to yellow and finally green. Some questions rely on Yes/No answers to arrive at the question score whereas others may use a numerical value, percentage, number of ticked boxes, or answer number to derive the question score. In a subset of CEEs, more than one question may lead to a final score of red or yellow. Once a color coded score has been derived, no further questions within the CEE should be assessed.

   Note: Supplemental information and references are included within the body of some CEE questions as 'Notes' to provide additional guidance to assessors in determining the score for a question.

7. **Final Score:** The final score for the CEE is entered in the SCORE box located at the bottom of the CEE and the result documented in the SIMS assessment Dashboard. CEEs are designed to highlight whether a problem exists; the scoring system does not provide detailed information about the problem or why the problem is occurring. Assessors may use the Comment field to provide additional information that may inform remediation. Investigation into the cause and corrective actions should be part of the remediation process triggered by a red or yellow score.

   Note: Question scores actual question content will provide insight into why a given final score was entered. That is, responses to assessment questions should be used to inform remediation and improvement plans.

Table 4. Description of Final CEE Scores

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

2.4.2 REQUIRED VS ELECTIVE CEES

As mentioned in the Section 2.1, SIMS prioritization is based upon performance (site, SNU or IP), program needs and program gaps. Similarly, SIMS Assessments have also been aligned to these criteria. SIMS CEEs are grouped into those that are Required and those that are Elective (Figure 4 and Table 5).

Required CEEs are diagnostic in nature, aligned with minimal standards for sites or above site functions, and (in many cases) outcome-oriented. Required CEEs must be assessed at every Comprehensive assessment provided those services are offered or activities supported (i.e. assess if applicable).

Elective CEEs can be process, structural or outcome-oriented. Elective CEEs are assessed based upon site level performance, program needs and program gaps. That is, an OU should determine which CEEs from the Elective pool should be assessed based on their own understanding, data and evidence of performance challenges or successes, program needs and program gaps. Similar to the criteria for site prioritization provided in Section 2.1, criteria to consider in making these decisions may include: site/PSNU or IP level performance data ('under-performing' or 'high performing' sites as defined by the OU), new partner(s) supporting a given site, incorporation of new sites into the PEPFAR portfolio, scaling an existing activity at a given site, or starting a new activity at a site.

Figure 4. Features of SIMS Required vs. Elective CEEs

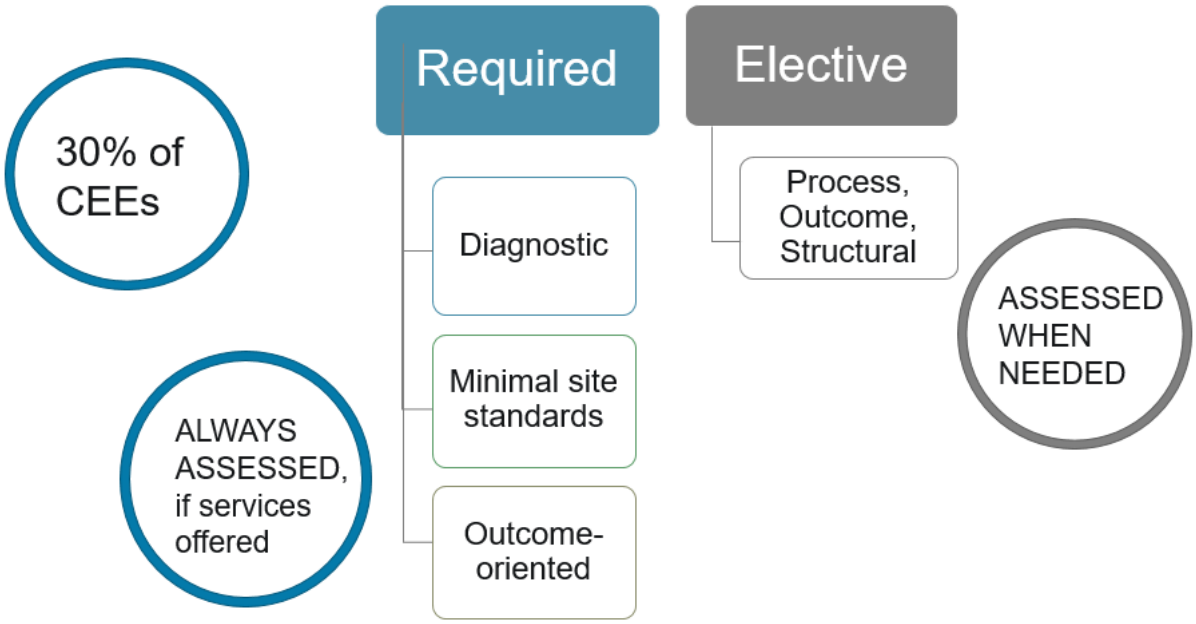


Table 5: Description of SIMS Assessment Types and Assessment Tool Composition

Assessment Tool	Assessment Type	Conducted by	CEEs to be Assessed
Site	Comprehensive	USG	All applicable* Required CEEs. All applicable* and relevant*** Elective CEEs
	Follow-Up	USG or IP**	All CEEs that previously scored red or yellow
Above Site	Comprehensive	USG	All applicable* Required CEEs. All applicable* relevant*** Elective CEEs

*Applicable means assessed if those services are provided or offered at the site or above-site location
**See Section 2.3 to determine whether USG or IP will conduct the follow-up assessment

***Relevant means assessed when needed, at the discretion of the OU but based on performance, program needs and program gaps

2.5 INTEGRATED ANALYSIS TO IMPROVE OR SUSTAIN PERFORMANCE AND QUALITY

Once the assessment is completed, the Assessment Team should review and summarize the key findings from the assessment with the Activity Manager for that IM. The assessment findings should highlight both areas for remediation and improvement (red and yellow scores) as well as summarizing areas where the site is meeting standards (green scores). To identify barriers and facilitators of performance and quality, the SIMS Team Lead or Activity Manager should work with the IP supporting that site to review and critically evaluate the following: the SIMS Dashboard, individual CEE findings down to the question-level, site level MER data, above site investments, community-led monitoring data, and IP workplans. Some questions and data sources to consider are:

- How were financial resources spent (on what, for whom)? – **Expenditure Reporting**
- Are any above site barriers affected site level progress and/or quality? Are you on track to reach above site benchmarks? - **Table 6**
- Any other policy barrier affecting site level progress and/or quality? – **Table 6, Above Site SIMS, other evidence**
- What are the barriers and enablers from the client perspective? – **community-led monitoring data**
- What support (DSD or TA-SDI) should the IP be providing? – **IP workplans**
- What other evidence could be useful to contextualize or frame performance? – **surveys, surveillance, MOH Data Alignment data**

2.6 CORRECTIVE ACTION PLANS

The Activity Manager should work with the IP to (1) develop a Corrective Action Plan to ensure barriers and bottlenecks will be addressed within 6 months, and (2) track progress towards remediation and improvement. Corrective Action Plans should be submitted to the SIMS Team/Activity Manager for review and tracking. Monitoring of site improvement and performance should be tracked via partner management and oversight meetings with USG Activity Managers and IP staff. All red and yellow CEE scores, from a site assessment, must be re-assessed within six months. The responsibility to conduct the follow-up assessment (USG or IP), is at the discretion of each OU, but the rationale for the selection (USG or IP) should be clearly documented in (at a minimum) the Corrective Action Plan for each site.

3.0 SIMS TOOLKIT

The SIMS Toolkit refers to a collection of assessment tools, policies, procedures, and other supporting documents required to plan and conduct SIMS assessments.

3.1 SIMS ASSESSMENT TOOLS

See Section 2.4

3.2 SIMS COVERSHEET

The Coversheet (Appendix 1) provides an overview of the entire assessment, and is used to collect information on the agency, partner, site, and the type of assessment. The SIMS Coversheet is completed for each assessment and requires assignment of an Assessment ID. This is a unique

identifier that allows any data collection and storage system to keep the information about each visit distinct. The Coversheet is also used to guide the SIMS Assessor through the process of selecting and assembling the appropriate Sets and CEEs into a tailored tool that will be used for a specific site.

3.3 SIMS DASHBOARDS

The Dashboards (Appendix 2) are formatted as a table that lists all the CEEs with space to indicate the color score for each CEE at a given site or above site location. The SIMS Dashboard may be modified to facilitate administration; however, the content of CEEs should not be changed. The Dashboard serves as a starting point for developing a corrective action plan with the relevant IP.

3.4 SIMS IMPLEMENTATION GUIDE

See Section 1.2

3.5 SIMS TRAINING

All SIMS Assessors are required to complete a SIMS training that is conducted by an experienced SIMS trainer or complete the online e-learning SIMS 100 training course on the PEPFAR Virtual Academy. The certificate received after someone successfully completes the SIMS 100 online course should be retained. A second SIMS course on "Site Prioritization: Choosing where are what to assess on a SIMS visit" is also available. Both courses are highly rated by those who have taken the courses. Both courses can be accessed here: https://learn.pepfar.net/courses/course-v1:learn-pepfar-net+PROG108SIMS100+2019_indefinite/about.

3.6 CONFIDENTIALITY AGREEMENT

The Confidentiality Agreement (Appendix 3) documents the agreement of SIMS team members to maintain the confidentiality of patient names and site locations. Names and/or identifiers should not be disclosed at any time, and assessors shall not discriminate in any way against beneficiaries of PEPFAR-funded projects, nor against the staff who serve those beneficiaries. Identifiable information on the site and implementing partner will only be collected and stored in a secure USG-approved data management system.

3.7 INFORMATION ON PEPFAR SIMS ASSESSMENT FORM

The Information on PEPFAR Site Assessment Form (Appendix 4) is read to the site staff prior to each SIMS assessment. The form outlines the purpose of SIMS and the visit, the voluntary nature of the assessment for site staff, and the collection and use of the SIMS data. The form is signed once by the USG SIMS Assessment Lead (only USG signature is required) and is kept on file in a secure location at the OU's office(s) after completion of the visit. Appendix 4 also includes recommended talking points for the SIMS Assessment Inbrief.

3.8 SIMS WORKSHEETS

SIMS worksheets (Appendix 6) are provided for almost each CEE to facilitate easy recording of information (especially for chart reviews) when assessing a CEE. These are highly recommended even if a tablet or laptop is being used during the assessment.

4.0 OPERATING UNIT/AGENCY SIMS COORDINATION & MANAGEMENT

4.1 OU/AGENCY SIMS COORDINATION

Interagency SIMS Coordination Teams should be created to facilitate efficient planning and standardized implementation of SIMS across the portfolio. This may involve training staff, preparing guidance for applying unique criteria per local policies, working on adaptations of the tools, etc. The Coordination Teams should also have a role in ensuring efficient collection, management, exchange, and integrated analysis of SIMS data to inform action and improvement.

4.2 MANAGEMENT & OPERATIONS (M&O)

It is likely each PEPFAR staff will be contributing some level of effort towards organizing and managing the implementation of SIMS. Minimum tasks may include:

- Assuring adequate assessment team composition, training and readiness (materials and communications)
- Securing transportation and travel logistics
- Site visit coordination and communication with both IP and the sites themselves, and
- Monitoring the ongoing conduct of both comprehensive and follow up site assessments to assure coverage.

4.3 TRAINING

All staff involved with the planning and implementation of SIMS are required to complete SIMS training and to maintain a signed Confidentiality Agreement on file. At a minimum, all new SIMS Assessors should complete the SIMS 100 course on the PEPFAR Virtual Academy. https://learn.pepfar.net/courses/course-v1:learn-pepfar-net+PROG108SIMS100+2019_indefinite/about.

OUs should maintain a current roster of staff that have completed the required training that includes the staff member's name, ID number, date of training, and information on which training the staff member has successfully completed. Agencies are responsible for ensuring that staff have met the training requirements before conducting an assessment. OUs and HQ Agencies should provide periodic trainings as needed (virtual or otherwise), have a system to track training of participants, and ensure the quality and consistency of the trainings delivered. Recommendations include integrating SIMS refresher training into recurring staff orientation/trainings. New assessors should be mentored by an experienced SIMS assessor during his/her first SIMS visit.

4.4 AGENCY-SPECIFIC REQUIREMENTS

4.4.1 U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

1. The CDC country team should be responsive to HQ requirements for implementation of a site monitoring system and reporting of the core essential elements.
2. Each CDC country team should have clearly defined staff roles and responsibilities for implementation of SIMS and collection and reporting of the CEEs.
3. Staff roles should include the following: SIMS Lead/Coordinator, Logistics Coordinator, Data Steward, and SIMS Assessors with representation from all major program areas
4. Functioning logistics system in country for planning and reporting site visits.
5. Each CDC country team should have defined procedures in place for responding to issues identified through SIMS, including standard documentation that is disseminated appropriately.

4.4.2 DEPARTMENT OF DEFENSE

Special considerations for conducting SIMS assessments at military sites include:

1. Obtain permission from Ministry of Defense (MOD) authorities prior to each visit
2. Schedule visits in consultation with partner military and site staff
3. All staff conducting SIMS must be cleared by MOD prior to each assessment
4. Partner military personnel will participate in SIMS assessment visits
5. Site-level data will be shared with partner militaries and remediation plans will be developed in collaboration with military partners and implementing partners
6. Military SIMS data will be summarized and reported at the national level by IM, not the site level
7. Site level data from military sites will not be publicly available. Refer to agency-specific guidance for further information.

4.4.3 DEPARTMENT OF STATE

No specific considerations.

4.4.4. HEALTH RESOURCES AND SERVICES ADMINISTRATION

1. HRSA maintains responsibility for all SIMS visits, coordinating closely with in country CDC and other USG staff, implementing partners, and sites to prepare for SIMS assessments. HRSA and CDC continue to seek opportunities to minimize logistical burden and maximize efficiency, information sharing, and program improvement in the planning and conduct of SIMS.
2. HRSA should have clearly defined staff roles and responsibilities for implementation of SIMS and collection and reporting of the CEEs.
    a) Staff roles should include the following: HRSA SIMS Coordinator, SIMS Assessment Team Lead, SIMS Assessors, Country POC, and Project Officer
    b) Functioning logistics system at HQ for planning and reporting site visits and transferring SIMS data to S/GAC.
3. All HRSA staff involved with the planning and implementation of SIMS are required to complete SIMS Training.
4. As applicable, HRSA project officers are working with their IPs to develop and implement corrective action plans with prioritized activities, deadlines, benchmarks, and identified additional resources needed to ensure timely and appropriate resolution of issues. HRSA will continue discussions with in-country PEPFAR teams, primarily CDC staff in countries where CDC assists with HRSA partner management support, to assess program scopes of work in order to leverage and maximize PEPFAR investments.

4.4.5 PEACE CORPS

Peace Corps does not currently participate in SIMS. The SIMS tools were piloted, and it was determined the tools did not align well to Peace Corps model due to timing of visits and concerns around security of the Volunteer. Peace Corps continues to engage in the SIMS process at Headquarters to see if there are opportunities to participate. Peace Corps is also committed to monitoring the quality of its programs through ongoing monitoring and evaluation, regular site visits and in-depth programmatic reviews.

4.4.5 U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

1. The USAID mission team should be responsive to the implementation and reporting requirements of SIMS. To ensure adherence to SIMS requirements, teams should:
    a) Utilize the SIMS Prioritization List to plan required assessments, monitor completion of required assessments, and track needed remediation visits for each implementing mechanism;
    b) Employ practices to ensure SIMS data quality;
    c) Integrate routine utilization of SIMS data in portfolio management; and

d) Ensure timeliness of SIMS data submission.

2. Each USAID mission team should have clearly defined staff roles and responsibilities for SIMS implementation and data use. This includes the following considerations:
    a) SIMS roles and responsibilities should be designated across program areas.
    b) AORs/CORs should review SIMS findings for their programs on a quarterly basis and work with activity managers to assure follow-up SIMS visits, as needed.
    c) For missions utilizing contractors, routine communication and data flow processes between contractors and USG staff must be developed.
    d) Staffing needs for SIMS should be routinely assessed.
3. USAID mission teams utilizing contractors must incorporate the following into their SIMS planning:
    a) Ensure that proposed contractors do not have an organizational conflict of interest (OCI).
        i. For current Bilateral contracts or proposed procurements, consult both the local Contracting Officer (CO) and Regional Legal Officer (RLO) in identifying potential OCI issues. Document your OCI determination process and rationale in a memorandum (*consulting and referencing FAR subpart 9.5, ADS 302 and CIB99-17*). Contractors should also have a process in place to ensure that individuals performing SIMS visits do not have a personal conflict of interest relative to the site being assessed.
        ii. Obtain RLO and CO clearance on the memorandum.
        iii. Submit to documents to agency SIMS POC for OHA review and concurrence.
        iv. OHA will communicate to SGAC that the mission has followed the appropriate Agency process for OCI determination.
    b) Ten percent of sites visited by contractors must be visited by USG staff to validate results.
    c) USG staff must meet with contractor staff to review and sign off on their findings. Any subsequent activities to address SIMS results are the responsibility of USG staff in collaboration with the partner(s) responsible for the site.
4. Issues with SIMS that arise should be brought to the attention of USAID/HQ either through Office of HIV/AIDS Senior Country Associates or USAID SIMS POCs.

Note: Personal conflicts of interest may include recent prior employment or close family members employed by the implementer/site being assessed. Please consult your RLO for further details.

5.0 PREPARING FOR THE SIMS ASSESSMENT

5.1 IN-PERSON VERSUS VIRTUAL ASSESSMENTS IN THE COVID-19 ENVIRONMENT

As shared in the 27 March 2020 Technical Guidance on COVID-19, "All PEPFAR programs are under Chief of Mission authority, therefore country teams and implementing partners should follow the US Embassy Front Office direction on all programing that requires personnel movement. Please also refer to the Operational Issues and Infection Prevention and Control sub-sections of this guidance document. We recognize that SIMS implementation and reporting has been limited by the pandemic and expect it will continue to be affected during this time. Teams are requested to keep their S/GAC chair and PEPFAR Program Manager updated on changes in SIMS implementation status". Should there be any changes to this guidance, it will be shared with all OUs.

Only if the safety and security of any staff will not be compromised, OUs may carefully consider implementing virtual SIMS assessments **provided all the following minimum conditions are met:**

- Any OU considering virtual SIMS assessments should email SGAC_SIMS@state.gov prior to beginning any planning for virtual SIMS assessments
- Follow-up assessments are prioritized, after the necessary site level remediation has occurred, over completing more Comprehensive SIMS assessments. Completing follow-up assessments before conducting more new comprehensive assessments is strongly recommended
- For virtual Follow-up assessments, at least one IP staff member or USG staff member must be present at the site to provide oversight and manage the overall assessment. Other USG and IP staff may be off-site/remote/virtual
- For virtual Comprehensive assessments, at least one USG staff member must be present at the site to lead the assessment (as per Section 2.3) and provide oversight and management of the overall assessment. Other USG and IP staff may be off-site/remote/virtual
- Video-conferencing technology exists at both the off-site/remote/virtual and on-site locations to facilitate collective understanding, ease of assessment, and oversight.
- Confidentiality and security of client/patient information is maintained throughout the virtual assessment (Section 5.6).

Note that there is NO requirement to record/log a 'virtual' assessment in any way that is different from a 'regular' or fully in-person SIMS assessment in agency data collection systems.

5.1 COMMUNICATION WITH THE IMPLEMENTING PARTNER AND SITE

Good communication is essential to maximize efficiencies and set a positive tone for SIMS assessments. Designated SIMS Team members or the Project Officer/Activity Manager should engage with IPs early in the process to help inform the IP about what will take place and to respond to any questions or concerns. For example, prepare a packet of information that can be shared with the partner ahead of the visit.

It is recommended that USG staff contact IP to arrange a date to conduct a SIMS assessment in advance of the proposed visit date, to allow ample time for planning and preparation by the IP and the site. Once the visit date has been confirmed, the SIMS team should assemble the Assessment Tool(s) and Dashboards in preparation for the assessment. A Notification Letter (Appendix 5) should be sent to the partner prior to the visit that outlines the proposed visit dates, the site(s)/above site locations to be assessed, recommendations for key site staff who should be available to participate in the visit, and the proposed USG SIMS assessment team (or at minimum the SIMS Team Lead/Assessment Lead or point of contact). The Activity Manager (AM) or SIMS Team Lead will schedule a meeting or call to confirm availability and finalize the date, review the visit objectives and procedures, set visit expectations, review CEEs to be assessed, and address any questions. S/he will also follow-up prior to the visit to reconfirm the agenda and availability of key staff.

5.2 ASSEMBLING A SIMS ASSESSMENT TEAM

SIMS assessments are conducted by USG staff who have been trained to conduct SIMS assessments. Teams characteristically utilize a two-team reviewer approach but may involve a larger number of assessors as required; factors considered in determining team composition include the type of site or

above site location and technical focus area, number of assessments to be conducted, number of Sets and CEEs to be assessed, language requirements, and budget.

Staff to be consulted when planning a visit include implementing partner and on-site/on-location working staff members most knowledgeable about the CEE technical areas. For key populations, this could include sex workers, Men who have sex with Men (MSM) or other peers who work with the site. Where it makes sense, the USG team should confer with the IP about ideal team size.

Prior to departure, each member of the SIMS assessment team should have completed the following:

- ❑ SIMS Assessment training specific to the assessment type being conducted (Site or Above-site)
- ❑ Review of the Implementation Guide and associated Appendices
- ❑ Review of the relevant SIMS Assessment Tool
- ❑ If conducting a Comprehensive assessment, selection of which Elective CEEs will be assessed based on performance, program needs and program gaps in collaboration with the rest of the SIMS Assessment team. Importantly, Elective CEEs can also be selected during the actual SIMS assessment, as needed
- ❑ Review of any prior SIMS Assessment Dashboards or other documentation for the selected site or above site location
- ❑ Review of the site-level MER data for at least the last four quarters
- ❑ Review of the workplan (including budget) for the IP supporting that site or above site location
- ❑ Review of any prior improvement plans, or corrective action plans previously developed for that site or above site location
- ❑ Signed the Confidentiality Agreement (version dated February 12, 2015) form **once** before, with the original, signed document placed in the USG member's personnel file.

5.3 BUILDING THE TAILORED TOOL AND DASHBOARD

Prior to conducting the SIMS assessment, the SIMS Assessment Team should gather relevant information regarding the IP/IM to help guide creation of the relevant tailored Assessment Tool, including review of the IP workplan, site-level MER data, IM budget data, and relevant above service delivery activities etc. As mentioned in Section 2.4.2 Required vs Elective CEEs, for a Comprehensive Assessment, selection of Elective CEEs to be assessed necessitates an understanding of site level performance, program needs and program gaps. OUs should revisit the rationale for including the site or above-site location in the SIMS Prioritization List to help identify Elective CEEs to be assessed. To streamline procedures, OUs should align information on specific PEPFAR funded activities for each IM/site with the Sets/CEEs to be assessed.

5.4 VERIFICATION OF THE TOOLS AND ASSEMBLING THE GO PACK

SIMS teams should assemble a "Go Pack" with all the materials needed to complete the assessment (Table 6).

Table 6. Sample "Go Pack" Checklist

	ITEM
	Information on PEPFAR Site Assessment Form (Appendix 4)
	Dashboard (Appendix 2) **and Worksheets** (Appendix 6) (completed dashboard left at site, with IP, photograph for agency copy)
	Disaggregated Site level MER Results (for Data Reporting Consistency CEEs and overall site performance context)

	Coversheet per Assessment (Appendix 1) (Provides details on assessment location and why assessment will occur. This is also included within the electronic data collection device)
	Tailored Assessment Tool (Sets assigned to specific assessors)
	One **Tablet or Laptop** for each member of the assessment team (if electronic data capture is used) OR one **paper copy** per member of the assessment team (if paper tools are used)

IPs should also review the tools and assessment procedures with the site staff prior to the visit. To avoid unnecessary delays on-site and/or incomplete data capture, in advance of the visit, provide the site with a complete list of resources and documents that should be available during the SIMS assessment.

5.5 OTHER CONSIDERATIONS PRIOR TO DEPARTURE

Other key best practices while preparing for a SIMS visit include:

1. To reduce costs, if multiple agencies are supporting the same site, plan to travel together.
2. To facilitate streamlining and integration of SIMS into core PEPFAR processes, where possible, incorporate a SIMS Comprehensive or Follow-up assessment into other visits to the site (e.g. a technical assistance site visit). However once at the site, to ensure efficient implementation and mitigate any disruption to service provision at the site, the SIMS assessment should be conducted separately from other program support/technical assistance activities.
3. SIMS CEEs should usually be divided among team members to ensure the assessment portion of the visit can be completed in a minimal amount of time. Additional time should be included in the visit agenda for inbrief and outbrief with the staff. Specific Sets or CEEs should be assigned during the planning phase to avoid taking up time at the site apportioning the CEEs among team members.

5.6 THE PEPFAR ETHICAL FRAMEWORK FOR ENGAGEMENT OF KEY POPULATIONS

The PEPFAR Ethical Framework for Engagement of Key Populations (KP) highlights that PEPFAR is inclusive, non-discriminatory, and engages individuals and communities in a way that reflects PEPFAR's commitments to affirm and protect human rights. As such, SIMS Assessors must adhere to rigorous ethical standards, data protection, and personal conduct regulations during all assessment visits.

Sites providing services to certain population segments (e.g. military, Key Populations) require special attention by members of the SIMS assessment team during the planning and/or data collection phases (special considerations for SIMS assessments conducted at military sites are summarized in Section 4.4 and please refer to agency-specific guidance for further information). SIMS assessors visiting assessment points that serve KP must be sensitive to the social and structural barriers of stigma and discrimination that many KP face, and the heightened vulnerability context that these social and structural realities create. Consequently, it is essential for all staff conducting SIMS assessments at sites serving KP to recognize the fundamental rights, dignity and worth of all people, and to refrain from undertaking any action that exacerbates the risk environment (e.g. use of mobile phone cameras for purposes other than documentation of the SIMS Dashboard).

Assessors who conduct SIMS visits at sites that serve KP should have technical experience and/or training in KP programs. Each OU should identify staff members who are skilled and sensitized to

conduct SIMS visits at sites that serve KP. All persons conducting a SIMS assessment must be aware of cultural and role differences of gender, race, ethnicity, caste, religion, sexual orientation, disability and socio-economic status. SIMS assessors must not participate in or condone any discriminatory practices based on the aforementioned differences. In the event that such issues arise, the SIMS visit should be terminated immediately, and the situation should be reported to the PEPFAR Coordinator and the SIMS designated Point of Contact in country. In countries where there are no PEPFAR Coordinators, the SGAC PEPFAR Program Manager should be notified.

SIMS assessors should read the PEPFAR Ethical Framework for Engagement of Key Populations (Figure 5) and be aware of the ethical considerations prior to embarking on SIMS visits to sites that serve KP. Violations of the ethics listed could potentially undermine the population served by the site and/or the staff who work at the site and must be reported as specified in the preceding paragraph.

Special data safety measures should be used for SIMS assessments at sites serving KP. The OU must determine whether SIMS data collection is too risky for a particular KP subgroup, or whether it's too risky to identify KP sites. It's possible that all sites in a particular country will need data safety measures if KP are threatened in that country and it is known that the sites serve KP. USG must keep a written record of who collects SIMS data for KP sites. Access to SIMS assessment data from sites that serve KP is restricted. In the case of paper-based data collection, forms must follow safe storage procedures.

Figure 5: PEPFAR Ethical Framework for Engagement of Key Populations

PEPFAR Ethical Framework for Engagement of Key Populations

- Confidentiality and consent should be explained for KP community and IP staff informants
- Consent may be obtained verbally but must be recorded (so bring appropriate materials)
- Interviewees and site staff can withdraw their consent at any time
- Never ask for names or other identifiable information
- Never scan, copy or remove any individual records from a site
- Do not leave any documents (paper or electronic forms) at the site that contain geo-coordinates and/or identifying information about the location of any KP sites
- Data collection, storage, and use must be explained
- All staff must conduct their activities in a way that does not damage the interest of the clients served at the site or site staff
- All staff must seek to promote integrity through honesty, fairness and respect for others

6.0 CONDUCTING THE SIMS ASSESSMENT

6.1 OPENING SESSION

It is important to initiate a positive discussion with site or above-site staff upon arrival to set the tone for a collaborative assessment and to ensure that site staff and the partner fully understand the purpose and parameters of the SIMS assessment. Before beginning the Inbrief, ensure that all members of the SIMS assessment team are present, including non-USG partners who are relevant to

your country context and agreements (e.g., Ministry of Defense partners for military assessments, Ministry of Health partners for facility assessments, etc.).

Ensure that all relevant site or above-site staff are present, including leadership and staff from the relevant assessment areas (e.g., clinic manager, lab director, maternity lead, project officer) to avoid the need to re-explain the purpose of the SIMS visit when assessors arrive at each area or if site/entity staff are not all present for the Inbrief. In many cases, site or above site leadership may only be available to participate in the opening session but not in the remainder of the assessment.

Opening Session Key Points (see also Appendix 6 for Inbrief Talking Points)

1. Gather and welcome key staff for the opening session and introduce the visiting team. Key Site and IP staff should also be introduced at this time.
2. Explain the SIMS assessment purpose and general methodology of the SIMS visit. Emphasize that the SIMS assessment is designed to optimize quality of care provided at sites through a collaborative and supportive approach to identified problems. Ask site staff if they have any questions.
3. Administer the Information on PEPFAR Site Assessment Form (Appendix 6) and answer any questions from staff.
4. Briefly confirm which services/programs are available at the site, update the tailored tool and visit materials as appropriate. If applicable, confirm that the IP has invoked the conscience clause for that site (which exempts them from provision of condoms).
5. Review the visit schedule, highlighting the times set aside for the Opening Session, Assessment, and Closing Session.
6. Set a tentative time and place for the Closing Session, ideally choosing one that maximizes participation by staff involved in the visit. If possible, allow at least 20 minutes; more time may be needed for larger sites in which many program areas are assessed.

6.2 ASSESSMENT AND DATA COLLECTION

The SIMS Assessment Team should be managed efficiently to ensure that high quality data are collected within the allotted time.

Good Assessment Practices include:

- Be aware of your presence, the volume of your voice, and the general way in which you and/or the team might be affecting beneficiaries who are at the site. Do everything possible to minimize disruption of the site's activities.
- Ensure the CEEs were divided among assessors in a way that optimizes everyone's time. Consider the work-load of each CEE as well as the assessor's experience.
- Consider assigning specific team members to do the chart/register/document reviews.
- Ensure that you respect the population-specific considerations
- Review any special initiative guidance (e.g. DREAMS) prior to the visit.
- Ask questions of site staff to ensure a complete understanding of the situation before assigning a score.
- Check your work to ensure data completeness and accuracy.

6.3 CLOSING SESSION

A SIMS assessment provides the opportunity to facilitate improvements at PEPFAR-funded sites and above-site locations. Thus, site staff should have real and perceived involvement in the SIMS

assessment, and the opportunity to provide feedback to critical components of SIMS. The closing session offers the first opportunity to initiate improvement activities since some issues identified do not require extensive improvement plans and can be discussed and remediated during and/or soon after the debrief. Active involvement and communication throughout the process promotes staff ownership of the services provided and accountability for improvement.

Sites and above-site staff should always receive same-day feedback. As such, it is critical to allow enough time for a final closing discussion at the end of the assessment. SIMS assessments should adopt a non-punitive approach that frames weaknesses in a manner that articulates the path to improvement.

Preparation for the Debrief

1. Plan to meet as a USG team approximately 15-20 minutes prior to the Closing Session. During this team time:
    a. Review the scores for each CEE and ensure that all relevant CEEs are complete.
    b. If necessary, discuss specific CEEs and agree as a team on the appropriate score.
2. Review and finalize the Dashboard.
    a. Assign a score to each CEE by placing a check mark in the appropriate box (scores may also be transcribed from the Tablet Dashboard)
    3. Add comments on each CEE as necessary. If possible, provide a comment on CEEs scoring yellow or red to note the primary reason for the low score (remember to review question-level responses). The focus of remediation and improvement should be on CEEs that scored a red or yellow.
    a. Complete the section on strengths, challenges, and preliminary recommendations for remediation and improvement. Be brief.
4. Make a copy of the Dashboard (via photocopy, photograph, or manual transcription) for team records and data entry.

Closing Session: Key Points

1. Always start by thanking the site staff for their time and cooperation and acknowledging the disruption that the SIMS visit likely caused.
2. Review the Dashboard with the staff.
    a. Avoid using SIMS jargon (i.e., reading out the CEE titles without explaining the standard) unless the staff are familiar with the tool and CEEs.
    b. Begin the discussion with recognition of site successes before discussing challenges. Highlight specific areas of optimal performance and best practices. The aim is to boost morale, encourage staff ownership of site service delivery, and inspire staff to pursue improvement of highlighted areas. It can be helpful to develop standardized messaging to explain the meanings of the scores.
    c. Next, cover areas that require significant improvement. Be sure to explicitly state that the results are not meant to be punitive, but to highlight areas where USG, IPs, and site staff will work together to improve service quality and performance. Significant breaches of policy or procedure that were observed should be brought to the attention of relevant leadership and/or clinical staff within the site.
3. Encourage staff to share their responses to the SIMS assessment
    a. Initiate discussions about how to remedy problems, including what other information would inform the collective understanding of successes, bottlenecks, and challenges to quality service provision.
    b. Encourage site staff to provide feedback on their experience with the SIMS assessment process, results and outcomes.

4. Identify coordination that should occur to facilitate remediation and improvements, both within the site and with relevant partners (e.g., sites with community-based cadres should ensure linkages with each other where appropriate).
    a. Clearly describe that a correction action plan will be developed
    b. Clearly describe that a follow-up assessment will occur within 6 months to re-score the CEEs that scored Red or Yellow
5. Leave a copy of Dashboard with the IP and site staff prior to departure. The IP and site should already have a copy of the SIMS Assessment tool so that staff can understand the criteria behind the scoring.

7.0 POST ASSESSMENT

See Section 2.5 Integrated Analysis and Action

8.0 CONFIDENTIAL STORAGE OF DOCUMENTS

The USG staff will be responsible for securely storing the data obtained from the SIMS assessment. Paper versions of the completed SIMS Assessment Tools will be securely transported from the site or above site location to the agency office at the conclusion of the assessment. Agencies should identify a secure location (locked filing cabinet inside lockable office space with access restricted to designate SIMS Team Members) for storage of completed SIMS Assessment tools and supporting documents. Electronic data collection devices (Tablets, Laptops) will be password protected and encrypted to protect data during and after the assessment visit. Information will be downloaded to a secure agency database prior to removing the data from tablets used in the field.

Paper versions of the assessment tools, coversheets, dashboards, and any completed worksheets should be securely stored in a folder or binder for future source verification purposes. These files should be retained for at least 6 months after data from the fourth quarter, for the fiscal year in which the assessment was conducted, has been reported to S/GAC. OUs should refer to agency specific guidance for longer term storage and retention of documents.

9.0 SIMS DATA COLLECTION & REPORTING

9.2 ELECTRONIC REPORTING

PEPFAR implementing USG agencies will deploy SIMS electronic data collection and storage solutions to ensure information timeliness, quality, and efficient dissemination of data for decision-making. Question level SIMS data will be collected through electronic reporting systems and included in DATIM Import protocols.

9.2.1 GUIDING PRINCIPLES OF USG AGENCY SIMS APPLICATIONS

1. Agency SIMS systems will be deployed by individual USG agencies to ensure design simplicity that meet agency HQ and field mission requirements.
2. Design of SIMS system components include data collection, data analysis and visualization tools for reporting.
3. Support for agency personnel (OU and HQ) will be provided for SIMS Applications by their respective agency.
4. Agencies will train their personnel on SIMS Application use. Agency SIMS Application training is agency specific.

5. SIMS applications will comply with a common set of standard security protocol specifications and information assurance policy to reduce security risks and to gain required agency approvals to operate as USG software.
6. System users will be trained on SIMS information assurance policy to insure compliance with USG cybersecurity policies.
7. Support for agency personnel (OU and HQ) for SIMS Applications will be provided by their respective agency.

9.2.2 SIMS DATA SYSTEMS

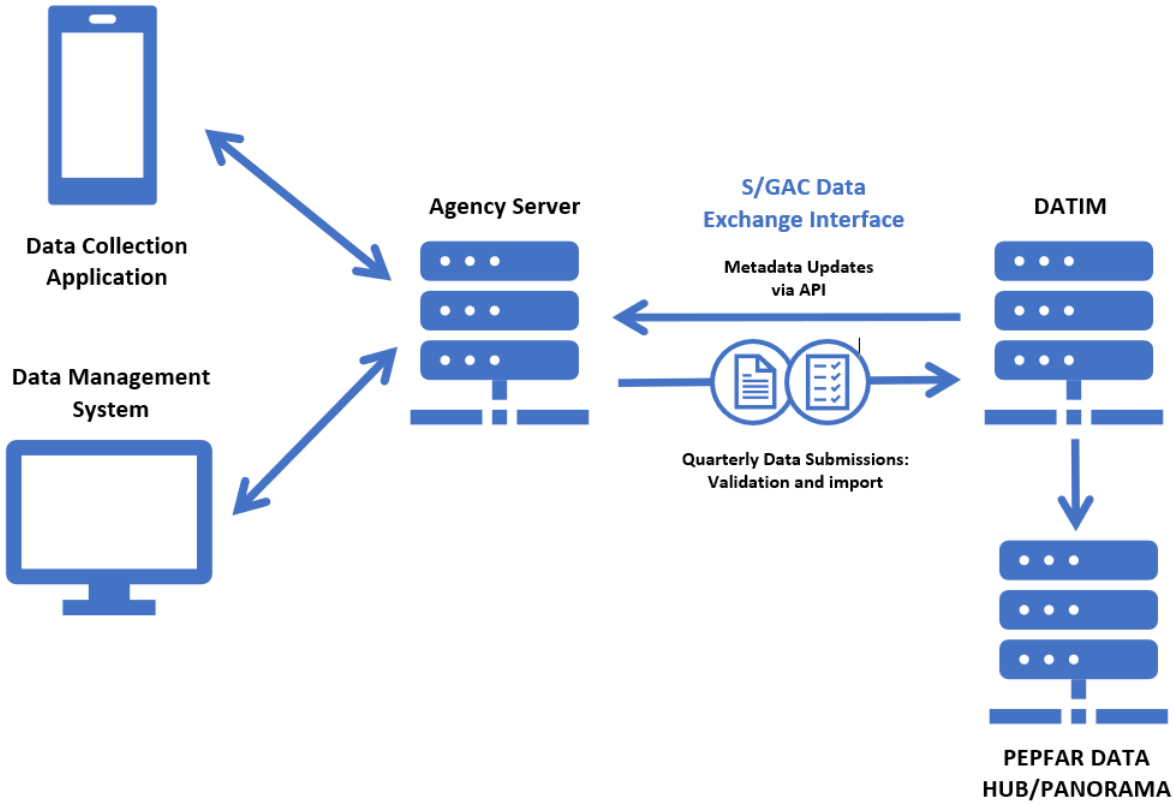
All SIMS data systems use common SIMS data tools for data collection. SIMS common security methods are jointly defined by USG participating agencies to ensure that information assurance is consistent across all agencies and to reduce technology security risks.

SIMS data systems have three components:

1. SGAC PRIME SIMS Data Exchange Schema
2. Agency SIMS Data Management System
3. Agency SIMS Applications for OU Data Collection

Agencies are required to report SIMS data to SGAC using a file exchange protocol that automates a machine-to-machine process for sending data from agency SIMS data systems to S/GAC DATIM. Agency headquarters administers the Agency SIMS Data System. Data are collected on paper or an electronic user device. Once a SIMS visit is complete and all CEE data are collected, the OU user will follow the Agency process for submitting the SIMS visit data to their agency SIMS Data Management System. There is no interagency approval process for SIMS visit data.

Figure 6. SIMS Data Flow



9.2.3 S/GAC DATIM

Agencies are required to report SIMS data to S/GAC electronically and on a quarterly basis as per the PEPFAR Reporting Calendar. The S/GAC data exchange protocol offers the ability to transfer SIMS data files electronically from agency SIMS systems to S/GAC for upload into DATIM. S/GAC then copies SIMS datasets from DATIM into the PEPFAR data warehouse (and eventually into PEPFAR Panorama). Additional details are available in the DATIM Import Guide available on DATIM Support. SIMS data for DoD military sites is not reported into DATIM. Moreover, site level data from military sites will not be made publicly available.

9.2.4 AGENCY SIMS DATA MANAGEMENT SYSTEM

Agency SIMS Data Management Systems provide a central database at each respective agency headquarters for administration of SIMS data system collection and reporting. The Agency SIMS Data Management Systems send an export file from the agency to S/GAC DATIM via the data exchange protocol in order for agencies to complete their SIMS reporting requirements to S/GAC.

- Agency SIMS Data Management Systems provide electronic data entry and allow data aggregation, querying, and exporting.
- Agency SIMS Data Management Systems administer SIMS coversheet reference data including user account management/access privileges, information assurance and data and system access security, implementing mechanism data, and site database on the DATIM Site List.
- Agency SIMS Data Management Systems will provide analysis and reporting functions.

9.2.5 AGENCY SIMS APPLICATIONS FOR OU DATA COLLECTION

Agency SIMS electronic data collection will be available to agency OU users on an electronic device including a tablet or laptop to conduct SIMS assessments.

- The user device provides a SIMS scoring/dashboard report for field operations
- The SIMS Application provides this dashboard of the assessment visit data in the field, for use during visits and dialogue with PEPFAR implementing partners.
- The SIMS Application can work in on-line or off-line modes of operation.
- The user device component provides immediate results for on-site feedback according to SIMS CEE scoring criteria
- The user device will allow secure local storing of data until SIMS data are sent to secure agency central server.

Once a SIMS assessment is complete and all CEE data are collected, the OU user will save/send SIMS visit dataset(s) to their respective agency database. Data collected on the electronic platform is transferred from the agency SIMS Application to the agency SIMS Data Management System. The SIMS Applications provide a flexible design to insure that all assessment activities can easily collect and manage data at OU offices, prior to reporting a SIMS assessment to agency headquarters.

10.0 APPENDICES

SIMS

SITE IMPROVEMENT THROUGH MONITORING SYSTEM (SIMS)

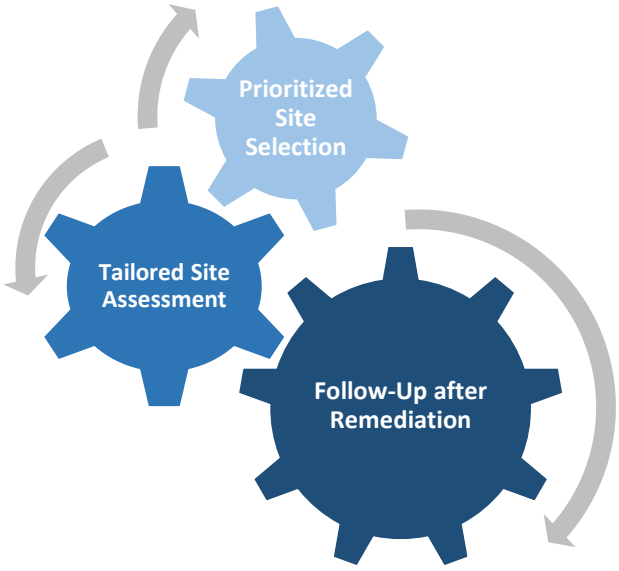
FY21 ABOVE-SITE ASSESSMENT TOOL

Version 4.1, 15 August 2020

SIMS

Site Improvement through Monitoring System

SIMS is a quality assurance tool used to monitor and improve program quality at PEPFAR-supported sites that guide and support service and non-service delivery functions.



Goals of SIMS 4.0

- ✓ Integrate SIMS into broader framework(s) for analysis, management and improvement
- ✓ Tailored, nimble, responsive site selection and implementation based on performance, program needs, and programmatic gaps
- ✓ Actionable to drive improvement or sustain quality

2 Assessment Tools

Site Level Tool

Site assessments are conducted at both facility and community sites (i.e. places where services are provided). Examples include clinics, hospitals, laboratories, and 'standalone' structures.

Above-Site Level Tool

Above-site assessments are conducted at PEPFAR-supported institutions that are above the service delivery point (i.e. not where services are provided or beneficiaries are reached). Examples include health offices at the national or subnational level.

2 Types of Assessments

Comprehensive Assessment is the first assessment at a site or above site location. All relevant standards (Required and Elective CEEs) should be assessed.

Follow-Up Assessment determines whether all CEEs that scored red or yellow during a prior assessment have improved (i.e. red or yellow to green).

Core Essential Elements (CEEs)

Standard: CEEs are built on program quality standards based upon World Health Organization supported evidence or guidelines and/or documentation of best practices.

Assessment Questions: Each CEE is composed of a series of questions that progressively assess the site against the standard.

Final Score: The final score is red, yellow, green or N/A. CEE scores are designed to highlight whether a problem exists.

Organization of SIMS Site Assessment Tool

Set #	Set Name
SET 1A	General
SET 1B	Commodities Management
SET 1C	Data Quality
SET 2A	Care And Treatment-General Population
SET 2B	Care And Treatment For HIV Infected Children
SET 3A	Key Populations-General
SET 3B	Care And Treatment – Key Populations
SET 4A	Preventing Mother to Child Transmission, Antenatal Care, Postnatal, and Labor and Delivery
SET 4B	HIV Exposed Infants
SET 5	Voluntary Medical Male Circumcision
SET 6	Adolescent Girls and Young Women and Gender-based Violence
SET 7	HIV Testing Services
SET 8	Tuberculosis Treatment Service Point
SET 9	Methadone or Buprenorphine Medication Assisted Treatment
SET 10A	Laboratory
SET 10B	Blood Safety

Organization of SIMS Above-Site Assessment Tool

Set #	Set Name
SET 1	HIV Planning, Coordination and Management
SET 2	Orphans and Vulnerable Children/Social Services
SET 3	Guidelines and Policies
SET 4	Private Sector Engagement and Advocacy
SET 5	Human Resources for Health
SET 6	Commodities
SET 7	Quality Management
SET 8	Laboratory and Blood Transfusion Support
SET 9	Strategic Information, Surveys, Surveillance and Evaluation
SET 10	Protecting Life in Global Health Assistance

Description of Final CEE Scores

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

REFERENCE INFORMATION

Set Names and Required vs. Elective Status

Set Name	Set #	Required	Elective
HIV Planning, Coordination, And Management – Health	Set 1		X
Orphans and Vulnerable Children/Social Services	Set 2		X
Guidelines and Policies	Set 3		X
Private Sector Engagement and Advocacy	Set 4		X
Human Resources for Health	Set 5	X	
Commodities	Set 6	X	
Quality Management	Set 7		X
Laboratory and Blood Transfusion Support	Set 8	X	
Strategic Information: Surveillance and Surveys	Set 9	X	
Protecting Life in Global Health Assistance	Set 10		X

Description of SIMS Assessment Types and Assessment Tool Composition

Assessment Tool	Assessment Type	Conducted by	CEEs to be Assessed
Site	Comprehensive	USG	For Required CEEs: All applicable* For Elective CEEs: All applicable* and relevant**
	Follow-Up	USG or IP	All CEEs that previously scored red or yellow.
Above Site	Comprehensive	USG	For Required CEEs: All applicable* For Elective CEEs: All applicable* and relevant**

*Applicable means if those services are provided or offered
**Relevant means assessed as needed (at the discretion of the Operating Unit based on performance, program needs and program gaps)

Explanation of Icons in the SIMS Assessment Tools

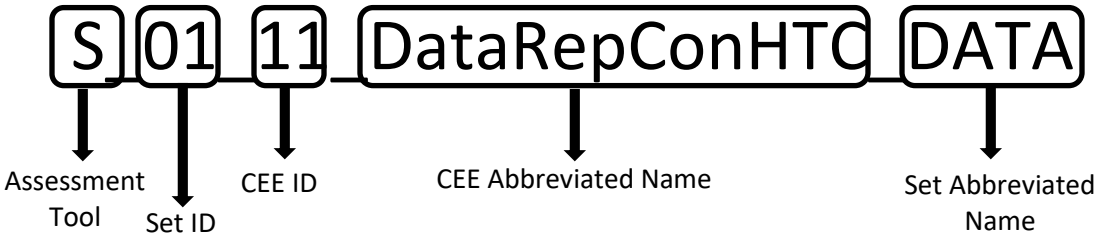
Icon	Description of Icon	Explanation
	Eyes	Question requires visual inspection of documents, charts/registers or materials
	Pink Square	Question requires Chart or register review

	Gray Circle	Question requires Materials review
	Blue Triangle	Question requires Document review

Description of Final CEE Scores

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

Figure 1: Core Essential Elements (CEE) Structure Used within this Tool



FY 21 SIMS ABOVE-SITE ASSESSMENT TOOL

Table of Contents

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SET 1: HIV PLANNING, COORDINATION, AND MANAGEMENT – HEALTH		
CEE #	*Abbreviated Title*	*Level*
AS_01_01	Management and Planning – National Strategic Planning -Health Sector	National
AS_01_02	Use of Data from Health Economics and Finance studies	National/Subnational
AS_01_03	Management and Planning-Operational Planning	Subnational
AS_01_04	Supervision – Health Sector	Subnational
AS_01_05	Data Collection/Review	Subnational
AS_01_06	Referrals	Subnational

CEE #: AS_01_01 Management and Planning – National Strategic Planning-Health sector (National) [PLAN MGT]			
STANDARD The national authority overseeing the delivery of HIV services has a current, multi-year HIV strategic plan that was developed in consultation with external stakeholders, based on data, and costed.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a national, current, multi-year HIV strategic plan for overseeing delivery of HIV services? ***Note:*** *The plan is current if it covers the current calendar year.*	Y N	If N=Red
	If Y, then Q2		
Q2	Was the strategic plan both developed and endorsed by stakeholders from relevant sectors?	Y N	If N =Yellow
	If Y, then Q3		
Q3	Was the strategic plan both developed and costed using existing HIV output and outcome data?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_01_02 Use of Data from Health Economics and Finance Studies (National/Subnational) [PLAN MGT]			
STANDARD: National and Subnational health economic or finance studies involve key stakeholders in reviewing underlying data and consuming finalized results.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Have the economic or financial data from these studies been reviewed by technical working groups or relevant stakeholders? ***Note**: Examples of stakeholders include: Ministry of Health officials, program managers, donor agencies, and multilateral stakeholders.*	Y N	If N=Red
	If Y, then Q2		
Q2	Have the findings of these studies been finalized and disseminated to stakeholders? ***Note**: Examples of stakeholders include: Ministry of Health officials, program managers, donor agencies, and multilateral stakeholders.*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_01_03 Management and Planning – Operational Planning (Subnational) [PLAN MGT]			
STANDARD: Sub-national entities overseeing service delivery sites have annual operational plans that are costed and data-driven.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there current annual operational plan which outlines priorities and actions for delivering services within the catchment area? ***Note:*** *A "current" plan was either created or updated within the past calendar year.*	Y N	If N=Red
	If Y, then Q2		
Q2	For the operational plan in question, are ALL of the following statements true? *Tick all that apply:* ☐ 1) It was developed in collaboration with key stakeholders who are providing a significant quantity of services, financing, supplies and technical assistance. ☐ 2) It includes all HIV activities being undertaken by key stakeholders. ☐ 3) It is costed. ☐ 4) It reflects the use of existing performance and health outcome data. ☐ 5) It includes a monitoring plan that documents progress towards completing activities. ***Note****: Examples of key stakeholders include Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs), and government facilities*.	# Ticked _____	If 0-4=Yellow If 5=Green
	SCORE		

CEE #: AS_01_04 Supervision – Health Sector (Subnational level) [PLAN MGT]			
STANDARD: Sub-National health authorities use standardized tools and processes to routinely conduct supervisory visits to at least 50% of facilities in their catchment area and document results of supervisory visits.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this sub-national health authority (e.g., District Health Management Team) routinely visit at least 50% of health facilities within its catchment area to supervise health care facility staff? ***Note:*** *"Routinely" as defined in national guidelines/health system supervision guidance*	Y N	If N=Red
	If Y, then Q2		
Q2	For the supervisory visits, does this sub-national health authority? *Tick all that apply:* ☐ 1) Use a standardized process and schedule? ☐ 2) Use a standardized tool? ☐ 3) Provide written feedback to the facility with action items or recommendations to address identified gaps and issues (e.g., through supervision logbooks left at the site)? ☐ 4) Maintain documentation of facility visits at the health authority's office?	# Ticked _____	If 0-3=Yellow If 4=Green
	SCORE		

CEE #: AS_01_05 Routine Data Collection/Review (Subnational level) [PLAN MGT]			
STANDARD: Sub-National health authorities routinely and in a timely way collect, review, and provide feedback on HIV indicator data from sites within their catchment area.			
Instructions: Check the programmatic area(s) included in routinely collected HIV indicator data: ☐ (1) Adult Care & Treatment ☐ (2) Pediatric Care & Treatment ☐ (3) PMTCT ☐ (4) VMMC ☐ (5) HTS ☐ (6) TB/HIV ☐ (7) Community Care & Support ☐ (8) Prevention ☐ (9) Condoms ☐ (10) Food & Nutrition ☐ (11) Lab ☐ (12) FP/HIV ☐ (13) Services for Key Populations ☐ (14) Gender norms ☐ (15) Post-violence care ☐ (16) Supply Chain ☐ (17) Blood Safety/Waste Management ☐ (18) IDV/MMT ☐ (19) QM/QI ☐ (20) Other (specify)_____			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this health authority routinely collect HIV program indicator data in a standard format (paper or electronic) from all sites within its catchment area per national guidelines?	Y N	If N =Red
	If Y, then Q2		
Q2	Are HIV program indicator summaries consistently reported on a timely basis to the next level of the health system, per national requirements?	Y N	If N=Red
	If Y, then Q3		
Q3	Is there documentation to show that program indicator summaries are reviewed for data quality by health authority staff routinely throughout the reporting cycle, with feedback to the sites reporting the data?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_01_06 Referrals (Subnational level) [PLAN MGT]			
STANDARD: Sub-National entities overseeing service delivery sites have documented processes in place to assess referral and linkage systems within their catchment area.			
Instructions: Check the programmatic area(s) included in referral and linkage system overseen by this institution: ☐ (1) Adult Care & Treatment ☐ (2) Pediatric Care & Treatment ☐ (3) PMTCT ☐ (4) VMMC ☐ (5) HTS ☐ (6) TB/HIV ☐ (7) Community Care & Support ☐ (8) Prevention ☐ (9) Condoms ☐ (10) Food & Nutrition ☐ (11) FP/Safe Motherhood Counseling ☐ (12) Services for Key Populations ☐ (13) Post-violence care ☐ (14) OVC/social services ☐ (15) IDV/MMT ☐ (16) Other (specify)_____			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a systematic approach to appropriately refer clients to HIV services between community service providers and health facilities?	Y N	If N=Red
	If Y, then Q2		
Q2	Are there standardized referral forms in use by facility and community service providers?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the HIV service referral system track clients receiving services and document completed referrals across service providers?	Y N	If N=Yellow If Y=Green
	SCORE		

SET 2: OVC/SOCIAL SERVICES		
CEE #	*Abbreviated Title*	*Levels*
AS_02_01	Management and Planning – strategic planning (Social Services) (National level) [SOC OVC]	National
AS_02_02	Social Protection/Child Protection Management Information Systems (Sub-national level) [SOC OVC]	Subnational
AS_02_03	Management and Planning – operational planning (Social Services) (Sub-national level) [SOC OVC]	Subnational
AS_02_04	Supervision – Social Services (Sub-national level) [SOC OVC]	Subnational

CEE #: AS_02_01 Management and Planning – Strategic Planning (Social Services) (National) [SOC OVC]			
STANDARD: National authority overseeing delivery of social services to children and families affected by HIV has a current, multi-year strategic plan that was developed in consultation with external stakeholders, is based on data and is costed.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a national, current, multi-year strategic plan for overseeing delivery of social services to children and families affected by HIV? ***Note:*** *The plan is current if it covers the current calendar year. The plan may oversee delivery of social services to a broader population but must include but must include plans for addressing the health, education, protection, legal and pyscho-social needs of children and families affected by HIV, supporting case management, and supporting the workers delivering these services)*	Y N	If N=Red
	If Y, then Q2		
Q2	Was the strategic plan developed involving stakeholders and endorsed by stakeholders from relevant sectors?	Y N	If N=Red
	If Y, then Q3		
Q3	Do **All** of the following apply to the strategic plan? *Tick all that apply:* ☐ 1) Developed using existing social service output and outcome evidence (including relevant health, education, protection, and legal data) ☐ 2) Costed ☐ 3) Includes a monitoring plan that documents progress towards completing the activities ☐ 4) Aligned with the national child protection policy framework, and has provisions for children's needs and rights	# Ticked _____	If 0-3=Yellow If 4=Green
	SCORE		

CEE #: AS_02_02 Social Protection/Child Protection Management Information Systems (Subnational) [SOC OVC]			
STANDARD: Authorities use nationally recognized OVC (including social protection/child protection) information management systems for data collection and analysis processes.			
Instructions: Select the programmatic area(s) addressed by the information management system: ☐ (A) *Social protection* ☐ (B) *Child protection*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this Sub-National Unit (SNU) authority routinely collect and submit data through an existing nationally recognized information management system?	Y N	If N=Red
	If Y, then Q2		
Q2	Does this SNU authority have routine access to analyzed data through the existing nationally recognized information management system?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_02_03 Management and Planning – Operational Planning (Social Services) (Subnational) [SOC OVC]			
STANDARD: The Sub-National Unit (SNU)-level governmental or non-governmental entity overseeing service delivery sites has a costed, data-driven annual operational plan that is developed with, and includes services offered by, governmental and/or non-governmental service delivery points.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a current operational plan which outlines priorities and actions for delivering social services to children and families affected by HIV within the catchment area of this Sub-National Unit? ***Note:*** *The plan is "current" if it covers the current calendar year. The plan may oversee delivery of social services to a broader population but must include plans for addressing the health, education, protection, legal and psychosocial needs of children and families affected by HIV, supporting case management, and supporting the workers delivering these services. Examples of the catchment area include: district, province or geographical area served by a NGO network*	Y N	If N=Red
	If Y, then Q2		
Q2	For the operational plan in question, do **BOTH** apply? *Tick all that apply:* ☐ 1) Was it developed in collaboration with key stakeholders who are providing a significant quantity of services, financing, supplies and technical assistance? ☐ 2) Does the plan include social service activities for children and families affected by HIV that are being undertaken by key stakeholders? ***Note****: Examples of key stakeholders include: Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs), and government facilities*	# Ticked _____	If 0-1=Yellow
	If 2, then Q3		
Q3	For the operational plan in question, do **ALL** apply? *Tick all that apply*: ☐ 1) Costed ☐ 2) Developed using existing social service output and outcome data (including relevant health, education, protection and legal data) ☐ 3) Include a monitoring plan that documents progress towards completing the activities and outcomes of the plan?	# Ticked _____	If 0-2=Yellow If 3=Green
	SCORE		

CEE #: AS_02_04 Supervision – Social Services (Subnational) [SOC OVC]			
STANDARD: Sub-national unit (SNU), regional level or non-governmental social service authorities routinely conduct supervisory visits to social service organizations in their catchment area using standardized tools and processes.			
Instructions: *Check the institution type:* ☐ (1) Sub-National Unit (SNU) – Level Governmental ☐ (2) Regional Unit – Level Governmental ☐ (3) Non-government Level			
Comment:			
	Question	**Response**	**Scoring**
Q1	For the supervisory visits, does this SNU Social Service Office use **ALL** of the following? *Tick all that apply:* ☐ 1) Coordinate routine visits to social service organizations ☐ 2) A standardized process for assessing the quality of social services ☐ 3) A standardized tool ***Note:*** *Quality can be assessed through national quality standards for social service provision or international standards for residential care institutions). Routinely as defined by the social service system supervision guidance* ***Note:*** *The visit may monitor the quality of services to a broader population but must include children and families affected by HIV*	# Ticked _____	If 0-2=Red
	If all 3, then Q2		
Q2	Does the standardized process followed by the SNU Social Service Office include **BOTH**? *Tick all that apply:* ☐ 1) Written feedback to the social service organization with action items or recommendations to address identified gaps and issues (e.g., through supervision logbooks left at the site) ☐ 2) Documentation of social service visits that is maintained at the district office	# Ticked _____	If 0-1=Yellow
	If 2, then Q3		

Q3	In the last quarter, what percent of required supervision visits by the SNU Social Service Office were conducted and documented? *Numerator: Number of required supervision visits by SNU Social service Office conducted and documented* *Denominator: Number of required supervision visits by SNU Social Service*	_____%	If ≤80%=Yellow If >80%= Green
	SCORE		

SET 3: GUIDELINES AND POLICIES		
CEE #	*Abbreviated Title*	*Levels*
AS_03_01	National Guidelines for Key Populations	National
AS_03_02	Key Populations National Quality Norms	National
AS_03_03	Guideline Development	National
AS_03_04	Guideline Distribution	Subnational
AS_03_05	WHO Guidelines for ART Initiation in Different Populations	National
AS_03_06	Data Protection Policies for Collection and Use of Patient Level Data	National
AS_03_07	Enabling Policies and Legislation	National
AS_03_08	Index Testing Services in National HTS Guidelines	National

CEE #: AS_03_01 National Guidelines for Key Populations (National) [GUIDE]			
STANDARD: National guidelines specific to key populations (sex workers, men who have sex with men (MSM), Transgender persons and people who inject drugs (PWID), and persons in closed settings) are updated on a periodic basis to reflect new evidence.			
Instructions: Check the Key Populations (KP) identified in national guidelines: ☐ (1) Sex Workers ☐ (2) MSM ☐ (3) Transgender persons ☐ (4) PWID ☐ (5) Persons in closed settings			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there HIV national guidelines that address specialized KP programmatic concerns?	Y N	If N=Red
	If Y, then Q2		
Q2	Do the national guidelines include specific recommendations for each of the key populations selected above?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Has this national guideline been updated within the last 5 years?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_03_02 Key Populations National Quality Norms (National) [GUIDE]			
STANDARD: National HIV programs set quality norms for the delivery of key population programs to address factors unique to the vulnerability, risk and service access needs of key populations.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do these key population quality norms include **ALL** the following standards? *Tick all that apply:* ☐ 1) Client confidentiality is required for all services ☐ 2) An anti-discrimination policy and code of conduct for all services ☐ 3) People from key populations are not required to meet specific criteria in order to access services ☐ 4) HIV services are provided at no-cost or at a cost that is affordable	Y # Ticked _____	If 0-3 = Red
	If all 4, then Q2		
Q2	Do these key population quality norms include **ALL** the following standards? *Tick all that apply:* ☐ 1) Staff implementing key population services are required to receive annual training and sensitization to address key population needs ☐ 2) A mechanism to maintain confidential feedback from clients is in place for services	# Ticked _____	If 0-1=Yellow
	If both boxes ticked then**, then Q3**		
Q3	Do these key population quality norms include the minimum service package per PEPFAR guidance for key populations? *Tick all that apply:* ☐ 1) Peer education and community-based outreach ☐ 2) Sexually Transmitted Infection (STI) prevention, screening and treatment ☐ 3) Condoms ☐ 4) Condom-compatible lubricants ☐ 5) HIV Testing and Counseling Services (HTS) ☐ 6) Antiretroviral Therapy (ART) for all KP living with HIV ☐ 7) Harm reduction for people who inject drugs (PWID) ☐ 8) Reducing stigma and discrimination	# Ticked ___	If 0-5=Yellow If ≥6= Green
	SCORE		

CEE #: AS_03_03 Guideline Development (National) [GUIDE]			
STANDARD: Development of national guidelines is informed by multi-sectoral stakeholders and documents key aspects of the development process that led to recommended guidelines.			
Instructions: From the list below select all technical areas that are the focus of the guideline(s) being supported by this Implementing Mechanism. Check all that apply: ☐ (A) *Adult Care & Treatment* ☐ (F) *VMMC* ☐ (K) *HTS* ☐ (B) *Community Care & Support* ☐ (G) *PMTCT* ☐ (L) *Key Populations services* ☐ (C) *Pediatric Care & Treatment* ☐ (H) *Condoms* ☐ (M) *OVC/Social Service* ☐ (D) *Other Prevention* ☐ (I) *Food & Nutrition* ☐ (N) *IDV/MMT* ☐ (E) *TB/HIV* ☐ (J) *Post-violence care* ☐ (0) *Family Planning/Safe Motherhood* *Counseling* ☐ (P) *Other* _____ *Use the comment section to record instructional area inconsistencies as they relate to the CEE responses.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	During the development of national guidelines was a group convened and did it consist of the following*?* *Tick all that apply:* ☐ 1) Content experts from specialties involved ☐ 2) Representatives of service provider groups ☐ 3) Representatives of patients, consumers, or civil society ***Note**: Development of national guidelines also includes adoption or adaptation of international guidelines*	# Ticked _____	If 0=Red If 1-2=Yellow
	If All 3, then Q2		
Q2	For guidelines that have reached at least an initial draft stage, do they include **BOTH** of the following? *Tick all that apply:* ☐ (1) A summary of the development process ☐ (2) Specific recommendations graded according to the evidence	# Ticked _____	If 0-1=Yellow If 2=Green
	SCORE		

CEE #: AS_03_04 Guideline Distribution (Subnational) [GUIDE]			
STANDARD: Institutions that are responsible for any aspect of guidelines distribution maintain current copies of national guidelines and distribute them to lower-level facilities in a routine and timely manner.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are current copies of all applicable HIV-related guidelines available at this institution?	Y N	If N=Red
	If Y, then Q2		
Q2	For national guidelines received by this institution from a higher level this year, were those guidelines distributed to lower-level sites within 3 months of receipt?	Y N	If N=Yellow If Y = Green
	SCORE		

CEE #: AS_03_05 WHO Guidelines for ART Initiation in Different Populations (National) [GUIDE]			
STANDARD: National HIV/AIDS technical practice should follow current WHO guidelines for initiation of ART for all patient populations, i.e., Test and Start/Treat All.			
Instructions: Only assess this CEE at the Ministry of Health or National AIDS Control Program offices.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART, i.e., Test and Start/Treat All for each of the following populations? *Tick all that apply:* ☐ 1) Adults (>19 years) ☐ 2) Pregnant and Breastfeeding Mothers ☐ 3) Adolescents (10-19 years) ☐ 4) Children (<10 years)	# Ticked _____	If 0-1= Red If 2-3=Yellow If 4=Green
	SCORE		

CEE #: AS_03_06 Data Protection Policies for Collection and Use of Patient Level Data (National) [GUIDE]			
STANDARD: The government has policies in place that support and govern the collection of patient-level data for health, which include use of data for public health purposes, protection of privacy of the individual, confidentiality of the data, and use of data in criminal cases.			
Instructions: Only assess this CEE at National level MOH			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the government/Ministry have policies in place that support and govern the collection and appropriate use of patient-level data for health, including HIV/AIDS, for all of the following? *Tick all that apply:* ☐ 1) Collection of patient-level data for public health purposes, including surveillance ☐ 2) Collection and use of unique identifiers such as national ID for health records ☐ 3) Privacy and confidentiality of health outcomes matched with personally identifiable information ☐ 4) Use of patient-level data, including protection against its use in criminal cases	# Ticked _____	If 0-1= Red If 2-3=Yellow If 4=Green
	SCORE		

CEE #: AS_03_07 Enabling Policies and Legislation (National) [GUIDE]			
STANDARD: Policies or legislation exist that govern HIV/AIDS service delivery or health care that is inclusive of HIV service delivery.			
Instructions: Only assess this CEE at National level Ministry of Health.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care, which is inclusive of HIV service delivery? *Tick all that apply:* ☐ 1) Polices that permit patients stable on ART to have reduced ARV pickups (i.e., every 3-6 months) ☐ 2) Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☐ 3) Polices that permit HIV self-testing ☐ 4) Policies that permit pre-exposure prophylaxis (PrEP)	# Ticked _____	If 0-3 = Red
	If 4, then Q2		
Q2	Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care, which is inclusive of HIV service delivery? *Tick all that apply:* ☐ 1) A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ 2) A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits	# Ticked _____	If 0-1 = Yellow If 2 = Green
	SCORE		

CEE #: AS_03_08 Index Testing Services in National HTS Guidelines (National) [Guide]			
STANDARD: National HIV Testing Services (HTS) guidelines include standards on the provision of Index testing services at the site level. These guidelines include use of a standardized index testing curriculum to train site level providers.			
Instructions: Only assess this CEE at National level Ministry of Health. This CEE can only be assessed if national index testing guidelines exist. *Index testing, also known as partner notification or contact tracing, is defined as a voluntary process whereby a trained provider asks an HIV-positive client about their sexual partners, drug injecting partners, and biological children. If the HIV-positive client agrees to these services, the trained provider then offers HTS to these partners and/or children.*			
Internal Notes:			
	Question	**Response**	**Scoring**
Q1	Do the most recent national HIV Testing Services (HTS) or ART guidelines include standards on the provision of Index Testing Services (ICT) or voluntary Partner Notification Services (PNS)?	Y N	If N = Red
	If Y, then Q2		
Q2	Is there a national standardized training curriculum for ICT or PNS that includes the WHO 5 Cs **AND** how to assess and address intimate partner violence in the context of index testing services?	Y N	If N = Red
	If Y, then Q3		
Q3	Are there national tools for documenting the provision of index testing services (e.g. an ICT register, patient forms, space on an ART card, etc.?)	Y N	If N = Yellow If Y = Green
	SCORE		

SET 4: PRIVATE SECTOR ENGAGEMENT AND ADVOCACY		
CEE #	*Abbreviated Title*	*Levels*
AS_04_01	Public-Private Partnerships	National/Subnational
AS_04_02	Performance and Service Delivery Transparency	National
AS_04_03	Advocacy	National/Subnational
AS_04_04	Health Communication	National/Subnational

CEE #: AS_04_01 Public-Private Partnerships (National/Subnational [PPP-ADVOCACY]			
STANDARD: Maintenance of public-private partnerships (PPPs) involves regular and systematic engagement of partners.			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, do **ALL** of following apply? *Tick all that apply:* ☐ 1) Partner meetings were held at least quarterly? ☐ 2) Partner meetings included representatives from members of the partnership? ☐ 3) Partner meetings resulted in clearly-defined action items?	# Ticked _____	If 0-2=Red
	If all 3, then Q2		
Q2	Are there protocols in place for managing roles and responsibilities between partners?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_04_02 Performance and Service Delivery Transparency (National) [PPP-ADVOCACY]			
STANDARD: The government makes HIV/AIDS program performance and service delivery data available within 6 months after the date of programming.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the government make annual HIV/AIDS program performance and service delivery data available? *Tick only **one** box:* ☐ 1) More than one year after the date of programming ☐ 2) Within 6-12 months after the date of programming ☐ 3) Within 6 months after the date of programming	A-NUM _____#	If #1= Red If #2=Yellow If #3=Green
	SCORE		

CEE #: AS_04_03 Advocacy (National/Subnational) [PPP-ADVOCACY]			
STANDARD: Entities advocate for issues related to the HIV response, engage key and affected populations in developing an advocacy plan(s) and provide feedback on implementation progress.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has at least one advocacy plan been developed related to an HIV response issue?	Y N	If N=Red
	If Y, then Q2		
Q2	Have those affected by the advocacy issue been involved in developing the advocacy plan? ***Note**: Examples of those affected by advocacy include: community representatives, civil society organizations*	Y N	If N=Red
	If Y, then Q3		
Q3	Has feedback on the progress of advocacy implementation been provided in the last 12 months to the following stakeholders? *Tick all that apply:* ☐ 1) Civil society representatives ☐ 2) Governmental technical officials (e.g., Ministry of Health) ☐ 3) Political authorities (e.g., elected decision makers)	# Ticked _____	If 0=Red If 1-2=Yellow If 3=Green
	SCORE		

CEE #: AS_04_04 Health Communication (National/Subnational) [PPP-ADVOCACY]			
STANDARD: Health communication efforts are developed and implemented using best practice and evidence-based methods.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Where the following activities included in the design of health communication materials? *Tick all that apply:* ☐ 1) Formative research, such as primary or secondary research, qualitative or quantitative? ☐ 2) Identification and rationalization of audience ☐ 3) Pre-testing of messages and tools	# Ticked _____	If 0-2=Red
	If all 3, then Q2		
Q2	Were **BOTH** of the following activities included in the implementation of advocacy materials for key and affected populations? *Tick all activities that apply:* ☐ 1) Informed by formative research ☐ 2) Mentioned/prioritized in the national HIV strategy or related documents	# Ticked _____	If 0-1=Yellow If 2=Green
	SCORE		

SET 5: HUMAN RESOURCES FOR HEALTH		
CEE #	*Abbreviated Title*	*Levels*
AS_05_01	HRH Staffing [HRH]	National/Subnational
AS_05_02	In-Service Training [HRH]	National/Subnational
AS_05_03	Pre-Service Education [HRH]	National
AS_05_04	HRH Regulation [HRH]	National
AS_05_05	Faculty Development [HRH]	National

CEE #: AS_05_01 HRH Staffing (National/Subnational) [HRH]			
STANDARD: The unit responsible for Human Resources (HR) functions makes data-driven decisions to match staffing to health data at sites over which it has oversight.			
*Instructions: Check if the HR unit conducts **any** of the following activities:* ☐ (1) Staffing Allocation ☐ (2) Deployment ☐ (3) Transfers ☐ (4) Recruitment ☐ (5) Retention *If **No** to All, check NA, and **SKIP** this CEE:* ☐ **NA**			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the HR unit have access to health worker data from an on-site manual or electronic HRH database (i.e., HRIS)?	Y N	If N=Red
Q2	In the last 12 months, has the HR unit used the following to guide allocation, deployment and/or transfer decisions for cadres working at sites offering HIV services? *Tick all that apply.* ☐ 1) Health worker data ☐ 2) Other health data (e.g., HMIS, disease burden)	# Ticked ____	If 0=Red If 1=Yellow If 2=Green
	SCORE		

CEE #: AS_05_02 In-Service Training (National/Subnational) [HRH]

STANDARD: In-service training provider(s) for health workers utilize curricula aligned with national norms (e.g., policies, guidelines, regulations, etc.) and PEPFAR policies on non-discrimination, as well as processes that increase training effectiveness.

Instructions: Check the In-Service Training provider type:

☐ (1) IP Office ☐ (2) District/Regional Training Center ☐ (3) National Training/IST Unit
☐ (4) Other

From the following In-Service Training instructional area(s) please select all those offered or coordinated by the provider and supported by this Implementing Mechanism. Check all that apply:

☐ (A) *Adult Care & Treatment* ☐ (H) *Community Care & Support* ☐ (O) *Pediatric Care & Treatment*
☐ (B) *PMTCT* ☐ (I) *VMMC* ☐ (P) *Prevention*
☐(C) *Food & Nutrition* ☐ (J) *HTC* ☐ (Q) *Post-violence care*
☐ (D) *TB/HIV* ☐ (K) *Gender* ☐ (R) *Key Populations*
☐ (E) *Supply Chain Management* ☐ (L) *Blood Safety/Waste Management* ☐ (S) *Leadership &*
☐(F) *QM/QI* ☐ *(M) FP/HIV* ☐ (T) *IDV/MMT*
☐ (G) *Lab* ☐ *(N) Other (specify in the comments field)*

Use the comment section to record any instructional area inconsistencies as they relate to the CEE responses.

Comment:

	Question	Response	Scoring
Q1	Do the in-service trainings offered by the training provider(s) do the following? *Tick all that apply:* ☐ 1) Use national curricula or are compliant with national policies and guidelines ☐ 2) Use standards and regulations set by national authorities ☐ 3) Align with national human resource plans ☐ 4) Include information on non-discrimination ***Note**: Examples of information on non-discrimination include how to deliver clinically appropriate, sensitive and non-stigmatizing care.*	# Ticked _____	If 0-3=Red
	If all 4, then Q2		

Q2	Does the in-service training provider(s) track and submit data on in-service training administered to the authority responsible for oversight of IST data? ***Note**: Examples of authorities responsible for oversight of IST data include: national training coordination unit, professional councils, and regulatory bodies.*	Y N	If N=Yellow
	If Y, then Q3		
Q3	***If the CEE is <u>not</u> administered at a national training coordinating body, ask:*** Does the in-service training provider(s) utilize the design and delivery practices listed below? *(Tick all that apply from the list below)* ***If the CEE is administered at a national training coordinating body, ask:*** Does the institution promote the design and delivery practices listed below: *Tick all that apply:* ☐ 1) Use team-based learning and/or active approaches and methodologies ☐ 2) Provide guidance for trainee selection ☐ 3) Use modes of delivery that reduce site absenteeism (e.g., on-the-job, distance learning) ☐ 4) Conduct participant follow-up / post-training evaluation ☐ 5) Apply follow-up evaluation data to improve future training	# Ticked _____	If 0-1=Yellow If ≥2 = Green
	SCORE		

CEE #: AS_05_03 Pre-Service Education (National) [HRH]			
STANDARD: Pre-service education for clinical and public health workers comprises competency-based curricula, student practica at high volume HIV sites, and faculty is proficient in current HIV methods.			
Instructions: Select the pre-service education profession type(s) being supported by this Implementing Mechanism. Check all that apply: ☐ (1) Medical Doctors ☐ (2) Nurses ☐(3) Midwives ☐(4) Clinical officers ☐ (5) Pharmacy ☐ (6) Laboratory ☐ (7) Public health ☐ (8) Paraprofessionals ☐ (9) Other *Use the comment section to record any profession type inconsistencies as they relate to the CEE responses.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	For the pre-service program, do **ALL** of the following apply? *Tick all that apply:* ☐ 1) The curriculum (e.g. degree program) has HIV content that reflects national standards of practice for cadres offering HIV services ☐ 2) The curriculum and course content have been updated in the last 3 years ☐ 3) Faculty received training on the updated curriculum or course content	# Ticked _____	If 0-2=Red
	If all 3, then Q2		
Q2	For the pre-service program, do **BOTH** of the following apply? *Tick all that apply:* ☐ 1) The pre-service curriculum content is competency based ☐ 2) Students complete practica at high volume HIV sites	# Ticked _____	If 0-1=Yellow If 2=Green
	SCORE		

CEE #: AS_05_04 HRH Regulation (National) [HRH]			
STANDARD: There is a system to register health workers and a continuing professional development program in place.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a system to register health care workers within their cadre?	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a national continuous professional development (CPD) program?	Y N	If N=Yellow If Y-Green
	SCORE		

CEE #: AS_05_05 Faculty Development (National) [HRH]			
STANDARD: Academic institutions have a system in place to support the development of faculty to effectively provide learners with the skills and abilities to deliver quality HIV services.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this academic institution have processes in place to determine faculty development needs? ***Note**: Examples of processes in place to determine faculty needs include: needs assessment, new faculty training survey*	Y N	If N=Red
	If Y, then Q2		
Q2	Does this academic institution provide faculty with the following? *Tick all that apply:* ☐ 1) Orientation and educational training for new staff ☐ 2) Ongoing faculty development programs	# Ticked _____	If 0-1 =Yellow
	If 2, then Q3		
Q3	Does this academic institution have the following key factors in place to support the continued development of faculty? *Tick all that apply:* ☐ 1) Established health professional education department (or responsible unit) that coordinates, administers, monitors and evaluates the faculty development programs ☐ 2) Budgeted internal and/or external resources to support the continued implementation of the faculty development plan ☐ 3) Provisions to link faculty development programs to funding, promotion, and reward	# Ticked _____	If 0 =Yellow If ≥1= Green
	SCORE		

SET 6: COMMODITIES		
CEE #	*Abbreviated Title*	*Levels*
AS_06_01	Supply Chain: ARVs	National
AS_06_02	Data Use for ARV Distribution Decision making	National/Subnational
AS_06_03	Supervision/Monitoring for ARV Supply Chain	National/Subnational
AS_06_04	Supply Chain: Rapid Test Kits/Diagnostics	National
AS_06_05	Data Use for RTK Distribution Decision making	National/Subnational
AS_06_06	Supervision/Monitoring for RTK Supply Chain	National/Subnational
AS_06_07	Supply Chain: Food and Nutrition	National
AS_06_08	Data Use for Food and Nutrition Commodity Distribution Decision making	National/Subnational
AS_06_09	Supervision/Monitoring for Food and Nutrition Supply Chain	National/Subnational
AS_06_10	Medicines Regulatory System - Registration	National
AS_06_11	Medicines Regulatory System – Quality Assurance / Quality Control	National
AS_06_12	Medicines Regulatory System – Pharmacovigilance	National

CEE #: AS_06_01 Supply Chain: ARVs (National) [COMMODITIES]			
STANDARD: National HIV programs routinely oversee the review of ARV supply requirements, and coordinate procurements and delivery/facility ARV distribution schedules.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Is there a group that is responsible for overseeing forecasting and supply planning for ARVs at a national level which meets and updates the forecast and supply plan at least semi-annually?	Y N	If N=Red
	If Y, then Q2		
Q2	Does this group have access to data no more than 3 months old for ARV stock on hand at health facilities, distribution centers, and/or warehouses? ***Note:*** *Although not ideal, it is acceptable to have collated data from districts if the districts have full visibility into stock on hand.*	Y N	If N=Yellow
	If Y, then Q3		
Q3	For all ARVs procured or donated, does the supply planning group do **ALL** of the following at least quarterly? *Tick all that apply:* ☐ 1) Review stock on hand and issues data (or where available, consumption data) from facilities ☐ 2) Review stock on hand and issues data from all appropriate warehouses ☐ 3) Update forecasted consumption ☐ 4) Estimate future funding needs/gaps for procurement in the supply plan ☐ 5) Review delivery schedules of stakeholders procuring/donating ARVs to ensure a continuous supply according to desired stock levels as defined in the supply chain system design ☐ 6) Convene relevant stakeholders and mobilize resources ☐ 7) Coordinate facility distribution functions with involved stakeholders ☐ 8) Monitor and evaluate logistics system performance using fixed, national metrics (metrics from a national PMP or another universally available document)	# Ticked _____	If 0-7=Yellow If 8 = Green
	SCORE		

CEE #: AS_06_02 Data Use for ARV Distribution Decision making (National /Subnational) [COMMODITIES]			
STANDARD: HIV programs have routine access to supply chain data and have a mechanism in place to respond to emergency orders, to ensure a continuous supply of ARVs.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does the central level authority have routine access to **BOTH** of the following supply chain data for each distribution center*? Tick all that apply:* ☐ 1) Timely data on stock on hand for all of the relevant commodity at every distribution center during the latest reporting period ☐ 2) Timely data on stock for all of the relevant commodity issued to health facilities during the last re-supply cycle/ reporting period ***Note:*** *Timely is defined as not older than 3 months or per national standards*	# Ticked _____	If 0-1= Red
	If 2, then Q2		
Q2	Does the central level authority use supply chain data to plan and implement re-positioning or redistribution of stock between distribution centers to avoid low stock levels and expiries or in response to emergency orders?	Y N	If N = Yellow
	If Y, then Q3		
Q3	Are the logistics data on stock status of the relevant commodity and issues data routinely shared with the following audiences that are not primarily concerned with commodity availability, within the broader HIV program? *Tick all that apply:* ☐ 1) Ministry of Health senior leadership ☐ 2) Sub-national level MOH officials ☐ 3) National stakeholders ☐ 4) Supply Chain Implementing Partners ***Note****: Examples of logistics data include: stock-outs, overstocks, expiries, losses.*	# Ticked _____	If 0-3= Yellow If 4= Green
	SCORE		

CEE #: AS_06_03 Supervision/Monitoring for ARV Supply Chain (National/Subnational) [COMMODITIES]			
STANDARD: HIV programs routinely conduct supervisory and monitoring visits aimed at mentoring health workers at facilities to improve the availability of HIV commodities.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does a health official at the national or subnational level conduct quarterly visits using a standardized process on which they have been trained to distribution centers within the country to monitor and supervise activities related to HIV commodity availability? ***Note:*** *Visits do not have to exclusively address HIV commodity availability but must be capable of addressing HIV-product-specific issues*	Y N	If N=Red
	If Y, then Q2		
Q2	Does the standardized process for monitoring and supervisory visits prompt officials to mentor staff on **ALL** of the following? *Tick all that apply:* ☐ 1) Record keeping ☐ 2) Complete, accurate and timely ordering and reporting ☐ 3) Appropriate clean, well-organized with a regularly updated inventory management system, well-ventilated storage conditions for commodities (without commodities on the floor but rather on shelves or pallets) ☐ 4) Adherence to the maximum and minimum stock levels according to national standards as found in the national supply chain SOP/national system design to avoid overstock, stock-outs, losses and expiries ☐ 5) Stock status and commodity availability at the site (which is in part, due to order fill rates and on-time delivery)	# Ticked _____	If 0-4= Yellow
	If all 5, then Q3		
Q3	Are there formal groups or mechanisms (e.g., committees, TWGs) for health officials to gather to discuss HIV product issues that come up during the monitoring and supervisory visits with Central Medical Store, Ministry of Health and other related officials?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_06_04 Supply Chain: Rapid Test Kits/Diagnostics (National) [COMMODITIES]			
STANDARD: National HIV programs have a group that routinely meets and reviews data to oversee commodities forecasting and supply planning.			
INSTRUCTIONS: *Check the products routinely used by the national program and answer questions for only those products which are relevant to the national program:* ☐ (1) RTKs ☐ (2) CD4 ☐ (3) VL ☐ (4) EID/IVT ☐ (5) TB			
Comments:			
	Question	**Response**	**Scoring**
Q1	Is there a group that meets at least semi-annually and is responsible for overseeing the forecasting and supply planning for **ALL** commodities relevant to the national program (*as checked above*)?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the group have timely stock data (3 or fewer months old) from health facilities, distribution centers and warehouses for **ALL** commodities relevant to the national program (*as checked above*)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Quarterly, does the group do **ALL** of the following*? Tick all that apply:* ☐ 1) Review national stock levels ☐ 2) Review stock on hand and issues data from all appropriate warehouses ☐ 3) Update forecasted consumption ☐ 4) Estimate funding needs/gaps for procurement ☐ 5) Review delivery schedules to ensure a continuous supply according to desired stock levels and avoiding stock-outs ☐ 6) Convene relevant stakeholders and mobilize resources ☐ 7) Coordinate distribution functions with involved stakeholders ☐ 8) Monitor and evaluate logistics system performance using fixed, national metrics (metrics from a national PMP or another universally available document)	# Ticked _____	If 0-7= Yellow If 8=Green
	SCORE		

CEE #: AS_06_05 Data Use for RTK Distribution Decision making (National/Subnational) [COMMODITIES]			
STANDARD: HIV programs have routine access to supply chain data and have a mechanism in place to respond to emergency orders, to ensure a continuous supply of HIV-related commodities.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does the central level authority have routine access to **BOTH** of the following supply chain data for each distribution center? *Tick all that apply:* ☐ 1) Timely data on stock on hand for all of the relevant commodity at every distribution center during the latest reporting period ☐ 2) Timely data on stock for all of the relevant commodity issued to health facilities during the last re-supply cycle/ reporting period ***Note:*** *Timely is defined as not older than 3 months or national standards*	# Ticked _____	If 0-1 = Red
	If 2, then Q2		
Q2	Does the central level authority use supply chain data to plan and implement re-positioning or redistribution of stock between distribution centers to avoid low stock levels and expiries or in response to emergency orders?	Y N	If N =Yellow
	If Y, then Q3		
Q3	Are all of the logistics data on stock status of the relevant commodity (e.g., stock-outs, overstocks, expiries, losses) and issues data routinely shared with the following audiences that are not primarily concerned with commodity availability, within the broader HIV program? *Tick all that apply:* ☐ 1) Ministry of Health senior leadership ☐ 2) Sub-national level MOH officials ☐ 3) National stakeholders ☐ 4) Supply Chain Implementing Partner ***Note****: Examples of logistics data include: Stock-outs, overstocks, expiries, losses*	# Ticked _____	If 0-3 = Yellow If 4= Green
	SCORE		

CEE #: AS_06_06 Supervision/Monitoring for RTK Supply Chain (National/Subnational) [COMMODITIES]			
STANDARD: HIV programs routinely conduct supervisory and monitoring visits aimed at mentoring health workers at facilities to improve the availability of RTKs.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does a health official conduct quarterly visits using a standardized process on which they have been trained to distribution centers to monitor and supervise activities related to HIV commodity availability? ***Note:*** *Visits do not have to exclusively address HIV commodity availability but must be capable of addressing HIV-product-specific issues*	Y N	If N=Red
	If Y, then Q2		
Q2	Does the standardized process for monitoring and supervisory visits prompt officials to mentor staff on **ALL** of the following? *Tick all that apply:* ☐ 1) Record keeping ☐ 2) Complete, accurate and timely ordering and reporting ☐ 3) Appropriate clean, well-organized with a regularly updated inventory management system, well-ventilated storage conditions for commodities (without commodities on the floor but rather on shelves or pallets) ☐ 4) Adherence to the maximum and minimum stock levels according to national standards as found in the national supply chain SOP/national system design to avoid overstock, stock-outs, losses and expiries ☐ 5) Stock status and commodity availability at the site (which is in part, due to order fill rates and on-time delivery)	# Ticked _____	If 0-4=Yellow
	If all 5, then Q3		
Q3	Are there formal groups or mechanisms (e.g., committees, TWGs) at the national level for health officials to gather to discuss HIV product issues that come up during the monitoring and supervisory visits with Central Medical Store, Ministry of Health and other related officials	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_06_07 Supply Chain: Food and Nutrition (National) [COMMODITIES]			
STANDARD: Therapeutic and supplementary foods that are procured meet local regulatory authority and international standards for quality and safety, and are stored properly.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does evidence exist that therapeutic and supplementary foods provided within the country for treatment of severe and moderate malnutrition meet international quality and safety standards?	Y N	If N=Red
	If Y, then Q2		
Q2	Are therapeutic and supplementary foods properly stored (lockable, well-ventilated, clean storage site, free from insects and animals, stored on pallets or shelves, away from the sun, with an inventory control system) before they are provided to health facilities (in regional and central warehouses)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Is procurement of therapeutic and supplementary foods guided by a forecast and supply plan that is updated on a quarterly basis with consumption data?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_06_08 Data Use for Food and Nutrition Commodity Distribution Decision making (National/Subnational) [COMMODITIES]			
STANDARD: HIV programs have routine access to supply chain data and have a mechanism in place to respond to emergency orders, to ensure a continuous supply of HIV-related Food and Nutrition commodities.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does the central level authority have routine access to **BOTH** of the following supply chain data for each distribution center? *Tick all that apply:* ☐ 1) Timely data on stock on hand for all of the relevant commodity at every distribution center during the latest reporting period ☐ 2) Timely data on stock for all of the relevant commodity issued to health facilities during the last re-supply cycle/ reporting period ***Note:*** *Timely as defined as not older than 3 months or national standards*	# Ticked _____	If 0-1=Red
	If 2, then Q2		
Q2	Does the central authority use supply chain data to plan and implement re-positioning or redistribution of stock between distribution centers to avoid low stock levels and expiries or in response to emergency orders?	Y N	If N =Yellow
	If Y, then Q3		
Q3	Are the logistics data on stock status of the relevant commodity (e.g., stock-outs, overstocks, expiries, losses) and issues data routinely shared with the following audiences that are not primarily concerned with commodity availability, within the broader HIV program? *Tick all that apply:* ☐ 1) Ministry of Health senior leadership ☐ 2) Sub-national level MOH officials ☐ 3) National stakeholders ☐ 4) Supply Chain Implementing Partners ***Note****: Examples of logistics data include: stock-outs, overstocks, expiries, losses*	# Ticked ____	If 0-3= Yellow If 4= Green
	SCORE		

CEE #: AS_06_09 Supervision/Monitoring for Food and Nutrition Supply Chain (National/Subnational) [COMMODITIES]			
STANDARD: HIV programs routinely conduct supervisory and monitoring visits aimed at mentoring health workers at facilities to improve the availability of Food and Nutrition commodities.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Does a health official conduct quarterly visits using a standardized process on which they have been trained to distribution centers to monitor and supervise activities related to HIV commodity availability? ***Note:*** *visits do not have to exclusively address HIV commodity availability but must be capable of addressing HIV-product-specific issues*	Y N	If N=Red
	If Y, then Q2		
Q2	Does the standardized process for monitoring and supervisory visits prompt officials to mentor staff on **ALL** of the following? *Tick all that apply:* ☐ 1) Record keeping ☐ 2) Complete, accurate and timely ordering and reporting ☐ 3) Appropriate clean, well-organized with a regularly updated inventory management system, well-ventilated storage conditions for commodities (without commodities on the floor but rather on shelves or pallets) ☐ 4) Adherence to the maximum and minimum stock levels according to national standards as found in the national supply chain SOP/national system design to avoid overstock, stockouts, losses and expiries ☐ 5) Stock status and commodity availability at the site (which is in part, due to order fill rates and on-time delivery)	# Ticked _____	If 0-4=Yellow
	If all 5, then Q3		
Q3	Are there formal groups or mechanisms (e.g., committees, TWGs) at the national level for health officials to gather to discuss HIV product issues that come up during the monitoring and supervisory visits with Central Medical Store, Ministry of Health and other related officials?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: AS_06_10 Medicines Regulatory System - Registration (National) [COMMODITIES]			
STANDARD: A country pharmaceutical product registration system is in place that can effectively and efficiently register medicines and other health products.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there national legislation for pharmaceuticals and medical devices requiring product evaluation, registration, and fast-tracking for products of public health importance? ***Note**: Pharmaceuticals encompass: medicines, vaccines, biologics.* ***Note**: Specific products of particular public health importance include ARVs and other essential medicines and products for the HIV program.*	Y N	If N =Red
	If Y, then Q2		
Q2	Does the regulatory authority accept WHO prequalification or marketing authorizations from stringent regulatory authorities (SRAs)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Is there at least one product registered for all of the medicines recommended in the standard treatment guidelines for HIV? ***Note**: Standard treatment guidelines may also be known as a national treatment policy.*	Y N	If N=Yellow If Y =Green
	SCORE		

CEE #: AS_06_11 Medicines Regulatory System – Quality Assurance / Quality Control (National) [COMMODITIES]			
STANDARD: Countries have a quality assurance system in place to ensure the quality of medicines according to established pharmacopeia standards and to combat the availability of substandard and counterfeit medicines in the national treatment policy for HIV or related opportunistic infections.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is quality control testing of medicines by qualified government or independent laboratories informed by a sample collection strategy aligned with the medicines in the standard treatment guidelines for HIV or related opportunistic infections? ***Note**: Standard treatment guidelines may also be known as a national treatment policy.*	Y N	If N =Red
	If Y, then Q2		
Q2	Does the government have its own national drug quality control laboratory, or are there existing MOUs or official agreements with other qualified labs used by the government for drug quality control testing?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Did the government identify and confirm any substandard or counterfeit medicines through testing that resulted in regulatory or legal action? ***Note**: Medicines may be general or HIV-specific.*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_06_12 Medicines Regulatory System – Pharmacovigilance (National) [COMMODITIES]			
STANDARD: Medicine safety surveillance (pharmacovigilance) is governed by legislation and a national pharmacovigilance center or unit that has core structures in place.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the country have specific legal provisions for medicines safety (pharmacovigilance) in national medicines legislation or similar legislation? **AND** Is there a national pharmacovigilance center or unit with **ALL** of the following? *Tick all that apply:* ☐ 1) Designated staff? ☐ 2) Stable basic funding? ☐ 3) A clear mandate? ☐ 4) Defined structure and roles and responsibilities? ☐ 5) An Adverse Drug Reaction (ADR) reporting form?	# Ticked _____	If 0-4=Red
	If all 5, then Q2		
Q2	Is there a national database or system for coordination and collation of pharmacovigilance data to and from stakeholders in the country? ***Note:*** *Examples include national public health programs, pharmacies, health care facilities, consumers, market authorization holders/industry, safety surveillance studies.*	Y N	If N=Yellow
	If Y, then Q3		
Q3	Have any regulatory actions been taken as the result of pharmacovigilance information and/or adverse events reported in the last 12 months?	Y N	If N =Yellow If Y = Green
	SCORE		

SET 7: QUALITY MANAGEMENT		
CEE #	*Abbreviated Title*	*Levels*
AS_07_01	Quality Management/Quality Improvement (QM/QI) System [QM]	National/Subnational
AS_07_02	Quality Management/Quality Improvement (QM/QI) Consumer Involvement [QM]	National/Subnational
AS_07_03	Quality Assurance: Voluntary Medical Male Circumcision (VMMC) [QM]	National/Subnational

CEE #: AS_07_01 Quality Management/Quality Improvement (QM/QI) System (National/Subnational) [QM]			
STANDARD: The national HIV program or sub-national unit has a QM/QI system with dedicated leadership, a budget line item for the QM program, peer learning opportunities, and a current QM/QI plan.			
Instructions: Check the programmatic area(s) included in the QM/QI system: ☐ (1) Adult Care & Treatment ☐ (2) Pediatric Care & Treatment ☐ (3) PMTCT ☐ (4) VMMC ☐ (5) HTS ☐ (6) TB/HIV ☐ (7) Community Care & Support ☐ (8) Prevention ☐ (9) Food & Nutrition ☐ (10) FP/HIV ☐ (11) Services for Key Populations ☐ (12) IDV/MMT ☐ (13) Gender ☐ (14) Post-violence care ☐ (15) OVC/Social Service ☐ (16) Lab ☐ (17) Supply Chain ☐ (18) Blood Safety ☐ (19) Other (specify)_____			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a QM/QI system in place for all supported programmatic areas with all of the following: ☐ 1) Dedicated leadership ☐ 2) Budget line item for the QM program ☐ 3) Peer learning opportunities available to site QA participants to gain insights from other sites and interventions?	# Ticked _____	If 0-2=Red
	If all 3, then Q2		
Q2	Is there a current QM/QI plan? ***Note**: The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan. "Current" means updated within the last 2 years.*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_07_02 Quality Management/Quality Improvement (QM/QI) Consumer Involvement (National/Subnational) [QM]			
STANDARD: Consumers of health services formally engage in the functioning of the QM/QI program.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a system in place to solicit feedback from consumers in the QM/QI system? ***Note:*** *Patients are consumers.*	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a formal, documented process for ongoing and systematic participation of consumers in the QM/QI system? ***Note:*** *Participation might be through focus groups, surveys, or in-depth interviews.*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_07_03 Quality Assurance: VMMC (National/Subnational) [QM]			
STANDARD: The national VMMC program should have a national or subnational-level quality assurance (QA) body that regularly reviews VMMC service quality and safety outcomes data.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the QA committee or body regularly convene (e.g., quarterly, monthly, weekly)? ***Note:*** *As evidenced by reviewing the meeting minutes on file over the previous 3 months*	Y N	If N=Red
	If Y, then Q2		
Q2	Does this committee or body regularly review site, regional and/or national VMMC adverse event outcomes? ***Note****: As evidenced by reviewing the meeting minutes on file over the previous 3 months*	Y N	If N=Yellow
	If Y, then Q3		
Q3	Is there written documentation indicating that the committee or body reviews and calculates rates of moderate and severe adverse events at the site, regional, and/or national levels, and uses this data for program improvement? ***Note:*** Shown in the meeting minutes or summary report on file over the previous 3 months	Y N	If N = Yellow If Y = Green
	SCORE		

SET 8: LABORATORY AND BLOOD TRANSFUSION SUPPORT		
CEE #	*Abbreviated Title*	*Level*
AS_08_01	HIV Rapid Testing Proficiency Testing (PT)/External Quality Assurance (EQA)	National/Subnational
AS_08_02	CD4 Proficiency Testing (PT)/External Quality Assurance (EQA)	National/Subnational
AS_08_03	HIV Viral Load Proficiency Testing (PT)/External Quality Assurance (EQA)	National/Subnational
AS_08_04	HIV DNA PCR (EID) Proficiency Testing (PT)/External Quality Assurance (EQA)	National/Subnational
AS_08_05	Sputum Smear Microscopy Proficiency Testing (PT)/External Quality Assurance (EQA)	National/Subnational
AS_08_06	Xpert MTF/RIF Proficiency Testing (PT)/External Quality Assurance (EQA)	National/Subnational
AS_08_07	Laboratory/Point-of-Care Technology (POCT) Quality Improvement (QI) Program	National/Subnational
AS_08_08	Specimen Referrals	National/Subnational
AS_08_09	Quality Assurance of HIV Testing Services	National/Subnational
AS_08_10	National Blood Transfusion Service Accreditation	National
AS_08_11	National Laboratory Strategic Plan	National
AS_08_12	HIV Viral Load Capacity	National/Subnational

CEE #: AS_08_01 HIV Rapid Test Proficiency Testing (PT)/External Quality Assurance (EQA) (National/Subnational) [LAB]			
STANDARD: The PT/EQA Program provides PT panels or engages in other EQA activities, collects PT/EQA results from at least 90% of participating laboratories/sites, and provides feedback to all sites according to the schedule set by the program.			
Instructions: Assess this CEE at programs that support HIV Rapid Testing PT/EQA activities.			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, has the PT/EQA Program sent out PT panels or engaged in EQA activities to all enrolled sites according to the schedule set by the program?	Y N	If N=Red
	If Y, then Q2		
Q2	In the last 12 months, what percentage of enrolled sites has returned PT/EQA results to the PT/EQA Program within the schedule set by the program? *Numerator: # of enrolled sites which returned PT/EQA results* *Denominator: # of enrolled sites*	_____%	If <90%=Yellow
	If ≥90%, then Q3		
Q3	In the last 12 months, has the PT/EQA Program provided reports, documented feedback, or corrective action on the results of the PT/EQA*? Tick all that apply:* ☐ 1) To all enrolled sites, including to sites that did not return results? ☐ 2) Within the schedule set by the program?	# Ticked _____	If 0-1=Yellow If 2= Green
	SCORE		

CEE #: AS_08_02 CD4 Proficiency Testing (PT)/External Quality Assurance (EQA) (National/Subnational) [LAB]			
STANDARD: The PT/EQA Program provides PT panels or engages in other EQA activities, collects PT/EQA results from at least 90% of participating laboratories/sites, and provides feedback to all sites according to the schedule set by the program.			
Assess this CEE at programs that support CD4 PT/EQA activities			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, has the PT/EQA Program sent out PT panels or engaged in EQA activities to all enrolled sites according to the schedule set by the program?	Y N	If N=Red
	If Y, then Q2		
Q2	In the last 12 months, what percentage of enrolled sites has returned PT/EQA results to the PT/EQA Program within the schedule set by the program? ***Numerator*** *= # of enrolled sites which returned PT/EQA results* ***Denominator*** *= # of enrolled sites*	_____%	If <90%=Yellow
	If ≥90%, then Q3		
Q3	In the last 12 months, has the PT/EQA Program provided reports, documented feedback, or corrective action on the results of the PT/EQA*? Tick all that apply:* ☐ (1) To all enrolled sites, including to sites that did not return results? ☐ (2) Within the schedule set by the program?	# Ticked _____	If 0-1=Yellow If 2= Green
	SCORE		

CEE #: AS_08_03 HIV Viral Load Proficiency Testing (PT)/External Quality Assurance (EQA) (National/Subnational) [LAB]			
STANDARD: The PT/EQA Program provides PT panels or engages in other EQA activities, collects PT/EQA results from at least 90% of participating laboratories/sites, and provides feedback to all sites according to the schedule set by the program.			
Instructions: Assess this CEE at programs that support HIV Viral Load PT/EQA activities			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, has the PT/EQA Program sent out PT panels or engaged in EQA activities to all enrolled sites according to the schedule set by the program?	Y N	If N=Red
	If Y, then Q2		
Q2	In the last 12 months, what percentage of enrolled sites has returned PT/EQA results to the PT/EQA Program within the schedule set by the program? **Numerator** = _____# of enrolled sites which returned PT/EQA results **Denominator** = _____# of enrolled sites	_____%	If <90%=Yellow
	If ≥90%, then Q3		
Q3	In the last 12 months, has the PT/EQA Program provided reports, documented feedback, or corrective action on the results of the PT/EQA*? Tick all that apply:* ☐ 1) To all enrolled sites, including to sites that did not return results? ☐ 2) Within the schedule set by the program?	# Ticked _____	If 0-1=Yellow If 2= Green
	SCORE		

CEE #: AS_08_04 HIV DNA PCR (EID) Proficiency Testing (PT)/External Quality Assurance (EQA) (National/Subnational) [LAB]			
STANDARD: The PT/EQA Program provides PT panels or engages in other EQA activities, collects PT/EQA results from at least 90% of participating laboratories/sites, and provides feedback to all sites according to the schedule set by the program.			
Instructions: Assess this CEE at programs that support HIV DNA PCR (EID) PT/EQA activities			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, has the PT/EQA Program sent out PT panels or engaged in EQA activities to all enrolled sites according to the schedule set by the program?	Y N	If N=Red
	If Y, then Q2		
Q2	In the last 12 months, what percentage of enrolled sites has returned PT/EQA results to the PT/EQA Program within the schedule set by the program? **Numerator** = _____# of enrolled sites which returned PT/EQA results **Denominator** = _____# of enrolled sites	_____%	If <90%=Yellow
	If ≥90%, then Q3		
Q3	In the last 12 months, has the PT/EQA Program provided reports, documented feedback, or corrective action on the results of the PT/EQA*? Tick all that apply:* ☐ (1) To all enrolled sites, including to sites that did not return results? ☐ (2) Within the schedule set by the program?	# Ticked _____	If 0-1=Yellow If 2= Green
	SCORE		

CEE #: AS_08_05 Sputum Smear Microscopy Proficiency Testing (PT)/External Quality Assurance (EQA) (National/Subnational) [LAB]			
STANDARD: The PT/EQA Program provides PT panels or engages in other EQA activities, collects PT/EQA results from at least 90% of participating laboratories/sites, and provides feedback to all sites according to the schedule set by the program.			
Instructions: Assess this CEE at programs that support Sputum Smear Microscopy PT/EQA activities			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, has the PT/EQA Program sent out PT panels or engaged in EQA activities to all enrolled sites according to the schedule set by the program?	Y N	If N=Red
	If Y, then Q2		
Q2	In the last 12 months, what percentage of enrolled sites has returned PT/EQA results to the PT/EQA Program within the schedule set by the program? **Numerator** = _____# of enrolled sites which returned PT/EQA results **Denominator** = _____# of enrolled sites	_____%	If <90%=Yellow
	If ≥90%, then Q3		
Q3	In the last 12 months, has the PT/EQA Program provided reports, documented feedback, or corrective action on the results of the PT/EQA*? Tick all that apply:* ☐ 1) To all enrolled sites, including to sites that did not return results? ☐ 2) Within the schedule set by the program?	# Ticked _____	If 0-1=Yellow If 2= Green
	SCORE		

CEE #: AS_08_06 Xpert MTB/RIF Proficiency Testing (PT)/External Quality Assurance (EQA) (National/Subnational) [LAB]			
STANDARD: The PT/EQA Program provides PT panels or engages in other EQA activities, collects PT/EQA results from at least 90% of participating laboratories/sites, and provides feedback to all sites according to the schedule set by the program.			
Instructions: Assess this CEE at programs that support Xpert MTB/RIF PT/EQA activities			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the last 12 months, has the PT/EQA Program sent out PT panels or engaged in EQA activities to all enrolled sites according to the schedule set by the program?	Y N	If N=Red
	If Y, then Q2		
Q2	In the last 12 months, what percentage of enrolled sites has returned PT/EQA results to the PT/EQA Program within the schedule set by the program? **Numerator** = _____# of enrolled sites which returned PT/EQA results **Denominator** = _____# of enrolled sites	_____%	If <90%=Yellow
	If ≥90%, then Q3		
Q3	In the last 12 months, has the PT/EQA Program provided reports, documented feedback, or corrective action on the results of the PT/EQA*? Tick all that apply:* ☐ (1) To all enrolled sites, including to sites that did not return results? ☐ (2) Within the schedule set by the program?	# Ticked _____	If 0-1=Yellow If 2= Green
	SCORE		

CEE #: AS_08_07 Laboratory/Point-of-Care Technology (POCT) Quality Improvement (QI) Program ([LAB]			
STANDARD: Implementation of national QI Programs for laboratory and POCT leads to measurable QI progress in at least 75% of participating laboratories or testing sites.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a plan for implementation of the laboratory/POCT QI program been developed?	Y N	If N=Red
	If Y, then Q2		
Q2	What percent of the laboratories/POCT sites participating in the QI Program have achieved measurable QI progress? **Numerator**= _____# of enrolled sites with measurable QI progress **Denominator** = _____# of sites enrolled in QI program ***Note:*** *Examples of measurable QI progress include: accreditation, certification, or other documentation of achievement towards QI goals*	_____%	If <75% = Yellow If ≥75% = Green
	SCORE		

CEE #: AS_08_08 Specimen Referrals (National/Subnational) [LAB]			
STANDARD: Programs for specimen referral/result reporting have a defined specimen transportation schedule and standardized procedures for safe operations, ensuring that sites receive at least 80% of test results.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the specimen referral/result reporting network have a defined transportation schedule?	Y N	If N=Red
	If Y, then Q2		
Q2	Are there standardized procedures for **ALL** of the following: *Tick all that apply:* ☐ 1) Safe specimen packaging and transport? ☐ 2) Specimen tracking ☐ 3) Test results delivery	# Ticked _____	If 0-2= Red
	If all 3, then Q3		
Q3	What percent of laboratory test results arrive at HIV service delivery sites within the target turnaround time from specimen collection to time of result receipt? **Numerator** = ____ # of HIV service delivery sites that receives results with the target turnaround time **Denominator** =____ # of HIV service delivery sites that collect and send specimens for testing referral	____%	If <80% = Yellow If ≥80% = Green
	SCORE		

CEE #: AS_08_09 Quality Assurance of HIV Testing Services (National/Subnational) [LAB]			
STANDARD: The HIV Rapid Test Quality Improvement (QI) Program monitors the quality of HIV rapid testing including the use of standardized laboratory logbooks, verifying the quality of HIV rapid test kits, and regularly documented site visits to testing sites.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a process by the HIV Rapid Test QI program to ensure that data from the HTS rapid testing logbooks at the HIV testing sites gets reported and reviewed on a quarterly basis?	Y N	If N =Red
	If Y, then Q2		
Q2	Is each new batch/lot of HIV rapid test kits verified for quality before release to sites?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Do HIV rapid test program supervisors conduct and document site visits at least semi-annually to assess the quality of HIV testing at the sites y?	Y N	If N=Yellow If Y = Green
	SCORE		

CEE #: AS_08_10 National Blood Transfusion Service Accreditation (National) [LAB]			
STANDARD: Blood transfusion services have a roadmap to achieve accreditation from a regional or internationally-recognized blood service accrediting body.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has the National Blood Transfusion Service (NBTS) identified an appropriate blood banking accrediting body?	Y N	If N=Red
	If Y, then Q2		
Q2	Has the NBTS completed a pre-accreditation self-assessment process outlined by the identified accrediting body?	Y N	If N=Red
	If Y, then Q3		
Q3	Has the NBTS produced an accreditation roadmap based on gaps identified through the self-assessment? ***Note:*** *The roadmap will be used to direct external technical assistance activities and frame the use of any bi-lateral COP funding.*	Y N	If N=Yellow
	If Y, then Q4		
Q4	Is there evidence that NBTS is making progress towards remediating issues or gaps identified in the roadmap?	Y N	If N=Yellow
	If Y, then Q5		
Q5	What percentage of the total number of NBTS blood centers has achieved accreditation? *Numerator: Number of NBTS blood centers that achieved accreditation* *Denominator: Number of NBTS blood centers*	____%	If <50%=Yellow If ≥50%= Green
	SCORE		

CEE #: AS_08_11 National Laboratory Strategic Plan (National) [LAB]			
STANDARD: A National Laboratory Strategic Plan has been developed, approved, costed and implemented.			
Instructions: Assess this CEE at the Ministry(s) and Partners supporting Ministry(s) to develop a National Laboratory Strategic Plan			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a National laboratory Strategic plan been developed? **Note**: If the national strategic plan is under development, then select No	Y N	If N=Red
	If Y, then Q2		
Q2	Which of the following most accurately reflect the status of the National Laboratory Strategic Plan? *Tick all that apply:* ☐ 1) The National Laboratory Strategic has been approved ☐ 2) The National Laboratory Strategic plan has been costed ☐ 3) The National Laboratory Strategic plan has been implemented	# Ticked _____	If 0-2=Yellow If 3=Green
	SCORE		

CEE #: AS_08_12 HIV Viral Load Capacity (National) [LAB]			
STANDARD: Nationally, there is laboratory capacity to provide HIV viral load testing to meet the expected needs (per number of PLHIV) and reach sustained epidemic control.			
Instructions: Assess this CEE at Ministries and Partners providing support for HIV Viral Load testing scale-up.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there laboratory capacity to provide for HIV viral load testing that includes all of the following? *Tick all that apply:* ☐ 1) Adequate number of HIV viral load testing laboratories and efficient laboratories networks to provide testing to all PLHIV ☐ 2) Adequate number of HIV viral load Instruments at each laboratory to test the expected number of PLHIV ☐ 3) Support for Instrument maintenance and supply chain systems to prevent HIV viral load testing interruption. ☐ 4) Laboratory Information Management Systems for specimen and result management and provide data on HIV viral load testing capacity.	# Ticked _____	If 0-1= Red If 2-3=Yellow If 4=Green
	SCORE		

SET 9: STRATEGIC INFORMATION: SURVEILLANCE, SURVEYS AND EVALUATION		
CEE#	*Abbreviated Title*	*Levels*
AS_09_01	Surveillance and Survey Data Collection According to National Strategy	National
AS_09_02	Surveillance and Survey Data Collection According to an Approved Protocol	National/Subnational
AS_09_03	Surveillance and Survey Data Use and Availability	National/Subnational

CEE #: AS_09_01 Surveillance and Survey Data Collection According to National Strategy (National) [SI]			
STANDARD: The surveillance unit (or designated entity) collects surveillance and survey data per the national HIV Surveillance and Survey Strategy.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a written national HIV Surveillance and Survey Strategy, based on current epidemiological data from the in-country HIV epidemic?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the unit collect HIV surveillance and survey data among population groups and geographic locales specified in the national HIV Surveillance and Survey Strategy?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_09_02 Surveillance and Survey Data Collection According to an Approved Protocol (National/Subnational) [SI]			
STANDARD: The surveillance unit (or designated entity) collects and reviews HIV surveillance and survey data according to technical standards included in approved protocols.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Were all HIV surveillance and survey protocols approved by an in-country institutional review board prior to the start of field implementation?	Y N	If N=Red
	If Y, then Q2		
Q2	Within the last year, did the surveillance unit collect all HIV surveillance and/or survey data in accordance with technical protocols?	Y N	If N=Red
	If Y, then Q3		
Q3	Were data collected for HIV surveillance and surveys conducted within the last year reviewed for quality by a member of the surveillance unit staff?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: AS_09_03 Surveillance and Survey Data Use and Availability (National/Subnational) [SI]			
STANDARD: The surveillance unit (or designated entity) ensures that surveillance and survey reports are made available to stakeholders and the general public, and are used within the same year for HIV program planning and improvement.			
Comments:			
	Question	**Response**	**Scoring**
Q1	Are HIV surveillance and survey reports highlighting key results made available to stakeholders and the general public within 12 months of completion of data collection and field implementation?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the surveillance unit ensure that the most recent available HIV surveillance and survey data are used within the same year for all HIV program planning and improvement?	Y N	If N=Yellow If Y=Green
	SCORE		

SET 10: PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE (PLGHA)

Instructions:
The following questions are designed to help SIMS Assessors determine whether the PLGHA policy applies to the Implementing Mechanism being assessed during the Above-Site SIMS visit.

All implementing agencies and partners are expected to conduct agency-specific compliance monitoring activities at the site-level in addition to monitoring PLGHA policy compliance with this above-site CEE. This module is part of each PEPFAR implementing agency's broader processes related to ensuring compliance with the PLGHA policy.

Which mechanisms are subject to the PLGHA policy?

- PLGHA **APPLIES** to foreign non-governmental organizations (NGOs) receiving an award or sub-award of U.S. global health assistance, including PEPFAR funds and commodities. A foreign NGO is defined as a for-profit (commercial) or not-for-profit non-governmental organization that is not organized under the laws of the United States.
- U.S. NGOs are **NOT** subject to the terms of the policy, but U.S. NGOs are required to pass down the policy's requirements to foreign sub-recipients of global health assistance.
- The PLGHA policy also does **NOT** apply to foreign governments or parastatals, or to public international organizations and other multilateral entities in which sovereign nations participate.
- The policy applies to **ALL** cooperative agreements, grants, and grants under contract that provide global health assistance. The policy **DOES NOT** currently apply to contracts.

NOTE: The course, entitled ***Protecting Life in Global Health Assistance and Statutory Abortion Restrictions*** is available through the GH E-Learning Center and can be accessed using the link below.

https://www.globalhealthlearning.org/course/protecting-life-global-health-assistance-and-statutory

	Question	Response		Use of CEE
1	Is this award with a foreign government or a parastatal organization?	Y	N	**If Y = STOP** **If N = PROCEED**
2	Is this award with a public international organization or another multilateral (i.e. WHO, UNAIDS, Global Fund) entity in which sovereign nations participate?	Y	N	**If Y = STOP** **If N = PROCEED**
3	Is this award a contract?	Y	N	**If Y = STOP** **If N = PROCEED**
4	Does this implementing mechanism have the Protecting Life in Global Health Assistance Standard Provision in its award?	Y	N	**If Y = PROCEED** **If N = STOP**

CEE #: AS_10_01 Protecting Life in Global Health Assistance [PLGHA]

STANDARD: All partners subject to the PLGHA policy are implementing the policy as required and have systems in place to ensure compliance with the policy.

Instructions: *PLGHA applies to foreign non-governmental organizations (NGOs) receiving an award or sub-award U.S. global health assistance, which includes PEPFAR funds and commodities. U.S. NGOs are not subject to the terms of the policy, but U.S. NGOs are required to pass down the policy's requirements to foreign sub-recipients of global health assistance. A foreign NGO is defined as a for-profit (commercial) or not-for-profit non-governmental organization that is not organized under the laws of the United States.*

The PLGHA policy also does not apply to foreign governments or parastatals, or to public international organizations and other multilateral entities in which sovereign nations participate. The policy applies to cooperative agreements, grants, and grants under contract that provide global health assistance. The policy does not currently apply to contracts.

The PLGHA standard provision requires that, prior to furnishing global health assistance to a foreign NGO sub-recipient (e.g. through a new sub-award that provides global health assistance, or an amendment of an existing sub-award that provides global health assistance to add any new U.S. government funding), the recipient must ensure that such sub-award includes the PLGHA standard provision. Furnishing health assistance does not include the procurement of goods or services from an organization. The term "applicable" below refers to sub-awards subject to the policy.

Therefore, these questions should be asked of both U.S. and foreign NGO partners receiving global health funding through USG assistance mechanisms (i.e. grants and cooperative agreements).

Is this implementing mechanism currently subject to the Protecting Life in Global Health Assistance Standard Provision (use checklist on previous page to determine if the mechanism is subject to the policy)?

*If **NO**, check NA, and **SKIP** this CEE.*

NA ☐

Comment:

	Question	Response	Scoring
Q1	Do you ensure that the PLGHA standard provision is included in **applicable** global health sub-awards with foreign NGO sub-recipients to whom you furnish global health assistance (e.g. when you issue a new health sub-award to a foreign NGO, or when you provide additional funds to an existing health sub-award to a foreign NGO)?	Y N	If N = Red

	If Y, then Q2		
Q2	Do you ensure that relevant project staff, including **applicable** sub-partners, are trained on or oriented to the PLGHA policy requirements (eg: through the eLearning course or in-person)?	Y N	If N = Yellow
	If Y, then Q3		
Q3	Does the project have procedures or plans in place for conducting compliance monitoring of the PLGHA policy as applicable, including how to respond to potential vulnerabilities or violations?	Y N	If N = Yellow If Y = Green
	SCORE		

SIMS

SITE IMPROVEMENT THROUGH MONITORING SYSTEM (SIMS)

FY21 SITE ASSESSMENT TOOL

Version 4.1, 15 August 2020

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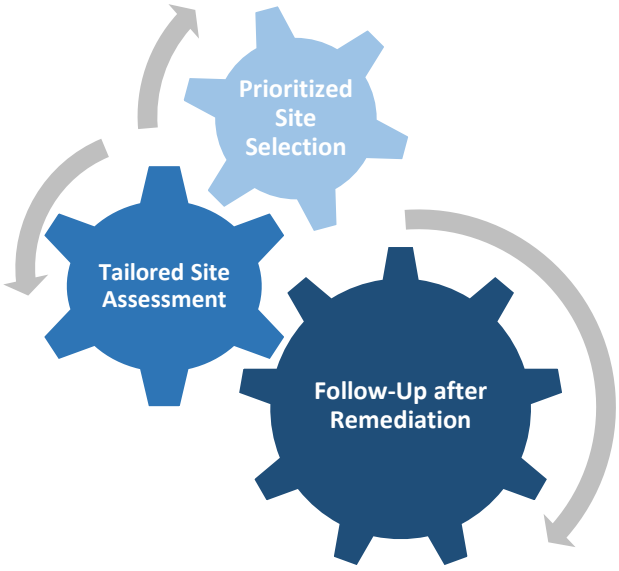
SIMS

Site Improvement through Monitoring System

SIMS is a quality assurance tool used to monitor and improve program quality at PEPFAR-supported sites that guide and support service and non-service delivery functions.



Goals of SIMS 4.0

- ✓ Integrate SIMS into broader framework(s) for analysis, management and improvement
- ✓ Tailored, nimble, responsive site selection and implementation based on performance, program needs, and programmatic gaps
- ✓ Actionable to drive improvement or sustain quality

2 Assessment Tools

Site Level Tool

Site assessments are conducted at both facility and community sites (i.e. places where services are provided). Examples include clinics, hospitals, laboratories, and 'standalone' structures.

Above-Site Level Tool

Above-site assessments are conducted at PEPFAR-supported institutions that are above the service delivery point (i.e. not where services are provided or beneficiaries are reached). Examples include health offices at the national or subnational level.

2 Types of Assessments

Comprehensive Assessment is the first assessment at a site or above site location. All relevant standards (Required and Elective CEEs) should be assessed.

Follow-Up Assessment determines whether all CEEs that scored red or yellow during a prior assessment have improved (i.e. red or yellow to green).

Core Essential Elements (CEEs)

Standard: CEEs are built on program quality standards based upon World Health Organization supported evidence or guidelines and/or documentation of best practices.

Assessment Questions: Each CEE is composed of a series of questions that progressively assess the site against the standard.

Final Score: The final score is red, yellow, green or N/A. CEE scores are designed to highlight whether a problem exists.

Organization of SIMS Site Assessment Tool

Set #	Set Name
SET 1A	General
SET 1B	Commodities Management
SET 1C	Data Quality
SET 2A	Care And Treatment-General Population
SET 2B	Care And Treatment For HIV Infected Children
SET 3A	Key Populations-General
SET 3B	Care And Treatment – Key Populations
SET 4A	Preventing Mother to Child Transmission, Antenatal Care, Postnatal, and Labor and Delivery
SET 4B	HIV Exposed Infants
SET 5	Voluntary Medical Male Circumcision
SET 6	Adolescent Girls and Young Women and Gender-based Violence
SET 7	HIV Testing Services
SET 8	Tuberculosis Treatment Service Point
SET 9	Methadone or Buprenorphine Medication Assisted Treatment
SET 10A	Laboratory
SET 10B	Blood Safety

Organization of SIMS Above-Site Assessment Tool

Set #	Set Name
SET 1	HIV Planning, Coordination and Management
SET 2	Orphans and Vulnerable Children/Social Services
SET 3	Guidelines and Policies
SET 4	Private Sector Engagement and Advocacy
SET 5	Human Resources for Health
SET 6	Commodities
SET 7	Quality Management
SET 8	Laboratory and Blood Transfusion Support
SET 9	Strategic Information, Surveys, Surveillance and Evaluation
SET 10	Protecting Life in Global Health Assistance

Description of Final CEE Scores

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

REFERENCE INFORMATION

Description of SIMS Assessment Types and Assessment Tool Composition

Assessment Tool	Assessment Type	Conducted by	CEEs to be Assessed
Site	Comprehensive	USG	For Required CEEs: All applicable* For Elective CEEs: All applicable* and relevant**
	Follow-Up	USG or IP	All CEEs that previously scored red or yellow.
Above Site	Comprehensive	USG	For Required CEEs: All applicable* For Elective CEEs: All applicable* and relevant**

*Applicable means if those services are provided or offered
**Relevant means assessed as needed (at the discretion of the Operating Unit based on performance, program needs and program gaps)

Explanation of Icons in the SIMS Assessment Tools

Icon	Description of Icon	Explanation
	Eyes	Question requires visual inspection of documents, charts/registers or materials
	Pink Square	Question requires Chart or register review
	Gray Circle	Question requires Materials review
	Blue Triangle	Question requires Document review

Description of Final CEE Scores

COLOR (# score)	DESCRIPTION
G: Green (3)	Meets standard
Y: Yellow (2)	Needs improvement
R: Red (1)	Needs urgent remediation
Gray (0)	Not Applicable selected

Core Essential Elements (CEE) Structure Used within this Tool

FY 21 SIMS SITE ASSESSMENT TOOL

Table of Contents

SET 1A: ALL SITES-GENERAL			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_01_01	Stakeholder Engagement		X
S_01_02	Condom Availability	X	
S_01_03	Patient Rights, Stigma and Discrimination Policies		X
S_01_04	Child Safeguarding		X
S_01_05	Support and Assessment of Staff Performance		X
S_01_06	TB Infection Control		X
S_01_07	Waste Management	X	
S_01_08	Injection Safety	X	
S_01_09	Provision of PreEP Services		X

CEE #: S_01_01 Stakeholder Engagement [ALL SITES-GEN]			
STANDARD: Each site developed a strategy/defined process for stakeholder engagement, including with Civil Society Organizations (CSOs) and beneficiaries of HIV services. The strategy/defined process includes activities to elicit and use stakeholder feedback for (1) program planning and implementation at least every 6-months and (2) review and/or evaluation of program performance data at least every 4 months.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has the service delivery site developed a written strategy/defined process for stakeholder engagement that includes the following? *Check all that apply:* ☐ 1) Eliciting and using stakeholder, including CSOs and beneficiaries, feedback for program planning and implementation? ☐ 2) Eliciting and using stakeholder, including CSOs and beneficiaries, feedback for review and/or evaluation of program performance data?	# Ticked	If 0-1= Red
	If 2, then Q2		
Q2	Are stakeholders, including CSOs and beneficiaries, engaged in planning and review activities? *Check all that apply:* ☐ 1) Stakeholders are engaged every 6-months in program planning and implementation activities ☐ 2) Stakeholders are engaged at least every 4 months in review and/or evaluation or performance data	# Ticked _____	If 0-1=Yellow If 2=Green
	SCORE		

CEE #: S_01_02 Condom Availability [ALL SITES-GEN]			
STANDARD: Each site has a reliable supply of condoms. Condoms have at least one month of shelf life before expiration, and are easily accessible to patrons/clients at the site.			
Comment:			
	Question	**Response**	**Scoring**
Q1 👀	Are both of these statements true? *Check all that apply:* ☐ 1) Condoms with at least one-month shelf life are available at this site? ☐ 2) Condoms with at least one-month shelf life are continuously available for the past three months	# Ticked _____	If 0-1=Red
	If 2, then Q2		
Q2 👀	Are condoms easily accessible to patrons/clients at the site (e.g., in a bowl on the counter, in a dispenser, or distributed directly to clients/patrons at the site)? ***Note**: Condoms are 'easily accessible' if available on-site, regardless of whether they are for sale or distributed free*.	Y N	If N=Yellow If Y =Green
	SCORE		

CEE #: S_01_03 Patient Rights, Stigma and Discrimination Policies [ALL SITES-GEN]			
STANDARD: Every site where HIV services are provided has a written statement, policy, or other written tools describing the rights of patients and the protection of all patients from stigma and discrimination regardless of age, disability, gender identity, HIV status, race, religion, or sex. All staff are trained on patient rights and protection of all patients from stigma and discrimination.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a written statement, policy or tools stating that all patients are entitled to equal access to services? ***Note:*** *Documents should be available in local language.*	Y N	If N=Red
	If Y, then Q2		
Q2	Are there practices in place by which patients are made aware of these rights (e.g., statement posted in plain view, provider explains their rights)?	Y N	If N=Red
	If Y, then Q3		
Q3	Are all staff initially trained and given annual refresher training on patient rights and protection of all patients from stigma and discrimination? ***Note:*** *Staff are clinicians, management staff, support staff, volunteers. Documentation includes training logs, records of trainings provided etc.*	Y N	If N=Yellow
	If Y, then Q4		
Q4	Are BOTH of these statements true? *Check all that apply?* ☐ 1) There is a documented process/procedure for patients to report any problem related to accessing services confidentially, including discrimination against them personally ☐ 2) There is evidence that the site takes action in response to these reports	# Ticked _____	If 0-1=Yellow If 2=Green
	SCORE		

CEE #: S_01_04 Child Safeguarding [ALL SITES-GEN]			
STANDARD: Each site where PEPFAR supports service provision to children, or where personnel and volunteers regularly contact children, has a written child safeguarding policy to prevent and respond to abuse, exploitation, or neglect by (1) personnel and volunteers or (2) as a result of PEPFAR-supported programming. All personnel and program volunteers are trained on this policy.			
Instructions: Does the site's agreement with the prime partner or implementing USG agency require a child safeguarding policy? *If **NO**, check NA, and **SKIP** CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have a written child safeguarding policy for preventing and responding to abuse, exploitation, or neglect by personnel and volunteers or as a result of PEPFAR-supported programming? ***Note:** (1) Personnel include clinical staff, management staff, support staff, and volunteers. (2) Documents should be available in local language.*	Y N	If N=Red
	If Y, then Q2		
Q2	Are all personnel trained on this child safeguarding policy? *Note: documentation may include training logs, personnel records, etc.*	Y N	If N=Red
	If Y, then Q3		
Q3	Is there at least one anonymous and/or confidential way to report abuse, exploitation, or neglect (i.e., suggestion box in the bathroom, call-in hotline, other)?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_01_05 Support and Assessment of Staff Performance [ALL SITES-GEN]			
STANDARD: Each site has adequate measures in place to monitor and support health worker performance.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do all site staff involved in the delivery of HIV services have a job description (different from national SOWs) or similar document that describes the staff roles and expectations (e.g., job aid, work flow charts that outline tasks for team members)?	Y N	If N=Red
	If Y, then Q2		
Q2	Which mechanisms are in place that facilitate performance feedback among health workers, their supervisors, and the clients? *Tick all that apply:* ☐ 1) Performance reviews that follow national plans/guidelines ☐ 2) Routine supervisory support ☐ 3) Quarterly collection of client feedback (e.g., survey, feedback box)	# Ticked _____	If 0-2=Yellow If 3 =Green
	SCORE		

CEE #: S_01_06 TB Infection Control [ALL SITES-GEN]			
STANDARD: Each facility has a TB infection control focal person, and implements a standard TB infection control plan to minimize the risk of TB transmission to patients and health care workers. The TB infection control plan includes the following: segregating and fast tracking of individuals who cough, instructing patients on cough etiquette, and well-ventilated waiting and clinic areas.			
Instructions: As part of the facility walk through for SIMS, assess Q2 and Q3 throughout and score based on any instance where the observations do not meet the requirements.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there an approved facility-specific TB infection control plan that addresses **All** of the following? *Tick all that apply:* ☐ 1) Identifying and segregating individuals who cough ☐ 2) Instructing patients on cough etiquette ☐ 3) Fast-tracking coughing patients for TB diagnostic work-up	# Ticked	If 0-2=Red
	If 3, then Q2		
Q2	Is there a staff person/focal person responsible for TB infection control activities?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the site include at least **one** of the following to minimize the risk of TB transmission to patients and health care workers: well-ventilated waiting area, air filtration, or UV irradiation? ***Note**: acceptable ventilation includes open windows that allow for a cross breeze and a window area that represents the equivalent of 20% of the floor area*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_01_07 Waste Management [ALL SITES-GEN]			
STANDARD: Each site implements procedures for collection, storage, and disposal of infectious waste to prevent exposures to workers, patients, and the public. Procedures include segregation of infectious waste, posted waste disposal guidance, and secure storage of infectious waste inside and outside the site.			
*Instructions: Assess all the components of this CEE throughout the site, then complete the CEE scoring based on **any** instance where the observations do not meet the requirements.* *If the site does not generate infectious waste, check NA, and **SKIP** this CEE* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is infectious waste segregated from general waste and securely stored in separate, labeled, color-coded waste containers inside and outside the facility?	Y N	If N=Red
	If Y, then Q2		
Q2	Is all infectious waste (*regardless if stored inside or outside the facility*) securely stored and not accessible to the public?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the facility have the following? *Tick all that apply:* ☐ 1) Written procedures for infectious waste management and disposal available? ☐ 2) Posted guidance or job aides describing the types of waste and the process for waste segregation?	# Ticked	If 0-1 = Yellow If 2 = Green
	SCORE		

CEE #: S_01_08 Injection Safety [ALL SITES-GEN]			
STANDARD: Each site has appropriate injection and phlebotomy equipment and supplies and written, standardized safety procedures available to reduce risk of blood borne pathogen transmission to patients and healthcare workers.			
*Instructions: Assess all the components of this CEE throughout the site, then complete the CEE scoring based on **any** instance where the observations do not meet the requirements.* Does this site provide injections or phlebotomy services to patients? *If **NO**, check NA, and **SKIP** CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are **ALL** of the following available in the areas where blood is drawn? *Tick all that apply:* ☐ 1) Disposable gloves ☐ 2) Hand washing materials ☐ 3) Rigid World Health Organization-approved sharps containers	# Ticked _____	If 0-2=Red
	If 3, then Q2		
Q2	Is appropriate size equipment available for all applicable patient ages? (*Example: pediatric venous and capillary blood collection*)?	Y N	If N= Red
	If Y, then Q3		
Q3	Are **ALL** of the following in place? ☐ 1) Written procedures for safe blood collection ☐ 2) Post-exposure prophylaxis (PEP) specific site protocol for health care staff working at the site ***Note:** Guidelines do not qualify as a specific site protocol.*	# Ticked _____	If 0-1=Red
	If 2, then Q4		
Q4	Are PEP drugs or starter packs available at this site?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: S_01_09 Provision of PrEP Services [ALL SITES-GEN]			
STANDARD: HIV-uninfected men and women who are at substantial risk of infection can access pre-exposure prophylaxis (PrEP) through high quality, safe, and friendly services.			
*Instructions: If the national policy does not include the provision of PrEP OR the site is not accredited to provide PrEP services, then check NA and **SKIP** CEE:* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standard training offered to site staff on PrEP provision?	Y N	If N=Red
	If Y, then Q2		
Q2	Is PrEP offered at an already existing service delivery point (ex. MCH, CTC/CCC, DIC etc.)? ***Note**: Examples of service delivery points include maternal and child health (MCH), Care and Treatment Clinics (CTC), Drop-in Centers (DIC), etc.*	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does a PrEP initiation visit, as documented in the client assessment- or intake- or other such- form, include **ALL** the following? *Tick all that apply:* ☐ 1) Risk assessment ☐ 2) HIV testing ☐ 3) Screening for contraindications ☐ 4) Risk reduction counseling ☐ 5) Clear counseling on PrEP, including benefits, side effects, risks ☐ 6) Linkage to, or verification of existing linkage to, community peers and support networks, and any other applicable referrals ☐ 7) Providing services in a non-judgmental and professional manner	# Ticked _____	If 0-6=Yellow If 7=Green
	SCORE		

	SET 1B: ALL SITES -COMMODITIES MANAGEMENT		
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_01_10	Supply Chain Management	X	
S_01_11	Medication Dispensing	X	
S_01_12	Supply Chain Reliability-Adult ARVs		X
S_01_13	Supply Chain Reliability-Cotrimoxazole		X
S_01_14	Supply Chain Reliability-Isoniazid Preventive Therapy/TB Preventive Therapy/Rifapentine		X
S_01_15	Supply Chain Reliability-Pediatric ARVs		X
S_01_16	Supply Chain-Pediatric Cotrimoxazole		X
S_01_17	Supply Chain Reliability-Pediatric Isoniazid Preventive Therapy/TB Preventive Therapy/Rifapentine		X
S_01_18	Supply Chain Reliability-Rapid Test Kits		X

CEE #: S_01_10 Supply Chain Management [ALL SITES-COMM]			
STANDARD: Each site has an inventory management protocol for antiretrovirals (ARVs), cotrimoxazole (CTX), isoniazid preventive therapy (IPT)/other TB preventive regimens, and HIV rapid test kits (RTKs), and submits routine and accurate orders to maintain adequate stock (between established minimum/maximum stock levels).			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a facility has an adequate supply. Does this site provide ARVs, CTX, IPT/TB preventive therapy or RTKs for PEPFAR-supported patients? *If **NO**, check NA and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site use or do all of the following? *Tick all that apply:* ☐ 1) The site use inventory management tools (e.g., stock cards) to keep stock records ☐ 2) Stock cards are updated on a transactional basis (i.e., whenever stock is sent from the storage site to another site within the facility) ☐ 3) The site submitted a timely order for the commodities mentioned above (as defined by the in-country re-supply schedule or during the past 3 months) ***Note:*** *Ask to see the order form and cross check for each applicable product.*	# Ticked _____	If 0-2=Red
	If 3, then Q2		
Q2	Are the commodities indicated above stored in a storage facility site which meets **ALL** the following criteria? *Tick all that apply:* ☐ 1) Clean, free from evidence of pests or animals; ☐ 2) Well-ventilated and cool; ☐ 3) Equipped to store products on shelves/pallets/in cabinets and not on the floor or crushing each other; ☐ 4) All products shielded from direct sunlight; ☐ 5) Free from ceiling leaks; ☐ 6) Able to separate expired products from usable products ☐ 7) Secure storage facility has a lock or the ability to lock away all commodities and/or a security guard.	# Ticked _____	If 0-6 = Red
	If ALL, then Q3		
Q3	Does the pharmacy have written standard procedures for ordering off-schedule/emergency supplies?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_01_11 Medication Dispensing [ALL SITES-COMM]			
STANDARD: Each site has a standard, written medication dispensing protocol and maintains complete and updated medication dispensing records or registers.			
Instructions: Assess this CEE at the main area where HIV-related medications are dispensed to patients. Does this facility dispense HIV-related medications (e.g., ARVs, IPT, and CTX) for patients? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there records (or documentation) of dispensed medications AND written medication dispensing protocols?	Y N	If N=Red
	If Y, then Q2		
Q2	*Look at the last 2 pages of the logbook or the medication dispensing records.* Are dispensing records legible, complete (i.e. all required information is provided) and up-to-date?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Are medication dispensing records reviewed routinely (i.e., at least monthly) to identify patients who have missed medication pick-ups? *Note: May include documentation of record review dates, documentation of follow-up actions to identify patients who missed a pick-up etc.*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_01_12 Supply Chain Reliability-Adult ARVs [ALL SITES-COMM]			
STANDARD: Each site has a reliable supply of adult ARVs.			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a site has an adequate supply. Does this site provide ARVs for adults? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of ARVs in the past 3 months resulted in an interruption of 1st or 2nd line ART (or a delay in ART initiation) for any patients at this site?	Y N	If Y=Red
	If N, then Q2		
Q2	Has a stock-out or low stock status of ARVs in the past 3 months required substitution of specific ARVs for any patients at this site?	Y N	If Y=Yellow
	If N, then Q3		
Q3	In the past 3 months, were any patients given appointments at short intervals to ration ARVs due to decreased ARV supply?	Y N	If Y=Yellow If N=Green
	SCORE		

CEE #: S_01_13 Supply Chain Reliability-Cotrimoxazole [ALL SITES-COMM]			
STANDARD: Each site has a reliable supply of adult cotrimoxazole (CTX).			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a facility has an adequate supply. Does this site provide CTX for adults? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of CTX in the past 3 months resulted in an interruption of CTX treatment for any patients in this site (e.g., ART, PMTCT, etc.)?	Y N	If Y =Red
	If N, then Q2		
Q2	Has a stock-out or low stock status of CTX in the past 3 months required placement of an emergency order?	Y N	If Y=Yellow
	If N, then Q3		
Q3	In the past 3 months, were any patients given appointments at short intervals to ration CTX due to decreased CTX supply?	Y N	If Y=Yellow If N=Green
	SCORE		

CEE #: S_01_14 Supply Chain Reliability- Isoniazid Preventive Therapy/TB Preventive Therapy/Rifapentine [ALL SITES-COMM]			
STANDARD: Each site has a reliable supply of adult isoniazid/other regimen for isoniazid preventive therapy (IPT)/TB preventive therapy (TPT).			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a site has an adequate supply. Does this site provide IPT/TPT for adults? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of medicines for TB preventive therapy (INH or other drugs) in the past 3 months resulted in an interruption of IPT/TPT treatment for any adult patients in this site?	Y N	If Y =Red
	If N, then Q2		
Q2	Has a stock-out or low stock status of IPT/TPT in the past 3 months required placement of an emergency order?	Y N	If Y=Yellow
	If N, then Q3		
Q3	In the past 3 months, were patients given appointments at short intervals to ration IPT/TPT due to decreased IPT/TPT supply?	Y N	If Y=Yellow If N= Green
	SCORE		

CEE #: S_01_15 Supply Chain Reliability -Pediatric ARVs [ALL SITES-COMM]			
STANDARD: Each site has a reliable supply of pediatric ARVs.			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a site has an adequate supply. Does this site provide ARVs for children? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of pediatric formulations of 1st or 2nd line ARVs in the past 3 months resulted in an interruption of ART (or a delay in ART initiation) for any children at this site?	Y N	If Y=Red
	If N, then Q2		
Q2	Has any stock-out or low stock status of ARVs in the past 3 months required substitution of specific pediatric ARVs for children (or were children given adult formulations when such a substitution was not otherwise indicated or planned)?	Y N	If Y=Yellow
	If N, then Q3		
Q3	In the past 3 months, were any children given appointments at short intervals to ration medications due to decreased supply of pediatric ARVs?	Y N	If Y=Yellow If N=Green
	SCORE		

CEE #: S_01_16 Supply Chain-Pediatric Cotrimoxazole [ALL SITES-COMM]			
STANDARD: Each site has a reliable supply of pediatric (liquid) cotrimoxazole (CTX).			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a site has an adequate supply. Does this site provide CTX for children? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of liquid CTX occurred in the past 3 months resulted in an interruption of CTX prophylaxis for pediatric patients?	Y N	If Y=Red
	If N, then Q2		
Q2	Has a stock-out or low stock status of liquid CTX in the past 3 months required placement of an emergency order?	Y N	If Y=Yellow
	If N, then Q3		
Q3	In the past 3 months, were any patients given appointments at short intervals to ration CTX due to decreased liquid CTX supply?	Y N	If Y=Yellow If N=Green
	SCORE		

CEE #: S_01_17 Supply Chain Reliability- Pediatric Isoniazid Preventive Therapy/TB Preventive Therapy/Rifapentine [ALL SITES-COMM]			
STANDARD: Each site has a reliable supply of pediatric isoniazid/other regimen for isoniazid preventive therapy (IPT)/TB preventive therapy (TPT).			
Instructions: Assess this CEE at the central pharmacy to ensure that each service delivery area within a site has an adequate supply. Does this site provide IPT/TPT for pediatric patients? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of medicines for TB preventive therapy (INH or other drugs) in the past 3 months resulted in an interruption of IPT/TPT treatment for any pediatric patients in this site (e.g., ART, PMTCT, etc.)?	Y N	If Y=Red
	If N, then Q2		
Q2	Has a stock-out or low stock status of IPT/TPT in the past 3 months required placement of an emergency order?	Y N	If Y=Yellow
	If N, then Q3		
Q3	In the past 3 months, were any pediatric patients given appointments at short intervals to ration of IPT/TPT due to decreased IPT/TPT supply?	Y N	If Y=Yellow If N=Green
	SCORE		

CEE #: S_01_18 Supply Chain Reliability-Rapid Test Kits [ALL SITES-COMM]			
STANDARD: Each service delivery point at each site has a reliable supply of rapid test kits.			
Instructions: This CEE is assessed at the place within the site where rapid test kits are managed (e.g., central store, pharmacy, laboratory, etc.). Does this site provide RTKs for HIV testing? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of rapid test kits in the past 3 months resulted in an individual not being tested at any one service delivery point within the site?	Y N	If Y=Red
	If N, then Q2		
Q2	Has a stock-out of rapid test kits in the past 3 months, which did **not** result in an interruption in delivery of HIV testing services, required placement of an emergency order?	Y N	If Y=Yellow
	If N, then Q3		
Q3	Is there adequate and secure space for storing rapid test kits according to the manufacturer's specifications?	Y N	If N=Yellow If Y=Green
	SCORE		

SET 1C: ALL SITES –DATA QUALITY			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_01_19	Data Quality Assurance (Routine Activities)		X
S_01_20	Assessment & Utilization of Performance Data in QI Activities		X
S_01_21	Data Reporting Consistency – TX_NEW-C&T	X	
S_01_22	Data Reporting Consistency – HTS_TST	X	
S_01_23	Data Reporting Consistency – PMTCT_STAT		X
S_01_24	Data Reporting Consistency – VMMC_CIRC		X

CEE #: S_01_19 Data Quality Assurance (Routine Activities) [ALL SITES-DATA QUAL]			
STANDARD: Each site follows routine data quality assurance (DQA) procedures to verify the accuracy and completeness of reported HIV program data on at least a quarterly basis.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a documented process or set of standard operating procedures to ensure that the data it collects and reports to stakeholders accurately reflect the services provided at the site?	Y N	If N=Red
	If Y, then Q2		
Q2	Which of the following data quality assurance or review activities are completed at least ***quarterly*** at the site? *Tick all that apply:* ☐ 1) Reviews of registers and/or client record systems for data completeness ☐ 2) Crosschecking (comparing) monthly reported results with client records, pharmacy records, registers, or other data sources ☐ 3) Categorizing and separating active or enrolled client records from inactive/LTFU clients for reporting accuracy and client follow-up ☐ 4) Assessing results during data review meetings with program staff; highlighting data discrepancies or outlier values; and documenting data quality concerns ***Note:*** *Routine data quality assurance activities may be conducted either by on-site staff, implementing partner staff, or an external team assigned to review the site.*	# Ticked _____	If 0=Red If 1-2 =Yellow If 3-4=Green
	SCORE		

CEE #: S_01_20 Assessment & Utilization of Performance Data in QI Activities [ALL SITES-DATA QUAL]			
STANDARD: Each site has a process for routinely recording, reviewing, and using program data to inform implementation of quality improvement (QI) activities.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site review key programmatic/performance indicators at least quarterly over the last 12 months at a minimum? ***Note:*** *Programmatic/performance indicators can include PEPFAR* Monitoring Evaluation and Reporting (MER) *and/or Quality Improvement indicators. Documentation may include run charts, bar graphs, site reports, QI team improvement journals etc. If the site only reports annual review of key indicators, this response should be "No"*	Y N	If N=Red
	If Y, then Q2		
Q2	Does a multidisciplinary team meet and discuss programmatic/performance data at least quarterly? *Note: Multidisciplinary team includes clinicians, program staff, M&E staff, lay counsellors, social workers, pharmacists, volunteers etc.*	Y N	If N=Yellow
	If Y, then Q3		
Q3	Is there a documented site level plan for program improvement or QI initiatives outlining roles, responsibilities, activities implemented and quantifiable projected outcomes?	Y N	If N=Yellow If Y =Green
	SCORE		

CEE #: S_01_21 Data Reporting Consistency – TX_NEW-C&T [ALL SITES-DATA QUAL]

STANDARD: Indicator reports in DATIM for PEPFAR Monitoring Evaluation Reporting (MER) indicator TX_NEW match summary reports maintained at facility level for the same reporting period.

Instructions: Does this facility report on the PEPFAR MER TX_NEW indicator?

*If **NO**, check NA, and **SKIP** this CEE.* **NA** ☐

If YES, assessor must retrieve the facility-level DATIM indicator report for the last PEPFAR quarterly report prior to visit.

Comment:

	Question	Response	Scoring
Q1	For TX_NEW, does the facility have the summary report (monthly or quarterly) or summary number for the **exact same** reporting period of the DATIM report retrieved by the assessor? ***Note:** A quarterly DATIM report may need to be reconstructed from 3 monthly reports found at the facility.*	Y N	If N=Red
	If Y, then Q2		
Q2	Using the DATIM report and the facility summary report(s), fill in the table below.	(E) **___%**	If>10% =Red If >5% and =<10% =Yellow If =<5% = Green

Indicator Name	(A) DATIM Report	(B) Facility Report (s)	(C) Difference DATIM – Facility (A-B)	(D) % Difference (C/B)	(E) Absolute difference proportion?
Example Indicator	*400*	*460*	*400-460 = -60*	*(-60/460) = -13%*	*13%*
TX_NEW					

	SCORE		

CEE #: S_01_22 Data Reporting Consistency – HTS_TST [ALL SITES-DATA QUAL]			
STANDARD: Indicator reports in DATIM for MER Indicator HTS_TST match summary reports maintained at facility level for the same reporting period.			
Instructions: Does this facility report on PEPFAR HTS_TST indicator? *If **NO**, check NA, and **SKIP** this CEE.* **NA** ☐ ***If YES, assessor must retrieve the facility-level DATIM indicator report for the last PEPFAR quarterly report prior to visit.***			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the facility have the summary report (monthly or quarterly) or summary number for the **exact same** reporting period of the DATIM report retrieved by the assessor for HTS_TST? ***Note:** A quarterly DATIM report may need to be reconstructed from 3 monthly reports found at the facility.* *HTS_TST is aggregated across all HIV testing points. Reports may need to be compiled from different testing points within a clinic; confirm with implementing partner which testing points contribute to the reported number in DATIM.*	Y N	If N=Red
	If Y, then Q2		
Q2	Using the DATIM report and the facility summary report(s), fill in the table below.	(E) ___**%**	If>10% =Red If >5% and =<10% =Yellow If =<5% = Green
	SCORE		

Indicator Name	(A) DATIM Report	(B) (A) Facility Report (s)	(C) Difference DATIM – Facility (A-B)	(D) % Difference (C/B)	(E) (B) Absolute difference proportion?
Example Indicator	*400*	*460*	*400-460 = -60*	*(-60/460) = -13%*	*13%*
HTS_TST					

CEE #: S_01_23 Data Reporting Consistency – PMTCT_STAT [ALL SITES-DATA QUAL]

STANDARD: Indicator reports in DATIM match summary reports maintained at facility level for the same reporting period.

Instructions: Does this facility report on PEPFAR PMTCT_STAT indicator?

*If NO, check NA, and **SKIP** this CEE.*

NA ☐

If YES, assessor must retrieve the facility-level DATIM indicator report for the last PEPFAR quarterly report prior to visit.

Comment:

	Question	Response	Scoring
Q1	Does the facility have the summary report (monthly or quarterly) or summary number for the **exact same** reporting period of the DATIM report retrieved by the assessor for PMTCT_STAT? ***Note:** A quarterly DATIM report may need to be reconstructed from 3 monthly reports found at the facility.*	Y N	If N=Red
	If Y, then Q2		
Q2	Using the DATIM report and the facility summary report(s), fill in the table below.	(E) **___%**	If>10% =Red If >5% and =<10% =Yellow If =<5% = Green

Indicator Name	(A) DATIM Report	(B) Facility Report (s)	(C) Difference DATIM – Facility (A-B)	(D) % Difference (C/B)	(E) Absolute difference proportion?
Example Indicator	*400*	*460*	*400-460 = -60*	*(-60/460) = -13%*	*13%*
PMTCT_STAT					

	SCORE		

CEE #: S_01_24 Data Reporting Consistency – VMMC_CIRC [ALL SITES-DATA QUAL]

STANDARD: Indicator reports in DATIM match summary reports maintained at facility level for the same reporting period.

Instructions: Does this facility report on PEPFAR VMMC_CIRC indicator?

*If **NO**, check NA, and **SKIP** this CEE.* **NA** ☐

If YES, assessor must retrieve the facility-level DATIM indicator report for the last PEPFAR quarterly report prior to visit.

Comment:

	Question	Response	Scoring
Q1	Does the facility have the summary report (monthly or quarterly) or summary number for the **exact same** reporting period of the DATIM report retrieved by the assessor for VMMC_CIRC? ***Note:** A quarterly DATIM report may need to be reconstructed from 3 monthly reports found at the facility.*	Y N	If N=Red
	If Y, then Q2		
Q2	Using the DATIM report and the facility summary report(s), fill in the table below.	(E) ___**%**	If>10% =Red If >5% and =<10% =Yellow If =<5% = Green

Indicator Name	(A) DATIM Report	(B) Facility Report (s)	(C) Difference DATIM – Facility (A-B)	(D) % Difference (C/B)	(E) Absolute difference proportion?
Example Indicator	*400*	*460*	*400-460 = -60*	*(-60/460) = -13%*	*13%*
VMMC_CIRC					

	SCORE		

SET 2A: CARE AND TREATMENT-GENERAL POPULATION (NON-KEY POPS FACILITIES)			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_02_01	Retesting for Verification before/at ART Initiation	X	
S_02_02	Patient Tracking-ART Patients*	X	
S_02_03	Rapid ART Initiation	X	
S_02_04	Viral Load Access and Monitoring		X
S_02_05	Management of High Viral Load	X	
S_02_06	Appointment Spacing and Multi-Month Drug Dispensing		X
S_02_07	Partner Services	X	
S_02_08	Routine HIV Testing of Children of Adult Patients	X	
S_02_09	TB Screening		X
S_02_10	TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT)	X	
S_02_11	Cotrimoxazole (CTX)		X
S_02_12	TB Diagnostic Evaluation Cascade		X
S_02_13	Community-Based Linkage and Retention Support Services		X
S_02_14	Service Referral and Linkage System		X
S_02_15	Family Planning / HIV Integration Service Delivery		X
S_02_16	Community-Based Delivery of Family Planning Services		X
S_02_17	Cervical Cancer Screening Capacity		X

CEE #: S_02_01 Retesting for Verification before/at ART Initiation [C&T GEN POP]			
STANDARD: All newly diagnosed HIV-positive and pre-ART adult and adolescent patients are retested to verify their HIV diagnosis prior to, or at the time of, ART initiation using the national HIV testing algorithm.			
Instructions: HIV Retesting for verification occurs prior to or at the time of ART initiation using a new specimen from either (1) a newly diagnosed individual or (2) a previously diagnosed individual who has not initiated ART. In either case, a provider who is different from the provider who performed the previous HIV tests for that individual must conduct retesting for verification.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do the national HIV Testing Services (HTS) or ART guidelines include retesting for verification prior to or at ART initiation?	Y N	If N = Red
	If Y, then Q2		
Q2	Is a standardized process available for conducting and documenting retesting for verification prior to or at ART initiation?	Y N	If N = Yellow
	If Y, then Q3		
Q3	*Review the last 10 register entries or charts (whichever source has the most updated information) of adult and adolescent patients ≥15 years old who newly initiated ART in the last 3 months to confirm that retesting for verification* prior to or at ART initiation *is documented.* What percent of adult and adolescent patient records reviewed have documentation that retesting for verification occurred before ART initiation? *(i.e., the site knows the client or patient was retested for verification before/at ART initiation)* ***Numerator*** *= _____# of records with documented retesting for verification* ***Denominator*** *= _____# Total number of records reviewed*	_____ %	If <80% = Yellow If ≥80% = Green
	SCORE		

CEE #: S_02_02 Patient Tracking-ART Patients [C&T GEN POP] (DUP)			
STANDARD: Each ART site has a standard procedure for identifying and tracking adult and adolescent ART patients who have defaulted on their appointments. The system includes procedures for patient identification and tracking; standardized documentation showing evidence of more than one attempt to bring the patient back into care; and the results/outcome of tracking efforts.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standard procedures for identifying and tracking adult and adolescent ART patients who have missed an appointment?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review tracking documents (logbooks, registers, patient files etc) for the last the last ten ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from ART patients who missed their most recent appointment, had evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers) documented? ***Numerator*** *= _____ # of ART tracking documents reviewed, for ART patients who missed their most recent appointment, that include evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers)* ***Denominator =*** *_____ # of ART tracking documents reviewed for patients who missed their most recent appointment*	____%	If =<80%=Red
	If >80%, then Q3		

Q3 	*Review tracking documentation (logbooks, registers, patient files etc) for the last the last ten ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from ART patients who missed their most recent appointment, have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented? ***Numerator =*** *_____ # of ART tracking documents reviewed, for ART patients who missed their most recent appointment, that have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented* ***Denominator =*** *_____ # of ART patient tracking documents reviewed for patients who missed their most recent appointment*	_____%	If <80% =Yellow If >= 80% =Green
	SCORE		

CEE #: S_02_03 Rapid ART Initiation [C&T GEN POP]			
STANDARD: HIV-positive individuals are offered the option of rapid or same-day ART, according to guidelines and national policy. *Instructions: Is rapid or same-day ART currently a part of or allowed per national guidelines?* *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site offer rapid ART initiation/test and start (within 14 days of diagnosis) **OR** same-day initiation to newly diagnosed adults and adolescents ≥15 years old?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of newly diagnosed HIV-positive adult and adolescent patients ≥15 years old who attended the clinic within the last 90 days.* What percentage of register entries or charts reviewed show evidence that HIV-positive patients received same day or rapid ART initiation? ***Note:** Records should only be from newly diagnosed HIV-positive patients.* ***Numerator**_____# of register entries or charts reviewed of newly diagnosed adolescent patients, ≥15 years old who attended the clinic within the last 90 days, showing evidence that HIV-positive patients received same day or rapid ART initiation* ***Denominator**: _____# of register entries or charts reviewed of newly diagnosed adolescent patients ≥15 years old who attended the clinic within the last 90 days.*	_____%	If =<80% = Yellow If >80% = Green
	SCORE		

CEE #: S_02_04 Viral Load Access and Monitoring [C&T GEN POP] (DUP)			
STANDARD: Patients on antiretroviral therapy (ART) receive routine monitoring for virologic suppression through assessment of viral load, per national guidelines, and the results are documented in the medical record.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have access to viral load testing for adolescent and adult patients?	Y N	If N = Red
	If Y, then Q2		
Q2 👀	*Review 10 charts of adult and adolescent patients ≥15 years old on ART ≥12 months.* What percentage of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, show that the most recent viral load test was ordered within the appropriate interval, per the national guidelines? ***Note:*** *Modify chart review to fit the national guidelines. Countries may opt to exclude charts if viral load was collected within the last 4 weeks to allow adequate time for results to be returned; replace any excluded charts to review a total of ten. Viral load monitoring is expected to occur on an ongoing basis (e.g., every 3, 6, or 12 months per national guidelines).* ***Numerator****: _____# of* charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, showing that the most recent viral load test was ordered within the appropriate interval, per the national guidelines ***Denominator***: *_____# of charts reviewed from adult and adolescent patients ≥15 years old on ART ≥12 months*	_____%	If <80% = Yellow
	If ≥80%, then Q3		
Q3 👀	*Review the same 10 charts of adult and adolescent patients ≥15 years old on ART ≥12 months.* What percent of adult and adolescent charts reviewed have a documented <u>result returned</u> for the most recent viral load test? *Numerator: ____# of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, with a documented returned result for the most recent viral load test*	_____%	If <70% = Red If ≥70% and <90% =Yellow If ≥90% = Green

	Denominator: ____Total # of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, with recent viral load test		
	SCORE		

CEE #: S_02_05 Management of High Viral Load [C&T GEN POP] (DUP)			
STANDARD: Patients on antiretroviral therapy (ART) with virologic non-suppression are tracked and receive enhanced adherence counseling (EAC) and repeat viral load monitoring per national guidelines to assess for virologic failure and the potential need to switch ART regimens.			
Instructions: EAC includes focused counseling sessions, typically led by a lay health worker or counselor, on the importance of adhering to the medication. *If a site does not offer these services, check NA and **SKIP** this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a written procedure, which includes the following features, to manage patients with non-suppressed viral load results? *Tick all that apply:* ☐ 1) Tracking and urgently following-up with patients who have non-suppressed viral load results ☐ 2) Providing age-appropriate EAC ☐ 3) Follow-up viral load testing ☐ 4) Assessing the need to switch ART regimens in patients with virologic failure after completing EAC	# Ticked _____	If 0-1= Red
	If ≥2, then Q2		
Q2	*Review 10 records (e.g., charts, high viral load register, EMR entries) of adult and adolescent patients on ART ≥12 months with virologic non-suppression.* ***Notes:** This review should distinguish the management of patients with non-suppressed viral load results from patients with virologic suppression.* • *If assessing Set 2B at this site and reviewing pediatric records, select only adults ≥20 years old. If **only** assessing Set 2A, select both adolescents and adults ≥15 years old.* What percent of records reviewed have documentation of at least 1 EAC session after the date of virologic non-suppression (e.g., VL ≥1000 copies/mL or criteria based on national guidelines)? ***Numerator** = _____ # of records of patients who received at least 1 EAC session after date of virologic non-suppression* ***Denominator** = _____# of records reviewed of adult and adolescent patients on ART ≥12 months with virologic non-suppression.*	_____%	If <70% = Red
	If ≥ 70%, then Q3		

Q3 	*Review the same 10 records of patients on ART ≥12 months with virologic non-suppression.* What percent of the same records reviewed (e.g., charts, high viral load register or EMR entries) have documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL)? ***Numerator**= _____ # of records reviewed (e.g., charts, high viral load register or EMR entries) with documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL* ***Denominator**= _____ # of records reviewed of adult and adolescent patients on ART ≥12 months with virologic non-suppression.*	_____%	If <70% = Yellow If ≥70% = Green
	SCORE		

CEE #: S_02_06 Appointment Spacing and Multi-Month Drug Dispensing [C&T GEN POP] (DUP)			
STANDARD: Each site offers differentiated models of service delivery for adolescent and adult patients ≥15 years old (e.g., appointment spacing, multi-month drug dispensing, and community dispensation) to meet the needs of stable ART patients and triage or fast-track of appointments for unstable ART patients and those with advanced HIV infection.			
Instructions: Are differentiated models of service delivery (e.g., appointment spacing, multi-month dispensing) currently allowed in national guidelines? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site distinguish between stable and unstable patients, and have a standard definition of a 'stable ART patient' for adolescent and adult patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the site use or provide the following for adolescent and adult patients? *Tick all that apply:* ☐ 1) 3-6 month routine follow-up visits for stable ART patients ☐ 2) Multi-month (≥3 months) ARV prescribing for stable patients ☐ 3) Multi-month ARV dispensing (≥3 month supply) for stable ART patients ☐ 4) Fast-track pharmacy pick-up of ARVs for stable ART patients ☐ 5) Community service delivery models (e.g., community ART groups or distribution points like home distribution)	# Ticked _____	If 0-2=Yellow If 3-5= Green
	SCORE		

CEE #: S_02_07 Partner Services [C&T GEN POP] (DUP)			
STANDARD: HIV-positive patients are offered partner services that include counseling on safe disclosure of HIV status to their sex partner(s) and/or injecting drug partner(s) and HIV partner testing, either onsite or through referral to a health facility or through or community-based approaches.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is counseling on the importance of both safe disclosure and testing of all sexual and/or injecting drug partner(s) provided?	Y N	If N=Red
	If Y, then Q2		
Q2	Are partner HIV-testing services provided (either onsite or through referral)? ***Note:*** *Partner testing approaches include any of the following: 1) contact referral, 2) provider referral, 3) dual referral, 4) client referral, 5) HIV self-testing kits provided to clients to provide to their sex partner(s). HIV testing of the partner(s) may be offered onsite, at a standalone VCT clinic located within the facility, or via HIV self-test kits.*	Y N	If N=Red
	If Y, then Q3		
Q3 	*Review 10 register entries (individual or index/partner testing logbook) or charts (whichever source has the most updated information) of HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months.* What percent of reviewed patient records document HIV testing or HIV status of all elicited partner(s)? **Numerator** = ____*# of HIV-positive patient records reviewed that have all elicited partner(s) with documented HIV-testing status (e.g., positive, known positive, negative, declined, or unable to reach)* ***Denominator*** *= ____ # of HIV-positive patient records reviewed*	_____%	If <90%=Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_08 Routine HIV Testing of Children of Adult Patients [C&T GEN POP]			
STANDARD: Biological children and adolescents (<15 years old) of HIV-positive adults have a documented (or known) HIV status.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice to ensure routine testing of biological children (<15 years old) of adult ART patients?	Y N	If N=Red
	If Y, then Q2		
Q2 	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adults and adolescent patients ≥15 years old on ART ≥12 months.* What percentage of reviewed charts have documentation of HIV testing status (e.g., positive, negative, declined) for all biological children <15? ***Numerator** = _____# of charts reviewed where all biological children <15 have documented HIV-testing status (e.g., positive, negative, declined)* ***Denominator** = _____# of HIV positive patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% Yellow If ≥90%= Green
	SCORE		

CEE #: S_02_09 TB Screening [C&T GEN POP] (DUP)			
STANDARD: Each site has standardized procedures for performing and documenting screening for active tuberculosis (TB) on intake and at each clinical visit for HIV-positive adult and adolescent patients. The TB screening includes all 4 of the following symptoms: cough, fever, night sweats, and weight loss.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for TB screening and documentation at each clinical assessment per national guidelines?	Y N	If N=Red
	If Y, then Q2		
Q2 👀	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months.* What percent of adult and adolescent records reviewed have documented TB-symptom screening results (i.e., screen positive or negative; presence of cough, fever, night sweats, or weight loss) at the last clinical assessment? ***Numerator**: _____# of register entries or charts reviewed, from HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months, with documented TB-symptom screening results at the last clinical assessment* ***Denominator**: _____# of register entries or charts reviewed* from *HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months*	_____%	If <70%=Red If ≥70% and <90% Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_10 TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) [C&T GEN POP] (DUP)			
STANDARD: HIV-positive patients who screen negative for active tuberculosis (TB) receive TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) per national guidelines.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for administration of TPT/IPT among HIV-positive adult and adolescent patients?	Y N	If N=Red
	If Y, then Q2		
Q2 👀	Does this site have a TPT/IPT register and/or another method that allows tracking of who *started* and *completed* TPT/IPT within a given reporting period? ***Note:*** *"Completed" includes those patients who started and completed 6 months of TPT/IPT and those on continuous TPT/IPT after 6 months of "completion".*	Y N	If N=Red
	If Y, then Q3		
Q3 👀	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months).* What percent of reviewed records show evidence that HIV-positive adult and adolescent patients, who screened negative for active TB during their HIV clinic visits, were ever initiated on TPT/IPT? ***Numerator****: _____# of register entries or charts reviewed, from HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months who screened negative for active TB during their HIV clinic visits, with evidence showing the patient was started on TPT/IPT?* ***Denominator****: _____# of register entries or charts reviewed* from *HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months who screened negative for active TB during their HIV clinic visits*	_____%	If <70%=Red If ≥70% and <90% = Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_11 Cotrimoxazole (CTX) [C&T GEN POP] (DUP)			
STANDARD: Eligible patients have documented prescription of cotrimoxazole (CTX), according to national guidelines.			
Instructions: *If **NO** HIV-positive patients were eligible within the specified time period, check NA and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adults and adolescent patients ≥15 years old on ART >12 months.* *Of the total 10 records, select patients that are eligible for CTX based on the national guidelines. Include that number in the denominator, even if it is less than 10.* What percent of adult and adolescent patient records reviewed have documentation of CTX prescription per the national guidelines at the last clinical assessment? ***Numerator** = _____ # of those eligible, who received a CTX prescription* ***Denominator** = _____# of HIV positive, CTX eligible (per national guidelines) patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_12 TB Diagnostic Evaluation Cascade [C&T GEN POP] (DUP)			
STANDARD: Every site has standardized procedures for documenting HIV-positive adult and adolescent patients with presumptive tuberculosis (TB) (in a line list or register) and a referral and follow-up mechanism to ensure TB diagnostic evaluation, in accordance with national testing algorithms.			
Instructions: *If there are **NO** adult or adolescent patients with presumptive TB, check NA, and skip this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standardized procedures for documenting HIV-positive adult and adolescent patients with presumptive TB and providing referral and follow-up to ensure TB diagnostic evaluation (e.g., smear, culture or Xpert MTB/RIF)?	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a line list/register for HIV-positive adult and adolescent patients with presumptive TB to document diagnostic evaluation and treatment?	Y N	If N=Red
	If Y, then Q3		
Q3	*Review the last 10 entries in the line list/register of HIV-positive adult and adolescent patients ≥15 with presumptive TB.* What percent of the reviewed entries of HIV-positive adult and adolescent patients who are presumed to have TB have documented smear microscopy, culture or Xpert MTB/RIF results? ***Numerator**: ____# of reviewed entries of HIV-positive adult and adolescent patients ≥15 who are presumed to have TB with documented smear microscopy, culture or Xpert MTB/RIF results* ***Denominator**_____# of reviewed entries of HIV-positive adults and adolescent patients ≥15 who are presumed to have TB*	_____%	If <80%=Yellow
	If ≥80%, then Q4		

Q4 	*Review the same last 10 entries in the line list/register of HIV-positive adult and adolescent patients presumptive TB*. What percent of the same reviewed entries of HIV-positive adult and adolescent patients who are presumed to have TB received molecular testing as their first-line diagnostic test? ***Numerator**: ____# of same reviewed entries, of HIV-positive adult and adolescent patients ≥15 who are presumed to have TB, with documented receipt of molecular testing as their first-line diagnostic test* ***Denominator**: ___# of same reviewed entries of HIV-positive adults and adolescent patients ≥15 who are presumed to have TB*	_____%	If <90%=Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_13 Community-Based Linkage and Retention Support Services [C&T GEN POP]			
STANDARD: Each site that provides care and support services has standardized procedures for providing and documenting all the following core elements: • Retention/adherence support for ART beneficiaries/clients • Referral and linkage to health facilities providing comprehensive HIV care • Basic beneficiary/client assessments, documenting psychosocial needs with linkage/referral to services as appropriate			
Comment:			
	Question	**Response**	**Scoring**
Q1	Which of the following services does this site provide? *Tick all that apply:* ☐ 1) Retention/adherence support for ART beneficiaries/clients ☐ 2) Referral and linkage to health facilities providing comprehensive HIV care ☐ 3) Basic beneficiary/client assessments, documenting psychosocial needs with linkage/referral to services as appropriate	# Ticked _____	If 0 = Red If 1-2 = Yellow
	If 3, then Q2		
Q2	Is there a written SOP addressing each of the core elements? *Tick all that apply:* ☐ 1) Support for retention for ART beneficiaries/clients ☐ 2) Referral and linkage to health facilities providing comprehensive HIV care ☐ 3) Basic beneficiary/client assessments, documenting clinical and psychosocial needs with linkage/referral to other services as appropriate	# Ticked _____	If 0-2 = Yellow If 3 = Green
	SCORE		

CEE #: S_02_14 Service Referral and Linkage System [C&T GENPOP]			
STANDARD: Sites supporting prevention and care outreach programs refer beneficiaries/clients to other high-impact HIV services (both community and facility) and track those referrals to support their successful completion.			
Comment:			
	Question	**Response**	**Scoring**
Q1	A system is in place with standardized tools (e.g., referral forms/vouchers given to beneficiaries, registers used for tracking) to track the following: *Tick all that apply:* ☐ 1) Referrals made to high-impact services (e.g., HTSC, STI screening and treatment, HIV care, PLHIV support groups, OVC programs, PMTCT, TB, VMMC, condom and lubricant provision, post-violence care, PrEP) ☐ 2) Whether the beneficiary/client received those services	# Ticked _____	If 0-1 = Red
	If 2, then Q2		
Q2	*Review 10 referral records (individual or logbook) for any 10 clients/beneficiaries from the last three months.* Of the reviewed referral records to any of the above high-impact services, what percentage have been successfully linked to those services (e.g., evidence of a signed counter-referral slip from the receiving site or service)? ***Numerator**: ____# of referral records reviewed, for clients/beneficiaries in the last three months, to any high-impact service with documentation of successful linkage to those services (e.g., evidence of a signed counter-referral slip from the receiving site or service)* ***Denominator**: _____# of referral records reviewed, for clients/beneficiaries in the last three months, to any high-impact service*	____%	If <70% = Yellow If ≥70% = Green
	SCORE		

CEE #: S_02_15 Family Planning /HIV Integration Service Delivery [C&T GEN POP]			
STANDARD: All clients attending HIV services have access to high-quality, voluntary family planning counseling and services, including safer pregnancy counseling and contraceptives, depending upon their fertility intentions.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is family planning education and/or counseling routinely offered onsite to clients who wish to delay or prevent pregnancy?	Y N	If N=Red
	If Y, then Q2		
Q2	Is safer conception/pregnancy counseling routinely offered onsite to PLHIV who wish to have children?	Y N	If N=Red
	If Y, then Q3		
Q3	Do clients have access to at least three contraceptive methods either onsite or through referral? (e.g., condoms, oral contraceptive pills, injectables, implants, intra-uterine devices (IUDs), fertility awareness methods, vasectomy, tubal ligation)	Y N	If N=Yellow
	If Y, then Q4		
Q4	Are education materials (IEC) about contraception and safe conception on display or available to clients (e.g., pamphlets, posters, brochures, inserts) accessing this service delivery point?	Y N	If N=Yellow
	If Y, then Q5		
Q5	Has there been a stockout within the past 3 months of any contraceptive methods usually provided onsite?	Y N	If Y=Yellow If N= Green
	SCORE		

CEE #: S_02_16 Community-Based Delivery of Family Planning Services [C&T GEN POP]			
STANDARD: Community-based delivery of family planning services should include high quality, voluntary family planning counseling and services, including safe conception/pregnancy counseling and contraceptives.			
Instructions: This CEE should be assessed at sites where contraceptives are distributed in the community. *Does this site's agreement with the prime partner or USG implementing agency include funding to support family planning education and services, directly or through referrals?* *If **NO**, check NA, and **SKIP** CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do trained community care providers deliver information on family planning, safe conception/pregnancy, and available family planning services to community members and groups?	Y N	If N = Red
	If Y, then Q2		
Q2	Do all community care providers provide referrals to a health facility for additional information on family planning services and methods?	Y N	If N = Red
	If Y, then Q3		
Q3	Do health providers and/or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of family planning activities provided by community care providers?	Y N	If N = Yellow
	If Y, then Q4		
Q4	Is there a process for tracking family planning referrals to confirm the beneficiary/client received the service? Note: If the service is directly provided, then Y.	Y N	If N=Yellow If Y= Green
	SCORE		

CEE#: S_02_17 Cervical Cancer Screening Capacity [C&T GEN POP]			
STANDARD: All sites offering cervical cancer screening and/or precancerous lesion treatment services have in place the procedures, equipment and processes necessary to provide high-quality services.			
Instructions: Assess this CEE based on which activities this site is expected to provide (e.g., cervical cancer screening, cryotherapy) *Does this site use ANY PEFPAR funding or PEPFAR support to provide cervical cancer screening and/or precancerous lesion treatment services to HIV positive women? If **NO**, check NA, and **SKIP** CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have the following? *Tick all that apply:* ☐ 1) Standardized procedures (and algorithms, where applicable) for onsite provision of cervical cancer screening *(Look for documentation)* ☐ 2) Standardized procedures for management of women with positive screening results, including referral (e.g., for cryotherapy (if not available onsite), loop electrosurgical excision procedure (LEEP), and further evaluation for suspected invasive cervical cancer) *(Look for documentation)* ☐ 3) Clinical staff, who provide cervical cancer secondary prevention services, are trained for screening and cervical cryotherapy ***Note:** Clinical staff include nurses, midwives, doctors, clinical officers*	# Ticked ____	If 0-2=Red
	If 3, then Q2		
Q2	Does the facility area where cervical cancer screening services are provided have the following basic elements? *Tick all that apply:* ☐ 1) Private area with gynecological exam table ☐ 2) Sterilized reusable (or new disposable) specula ☐ 3) Bright light source ☐ 4) Exam gloves ☐ 5) Disinfectant for specula and other equipment (i.e., facilities for universal precaution) ☐ 6) Hand washing station ☐ 7) Appropriate screening tools (3%-5% acetic acid for visual inspection with acetic acid (VIA) screening; or HPV test kit for HPV testing; or glass slides, cover slips, and fixatives for Pap smear)	# Ticked ____	If 0-6=Red

	If 7, then Q3		
Q3 	*Review cervical screening register or logbook entries from all women screened 90 days prior OR the previous 10 entries/records (whichever is less), of women with positive cervical cancer screening test results.* What percentage of women having a positive cervical cancer screening test result were either referred for precancerous lesion treatment or completed treatment onsite? ***Numerator**= ___# of women with positive cervical cancer screening result who were REFERRED for OR COMPLETED precancerous lesion treatment* ***Denominator**= ____# of women with positive cervical cancer screening results*	____%	<80% = Yellow ≥80% = Green
	SCORE		

SET 2B: CARE AND TREATMENT FOR HIV-INFECTED CHILDREN			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_02_18	Retesting for Verification before/at ART Initiation	X	
S_02_19	Patient Tracking-ART Patients	X	
S_02_20	First-line ART Regimen for Young Children		X
S_02_21	Dosing of Pediatric and Adolescent ARVs		X
S_02_22	Viral Load Access and Monitoring	X	
S_02_23	Management of High Viral Load	X	
S_02_24	Appointment Spacing and Multi-Month Drug Dispensing		X
S_02_25	Routine HIV Testing for Children and Adolescents		X
S_02_26	TB Screening		X
S_02_27	TB Preventive Therapy (TPT) / Isoniazid Preventive Therapy (IPT)	X	
S_02_28	Cotrimoxazole (CTX)		X
S_02_29	TB Diagnostic Evaluation Cascade		X
S_02_30	Support Services for Adolescents Living with HIV		X
S_02_31	Community -Based Linkage and Retention Support Services		X
S_02_32	Service Referral and Linkage System		X

CEE #: S_02_18 Retesting for Verification before/at ART Initiation [C&T PEDS] (DUP)			
STANDARD: All newly diagnosed HIV-positive pediatric patients are retested to verify their HIV diagnosis prior to, or at the time of, ART initiation using the national HIV testing algorithm.			
Instructions: HIV Retesting for verification occurs prior to or at the time of ART initiation using a new specimen from either (1) a newly diagnosed individual or (2) a previously diagnosed individual who has not initiated ART. In either case, a provider who is different from the provider who performed the previous HIV tests for that individual must conduct retesting for verification.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do the national HIV Testing Services (HTS) or ART guidelines include retesting for verification prior to or at ART initiation?	Y N	If N = Red
	If Y, then Q2		
Q2	Is there a standardized process for conducting and documenting the retesting for verification prior to or at ART initiation?	Y N	If N = Yellow
	If Y, then Q3		
Q3	*Review 10 register entries or charts (whichever source has the most updated information) of pediatric patients who newly initiated on ART in the last 3 months to confirm that retesting for verification prior to or at initiation is documented.* What percent of pediatric patient records reviewed have documentation that retesting for verification occurred before ART initiation? *(i.e., the site knows the client or patient was retested for verification prior to or at ART initiation)* **Numerator** = _____# *of records reviewed, from pediatric patients who newly initiated ART in the last three months, with documented retesting for verification* **Denominator** = _____# *Total number of records reviewed from pediatric patients who newly initiated ART in the last three months*	_____ %	If <80% = Yellow If ≥80% = Green
	SCORE		

CEE #: S_02_19 Patient Tracking-ART Patients [C&T PEDS] (DUP)			
STANDARD: Each ART site has a standard procedure for identifying and tracking pediatric ART patients who have defaulted on their appointments. The system includes procedures for patient identification and tracking; standardized documentation showing evidence of more than one attempt to bring the patient back into care; and the results/outcome of tracking efforts.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standard procedures for identifying and tracking pediatric ART patients who have missed an appointment?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review tracking documentation (*logbooks, registers, patient files etc.) *for the last the last ten pediatric ART patients who missed their most recent appointment.* Is ART patient tracking documentation updated with evidence of more than one attempt to bring the pediatric patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers)? ***Numerator**: _____# of ART tracking documents reviewed, for pediatric ART patients who missed their most recent appointment, that include evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers)* ***Denominator**: _____# of ART tracking documents reviewed for pediatric ART patients who missed their most recent appointment*	% _____	If ≤80% = Red
	If >80%, then Q3		

Q3 	*Review tracking documentation (*logbooks, registers, patient files etc.) *for the last the last ten pediatric ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from ART pediatric patients who missed their most recent appointment, have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented? ***Numerator****: Number of ART tracking documents reviewed, for pediatric ART patients who missed their most recent appointment, that* have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented ***Denominator****: Number of ART patient tracking documents reviewed for pediatric patients who missed their most recent appointment*	% _____	If <80% = Yellow If ≥80% = Green
	SCORE		

CEE#: S_02_20 First-line ART Regimen for Young Children [C&T PEDS]			
STANDARD: Lopinavir/ritonavir available as a standard first-line antiretroviral treatment regimen for children living with HIV who are less than three years of age.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are pediatric formulations of lopinavir/ritonavir available onsite (including tablets)?	Y N	If N= Red
	If Y, then Q2		
Q2 👀	Is a 'child-friendly' formulation of lopinavir/ritonavir available for children <3, who are unable to swallow tablets? ☐ 1) Syrup ☐ 2) Pellets or granules	# Ticked ____	If 0 = Yellow If ≥1 = Green
	SCORE		

CEE #: S_02_21 Dosing of Pediatric and Adolescent ARVs [C&T PEDS]			
STANDARD: Each site providing treatment services to children should be equipped, at the point of care for pediatric patients, with current pediatric ARV weight band dosing tools to provide appropriate pediatric dosing according to national guidelines.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a pediatric ARV dosing tool (e.g., table, wheel, and brochure) that provides all ARVs in the nationally recommended regimens available to the ARV provider? ***Note**: A tool must available to review. If a tool is not present or unavailable for inspection, mark response as No.*	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a specific place to document the child's weight and ART dose for each clinic visit in the patient chart or register?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_02_22 Viral Load Access and Monitoring [C&T PEDS] (DUP)			
STANDARD: Pediatric patients on antiretroviral therapy (ART) receive routine monitoring for virologic suppression through assessment of viral load per national guidelines, and the results are documented in the medical record.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have access to viral load testing for pediatric patients?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 charts of pediatric patients <15 years old on ART ≥12 months.* What percentage of charts reviewed document that the most recent viral load test was ordered within the appropriate interval, per the national guidelines*?* ***Note:*** *Modify chart review to fit the national guidelines. Countries may opt to exclude charts if viral load was collected within the last 4 weeks to allow adequate time for results to be returned; replace any excluded charts to review a total of ten. Viral load monitoring is expected to occur on an ongoing basis (e.g., every 3, 6, or 12 months per national guidelines).* ***Numerator****: ____# of charts reviewed, of pediatric patients on ART for least 12 months, with a documented viral load test ordered within the appropriate interval, per the national guidelines* ***Denominator****: ____Total # of charts reviewed, of pediatric patients on ART for at least 12 months*	% _____	If ≤ 70% = Red
	If >70%, then Q3		
Q3	*Review the same 10 charts of pediatric patients<15 years old on ART ≥12.* What percent of charts reviewed have a documented result returned for the most recent viral load test? ***Numerator****: ____# of charts reviewed, of pediatric patients on ART for least 12 month, with a documented returned result for the most recent viral load test* ***Denominator****: ____Total # of charts reviewed, of pediatric patients on ART for least 12 months, with recent viral load test documented*	_____%	If <70% = Red If ≥70% and <90% =Yellow If ≥90% = Green
	SCORE		

CEE #: S_02_23 Management of High Viral Load [C&T PEDS] (DUP)			
STANDARD: Pediatric and adolescent patients on antiretroviral therapy (ART) with virologic non-suppression are tracked and receive enhanced adherence counseling (EAC) and repeat viral load monitoring per national guidelines to assess for virologic failure and the potential need to switch ART regimens.			
Instructions: EAC includes focused counseling sessions, typically led by a lay health worker or counselor, on the importance of adhering to the medication. *If a site does not offer these services, check NA and **SKIP** this CEE.* **NA** ☐			
Comment:			
	Question	**Respons e**	**Scoring**
Q1	Does the site have a written procedure, which includes the following features, to manage pediatric patients with non-suppressed viral load results? *Tick all that apply:* ☐ 1) Tracking and urgently following-up with patients who have non-suppressed viral load results ☐ 2) Providing age-appropriate EAC ☐ 3) Follow-up viral load testing ☐ 4) Assessing the need to switch ART regimens in patients with virologic failure after completing EAC	# Ticked _____	If ≤1 = Red
	If ≥2, then Q2		
Q2	*Review 10 records (e.g., charts, high viral load register, EMR entries) of 5 pediatric (<10 years old) and 5 adolescent (10-19 years old) patients on ART ≥12 months with virologic non-suppression.* ***Note:** This review should distinguish the management of patients with non-suppressed viral load results from patients with virologic suppression.* What percent of pediatric and adolescent records reviewed have documentation of at least one EAC session after the date of virologic non-suppression (e.g., VL ≥1000 copies/mL or criteria based on national guidelines)? ***Numerator** = _____ # of patient records reviewed, from pediatric patients with virologic non-suppression, with documentation of at least one EAC session after the date of virologic non-suppression* ***Denominator** = _____# of patient records reviewed for patients with virologic non-suppression*	_____%	If <70% = Red
	If ≥ 70%, then Q3		

Q3 	*Review the same 10 records of 5 pediatric (<10 years old) and 5 adolescent (10-19 years old) patients on ART ≥12 months with virologic non-suppression.* What percent of the same pediatric and adolescent records reviewed (e.g., charts, high viral load register or EMR entries) have documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL)? ***Numerator**: Number of patient records reviewed (e.g., charts, high viral load register or EMR entries) with documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL)* ***Denominator**: Number of patient records reviewed of patients on ART ≥12 months with virologic non-suppression.*	_____%	If <70% = Yellow If ≥70% = Green
	SCORE		

CEE #: S_02_24 Appointment Spacing and Multi-Month Drug Dispensing [C&T PEDS] (DUP)			
STANDARD: Each site offers differentiated models of service delivery for pediatric patients (e.g., appointment spacing, multi-month drug dispensing, and community dispensation) to meet the needs of stable ART patients and triage or fast-track of appointments for unstable ART patients and those with advanced HIV infection.			
Instructions: Are differentiated models of service delivery (e.g., appointment spacing, multi-month dispensing) currently allowed for pediatric patients in national guidelines? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site distinguish between stable and unstable patients, and have a standard definition of a 'stable ART patient' for pediatric patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the site use or provide the following for pediatric patients? *Tick all that apply:* ☐ 1) 3-6 month routine follow-up visits for stable ART patients ☐ 2) Multi-month (≥3 months) ARV prescribing for stable patients ☐ 3) Multi-month ARV dispensing (≥3 month supply) for stable ART patients ☐ 4) Fast-track pharmacy pick-up of ARVs for stable ART patients ☐ 5) Community service delivery models (e.g., community ART groups or distribution points like home distribution)	# Ticked _____	If ≤2=Yellow If ≥3= Green
	SCORE		

CEE #: S_02_25 Routine HIV Testing for Children and Adolescents [C&T PEDS]			
STANDARD: Routine, systematic HIV testing of all children and adolescents (0-19 years old) with undocumented HIV status is conducted at key entry points.			
Instructions: For Q1, answer based on the applicable service delivery points available at the site: *1) Pediatric inpatient ward* *2) Outpatient ward* *3) Malnutrition services* *4) Tuberculosis clinic* *If **NONE** of these pediatric service delivery points exists at this site, check NA, and skip this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1 👀	Do the registers or records in each of the following entry points present in this facility allow for documentation of the HIV status of children? ☐ 1)Pediatric inpatient *wards* ☐ 2) Outpatient ward ☐ 3) Malnutrition services ☐ 4) Tuberculosis clinics	# Ticked _____	If 0-3 = Red
	If 4, then Q2		
Q2 👀	Does this site use a systematic criteria (e.g., screening algorithm) to determine which children should receive HIV testing at OPD*?* *Note: Ask to see evidence of systematic criteria (e.g., screening algorithm)*	Y N	If N = Yellow
	If Y, then Q3		
Q3 👀	*Select one of the available registers using the following criteria: Prioritize pediatric inpatient ward register. If site has pediatric inpatient ward, use pediatric ward register. If no pediatric ward, use the register for any of the entry points listed in Q1. In the selected register, review the last 10 patient entries to check for documented HIV status (e.g., positive, negative, declined).* What percentage of entries reviewed have documented HIV-testing status? ***Numerator**: _____# of pediatric and adolescent patients entries with documented HIV Status (e.g., positive, negative, declined).* ***Denominator**: ____# of pediatric and adolescent patient entries*	_____%	If <70% = Yellow If ≥70% = Green
	SCORE		

CEE #: S_02_26 TB Screening [C&T PEDS]			
STANDARD: Each site has standardized procedures for performing and documenting screening for active tuberculosis (TB) on intake and at each clinical visit for HIV-positive pediatric patients. The TB screening includes all 4 of the following symptoms: cough, fever, night sweats, and weight loss; and contact with a TB patient.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for TB screening and documentation at each clinical assessment per national guidelines?	Y N	If N=Red
	If Y, then Q2		
Q2 	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive pediatric patients <15 on ART ≥12 months.* What percent of pediatric records reviewed have documented TB-symptom screening results (i.e., screen positive or negative; presence of cough, fever, night sweats, and weight loss; and contact with a TB patient) at the last clinical assessment? ***Numerator**: _____# of register entries or charts reviewed, from HIV-positive pediatric patients <15 years old on ART ≥12 months, with documented TB-symptom screening results at the last clinical assessment* ***Denominator**: _____# of register entries or charts reviewed* from *HIV-positive pediatric patients <15 years old on ART ≥12 months*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_27 TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) [C&T PEDS] DUP			
STANDARD: HIV-positive pediatric patients who screen negative for active tuberculosis (TB) receive TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) per national guidelines.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for administration of TPT/IPT among HIV-positive pediatric patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does this site have a TPT/IPT register and/or another method that allows tracking of who started and who completed TPT/IPT within a given reporting period? ***Note:*** *"Completed" includes those patients who started and completed 6 months of TPT/IPT and those on continuous TPT/IPT after 6 months of "completion".*	Y N	If N=Red
	If Y, then Q3		
Q3	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive pediatric patients on ART ≥12 months.* What percent of reviewed records show evidence those HIV-positive pediatric patients who screened negative for active TB during their HIV clinic visits were ever initiated on TPT/IPT? ***Numerator****: _____# of register entries or charts reviewed, from HIV-positive pediatric patients <15 years old on ART ≥12 months who screened negative for active TB during their HIV clinic visits, with evidence showing the patient was started on TPT/IPT?* ***Denominator****: _____# of register entries or charts reviewed from HIV-positive pediatric patients <15 years old on ART ≥12 months who screened negative for active TB during their HIV clinic visits*	_____%	If <70%=Red If ≥70% and <90% Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_28 Cotrimoxazole (CTX) [C&T PEDS] (DUP)			
STANDARD: Eligible pediatric patients have documented prescription of cotrimoxazole (CTX) according to national guidelines.			
Instructions: *If **NO** HIV-positive patients were eligible within the specified time period, check NA and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive pediatric patients <15 on ART >12 months.* *Of the total 10 records, select patients that are eligible for CTX based on the national guidelines. Include that number in the denominator in Q1, even if it is less than 10.* What percent of pediatric patient records reviewed have documentation of CTX prescription per the national guidelines at the last clinical assessment? **Numerator** = _____ *# of pediatric patients eligible to receive CTX per national guidelines, who received a CTX prescription at the last clinical assessment* **Denominator** = _____*# of HIV positive, CTX eligible (per national guidelines) pediatric patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_02_29 TB Diagnostic Evaluation Cascade [C&T PEDS]			
STANDARD: Every site has standardized procedures for documenting HIV-positive pediatric patients with presumptive tuberculosis (TB) (in a line list or register) and a referral and follow-up mechanism to ensure TB diagnostic evaluation in accordance with national testing algorithms.			
Instructions: *If there are **NO** pediatric patients with presumptive TB, check NA, and skip this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standardized procedures for documenting HIV-positive pediatric patients with presumptive TB and providing referral and follow-up to ensure TB diagnostic evaluation (e.g., smear, culture or Xpert MTB/RIF)?	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a line list/register for HIV-positive pediatric patients with presumptive TB to document diagnostic evaluation and treatment?	Y N	If N=Red
	If Y, then Q3		
Q3	*Review the last 5 entries in the line list/register of HIV-positive pediatric patients <15 years with presumptive TB recorded in line list/register*. What percent of the reviewed entries of HIV-positive pediatric patients < 15 years who are presumed to have TB have documented smear microscopy, culture or Xpert MTB/RIF results? ***Numerator**: ____# of reviewed entries of HIV-positive pediatric patients <15 who are presumed to have TB with documented smear microscopy, culture or Xpert MTB/RIF results* ***Denominator**: ___# of reviewed entries of HIV-positive pediatric patients <15 who are presumed to have TB*	% _____	If ≤ 80%=Yellow If >80% = Green
	SCORE		

CEE #: S_02_30 Support Services for HIV-Positive Adolescents [C&T PEDS]			
STANDARD: Adolescent-friendly clinical services are provided to cater to the specific treatment, support and general health needs of children and adolescents, aged 0 to 19 years old living with HIV.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Does the site have **ALL** of the following? *Tick all that apply*: ☐ 1) A system for documentation of disclosure to children and adolescents (visual inspection) ☐ 2) A written policy for consent to HIV treatment for adolescents, including provisions for treatment of emancipated minors without consent from parent, guardian or spouse (visual inspection) ☐ 3) ART provider trained to provide and provides adolescent-friendly health services	# Ticked _____	If 0-2=Red
	If 3, then Q2		
Q2	Does the site provide the following? *Tick all that apply:* ☐ 1) Psychosocial support (e.g., enhanced adherence counseling, disclosure tailored to adolescents) ☐ 2) Sexual and reproductive services and education (e.g., STI screening, family planning) ☐ 3) Adolescent-specific peer leaders, mentors, or support groups ☐ 4) Extended/weekend or dedicated hours for adolescents to receive clinical services	# Ticked _____	If 0-2=Yellow If ≥3=Green
	SCORE		

CEE #: S_02_31 Community-Based Linkage and Retention Support Services [C&T PEDS] (DUP)			
STANDARD: Each site that provides care and support services for pediatric patients has standardized procedures for providing and documenting all the following core elements: • Retention/adherence support for ART beneficiaries/clients • Referral and linkage to health facilities providing comprehensive HIV care • Basic beneficiary/client assessments, documenting psychosocial needs with linkage/referral to services as appropriate			
Comment:			
	Question	**Response**	**Scoring**
Q1	Which of the following services does this site provide? *Tick all that apply:* ☐ 1) Retention/adherence support for pediatric beneficiaries/clients ☐ 2) Referral and linkage to health facilities providing comprehensive HIV care ☐ 3) Basic beneficiary/client assessments, documenting psychosocial needs with linkage/referral to services as appropriate	# Ticked _____	If 0 = Red If 1-2 = Yellow
	If 3, then Q2		
Q2	Is there a written SOP addressing each of the core elements? *Tick all that apply:* ☐ 1) Support for retention for pediatric beneficiaries/clients ☐ 2) Referral and linkage to health facilities providing comprehensive HIV care ☐ 3) Basic beneficiary/client assessments, documenting clinical and psychosocial needs with linkage/referral to other services as appropriate	# Ticked _____	If 0-2 = Yellow If 3 = Green
	SCORE		

CEE #: S_02_32 Service Referral and Linkage System [C&T PEDS] (DUP)			
STANDARD: Sites supporting prevention and care outreach programs for pediatric patients refer beneficiaries/clients to other high-impact HIV services (both community and facility) and track those referrals to support their successful completion.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is a system in place with standardized tools (e.g., referral forms/vouchers given to beneficiaries, registers used for tracking) to track the following? *Tick all that apply:* ☐ 1) Referrals made to high-impact services (HIV care, PLHIV support groups, OVC programs, TB, VMMC) ☐ 2) Whether the beneficiary/client received those services	# Ticked _____	If 0-1=Red
	If 2, then Q2		
Q2	*Review 10 referral records (individual or logbook) for any 10 clients/beneficiaries from the last three months.* Of the reviewed referral records to any of the above high-impact services, what percentage have been successfully linked to those services (e.g., evidence of a signed counter-referral slip from the receiving site or service)? ***Numerator**: ____# of referral records reviewed, for pediatric clients/beneficiaries in the last three months, to any high-impact service with documentation of successful linkage to those services (e.g., evidence of a signed counter-referral slip from the receiving site or service)* ***Denominator**: ____# of referral records reviewed, for pediatric clients/beneficiaries in the last three months, to any high-impact service*	____%	If <60% = Yellow If ≥60% = Green
	SCORE		

SET 3A: KEY POPULATIONS-GENERAL			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_03_01	Lubricant Availability at Site		X
S_03_02	STI Screening and Management for Key Populations		X
S_03_03	Peer Outreach Management	X	
S_03_04	Family Planning/HIV Integration Service Delivery		X
S_03_05	Ability to Produce KP-specific Program Data	X	
S_03_06	Human-centered Approaches to Providing Sensitized Services		X
S_03_07	Provision of PrEP Services		X

CEE #: S_03_01 Lubricant Availability at Site [KP]			
STANDARD: Each site that targets sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), people in closed spaces, or transgender persons has a reliable supply of water- or silicone-based lubricants. Lubricants have at least one month of shelf life before expiration, and are easily accessible to patrons/clients at the site.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Both of the following are true: *Check all that apply* ☐ 1) Water- or –silicone-based lubricants with at least one month shelf life are available at the site ☐ 2) A continuous supply of water or silicone based lubricants with at least one-month shelf life was available for the last three months	# Ticked _____	If 0-1 = Red
	If 2, then Q2		
Q2 	Are lubricants easily accessible to patrons/clients at the site (e.g., in a bowl on the counter, in a dispenser, or distributed directly to clients/patrons at the site)? ***Note**: Lubricants are 'easily accessible' if available on-site, regardless of whether they are for sale or distributed free*.	Y N	If N=Yellow If Y =Green
	SCORE		

CEE #: S_03_02 STI Screening and Management for Key Populations [KP]			
STANDARD: Each site that targets sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), people in enclosed spaces, or transgender persons regardless of HIV sero-status performs and documents syndromic screening for sexually transmitted infections (STI). All facilities offer STI management and treatment according with national or WHO STI guidelines either onsite or through referral.			
Instructions: If national guidelines do not recommend routine syphilis testing for sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), people in enclosed spaces, or transgender persons, check NA and SKIP this CEE. ***NA*** ☐			
	Question	**Response**	**Scoring**
Q1	Is there a protocol/SOP describing how to routinely offer syndromic screening for STIs [vaginal or urethral discharge, (ano)genital ulcer disease, or, for women, lower abdominal pain] to patrons/clients regardless of HIV ser0-status at every clinical visit?	Y N	If N=Red
	If Y, then Q2		
Q2	Are all clients offered syphilis testing at every clinical visit?	Y N	If N=Red
	If Y, then Q3		
Q3	Is there a protocol/SOP describing how clients/patrons with STI signs or symptoms can get access to STI treatment, according to national or WHO STI guidelines, either on-site or through referral?	Y N	If N=Yellow
	If Y, then Q4		
Q4	*Review 10 randomly selected charts of clients/patrons who visited the site within the past 12 months.* What percent of reviewed charts documented syndromic screening for STIs at the last clinical assessment? ***Numerator**: ____# of charts reviewed that documented syndromic screening for STIs at the last clinical assessment* ***Denominator**: ____# of charts reviewed of clients/patrons who visited the site within the past 12 months*	_____%	If ≤70%=Yellow If >70% = Green
	SCORE		

CEE #: S_03_03 Peer Outreach Management [KP]			
STANDARD: Each site provides peer educators with standardized onsite supportive supervision, including mentorship and training, to improve their peer outreach services for key populations. Supportive supervision comments and recommendations are shared with peer educators.			
Instructions: Does this site conduct peer outreach services for key populations? *If **NO**, check NA, and **SKIP** CEE.*			**NA** ☐
Comment:			
	Question	**Response**	**Scoring**
Q1	Do all peer educators have a performance plan/work plan that includes the following for peer outreach services: objectives, activities, and targets?	Y N	If N=Red
	If Y, then Q2		
Q2	Have all peer educators received onsite supportive supervision of their peer outreach efforts, at least once within the past 3 months?	Y N	If N=Red
	If Y, then Q3		
Q3	Are standardized tools or materials used to conduct supportive supervision for outreach services?	Y N	If N=Yellow
	If Y, then Q4		
Q4	Are supportive supervision comments and recommendations documented and shared with peer educators?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_03_04 Family Planning/HIV Integration Service Delivery [KP]			
STANDARD: Each site providing services for key populations provides access to high quality family planning (FP) education and services, on-site or through referrals.			
Instructions: *If this site provides services exclusively to men who have sex with men (MSM)* ***OR*** *if the agreement with the prime partner or USG implementing agency does not include funding to support family planning education and services, on-site or through referrals, check NA, and* ***SKIP*** *CEE.* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do trained providers deliver information on family planning, safe pregnancy, and available FP services to all clients/patrons at the site, including community members?	Y N	If N=Red
	If Y, then Q2		
Q2	Do all providers provide referrals on-site or (if FP services are not available on-site) to a health facility for additional FP services and FP methods?	Y N	If N=Red
	If Y, then Q3		
Q3	Do health providers or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of FP activities provided by community care providers?	Y N	If N=Yellow
	If Y, then Q4		
Q4 	Is there a documented process to track FP referrals to confirm the patron/client received the service for which s/he was referred?	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_03_05 Ability to produce KP-specific program data [KP]			
STANDARD: Each site that provides services to key populations documents each client/patron's KP classification (i.e., KP group with which the client/patron identifies).			
*Instructions: If the site is unable to document this information due to confidentiality and security issues, check NA, and **SKIP** CEE:*		***NA*** ☐	
Comment:			
	Question	**Response**	**Scoring**
Q1	Have all providers (e.g., HIV Testing Services counselors, physicians, nurses, other health care workers, etc.) who conduct patient assessments received training on screening patrons/clients for KP classification?	Y N	If N=Red
	If Y, then Q2		
Q2	Do patient registers or enrollment forms have a place to indicate KP classification?	Y N	If N=Red
	If Y, then Q3		
Q3	Is screening for KP classification conducted in a space where safety and confidentiality can be assured?	Y N	If N=Yellow
	If Y, then Q4		
Q4	*Review 10 randomly selected records from the past 3 months.* What percent of reviewed records have documentation of KP classification? ***Numerator**: ____# of records, from the last three months, that have documentation of KP classification* ***Denominator**: ____# of records from the past three months*	_____%	If <70%=Yellow If ≥70%=Green
	SCORE		

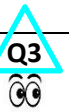
CEE #: S_03_06 Human-centered Approaches to Providing Sensitized Services [KP]			
STANDARD: Services at each site must be provided in a sensitive and friendly manner, particularly to key populations (sex workers, men who have sex with men, people who inject drugs, people in closed settings, and transgender persons) who face stigma, discrimination and high risk of HIV.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standard training that site staff receive that includes information on stigma, discrimination and high risk of HIV among key populations (KPs)?	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a mechanism (e.g. electronic message, suggestion box) by which clients/patrons to the site can provide anonymous feedback on their experience receiving services and suggestions for improving service quality?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the standard training offered at this site cover the following topics? *Tick all that apply based on materials shown to the assessor:* ☐ 1) Client-centered approaches ☐ 2) Referral mechanisms to community resources ☐ 3) Providing services in a non-judgmental and professional manner ☐ 4) Gender and sexual diversity ☐ 5) KP-specific HIV risks ☐ 6) KP-specific HIV needs ☐ 7) Strategies for reducing stigma and discrimination among key populations ☐ 8) Safety and security for service providers, including addressing harassment by the public and officials	# Ticked _____	If <5=Yellow If ≥5=Green
	SCORE		

CEE #: S_03_07 Provision of PrEP Services [KP]			
STANDARD: HIV-uninfected men and women who are at substantial risk of infection can access pre-exposure prophylaxis (PrEP) through high quality, safe, and friendly services.			
*Instructions: If the national policy does not include the provision of PrEP OR the site is not accredited to provide PrEP services, then check NA and **SKIP** CEE:* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standard training offered to site staff on PrEP provision?	Y N	If N=Red
	If Y, then Q2		
Q2	Is PrEP offered at an already existing service delivery point (ex. MCH, CTC/CCC, DIC etc.)? ***Note**: Examples of service delivery points include maternal and child health (MCH), Care and Treatment Clinics (CTC), Drop-in Centers (DIC), etc.*	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does a PrEP initiation visit, as documented in the client assessment- or intake- or other such- form, include **ALL** the following? *Tick all that apply:* ☐ 1) Risk assessment ☐ 2) HIV testing ☐ 3) Screening for contraindications ☐ 4) Risk reduction counseling ☐ 5) Clear counseling on PrEP, including benefits, side effects, risks ☐ 6) Linkage to, or verification of existing linkage to, community peers and support networks, and any other applicable referrals ☐ 7) Providing services in a non-judgmental and professional manner	# Ticked _____	0-6=Yellow 7= Green
	SCORE		

SET 3B: CARE AND TREATMENT-KEY POPULATIONS (C&T KEY POPS)

CEE #	*Abbreviated Title*	*Required*	*Elective*
S_03_08	Retesting for Verification before/at ART Initiation	X	
S_03_09	Patient Tracking-ART Patients*	X	
S_03_10	Rapid ART Initiation	X	
S_03_11	Viral Load Access and Monitoring		X
S_03_12	Management of High Viral Load	X	
S_03_13	Appointment Spacing and Multi-Month Drug Dispensing		X
S_03_14	Partner Services	X	
S_03_15	Routine HIV Testing of Children of Adult Patients	X	
S_03_16	TB Screening		X
S_03_17	TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT)	X	
S_03_18	Cotrimoxazole (CTX)		X
S_03_19	TB Diagnostic Evaluation Cascade		X
S_03_20	Community-Based Linkage and Retention Support Services		X
S_03_21	Service Referral and Linkage System		X
S_03_22	Family Planning / HIV Integration Service Delivery		X
S_03_23	Community-Based Delivery of Family Planning Services		X
S_03_24	Cervical Cancer Screening Capacity		X

CEE #: S_03_08 Retesting for Verification before/at ART Initiation [C&T KP] (DUP)			
STANDARD: All newly diagnosed HIV-positive and pre-ART adult and adolescent patients are retested to verify their HIV diagnosis prior to, or at the time of, ART initiation using the national HIV testing algorithm.			
Instructions: HIV Retesting for verification occurs prior to or at the time of ART initiation using a new specimen from either (1) a newly diagnosed individual or (2) a previously diagnosed individual who has not initiated ART. In either case, a provider who is different from the provider who performed the previous HIV tests for that individual must conduct retesting for verification.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do the national HIV Testing Services (HTS) or ART guidelines include retesting for verification prior to or at ART initiation?	Y N	If N = Red
	If Y , then Q2		
Q2	Is there a standardized process for conducting and documenting the retesting for verification prior to or at ART initiation?	Y N	If N = Yellow
	If Y, then Q3		
Q3	*Review 10 register entries or charts (whichever source has the most updated information) of adult and adolescent patients ≥15 years old who newly initiated on ART in the last 3 months to confirm that retesting for verification prior to or at ART initiation is documented.* What percent of adult and adolescent patient records reviewed have documentation that retesting for verification occurred before ART initiation? *(i.e., the site knows the client or patient was retested for verification prior to or at ART initiation)* ***Numerator** = _____# of records, of adult and adolescent patients ≥15 years old who newly initiated on ART in the last 3 months, with documented retesting for verification* ***Denominator** = _____# Total number of records reviewed of adult and adolescent patients ≥15 years old who newly initiated on ART in the last 3 months*	_____ %	If <80% = Yellow If ≥80% = Green
	SCORE		

CEE #: S_03_09 Patient Tracking-ART Patients [C&T KP] (DUP)			
STANDARD: Each ART site has a standard procedure for identifying and tracking adult and adolescent ART patients who have defaulted on their appointments. The system includes procedures for patient identification and tracking; standardized documentation showing evidence of more than one attempt to bring the patient back into care and the results/outcome of tracking efforts.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Are there standard procedures for identifying and tracking adult and adolescent ART patients who have missed an appointment?	Y N	If N=Red
	If Y, then Q2		
Q2 	*Review tracking documentation (logbooks, registers, patient files etc) for the last the last ten adult and adolescent ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from adult and adolescent ART patients who missed their most recent appointment, had evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers) documented? ***Numerator**: _____# of ART tracking documents reviewed, for ART patients who missed their most recent appointment, that include evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers)* ***Denominator**: _____# of ART tracking documents reviewed for patients who missed their most recent appointment*	_____%	If <80%=Red
	If ≥80%, then Q3		
Q3 	*Review tracking documentation (logbooks, registers, patient files etc) for the last the last ten adult and adolescent ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from ART patients who missed their most recent appointment, have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented? ***Numerator**: _____# of ART tracking documents reviewed, for ART patients who missed their most recent appointment, that have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented*	_____%	If <80% = Yellow If ≥80% = Green

	***Denominator**: _____# of ART patient tracking documents reviewed for patients who missed their most recent appointment*		
	SCORE		

CEE #: S_03_10 Rapid ART Initiation (C&T KP)			
STANDARD: HIV-positive individuals are offered the option of rapid or same-day ART initiation, according to guidelines and national policy. *Instructions: Is rapid or same-day ART currently a part of or allowed per national guidelines?* *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site offer rapid ART initiation/test and start (within 14 days of diagnosis) **OR** same-day initiation to newly diagnosed adults and adolescents ≥15 years old?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of newly diagnosed HIV-positive adult and adolescent patients ≥15 years old who attended the clinic within the last 90 days.* What percentage of register entries or charts reviewed show evidence that HIV-positive patients received same day or rapid ART initiation? ***Note:** Records should only be from newly diagnosed HIV-positive patients.* ***Numerator**: _____# of register entries or charts reviewed of newly diagnosed adolescent patients, ≥15 years old who attended the clinic within the last 90 days, showing evidence that HIV-positive patients received same day or rapid ART initiation* ***Denominator**: _____# of register entries or charts reviewed of newly diagnosed adolescent patients ≥15 years old who attended the clinic within the last 90 days.*	_____%	If <90% = Yellow If ≥90% = Green
	SCORE		

CEE #: S_03_11 Viral Load Access and Monitoring [C&T KP] (DUP)			
STANDARD: Patients on antiretroviral therapy (ART) receive routine monitoring for virologic suppression through assessment of viral load per national guidelines, and the results are documented in the medical record.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have access to viral load testing for adolescent and adult patients?	Y N	If N = Red
	If Y, then Q2		
Q2 	*Review 10 charts of adult and adolescent patients ≥15 years old on ART ≥12 months.* What percentage of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, show that the most recent viral load test was ordered within the appropriate interval, per the national guidelines? ***Note:*** *Modify chart review to fit the national guidelines. Countries may opt to exclude charts if viral load was collected within the last 4 weeks to allow adequate time for results to be returned; replace any excluded charts to review a total of ten. Viral load monitoring is expected to occur on an ongoing basis (e.g., every 3, 6, or 12 months per national guidelines).* ***Numerator****: _____# of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, showing that the most recent viral load test was ordered within the appropriate interval, per the national guidelines* ***Denominator****: _____# of charts reviewed from adult and adolescent patients ≥15 years old on ART ≥12 months*	____%	If <80%=Red
	If ≥80%, then Q3		
Q3 	*Review the same 10 charts of adult and adolescent patients ≥15 years old on ART ≥12 months.* What percent of adult and adolescent charts reviewed have a documented result returned for the most recent viral load test? *Numerator: ____# of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, with a documented returned result for the most recent viral load test*	_____%	If <70% = Red If ≥70% and <90% =Yellow If ≥90% = Green

	Denominator: ____Total # of charts reviewed, from adult and adolescent patients ≥15 years old on ART ≥12 months, with recent viral load test		
	SCORE		

CEE #: S_03_12 Management of High Viral Load [C&T KP] (DUP)			
STANDARD: Patients on antiretroviral therapy (ART) with virologic non-suppression are tracked and receive enhanced adherence counseling (EAC) and repeat viral load monitoring per national guidelines to assess for virologic failure and the potential need to switch ART regimens.			
Instructions: EAC includes focused counseling sessions, typically led by a lay health worker or counselor, on the importance of adhering to the medication. *If a site does not offer these services, check NA and **SKIP** this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a written procedure, which includes the following features, to manage patients with non-suppressed viral load results? *Tick all that apply:* ☐ 1) Tracking and urgently following-up with patients who have non-suppressed viral load results ☐ 2) Providing age-appropriate EAC ☐ 3) Follow-up viral load testing ☐ 4) Assessing the need to switch ART regimens in patients with virologic failure after completing EAC	# Ticked _____	If ≤1 = Red
	If ≥2, then Q2		
Q2	*Review 10 records (e.g., charts, high viral load register, EMR entries) of adult and adolescent patients on ART ≥12 months with virologic non-suppression.* ***Notes:** This review should distinguish the management of patients with non-suppressed viral load results from patients with virologic suppression.* • *If assessing Set 2B at this site and reviewing pediatric records, select only adults ≥20 years old. If **only** assessing Set 2A, select both adolescents and adults ≥15 years old.* What percent of records reviewed have documentation of at least 1 EAC session after the date of virologic non-suppression (e.g., VL ≥1000 copies/mL or criteria based on national guidelines)? ***Numerator** = _____ # of adult and adolescent patient records with evidence of at least one EAC session after date of virologic non-suppression* ***Denominator** = _____# of adult and adolescent patient records reviewed for patients with virologic non-suppression*	_____%	If <70% = Red
	If ≥ 70%, then Q3		

Q3 	*Review the same 10 records of patients on ART ≥12 months with virologic non-suppression.* What percent of the same records reviewed (e.g., charts, high viral load register or EMR entries) have documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL)? ***Numerator**: Number of records reviewed (e.g., charts, high viral load register or EMR entries) with documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL* ***Denominator**: Number of records reviewed of adult and adolescent patients on ART ≥12 months with virologic non-suppression.*	_____%	If <70% = Yellow If ≥70% = Green
	SCORE		

CEE #: S_03_13 Appointment Spacing and Multi-Month Drug Dispensing [C&T KP] (DUP)			
STANDARD: Each site offers differentiated models of service delivery for adolescent and adult patients ≥15 years old (e.g., appointment spacing, multi-month drug dispensing, and community dispensation) to meet the needs of stable ART patients and triage or fast-track of appointments for unstable ART patients and those with advanced HIV infection.			
Instructions: Are differentiated models of service delivery (e.g., appointment spacing, multi-month dispensing) currently allowed in national guidelines? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site distinguish between stable and unstable patients, and have a standard definition of a 'stable ART patient' for adolescent and adult patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the site use or provide the following for adolescent and adult patients? *Tick all that apply:* ☐ 1) 3-6 month routine follow-up visits for stable ART patients ☐ 2) Multi-month (≥3 months) ARV prescribing for stable patients ☐ 3) Multi-month ARV dispensing (≥3 month supply) for stable ART patients ☐ 4) Fast-track pharmacy pick-up of ARVs for stable ART patients ☐ 5) Community service delivery models (e.g., community ART groups or distribution points like home distribution)	# Ticked _____	If≤2=Yellow If 3-5= Green
	SCORE		

CEE #: S_03_14 Partner Services [C&T KP] (DUP)			
STANDARD: All HIV-positive patients are offered partner services that include counseling on safe disclosure of HIV status to their sex partner(s) and/or injecting drug partner(s) and HIV partner testing, either onsite or through referral to a health facility, or community-based approaches.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is counseling on the importance of both safe disclosure **and** testing of all sexual and/or injecting drug partner(s) provided?	Y N	If N=Red
	If Y, then Q2		
Q2	Are partner HIV-testing services provided (either onsite or through referral)? ***Note:*** *Partner testing approaches include any of the following: 1) contact referral, 2) provider referral, 3) dual referral, 4) client referral, 5) HIV self-testing kits provided to clients to provide to their sex partner(s). HIV testing of the partner(s) may be offered onsite, at a standalone VCT clinic located within the facility, or via HIV self-test kits.*	Y N	If N=Red
	If Y, then Q3		
Q3	*Review 10 register entries (individual or index/partner testing logbook) or charts (whichever source has the most updated information) of HIV-positive adult and adolescent patients ≥15 years old.* What percent of reviewed patient records document HIV testing or HIV status of all elicited partner(s)? **Numerator** = ____*# of HIV-positive patient records reviewed that have all elicited partner(s) with documented HIV-testing status (e.g., positive, known positive, negative, declined, unable to locate)* ***Denominator*** *= ____ # of HIV-positive patient records reviewed*	_____%	If <90%=Yellow If ≥90%=Green
	SCORE		

CEE #: S_03_15 Routine HIV Testing of Children of Adult Patients [C&T KP]			
STANDARD: Biological children and adolescents (<15 years old) of HIV-positive adults have a documented (or known) HIV status.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice to ensure routine testing of biological children (<15 years old) of adult ART patients?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adults and adolescent patients ≥15 years old on ART ≥12 months.* What percentage of reviewed charts have documentation of HIV testing status (e.g., positive, negative, declined) for all biological children <15? ***Numerator** = _____# of charts reviewed where all biological children <15 have documented HIV-testing status (e.g., positive, negative, declined)* ***Denominator** = _____# of HIV positive patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%= Green
	SCORE		

CEE #: S_03_16 TB Screening [C&T KP] (DUP)			
STANDARD: Each site has standardized procedures for performing and documenting screening for active tuberculosis (TB) on intake and at each clinical visit for HIV-positive adult and adolescent patients. The TB screening includes all 4 of the following symptoms: cough, fever, night sweats, and weight loss.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for TB screening and documentation at each clinical assessment per national guidelines?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months.* What percent of adult and adolescent records reviewed have documented TB-symptom screening results (i.e., screen positive or negative; presence of cough, fever, night sweats, or weight loss) at the last clinical assessment? ***Numerator**: _____# of register entries or charts reviewed, from HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months, with documented TB-symptom screening results at the last clinical assessment* ***Denominator**: _____# of register entries or charts reviewed* from *HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_03_17 TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) [C&T KP] (DUP)			
STANDARD: HIV-positive patients who screen negative for active tuberculosis (TB) receive TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) per national guidelines.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for administration of TPT/IPT among HIV-positive adult and adolescent patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does this site have a TPT/IPT register and/or another method that allows tracking of who ***started*** and ***completed*** TPT/IPT within a given reporting period? ***Note:*** *"Completed" includes those patients who started and completed 6 months of TPT/IPT and those on continuous TPT/IPT after 6 months of "completion".*	Y N	If N=Red
	If Y, then Q3		
Q3	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months).* What percent of reviewed records show evidence that HIV-positive adult and adolescent patients, who screened negative for active TB during their HIV clinic visits, were ever initiated on TPT/IPT? ***Numerator****: _____# of register entries or charts reviewed, from HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months who screened negative for active TB during their HIV clinic visits, with evidence showing the patient was started on TPT/IPT?* ***Denominator****: _____# of register entries or charts reviewed* from *HIV-positive adult and adolescent patients ≥15 years old on ART ≥12 months who screened negative for active TB during their HIV clinic visits*	_____%	If <70%=Red If ≥70% and <90% = Yellow If ≥90%=Green
	SCORE		

CEE #: S_03_18 Cotrimoxazole (CTX) [C&T KP] (DUP)			
STANDARD: Eligible patients have documented prescription of cotrimoxazole (CTX) according to national guidelines.			
Instructions: *If **NO** HIV-positive patients were eligible within the specified time period, check NA and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adults and adolescent patients ≥15 years old on ART >12 months.* *Of the total 10 records, select patients that are eligible for CTX based on the national guidelines. Include that number in the denominator, even if it is less than 10.* What percent of adult and adolescent patient records reviewed have documentation of CTX prescription per the national guidelines at the last clinical assessment? ***Numerator** = _____ # of eligible HIV positive adults and adolescent patients ≥15 years old on ART >12 months, who received a CTX prescription* ***Denominator** = _____# of HIV positive, CTX eligible (per national guidelines) patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_03_19 TB Diagnostic Evaluation Cascade [C&T KP] (DUP)			
STANDARD: Every site has standardized procedures for documenting HIV-positive adult and adolescent patients with presumptive tuberculosis (TB) (in a line list or register) and a referral and follow-up mechanism to ensure TB diagnostic evaluation in accordance with national testing algorithms.			
Instructions: *If there are **NO** adult or adolescent patients with presumptive TB, check NA, and skip this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standardized procedures for documenting HIV-positive adult and adolescent patients with presumptive TB and providing referral and follow-up to ensure TB diagnostic evaluation (e.g., smear, culture or Xpert MTB/RIF)?	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a line list/register for HIV-positive adult and adolescent patients with presumptive TB to document diagnostic evaluation and treatment?	Y N	If N=Red
	If Y, then Q3		
Q3	*Review the last 10 entries in the line list/register of HIV-positive adult and adolescent patients ≥15 with presumptive TB*. What percent of the reviewed entries of HIV-positive adult and adolescent patients who are presumed to have TB have documented smear microscopy, culture or Xpert MTB/RIF results? ***Numerator**: ____# of reviewed entries of HIV-positive adult and adolescent patients ≥15 who are presumed to have TB with documented smear microscopy, culture or Xpert MTB/RIF results* ***Denominator**: ___# of reviewed entries of HIV-positive adults and adolescent patients ≥15 who are presumed to have TB*	_____%	If <80%=Yellow
	If ≥80%, then Q4		

Q4 	*Review the same last 10 entries in the line list/register of HIV-positive adult and adolescent patients presumptive TB*. What percent of the same entries of HIV-positive adult and adolescent patients who are presumed to have TB received molecular testing as their first-line diagnostic test? ***Numerator**: ____# of same reviewed entries, of HIV-positive adult and adolescent patients ≥15 who are presumed to have TB, with documented receipt of molecular testing as their first-line diagnostic test* ***Denominator**: ___# of same reviewed entries of HIV-positive adults and adolescent patients ≥15 who are presumed to have TB*	_____%	If <90%=Yellow If ≥90%=Green
	SCORE		

CEE #: S_03_20 Community-Based Linkage and Retention Support Services [C&T KP]			
STANDARD: Each site that provides care and support services has standardized procedures for providing and documenting all the following core elements: • Retention/adherence support for ART beneficiaries/clients • Referral and linkage to health facilities providing comprehensive HIV care • Basic beneficiary/client assessments, documenting psychosocial needs with linkage/referral to services as appropriate			
Comment:			
	Question	**Response**	**Scoring**
Q1	Which of the following services does this site provide? *Tick all that apply:* ☐ 1) Retention/adherence support for ART beneficiaries/clients ☐ 2) Referral and linkage to health facilities providing comprehensive HIV care ☐ 3) Basic beneficiary/client assessments, documenting psychosocial needs with linkage/referral to services as appropriate	# Ticked _____	If 0 = Red If 1-2 = Yellow
	If All 3, then Q2		
Q2	Is there a written SOP addressing each of the core elements? *Tick all that apply:* ☐ 1) Support for retention for ART beneficiaries/clients ☐ 2) Referral and linkage to health facilities providing comprehensive HIV care ☐ 3) Basic beneficiary/client assessments, documenting clinical and psychosocial needs with linkage/referral to other services as appropriate	# Ticked _____	If 0-2 = Yellow If 3 = Green
	SCORE		

CEE #: S_03_21 Service Referral and Linkage System [C&T KP]			
STANDARD: Sites supporting prevention and care outreach programs refer beneficiaries/clients to other high-impact HIV services (both community and facility) and track those referrals to support successful completion.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is a system in place with standardized tools (e.g., referral forms/vouchers given to beneficiaries, registers used for tracking) to track the following? *Tick all that apply:* ☐ (1) Referrals made to high-impact services (e.g., HTSC, STI screening and treatment, HIV care, PLHIV support groups, OVC programs, PMTCT, TB, VMMC, condom and lubricant provision, post-violence care, PrEP) ☐ (2) Whether the beneficiary/client received those services	# Ticked _____	If <2 = Red
	If 2, then Q2		
Q2	*Review 10 referral records (individual or logbook) from the last three months.* Of the reviewed referral records to any of the above high-impact services, what percentage have been successfully linked to those services (e.g., evidence of a signed counter-referral slip from the receiving site or service)? ***Numerator**: ____# of referral records reviewed, for clients/beneficiaries in the last three months, to any high-impact service with documentation of successful linkage to those services (e.g., evidence of a signed counter-referral slip from the receiving site or service)* ***Denominator**: ____# of referral records reviewed, for clients/beneficiaries in the last three months, to any high-impact service*	____%	If <60% = Yellow If ≥60% = Green
	SCORE		

CEE #: S_03_22 Family Planning /HIV Integration Service Delivery [C&T KP]			
STANDARD: All patients attending HIV services have access to high quality voluntary family planning counseling and services, including safer pregnancy counseling and contraceptives, depending upon their fertility intentions.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is family planning education and/or counseling routinely offered onsite to clients who wish to delay or prevent pregnancy?	Y N	If N=Red
	If Y, then Q2		
Q2	Is safer conception/pregnancy counseling routinely offered onsite to PLHIV who wish to have children?	Y N	If N=Red
	If Y, then Q3		
Q3	Do clients have access to at least three contraceptive methods either onsite or through referral? (e.g., condoms, oral contraceptive pills, injectables, implants, intra-uterine devices (IUDs), fertility awareness methods, vasectomy, tubal ligation)	Y N	If N=Yellow
	If Y, then Q4		
Q4	Are education materials (IEC) about contraception and safe conception on display or available to clients (e.g., pamphlets, posters, brochures, inserts) accessing this service delivery point?	Y N	If N=Yellow
	If Y, then Q5		
Q5	Has there been a stockout within the past 3 months of any contraceptive methods usually provided onsite?	Y N	If Y=Yellow If N= Green
	SCORE		

CEE #: S_03_23 Community-Based Delivery of Family Planning Services [C&T KP]			
STANDARD: Community-based delivery of family planning services should include high quality, voluntary family planning counseling and services, including safe conception/pregnancy counseling and contraceptives.			
Instructions: This CEE should be assessed at sites where contraceptives are distributed in the community. *Does this site's agreement with the prime partner or USG implementing agency include funding to support family planning education and services, directly or through referrals?* *If **NO**, check NA, and **SKIP** CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do trained community care providers deliver information on family planning, safe conception/pregnancy, and available family planning services to community members and groups?	Y N	If N = Red
	If Y, then Q2		
Q2	Do all community care providers provide referrals to a health facility for additional information on family planning services and methods?	Y N	If N = Red
	If Y, then Q3		
Q3	Do health providers and/or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of family planning activities provided by community care providers?	Y N	If N = Yellow
	If Y, then Q4		
Q4	Is there a process for tracking family planning referrals to confirm the beneficiary/client received the service? Note: If the service is directly provided, then Y.	Y N	If N=Yellow If Y= Green
	SCORE		

CEE#: S_03_24 Cervical Cancer Screening Capacity [C&T KP]			
STANDARD: All sites offering cervical cancer screening and/or precancerous lesion treatment services have in place the procedures, equipment and processes necessary to provide high-quality services.			
Instructions: Assess this CEE based on which activities this site is expected to provide (e.g., cervical cancer screening, cryotherapy) *Does this site use ANY PEFPAR funding or PEPFAR support to provide cervical cancer screening and/or precancerous lesion treatment services to HIV positive women? If **NO**, check NA, and **SKIP** CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have the following? *Tick all that apply:* ☐ 1) Standardized procedures (and algorithms, where applicable) for onsite provision of cervical cancer screening *(Look for documentation)* ☐ 2) Standardized procedures for management of women with positive screening results, including referral (e.g., for cryotherapy (if not available onsite), loop electrosurgical excision procedure (LEEP), and further evaluation for suspected invasive cervical cancer) *(Look for documentation)* ☐ 3) Clinical staff who provide cervical cancer secondary prevention services are trained for screening and cervical cryotherapy ***Note:** Clinical staff include nurses, midwives, doctors, clinical officers*	# Ticked _____	If 0-2=Red
	If 3, then Q2		
Q2	Does the facility area where cervical cancer screening services are provided have the following basic elements? *Tick all that apply:* ☐ 1) Private area with gynecological exam table ☐ 2) Sterilized reusable (or new disposable) specula ☐ 3) Bright light source ☐ 4) Exam gloves ☐ 5) Disinfectant for specula and other equipment (i.e., facilities for universal precaution) ☐ 6) Hand washing station ☐ 7) Appropriate screening tools (3%-5% acetic acid for visual inspection with acetic acid (VIA) screening; or HPV test kit for HPV testing; or glass slides, cover slips, and fixatives for Pap smear)	# Ticked ____	If 0-6=Red
	If 7, then Q3		
Q3	*Review cervical screening register or logbook entries from all women screened 90 days prior OR the previous 10 entries/records (whichever is less), of women with positive cervical cancer screening test results.* What percentage of women having a positive cervical cancer screening test result were either referred for precancerous lesion treatment or completed treatment onsite?	____%	<80% = Yellow ≥80% = Green

	***Numerator**= ___# of women with positive cervical cancer screening result who were REFERRED for OR COMPLETED precancerous lesion treatment* ***Denominator**= ____# of women with positive cervical cancer screening results*		
	SCORE		

SET 4A: PMTCT-ANC, POSTNATAL, and L&D			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_04_01	Retesting for Verification before/at ART Initiation	X	
S_04_02	Patient Tracking-ART Patients	X	
S_04_03	Viral Load Access and Monitoring		X
S_04_04	Management of High Viral Load	X	
S_04_05	Appointment Spacing and Multi-Month Drug Dispensing		X
S_04_06	Support Services for HIV-Positive Pregnant Adolescents in ANC		X
S_04_07	Partner Services	X	
S_04_08	Routine HIV Testing of Children of Adult Patients	X	
S_04_09	TB Screening		X
S_04_10	TB Preventative Treatment (TPT) / Isoniazid Preventive Therapy (IPT)	X	
S_04_11	Cotrimoxazole (CTX)		X
S_04_12	TB Diagnostic Evaluation Cascade		X
S_04_13	PITC for Maternity Patients	X	
S_04_14	ARVs at Labor and Delivery	X	

CEE #: S_04_01 Retesting for Verification before/at ART Initiation [C&T PMTCT]			
STANDARD: All newly diagnosed HIV-positive pregnant and breastfeeding patients are retested to verify their HIV diagnosis prior to, or at the time of, ART initiation using the national HIV testing algorithm.			
Instructions: HIV Retesting for verification occurs prior to or at the time of ART initiation using a new specimen from either (1) a newly diagnosed individual or (2) a previously diagnosed individual who has not initiated ART. In either case, a provider who is different from the provider who performed the previous HIV tests for that individual must conduct retesting for verification.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Do the national HIV Testing Services (HTS) or ART guidelines include retesting for verification prior to or at ART initiation?	Y N	If N = Red
	If Y , then Q2		
Q2	Is a standardized process available for conducting and documenting retesting for verification prior to or at ART initiation?	Y N	If N = Yellow
	If Y, then Q3		
Q3	*Review the last 10 register entries or charts (whichever source has the most updated information) of pregnant and breastfeeding patients who newly initiated ART in the last 3 months to confirm that retesting for verification* prior to or at ART initiation *is documented.* What percent of pregnant and breastfeeding patient records reviewed have documentation that retesting for verification occurred prior to or at ART initiation? (i.e., the site knows the client or patient was retested for verification prior to or at ART initiation) ***Numerator** = ____# of records with documented retesting for verification* ***Denominator** = _____Total number of records reviewed of pregnant and breastfeeding patients who newly initiated ART in the last 3 months*	_____ %	If <80% = Yellow If ≥80% = Green
	SCORE		

CEE #: S_04_02 Patient Tracking-ART Patients [C&T PMTCT] (DUP)			
STANDARD: Each ART site has a standard procedure for identifying and tracking pregnant and breastfeeding ART patients who have defaulted on their appointments. The system includes: procedures for patient identification and tracking; standardized documentation showing evidence of more than one attempt to bring the patient back into care; and the results/outcome of tracking efforts.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standard procedures for identifying and tracking pregnant and breastfeeding ART patients who have missed an appointment?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review tracking documentation (logbooks, registers, patient files etc.) for the last the last ten pregnant and breastfeeding ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from ART patients who missed their most recent appointment, had evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers) documented? ***Numerator***_____*# of ART tracking documents reviewed, for pregnant and breastfeeding ART patients who missed their most recent appointment, that include evidence of more than one attempt to bring the patient back into care (e.g., names of those with missed appointments, evidence of phone calls, linked to outreach workers)* ***Denominator****: _____# of ART tracking documents reviewed for pregnant and breastfeeding ART patients who missed their most recent appointment*	% _____	If <80%=Red
	If ≥80%, then Q3		
Q3	*Review tracking documentation (logbooks, registers, patient files etc.) for the last the last ten ART patients who missed their most recent appointment.* What percent of tracking documents reviewed, from pregnant and breastfeeding ART patients who missed their most recent appointment, have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented?	% _____	If <80% = Yellow If ≥80% = Green

	***Numerator**: _____# of ART tracking documents reviewed, for pregnant and breastfeeding ART patients who missed their most recent appointment, that* have the result of tracking efforts (e.g., transferred out, new appointment, not found, refusal, death) documented ***Denominator**: _____# of pregnant and breastfeeding ART patient tracking documents reviewed for patients who missed their most recent appointment*		
	SCORE		

CEE #: S_04_03 Viral Load Access and Monitoring [C&T PMTCT]			
STANDARD: Pregnant and breastfeeding patients on antiretroviral therapy (ART) receive routine monitoring for virologic suppression through assessment of viral load, per national guidelines, and the results are documented in the medical record.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have access to viral load testing for pregnant and breastfeeding patients?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 randomly selected charts of pregnant and breastfeeding patients on ART >6 months.* What percentage of charts reviewed, from pregnant and breastfeeding patients ≥15 years old on ART ≥12 months, show that the most recent viral load test was ordered within the appropriate interval, per the national guidelines? ***Note:*** *Modify chart review to fit the national guidelines. Countries may opt to exclude charts if viral load was collected within the last 4 weeks to allow adequate time for results to be returned; replace any excluded charts to review a total of ten. Viral load monitoring is expected to occur on an ongoing basis (e.g., every 3, 6, or 12 months per national guidelines).* ***Numerator****: _____# of charts reviewed, from pregnant and breastfeeding patients on ART >6 months, showing that the most recent viral load test was ordered within the appropriate interval, per the national guidelines* ***Denominator****: _____# of charts reviewed of pregnant and breastfeeding patients on ART >6 months*	____%	If <80%=Red
	If ≥80%, then Q3		
Q3	*Review the same 10 charts of pregnant and breastfeeding patients on ART >6 months.* What percent of adult and adolescent charts reviewed have a documented result returned for the most recent viral load test?	_____%	If <70% = Red If ≥70% and <90% =Yellow If ≥90% = Green

	Numerator: ____# of charts reviewed, from pregnant and breastfeeding patients on ART >6 months, with a documented returned result for the most recent viral load test *Denominator: ____Total # of charts reviewed, from pregnant and breastfeeding patients on ART >6 months, with recent viral load test*		
	SCORE		

CEE #: S_04_04 Management of High Viral Load [C&T PMTCT] (DUP)			
STANDARD: Pregnant and breastfeeding patients on antiretroviral therapy (ART) with virologic non-suppression are tracked and receive enhanced adherence counseling (EAC) and repeat viral load monitoring per national guidelines to assess for virologic failure and the potential need to switch ART regimens.			
Instructions: EAC includes focused counseling sessions, typically led by a lay health worker or counselor, on the importance of adhering to the medication. *If a site does not offer these services, check NA and **SKIP** this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a written procedure, which includes the following features, to manage patients with non-suppressed viral load? *Tick all that apply:* ☐ 1) Tracking and urgently following-up with patients who have non-suppressed viral load results ☐ 2) Providing age-appropriate EAC ☐ 3) Follow-up viral load testing ☐ 4) Assessing the need to switch ART regimens in patients with virologic failure after completing EAC	# Ticked _____	If ≤1 = Red
	If ≥2, then Q2		
Q2	*Review 10 records (e.g., charts, high viral load register, EMR entries) of pregnant and breastfeeding patients on ART ≥12 months with virologic non-suppression.* ***Notes:** This review should distinguish the management of patients with non-suppressed viral load results from patients with virologic suppression.* What percent of records from pregnant and breastfeeding women have documentation of at least one EAC session after the date of virologic non-suppression (*e.g., VL ≥1000 copies/mL or criteria based on national guidelines*)? ***Numerator** = _____ # of records of pregnant and breastfeeding patients on ART ≥12 months received at least 1 EAC session after date of virologic non-suppression* ***Denominator** =_____# of records of pregnant and breastfeeding patients on ART ≥12 months with virologic non-suppression*	_____ %	If <70% = Red
	If ≥ 70%, then Q3		

Q3 	*Review the same 10 records of pregnant and breastfeeding patients on ART ≥12 months with virologic non-suppression.* What percent of the same records of pregnant and breastfeeding women (e.g., charts, high viral load register or EMR entries) have documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL)? ***Numerator**: _____# of records* of pregnant and breastfeeding women *with documentation of a follow-up viral load result after the first result of virologic non-suppression (e.g., VL ≥1000 copies/mL* ***Denominator**: _____# of records reviewed of pregnant and breastfeeding women on ART ≥12 months with virologic non-suppression.*	_____ %	If <70% = Yellow If ≥70% = Green
	SCORE		

CEE #: S_04_05 Appointment Spacing and Multi-Month Drug Dispensing [C&T PMTCT] (DUP)			
STANDARD: Each site offers differentiated models of service delivery for pregnant and breastfeeding patients (e.g., appointment spacing, multi-month drug dispensing, community dispensation) to meet the needs of stable ART patients and triage or fast-track of appointments for unstable ART patients and those with advanced HIV infection.			
Instructions: Are differentiated models of service delivery (e.g., appointment spacing, multi-month dispensing) currently allowed in national guidelines? *If **NO**, check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site distinguish between stable and unstable patients, and have a standard definition of a 'stable ART patient' for pregnant and breastfeeding patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the site use or provide the following for pregnant and breastfeeding patients? *Tick all that apply:* ☐ 1) 3-6 month routine follow-up visits for stable ART patients ☐ 2) Multi-month (≥3 months) ARV prescribing for stable patients ☐ 3) Multi-month ARV dispensing (≥3 month supply) for stable ART patients ☐ 4) Fast-track pharmacy pick-up of ARVs for stable ART patients ☐ 5) Community service delivery models (e.g., community ART groups or distribution points like home distribution)	# Ticked _____	If ≤2=Yellow If ≥3= Green
	SCORE		

CEE #: S_04_06 Support Services for HIV-Positive Pregnant Adolescents in ANC [C&T-PMTCT]			
STANDARD: Adolescent-friendly clinical services are provided to cater to the specific treatment, support and general health needs of HIV-positive pregnant adolescents <20 years old.			
Instructions: If there are NO pregnant adolescents, check NA, and SKIP this CEE: NA ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have the following? *Tick all that apply:* ☐ 1) At least one health care provider at this site who is trained to provide adolescent friendly services ☐ 2) Dedicated time or space for pregnant adolescents to receive clinical services ☐ 3) Support available to provide adolescent-specific services (e.g., peer leaders, mentor mothers, support groups)	# Ticked _____	If 0 = Red If 1 or 2 = Yellow If 3 = Green
	SCORE		

CEE #: S_04_07 Partner Services [C&T PMTCT] (DUP)			
STANDARD: HIV-positive pregnant and breastfeeding patients are offered partner services that include counseling on safe disclosure of HIV status to their sex partner(s) and/or injecting drug partner(s) and HIV partner testing, either onsite or through referral to a health facility, or community-based approaches.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is counseling on the importance of both safe disclosure **and** testing of all sexual and/or injecting drug partner(s) provided?	Y N	If N=Red
	If Y, then Q2		
Q2	Are partner HIV-testing services provided (either onsite or through referral)? ***Note**: Partner testing approaches include any of the following: 1) contact referral, 2) provider referral, 3) dual referral, 4) client referral, 5) HIV self-testing kits provided to clients to provide to their sex partner(s). HIV testing of the partner(s) may be offered onsite, at a standalone VCT clinic located within the facility, or via HIV self-test kits.*	Y N	If N=Red
	If Y, then Q3		
Q3	*Review 10 register entries (individual or index/partner testing logbook) or charts (whichever source has the most updated information) of HIV-positive pregnant and breastfeeding patients on ART ≥12 months.* What percent of reviewed pregnant and breastfeeding patient records document HIV testing or HIV status of all elicited partner(s)? **Numerator** = ____*# of HIV-positive patient record reviewed that have all elicited partner(s) with documented HIV-testing status (e.g., positive, known positive, negative, declined, unable to locate)* ***Denominator** = ____ # of HIV-positive patient records reviewed*	_____%	If <90%=Yellow If ≥90%=Green
	SCORE		

CEE #: S_04_08 Routine HIV Testing of Children of Adult Patients [C&T PMTCT] (DUP)			
STANDARD: Biological children and adolescents (<15 years old) of HIV-positive pregnant and breastfeeding women have a documented (or known) HIV status.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice to ensure routine testing of biological children (<15 years old) of adult ART patients?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive pregnant and breastfeeding patients on ART ≥12 months.* What percentage of reviewed charts have documentation of HIV testing status (e.g., positive, negative, declined) for all biological children <15? ***Numerator** = _____# of charts reviewed where all biological children <15 have documented HIV-testing status (e.g., positive, negative, declined)* ***Denominator** = _____# of HIV positive patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% Yellow If ≥90%= Green
	SCORE		

CEE #: S_04_09 TB Screening [C&T PMTCT] (DUP)			
STANDARD: Each site has standardized procedures for performing and documenting screening for active tuberculosis (TB) on intake and at each clinical visit for HIV-positive pregnant and breastfeeding patients. The TB screening includes all 4 of the following symptoms: cough, fever, night sweats, and weight loss.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for TB screening and documentation at each clinical assessment per national guidelines?	Y N	If N=Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive pregnant and breastfeeding patients on ART ≥12 months.* What percent of pregnant and breastfeeding patient records have documented TB-symptom screening results (i.e., screen positive or negative; presence of cough, fever, night sweats, or weight loss) at the last clinical assessment? ***Numerator**: _____# of register entries or charts reviewed, from HIV-positive pregnant and breastfeeding patients on ART ≥12 months, with documented TB-symptom screening results at the last clinical assessment* ***Denominator**: _____# of register entries or charts reviewed* from *HIV-positive pregnant and breastfeeding patients on ART ≥12 months*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_04_10 TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) [C&T PMTCT] (DUP)			
STANDARD: HIV-positive pregnant and breastfeeding patients who screen negative for active tuberculosis (TB) receive TB Preventive Treatment (TPT) / Isoniazid Preventive Therapy (IPT) per national guidelines.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice for administration of TPT/IPT among HIV-positive pregnant and breastfeeding patients?	Y N	If N=Red
	If Y, then Q2		
Q2	Does this site have a TPT/IPT register and/or another method that allows tracking of who started and who ***completed*** TPT/IPT within a given reporting period? ***Note:*** *"Completed" includes those patients who started and completed 6 months of TPT/IPT and those on continuous TPT/IPT after 6 months of "completion".*	Y N	If N=Red
	If Y, then Q3		
Q3	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive pregnant and breastfeeding patients on ART ≥12 months.* What percent of reviewed records show evidence those HIV-positive pregnant and breastfeeding patients who screened negative for active TB during their HIV clinic visits were ever initiated on TPT/IPT? ***Numerator****: _____# of register entries or charts reviewed, from HIV-positive pregnant and breastfeeding patients on ART ≥12 months on ART ≥12 months who screened negative for active TB during their HIV clinic visits, with evidence showing the patient was started on TPT/IPT?* ***Denominator****: _____# of register entries or charts reviewed* from *HIV-positive pregnant and breastfeeding patients on ART ≥12 months who screened negative for active TB during their HIV clinic visits*	_____%	If <70%=Red If ≥70% and <90% = Yellow If ≥90%=Green
	SCORE		

CEE #: S_04_11 Cotrimoxazole (CTX) [C&T PMTCT] (DUP)			
STANDARD: Eligible pregnant and breastfeeding patients have documented prescription of cotrimoxazole (CTX) according to national guidelines.			
Instructions: *If **NO** HIV-positive patients were eligible within the specified time period, check NA and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	*Review 10 register entries or charts (whichever source has the most updated information) of HIV-positive adults and adolescent patients ≥15 years old on ART >12 months.* *Of the total 10 records, select patients that are eligible for CTX based on the national guidelines. Include that number in the denominator, even if it is less than 10.* What percent of pregnant and breastfeeding patient records have documentation of CTX prescription per the national guidelines at the last clinical assessment? ***Numerator** = _____ # of eligible HIV positive pregnant and breastfeeding patients on ART >12 months, who received a CTX prescription* ***Denominator** = _____# of HIV positive, CTX eligible (per national guidelines) patient records reviewed*	_____%	If <70%=Red If ≥70% and <90% =Yellow If ≥90%=Green
	SCORE		

CEE #: S_04_12 TB Diagnostic Evaluation Cascade [C&T PMTCT] (DUP)			
STANDARD: Every site has standardized procedures for documenting HIV-positive pregnant and breastfeeding patients with presumptive tuberculosis (TB) (in a line list or register) and a referral and follow-up mechanism to ensure TB diagnostic evaluation in accordance with national testing algorithms.			
*Instructions: If there are **NO** pregnant and breastfeeding patients with presumptive TB, check NA, and skip this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standardized procedures for documenting HIV-positive pregnant and breastfeeding patients with presumptive TB and providing referral and follow-up to ensure TB diagnostic evaluation (e.g., smear, culture or Xpert MTB/RIF)?	Y N	If N=Red
	If Y, then Q2		
Q2	Is there a line list/register for HIV-positive pregnant and breastfeeding patients with presumptive TB to document diagnostic evaluation and treatment?	Y N	If N=Red
	If Y, then Q3		
Q3	*Review the last 10 entries in the line list/register of HIV-positive pregnant and breastfeeding patients with presumptive TB.* What percent of the reviewed entries of HIV-positive pregnant and breastfeeding patients who are presumed to have TB have documented smear microscopy, culture or Xpert MTB/RIF results? ***Numerator**: ____# of reviewed entries of HIV-positive pregnant and breastfeeding patients who are presumed to have TB with documented smear microscopy, culture or Xpert MTB/RIF results* ***Denominator**: ___# of reviewed entries of HIV-positive pregnant and breastfeeding patients who are presumed to have TB*	_____%	If <80%=Yellow
	If ≥80%, then Q4		

Q4	*Review same last 10 entries in the line list/register of HIV-positive pregnant and breastfeeding patients presumptive TB*. What percent of the same entries of HIV-positive pregnant and breastfeeding patients who are presumed to have TB received molecular testing as their first-line diagnostic test? ***Numerator**: ____# of same reviewed entries, of HIV-positive pregnant and breastfeeding patients who are presumed to have TB, with documented receipt of molecular testing as their first-line diagnostic test* ***Denominator**: ___# of same reviewed entries of HIV-positive pregnant and breastfeeding who are presumed to have TB*	_____%	If <90%=Yellow If ≥90%=Green
	SCORE		

CEE #: S_04_13 PITC for Maternity Patients [C&T PMTCT]			
STANDARD: Routine provider-initiated testing and counseling (PITC) is provided to all eligible women attending maternity for labor and delivery (L&D).			
*Instructions: If NO maternity ward/labor and delivery services are provided at this site, then check NA and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the maternity register include known HIV-testing status or the date and result of last HIV test to establish eligibility for HIV testing? ***Note:** Eligible women are defined as those without a documented HIV test within the last 3 months.*	Y N	If N = Red
	If Y, then Q2		
Q2	*Review register entries of all women attending maternity in the past 2 weeks (no more than 100 women).* What percentage of women attending maternity in the past 2 weeks have a documented HIV-testing status within the 3 months prior to presenting to maternity OR a documented HIV-testing status at maternity? ***Numerator** = ____ # of register entries in past 2 weeks with documented HIV-testing status (e.g., positive, negative, declined) within the 3 months prior to presenting to maternity OR a documented HIV-testing status at maternity* ***Denominator** = _____# Total number of reviewed register entries of women attending maternity in the past 2 weeks*	_____%	If <90% = Yellow If ≥90% = Green
	SCORE		

CEE #: S_04_14 ARVs at Labor and Delivery [C&T PMTCT]			
STANDARD: ART for HIV-positive women and ARV prophylaxis for their exposed infants are provided at maternity and labor and delivery (L&D).			
Instructions: *If **NO** maternity ward/labor and delivery services are provided at this site or NO HIV-positive women were seen in the previous year, then check NA, and **SKIP** CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is ART for mothers and ARV prophylaxis for infants routinely available at L&D at all hours that the facility is open, including nights and weekends?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 register entries or charts (whichever source has the most updated information) of the most recently seen HIV-positive women in maternity (up to the last 12 months prior to today's SIMS assessment).* What percent of mother-infant pair entries have documentation of receipt of ART for mothers and prophylaxis for infants? ***Numerator**= ___# of mother-infant pairs that have documented receipt of ART for mothers and prophylaxis for infant* ***Denominator**= ___# of charts/register entries of HIV-positive mothers in maternity (up to the last 12 months prior to today's SIMS assessment)*	_____%	If ≤70% = Red If >70 and ≤90% = Yellow If >90% = Green
	SCORE		

SET 4B: HIV EXPOSED INFANTS (HEI)			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_04_15	Early Infant Diagnosis Provided to Caregiver		X
S_04_16	Tracking HIV-Exposed Infants		X
S_04_17	Collection of a Second Specimen for Confirmatory Testing		X
S_04_18	CTX for HIV-Exposed Infants		X
S_04_19	HEI Follow-up and Final HIV Status	X	
S_04_20	Enrollment of HIV-Infected Infants into ART Services	X	
S_04_21	Supply Chain Reliability (Early Infant Diagnosis) DBS or POC		X

CEE #: S_04_15 Early Infant Diagnosis Provided to Caregiver [HEI]
STANDARD: All HIV-exposed infants (HEIs) have a specimen collected for early infant diagnosis (EID). There is documented return of HIV results to caregivers within one month of sample collection.
*Instructions: If **NO** HIV-exposed infants were seen in the previous year, select NA, and **SKIP** this CEE:* **NA** ☐ *Select testing available at this site:* ☐ *1) Conventional laboratory-based testing* ☐ *2) Point-of-care testing (POCT)*
Comment:

	Question	Response	Scoring
Q1	*Review 10 records (register entries, charts, or HEI cards) of the 10 most recent HEIs (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment).* What percent of HIV-exposed infants had a specimen collected for EID? ***Numerator=*** *____ # of HEI records with documentation of specimens collected for both EID and IVT testing* ***Denominator*** *= ____#Total number of most recent HEI records (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment).*	____%	If ≤90% = Red
	If >90%, then Q2		
Q2	*Review the same 10 records (register entries, charts, or HEI cards) of the 10 most recent HEIs (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment).* *Look at the EID sample collected at the site.* What percent of HIV-exposed infants have documentation of a HIV-test result provided to a caregiver within one month of sample collection? ***Numerator****= _____# of HEI records with documentation that the caregiver has received the results of an HIV-test within one month of sample collection*	_____%	If <90% = Yellow If ≥90%= Green

	***Denominator** = _____# of most recent HEI records (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment).*		
	SCORE		

CEE #: S_04_16 Tracking HIV-Exposed Infants [HEI]			
STANDARD: Each site providing services for HIV-exposed infants (HEIs) has a standard procedure for identifying and tracking HEIs who have missed an appointment. The tracking system includes procedures for patient identification and tracking; standardized documentation showing evidence of more than one attempt to bring the patient back into care, and results of tracking efforts.			
Instructions: *If **NO** HIV-exposed infants, select NA, and **SKIP** this CEE:* ☐			**NA**
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standard written procedures for identifying and tracking HIV-exposed infants who missed an appointment?	Y N	If N = Red
	If Y, then Q2		
Q2	Is HIV-exposed infant tracking documentation up to date AND includes evidence of more than one attempt to bring the infant back into care (e.g., names of those with missed appointments, evidence of phone calls to care givers, evidence of being linked to outreach workers)? Note: tracking documentation includes logbooks, registers, patient files etc.	Y N	If N = Yellow
	If Y, then Q3		
Q3	Is there documentation of the result of the tracking efforts for each patient with a missed appointment (e.g., transferred out, new appointment, not found, refusal, death)? Note: tracking documentation includes logbooks, registers, patient files etc.	Y N	If N = Yellow If Y = Green
	SCORE		

CEE #: S_04_17 Collection of a Second Specimen for Confirmatory Testing [HEI]			
STANDARD: All infants with an initial positive virologic test result (from either Laboratory or Point of Care Testing) have a second specimen collected for confirmatory testing.			
Instructions: *If the site does not offer infant virologic testing onsite OR there are **NO** HIV-infected infants, select NA, and **SKIP** the CEE*: **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	*Review 10 records (register entries, charts, or HEI cards) of the most recent HIV-infected infants (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment) who had an initial positive virologic test result.* What percent of infants with an initial positive virologic test result have documentation of a confirmatory virologic test collected? ***Numerator**=_____# of records of HIV-infected infants WITH documentation of a confirmatory virologic test* ***Denominator** = ____#Total number of records of the most recent HIV-infected infants (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment) who had an initial positive virologic test result* ***Note:** This requires a separate chart pull to review records of **HIV-infected** infants only.*	_____%	If ≤ 70% = Red If >70% and <90% = Yellow If ≥90%= Green
	SCORE		

CEE #: S_04_18 CTX for HIV-Exposed Infants [HEI]			
STANDARD: All HIV-exposed infants (HEIs) initiate cotrimoxazole (CTX) by eight weeks of age.			
*Instructions: If **NO** HIV-exposed infants were seen in the previous year, select NA, and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	*Review 10 records (register entries, charts, or HEI cards) of the most recent HEIs of the most recent HEI (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment).* What percent of HIV-exposed infants have documented receipt of CTX by 8 weeks of age? ***Numerator**: ___ # of HEI initiated on CTX by 8 weeks of age* ***Denominator** = ____Total number of records of the most recent HEI (i.e. born 3 or more months prior to the SIMS assessment and up to the last 12 months prior to today's SIMS assessment)*	_____%	If ≤ 70% = Red If >70% and <90% = Yellow If ≥90%= Green
	SCORE		

CEE #: S_04_19 HEI Follow-Up and Final HIV Status [HEI]			
STANDARD: All HIV-exposed infants (HEIs) are tracked through the end of breastfeeding and have a documented final HIV outcome by 24 months of age.			
*Instructions: If **NO** HIV-exposed infants were seen in the previous year, select NA, and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a system in place for tracking HIV-exposed infants through the end of breastfeeding and documenting their final HIV status?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 records (register entries, charts, or HEI cards) of the most recent HEIs (i.e. born >24 but less than 36 months prior to the SIMS assessment).* What percent of HIV-exposed infants have documentation of final HIV status? ***Numerator**= _____# of most HEIs (i.e. born >24 but less than 36 months prior to the SIMS assessment) with documented final HIV status* ***Denominator** = ____Total number of records reviewed of most recent HEIs (i.e. born >24 but less than 36 months prior to the SIMS assessment).* ***Note:** Documented final HIV outcome is defined as an infant diagnosed HIV-positive at any point; diagnosed HIV-negative after >3 months following cessation of breastfeeding; with unknown status (e.g., LTFU, transferred out, or still breastfeeding/exposed); or who has died.*	_____%	If ≤ 70% = Red If >70% and ≤90% = Yellow If >90%= Green
	SCORE		

CEE #: S_04_20 Enrollment of HIV-Infected Infants into ART Services [HEI]			
STANDARD: All HIV-infected infants are enrolled into ART services.			
*Instructions: If the site does not offer infant virologic testing onsite OR there are **NO** HIV-infected infants, select NA, and **SKIP** the CEE*: **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice and documentation of linkage to treatment for HIV-infected infants (e.g., documented date of ART enrollment, ART number, ART regimen)?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review 10 records (e.g., register entries, charts, and HEI cards) of the last 10 **HIV-infected infants** born ≥3 months but less than 12 months prior to today's SIMS assessment.* *This requires a separate chart pull to review records of **HIV-infected** infants only.* What percent of HIV-infected infants have documentation of linkage into ART services? ***Numerator**= ____ # of HIV-infected infants with documented linkage to ART services/initiation on treatment* ***Denominator** = ____number of **HIV-infected infants** born ≥3 months but less than 12 months prior to today's SIMS assessment.*	_____#	If ≤70%= Red If > 70% and ≤90% = Yellow If >90% = Green
	SCORE		

CEE #: S_04_21 Supply Chain Reliability (Early Infant Diagnosis) DBS or POC [HEI]			
STANDARD: Each PMTCT site has a reliable supply of Early Infant Diagnosis (EID) collection supplies for specimens (including dried blood spot (DBS)) obtained for conventional laboratory-based testing or for point-of-care testing (POCT) and has fully functional platforms for testing.			
*Instructions: If specimen collection for EID does not occur at this site, check NA, and **SKIP** this CEE:* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has a stock-out of EID supplies or non-operational testing device/platform in the past 3 months resulted in an interruption of HIV testing for infants? ***Note:*** *For DBS collection, the necessary supplies include a collection card, alcohol swabs, gauze, lancets, and latex gloves (or a DBS bundle). For POCT, the necessary collection supplies include a blood transfer device (micro-EDTA or capillary tube) and/or cartridge, alcohol swabs, gauze, lancets, and latex gloves.*	Y N	If Y = Red
	If N, then Q2		
Q2	Was there a stock-out or low stock status of EID supplies in the past 3 months that required placement of an emergency order?	Y N	If Y = Yellow
	If N, then Q3		
Q3	Are the EID supplies distributed as standardized bundles to this site's testing points?	Y N	If N = Yellow If Y = Green
	SCORE		

SET 5: VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_05_01	Precision and Safeguarding of VMMC Surgical Records		X
S_05_02	Adverse Event (AE) Prevention and Management	X	

CEE #: S_05_01 Precision and Safeguarding of VMMC Surgical Records [VMMC]			
STANDARD: Each site retains accurate, complete, and updated VMMC patient records in a secure location.			
Instructions: This CEE applies to both electronic and paper based records. Although some sites may use both, assessors should collect data from the primary data source.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Are national or standardized VMMC client record forms or logbooks available?	Y N	If N = Red
	If Y, then Q2		
Q2 	*Review the last 10 VMMC client records from the national or standardized forms or logbooks* Do ALL ten of the VMMC client records reviewed meet the following criteria? *Tick all that apply*: ☐ 1) All ten VMMC client records entries include all of the following information: complete contact details, history and physical exam, weight, Blood Pressure, surgical method, follow-up date and presence/absence of Adverse Events ☐ 2) All ten VMMC records were stored in a secure locked location	# Ticked _____	If 0-1 = Yellow If 2 = Green
	SCORE		

CEE #: S_05_02 Adverse Event (AE) Prevention and Management [VMMC]			
STANDARD: Each VMMC site has processes in place to ensure the VMMC services provided are safe.			
Comment:			
	Question	**Response**	**Scoring**
Q1	In the areas where VMMC surgeries occur, are **ALL** required emergency supplies available AND appear to be working? ☐ 1) Stethoscope ☐ 2) Sphygmomanometer (i.e., blood pressure cuff) ☐ 3) Sodium chloride (i.e., normal saline solution for IV infusion; 0.9% Sodium Chloride) ☐ 4) Tourniquet ☐ 5) IV infusion tubing ☐ 6) 3 sizes of IV catheters (G18-green, G20-pink, G22-blue) ☐ 7) Adrenaline (unexpired) ☐ 8) Hydrocortisone (unexpired) ☐ 9) 2 sizes of syringes (2ml and 10ml) ☐ 10) 2 sizes of needles (G21 and G23) ☐ 11) Bags and masks (e.g., Ambu bag) ○ 1 child size ○ 1 adult size ☐ 12) Exam gloves ☐ 13) Alcohol swabs ☐ 14) Gauze ☐ 15) Adhesive Tape (strapping) ☐ 16) 3 sizes of oropharyngeal airways (green, yellow, and purple/red)	# Ticked _____	If <16=Red
	If 17, then Q2		
Q2	Is there a written inventory list of all emergency supplies for VMMC services in the areas where VMMC surgeries occur?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Are the following in place for the management of adverse events? ☐ 1) In the VMMC surgery and clinical care areas, a written procedure or algorithm is available. The written algorithm or procedure must have the following components: how to classify, document and manage adverse events (including emergencies and life-support measures) ☐ 2) Meeting minutes or summary reports from a site-level Adverse Events review committee showing that all moderate/severe adverse events were reviewed at least monthly AND corrective actions were taken (as necessary)?	# Ticked ____	If 0-1=Yellow If 2= Green
	SCORE		

SET 6: AGYW, GBV and OVC			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_06_01	Capacity to Provide Post-Violence Care Services		X
S_06_02	Availability of Post-Violence Care Services	X	
S_06_03	Gender Norms		X
S_06_04	Case Management Services	X	
S_06_05	Case Management Workforce Strengthening		X
S_06_06	Preventing HIV in Girls	X	
S_06_07	Services to support HIV Testing for OVC		X
S_06_08	Services to support HIV Treatment Linkage, Retention and Viral Suppression for OVC	X	

CEE #: S_06_01 Capacity to Provide Post-Violence Care Services [AGYW, GBV, and OVC]			
STANDARD: Each site providing post-violence care services has written procedures for provision of accessible and affordable post-violence care services for adults, adolescents, and children. All staff providing post-violence care services are trained on the provision and documentation of those services.			
Instructions: If this site does not provide post-violence care services, check NA, and SKIP this CEE. **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q 1	Are there written procedures or algorithms in place for providing post-violence care services for adults, children, and adolescents? ***Note**: There should be clear written procedures for dosing post-exposure prophylaxis (PEP) and other medications differently for adults and children as well as providing additional supportive services.* *Note: Post-violence care includes sexual violence among children and adults, physical and emotional intimate partner violence, and physical and emotional violence against children.*	Y N	If N = Red
	If Y, then Q2		
Q 2	Are post-violence care services accessible and affordable? *Tick all that apply:* ☐ 1) Post-violence care is offered during all hours a facility is open either by staff who are physically at the facility or on-call to respond ☐ 2) The survivor can receive essential care without reporting the assault to the police *(review intake protocol and/or forms to ensure police report is not required to receive services)* ☐ 3) Service fees are eliminated or reduced for post-violence survivors	# Ticked ____	If 0-2=Red
	If 3, then Q3		
Q 3	Have all providers administering post-violence care services been trained on these standard procedures (including clinical management specific to children **AND** adolescents if providers are working with adolescents)?	Y N	If N=Red
	If Y, then Q4		
Q 4	Is there a register or other means of documenting cases of violence that records **ALL** of the following? *Tick all that apply:* ☐ 1) Sex ☐ 2) Age ☐ 3) Type of Violence (sexual, physical, emotional; or multiple forms of violence)	# Ticked _____	If 0-2=Yellow If 3= Green
	SCORE		

CEE #: S_06_02 Availability of Post-Violence Care Services [AGYW, GBV, and OVC]			
STANDARD: Each site providing post-violence care services provides the minimum package of services and referrals.			
Instructions: The CEE is to be assessed only at sites that provide post-violence care services to AGYW, GBV, OVC populations. *If this site does not provide post-violence care services only, check NA, and SKIP this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is post exposure prophylaxis (PEP) for HIV provided at the site for eligible victims of sexual violence?	Y N	If N=Red
	If Y, then Q2		
Q2	Are **ALL** of the following additional post-violence services provided at the site? *Tick all that apply:* ☐ 1) Initial assessment of patient needs/counseling ☐ 2) Medical treatment or referral for serious or life threatening issues (e.g., lacerations, broken bones) ☐ 3) Rapid HIV Testing ☐ 4) Emergency contraception in cases of sexual violence ☐ 5) STI screening and/or presumptive treatment *Note: Post-violence care includes sexual violence among children and adults, physical and emotional intimate partner violence, and physical and emotional violence against children.*	# Ticked	If ≤4=Yellow
	If 5, then Q3		
Q3	Are the following referrals documented in a systematic manner in a logbook, case file, intake form etc.? *Tick all that apply:* ☐ 1) Longer term psycho-social support ☐ 2) Legal counsel ☐ 3) Police (e.g., investigations, restraining orders, etc.) ☐ 4) Child Protection Services (e.g., emergency out of family care, reintegration into family care when possible, permanency options when reintegration not possible) ☐ 5) Economic Empowerment ☐ 6) Emergency shelter	# Ticked _____	If ≤2=Yellow If ≥3= Green
	SCORE		

CEE #: S_06_03 Gender Norms [AGYW, GBV, and OVC]			
STANDARD: Each site providing or supporting gender norms interventions has staff trained in delivering these interventions and has staff performance monitored at least quarterly. These interventions use a standard curriculum and that entails more than a single stand-alone session.			
Instructions: CEE is to be assessed at sites funded to provide gender norms interventions to AGYW and/or OVC. *Does the site's agreement with the prime partner or USG implementing agency include funding to provide gender norms interventions? If **NO**, check NA, and **SKIP** CEE.* ***NA*** ☐ ***Note:*** *<u>Gender norms intervention:</u> Activities that address harmful gender norms related to HIV/AIDS seek to change traditional, cultural, and social norms that contribute to behaviors that increase HIV/AIDS risk in both men and women, including gender-based violence and that impede access to care and treatment services for those who need them.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is the gender norms intervention **BOTH?** *Tick all that apply:* ☐ 1) More than a single session ☐ 2) Based on a standard, evidence-based curriculum ***Note:*** *Standard curriculum is defined as having a strong theoretical base, an evaluation that demonstrates positive changes in gender norms or as an evidence-based curriculum with a focus or strong emphasis on gender norms or violence prevention see the DREAMS Guidance for a list of accepted curricula.*	# Ticked _____	If 0-1=Red
	If 2, then Q2		
Q2	Have the staff who deliver gender norms interventions completed a formal training on the particular intervention(s)? ***Note****: A formal training could be training on intervention delivery, or completion of a training-of-trainers process or workshop on the use of a training manual that accompanies the curriculum*.	Y N	If N= Yellow
	If Y, then Q3		
Q3	For staff delivering gender norms interventions, are **BOTH** of the below practiced? *Tick all that apply:* ☐ 1) Staff who deliver gender norms interventions are monitored for performance or reviewed for quality of work at least once every 3 months during the intervention period ☐ 2) Monitoring is documented ***Note:*** *Monitoring can include a review of feedback from participant training evaluations, classroom observations, and supervision activities.*	# Ticked _____	If ≤1 =Yellow If 2 =Green
	SCORE		

CEE #: S_06_04 Case Management Services [AGYW, GBV, and OVC]			
STANDARD: Each site has standard procedures for supporting case management for children and families affected by HIV including standard procedures to support identification, assessment, case plan development, case plan monitoring, case plan achievement/graduation, case closure, case file confidentiality, client satisfaction and minimize attrition.			
Instructions: The CEE is assessed at community sites providing OVC services only. *Does the community site provide OVC services only?* *If **NO**, check NA, and **SKIP** CEE* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have a comprehensive case management system (e.g. case management SOPs and case management tools) that is aligned with or meets national minimum standards for case management, ensures case files have been completed for all enrolled OVC and their families , and supports the following? *Tick all that apply:* ☐ 1) OVC identification ☐ 2) OVC and household assessment ☐ 3) Household case plan development ☐ 4) Referrals and referral tracking ☐ 5) Household case plan monitoring ☐ 6) Household case plan achievement/graduation – including benchmarks for assessing readiness to graduate ☐ 7) Case transfer ☐ 8) Case file confidentiality	# Ticked ____	If ≤7=Red
	If 8, then Q2		
Q2	*Randomly identify 10 active clients from the site roster and review their household case files* Do 100% of the active case files include the following: ☐ 1) Completed family assessments within the last year ☐ 2) Completed family case plans (focused on the minimum case plan achievement benchmarks) within the last year	# Ticked ____	If 0-1=Yellow
	If 2, then Q3		

Q3 	*Randomly identify 10 graduated clients from the site roster and review their household case files* If *the site does not have any closed cases or if none of the options below is checked, then the score is Yellow.* Do all of the closed case files show any of the following: ☐ 1) Case Plan Achievement, including confirmation of achievement of all required case plan achievement benchmarks (e.g. final assessment, completed benchmark checklist, date of program exit, signature of staff certifying exit) ☐ 2) Case transfer, including confirmation of transfer of clients to another program or source of support (e.g. name of organization receiving case, date of program exit, signature of staff certifying exit) ☐ 3) Exit without graduation including confirmation of efforts to track and re-enroll clients (e.g. reason for exit, description of efforts to re-enroll, date of program exit, signature of staff certifying exit)	# Ticked _____ _	If 0-2=Yellow If 3=Green
	SCORE		

SIMS Assessment ID_____ Assessment Date: _____

CEE #: S_06_05 Case Management Workforce Strengthening [AGYW, GBV, and OVC]			
STANDARD: Each site has standard procedures for planning, developing and supporting social service workers responsible for case management (including both professional or para-professional, paid or unpaid social service workers employed by government or non-governmental organizations), which are aligned with national standards.			
Instructions: The CEE is assessed at all sites providing OVC services only. *Does the site provide OVC services only?* *If **NO**, check NA, and **SKIP** CEE.* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site have standard procedures for planning developing and supporting social service workers responsible for case management, including **ALL** of the following? *Tick all that apply:* ☐ 1) Standard job descriptions/performance standards ☐ 2) Standard case manager to client ratios in line with national standards (*if no national standards exist, then check to ensure ratio is no larger than 30 cases*) ☐ 3) Standard training curricula (both pre-service and in-service in line with national standards *(if no national standards exist, then simply check to ensure curricula is standard across workers*) ☐ 4) Standard supervision and assessment mechanisms ☐ 5) Ethical standards	# Ticked _____	If ≤4 =Red
	If 5, then Q2		
Q2	*Randomly select 10 case managers from the assessment point roster and review their HR files.* Do 100% of the HR files include all of the following? *Tick all that apply:* ☐ 1) Job description/expectations ☐ 2) Evidence at least quarterly supervision meetings ☐ 3) Documentation of completed training/credentials ☐ 4) Documentation of appropriate case manager/client ratios	# Ticked _____	If ≤2 =Yellow If ≥3=Green
	SCORE		

CEE #: S_06_06 Preventing HIV in Girls [AGYW, GBV, and OVC]			
STANDARD: Each site provides or links vulnerable adolescent girls and young women (AGYW) ages 10-24 years to comprehensive interventions/services for HIV prevention.			
Instructions: *CEE is to be assessed at sites (community and facility) providing AGYW prevention services only.* *Does the site provide AGYW prevention services? If* ***NO****, check NA, and* ***SKIP*** *CEE.* ***NA*** ☐ ***Note:*** *Please refer to the DREAMS guidance for a list of approved, evidence-informed curricula and program.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a standard process for identifying girls who are vulnerable to HIV infection?	Y N	If N=Red
	If Y, then Q2		
Q2	How many of the following prevention interventions/services for adolescent girls does this site offer onsite? *Tick all that apply:* ☐ 1) Condom promotion and provision (male & female) ☐ 2) HTS services ☐ 3) PrEP ☐ 4) Post-violence care services ☐ 5) Access to voluntary, comprehensive FP services ☐ 6) Social asset building activities ☐ 7) School- or Community-based HIV and violence prevention ☐ 8) Community Mobilization & Norms Change ☐ 9) Parenting/caregiver programs ☐ 10) Educational subsidies ☐ 11) Combination socioeconomic approaches	# Ticked _____	If 0=Red
	If ≥1, then Q3		

Q3	How many of the following evidence-based interventions/services for adolescent girls does this site offer through referral? *Tick all that apply:* ☐ 1) Condom promotion and provision (male & female) ☐ 2) HTS services ☐ 3) PrEP ☐ 4) Post-violence care services ☐ 5) Access to voluntary, comprehensive FP services ☐ 6) Social asset building activities ☐ 7) School- or Community-based HIV and violence prevention ☐ 8) Community Mobilization & Norms Change ☐ 9) Parenting/caregiver programs ☐ 10) Educational subsidies ☐ 11) Combination socioeconomic approaches	# Ticked _____	If 0-4=Yellow If >4= Green
	SCORE		

CEE #: S_06_07 Services to Support HIV Testing for OVC [AGYW, GBV, and OVC]			
STANDARD: Each site has a case management system that captures pertinent information related to HIV status for children and their caregivers, including a standard process to assess children for HIV risk factors and to facilitate linkages to HIV testing if needed.			
Instructions: *This CEE is to be assessed at sites (community and facility) providing OVC services only.* *Does the site provide OVC services only?* *If No, check NA, and* ***SKIP*** *CEE.* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a standard process to assess children with unknown/undisclosed HIV status using the HIV risk algorithm prototype and to facilitate linkages to HIV testing if needed?	Y N	If N=Red
	If Y, then Q2		
Q2 👀	*Randomly select 10 beneficiaries from the assessment point roster and review their case files or client records (individual or logbook) from the last three months.* What percent of case files include documentation of the child's HIV status and the caregiver's HIV status as reported by the caregiver or child (i.e. self-report)? ***Numerator****: _____# of case files or client records that include documentation of the child's HIV status and the caregiver's HIV status (as reported by the caregiver or self)* ***Denominator****: _____# of case files or client records assessed* ***Note:*** *HIV status categories must include the following:* ● *Test not needed (based on HIV risk algorithm prototype)* ● *Positive* ● *Negative* ● *Undisclosed (child has tested but results were not disclosed to program)* ● *Not Tested and Status Unknown – File establishes that the child's status is unknown, i.e., child has not been assessed for HIV risk by the program, caregiver will not provide information that enables risk assessment; testing indicated but caregiver does not want to have child tested.*	_____%	If <80%=Yellow
	If ≥ 80%, then Q3		

Q3 	Of the case files that indicate unknown HIV status, what percent of case files include documentation that the site conducted the HIV risk algorithm prototype assessment of the child and caregiver and facilitate HIV testing? ***Numerator**: _____# of case files that include documentation that the site conducted the HIV risk algorithm prototype assessment of the child and caregiver and facilitated HIV testing* ***Denominator**: _____# of case files that indicate unknown HIV status*	_____%	If <90%=Yellow If ≥90%= Green
	SCORE		

SIMS Assessment ID_____ **Assessment Date:** _____

CEE #: S_06_08 Services to support HIV Treatment Linkage, Retention and Viral Suppression for OVC [AGYW, GBV, and OVC]			
STANDARD: Each site providing OVC services has case management procedures that capture pertinent information related to HIV Treatment Linkage, Retention, and Viral Suppression for children and their caregivers.			
Instructions: *The CEE is to be assessed at sites (i.e., community and/or facility) providing OVC services only. Does the site provide OVC services?* *If No, check NA, and* ***SKIP*** *CEE.* ***NA*** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have a standard process for ALL of the following: ☐ 1) linking children and caregivers living with HIV to HIV treatment ☐ 2) tracking completion of treatment referrals, ☐ 3) supporting disclosure of HIV status to adolescents ☐ 4) transitioning adolescent to adult care, ☐ 5) monitoring and supporting treatment retention, ☐ 6)monitoring and supporting viral suppression (if Viral Load Testing is available)	# Ticked _____	If <6= Red
	If 6, then Q2		
Q2	*Randomly identify 10 families with either a caregiver or child living with HIV from the site roster. Review their household case files* What percent of case files have documentation demonstrating the site is monitoring both the child and caregiver's (if applicable) HIV treatment status and disclosure status including all of the following: Treatment enrollment, Regularly attending treatment appointments, Correctly taking medication, Adhering to treatment, Virally suppressed if VL is available and accessible to site, and age-appropriate HIV Disclosure to child **N*umerator***: _____*# of case files with documentation the site is monitoring both the child and caregiver's (if applicable) HIV treatment status and disclosure status including all of the following: Treatment enrollment, Regularly attending treatment appointments, Correctly taking medication, Adhering to treatment, Virally suppressed if VL is available and accessible to site, and age-appropriate HIV Disclosure to child*	_____%	If≤90%= Red

	***Denominator**: _____# of case files with either a caregiver or child living with HIV from the site roster*		
	If >90%, then Q3		
Q3	*Review the same 10 case files.* What percent of case files indicate that the site engages clinicians treating children and caregivers at least semi-annually through case conferencing or other means to identify and address any treatment challenges or barriers to treatment (e.g. notes from case conferences)? ***Numerator**: _____# of case files documenting that the site engages clinicians treating children and caregivers at least semi-annually through case conferencing or other means to identify and address any treatment challenges or barriers to treatment (e.g. notes from case conferences)* ***Denominator**: _____# of case files with either a caregiver or child living with HIV from the site roster*	_____%	If ≤90%= Yellow
	If response is >90% then Q4		
Q4	*Review the same 10 case files.* What percent of case files indicate that the site helps children and caregivers to overcome treatment challenges or barriers to treatment (e.g. financial barriers, transportation barriers, nutritional or health concerns, social or cultural barriers, health challenges)? ***Numerator**: _____# of case files documenting that the site helps children and caregivers to overcome treatment challenges or barriers to treatment (e.g. financial barriers, transportation barriers, nutritional or health concerns, social or cultural barriers, health challenges)* ***Denominator**:_____# of case files with either a caregiver or child living with HIV from the site roster*	_____%	If ≤80%= Yellow If >80%= Green
	SCORE		

SET 7: HTS			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_07_01	Compliance with National Testing Algorithm and Strategy	X	
S_07_02	Quality Assurance of HIV Testing Services		X
S_07_03	HTS Linkage to HIV Care and Treatment at the Site Level	X	
S_07_04	Site Level HIV Proficiency Testing		X
S_07_05	HTS Safety Measures at the Site		X
S_07_06	Confidentiality of HIV Testing Services at the Site		X
S_07_07	HIV Self-Testing		X
S_07_08	Index Testing Training and Supportive Supervision		X
S_07_09	Monitoring Adverse Events		X
S_07_10	Secure Handling and Storage of Index Testing data		X
S_07_11	Intimate Partner Violence Risk Assessment and Support		X

CEE #: S_07_01 Compliance with National Testing Algorithm [HTS]			
STANDARD: Each site performs and records rapid HIV testing in accordance with national testing algorithms.			
Instructions: *If a 3rd rapid test is not required per national guidelines, make a note in the COMMENTS sections and CHECK #3 in Q2 so as to avoid incorrectly scoring Red.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site have written or printed testing protocols or other job aides that are in full accordance with the current national testing algorithm?	Y N	If N=Red
	If Y, then Q2		
Q2	Is the site collecting the following information in either an HTS (HIV Testing Services) register, rapid testing logbook, or some other data collection tool? *Tick all that apply:* ☐ 1) Test 1 (Name of test kit and result) ☐ 2) Test 2 (Name of test kit and result) ☐ 3) Test 3, if applicable (Name of test kit and result) ☐ 4) Final test result given to beneficiary	# Ticked _____	If 0-3=Red
	If 4, then Q3		
Q3	*Review the 20 most recent entries within the past 12 months where the final test result was HIV positive in the HTS register/rapid testing logbook.* What percent these entries are compliant with the national testing algorithm? ***Numerator****: ____# of entries that were fully compliant with the national testing algorithm.* ***Denominator****: ____ #r of entries within the past 12 months where the final HIV test result was HIV positive in the HTS register/rapid testing logbook*	_____%	If <70%=Red If ≥70 and <90%=Yellow If ≥90%= Green
	SCORE		

CEE #: S_07_02 Quality Assurance of HIV Testing Services [HTS]			
STANDARD: Quality assurance procedures are in place to monitor the quality of HIV rapid testing in a timely manner. These procedures include direct observation and the use of standardized laboratory logbooks.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does a manager or laboratorian observe and document each HTS provider conducting HIV rapid testing at least twice a year?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the manager or laboratorian at the HIV testing site review the standardized logbook (or HTS register with logbook variables integrated) <u>at least monthly</u> for evidence of compliance with national testing algorithms?	Y N	If N = Yellow
	If Y, then Q3		
Q3	In the HTS register or rapid testing logbook, is there a process in place to review quality assurance variables (e.g., positive concordance rate between test 1 and test 2, number of invalid test results, etc.) at least quarterly?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: S_07_03 HTS Linkage to HIV Care and Treatment at the Site Level [HTS]			
STANDARD: All sites that provide HTS have a standardized protocol or process for tracking successful and unsuccessful linkage of HIV-infected beneficiaries/clients to HIV care and treatment services.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is an active linkage to care and treatment protocol or standardized process available to facilitate linkage to HIV care and treatment services for those who test positive (e.g., use of standard referral forms, peer navigators, transport vouchers, etc.)?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the protocol or standardized process include requirements to confirm and document successful linkage to HIV care and treatment services (e.g., documented completed phone call, verification by a peer navigator, etc.)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the protocol or standardized protocol from above include following up with HIV-positive clients who fail to enroll in HIV care and treatment services (e.g., documented completed phone call, verification by a peer navigator, etc.)?	Y N	If N=Yellow
	If Y, then Q4		
Q4	*Review 10 clients identified as HIV positive within the last 3 months from the HTS register to determine the percentage of HIV positive clients who were successfully linked to treatment services.* Of the 10 clients selected for review, what percentage were successfully linked to treatment (i.e., the site knows the client or beneficiary was successfully initiated on ART)? ***Numerator:*** *____# of clients who were successfully linked to treatment (i.e., the site knows the client or beneficiary was successfully initiated on ART)* ***Denominator****: ____# of identified as HIV positive within the last 3 months*	_____%	If <90%=Yellow If ≥90%= Green
	SCORE		

CEE #: S_07_04 Site Level HIV Proficiency Testing [HTS]			
STANDARD: Sites offering HIV Testing services (HTS) meet HIV proficiency testing participation and pass rate requirements			
Instructions: *Is HIV proficiency testing part of the national guidelines for sites offering HTS?* *If **NO**, check NA, and **SKIP** CEE* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is the site currently enrolled in an HIV proficiency testing (PT) program?	Y N	If N=Red
	If Y, then Q2		
Q2	What percent of HTS providers at the site completed and submitted proficiency testing panels in the last 12 months? ***Numerator*** *= _____# of HTS providers who completed and submitted proficiency testing panels in the last 12 months* ***Denominator*** *= _____ # of HTS providers who received a proficiency testing panel in the last 12 months* ***Note****: HTS providers include laboratory staff conducting HIV testing.*	_____%	If <50%=Red If ≥50% and <80%=Yellow
	If ≥80%, then Q3		
Q3	*Review logbook or records or other documentation of all PT scores that were returned to the site within the last 12 months.* *Tick ONE of the following:* ☐ 1) All PT scores were NOT returned to the site ☐ 2) Unsatisfactory PT scores were returned to the site but no documentation of corrective action exists ☐ 3) Unsatisfactory PT scores were returned to site and documentation of corrective action exists ☐ 4) All PT scores that were returned to the site were satisfactory	Answer # _____	If 1 or 2 =Yellow If 3 or 4 =Green
	SCORE		

CEE #: S_07_05 HTS Safety Measures at the Site [HTS]			
STANDARD: Each site has HIV Testing Services (HTS) safety measures implemented by all HIV testing providers. These safety measures include use of disposable gloves, personal hygiene, and proper waste management.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Are **ALL** the following available for all HIV testing providers? *Tick all that apply*: ☐ 1) Sharps and waste containers for disposal of lancets, syringes and other sharps ☐ 2) Clean water, soap and disinfectant or hand sanitizer available for use before contact with each beneficiary/client ☐ 3) Disposable gloves for all HIV testing providers	# Ticked _____	If ≤2=Red
	If 3, then Q2		
Q2	Has a supervisor or manager visited this site within the last six months to document implementation of HTS safety measures (e.g. safe disposal of sharps and biohazardous waste, proper hand hygiene, and the use of disposable gloves) by all HIV testing providers?	Y N	If N =Yellow
	If Y, then Q3		
Q3	Have all HIV testing providers at this site received safety training on safe disposal of sharps and biohazardous waster, proper hand hygiene and the use of disposable gloves within the last 12 months?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: S_07_06 Confidentiality of HIV Testing Services at the Site [HTS]			
STANDARD: HIV testing services (HTS) are provided privately and confidentially, and include information on how to report violations of privacy and confidentiality.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Have all HTS staff at this site received training on the importance of maintaining privacy and confidentiality i.e. information discussed during the HTS session cannot be disclosed to anyone else without the expressed consent of the beneficiary/client?	Y N	If N=Red
	If Y, then Q2		
Q2 	Is HIV testing conducted in a space that protects the privacy and confidentiality of the beneficiary/client (i.e., conducted in a space where others cannot overhear)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Is the beneficiary/client aware of how violations of privacy or confidentiality can be reported anonymously?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: S_07_07 HIV Self-Testing [HTS]			
STANDARD: Use of HIV self-test kits, and linkage to additional HIV testing, is documented.			
Instructions: *Are HIV Self-Test kits distributed within the sub-national unit/district that this site is located? Is HIV self-testing part of the national HIV Testing Services (HTS) guidelines?* *If **NO to either question**, check NA, and **SKIP** CEE* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site's standardized process/protocol/SOP that describes how to provide HTS include inquiring whether the reason for HIV testing at this current time is due to a positive HIV self-test result?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the HTS register or logbook provide a space to document whether the HTS client indicated recent use of an HIV Self-test and need for additional testing as the reason for testing at this current time?	Y N	If N = Yellow If Y = Green
	SCORE		

CEE #: S_07_08 Index Testing Training & Supportive Supervision [HTS]			
STANDARD: All staff who provide index testing services are trained using a standardized national training curriculum that covers the WHO's 5Cs (consent, confidentiality, counseling, correct test results, and connection to treatment and/or prevention services) and the minimum standards for index testing, including an intimate partner violence (IPV) risk assessment and first line support following IPV disclosure, supportive supervision, and adverse event monitoring and response. All staff who provide index testing services continue to receive supportive supervision and mentorship at least quarterly. Supportive supervision comments and recommendations are shared with staff members.			
Instructions: *Only assess this CEE at sites that provide index testing services.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Have **ALL** staff conducting index testing services been trained according to a standardized, national training curriculum that covers the WHO's 5Cs and minimum standards for index testing, including an intimate partner violence (IPV) risk assessment and first line support following IPV disclosure, supportive supervision, and adverse event monitoring and response?	Y N	If N=Red
	If Y, then Q2		
Q2	Have all staff who currently provide Index Testing services received supportive supervision on index testing, at least once within the past 3 months? **Numerator** = _____Number of staff currently providing index testing services who received at least one documented supportive supervision in past 3 months **Denominator** = _____Number of staff currently providing index testing services ***Note:*** *data source can be staff records, supervision logbooks, supportive supervision forms.*	_____%	If <80%=Yellow
	If ≥80%, then Q3		
Q3	Are standardized tools or materials used to conduct supportive supervision for index testing services?	Y N	If N =Yellow
	If Y, then Q4		

Q4	Are supportive supervision comments and recommendations documented and shared with staff?	Y N	If N=Yellow If Y =Green
	SCORE		

CEE #: S_07_09 Monitoring Adverse Events from Index Testing [HTS]			
STANDARD: All sites where PEPFAR supports index testing service provision have procedures and processes in place to assess, mitigate and reduce potential risk for social harm or impact arising from partner notification and index testing. All personnel providing index testing services are trained on providing partner notification services appropriately and safely.			
Instructions: *Only assess this CEE at sites that provided index testing services. Social harm is defined as any intended or unintended cause of physical, economic, emotional or psychosocial injury or hurt from one person to another, a person to themselves, or an institution to a person, occurring before, during or after HTS, including partner notification services. Intimate partner violence (IPV) is defined as behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship, including acts of physical violence, sexual violence, stalking, emotional or psychological abuse and controlling behaviors.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the site routinely follow-up with index clients at the next clinical encounter to assess if they've experienced any social harm as a result of index testing service?	Y N	If N = Red
	If Y, then Q2		
Q2	Are reports of social harms, including IPV, following index testing services documented in the client's charts and/or index testing register?	Y N	If N = Yellow
	If Y, then Q3		
Q3	Does the site have an SOP in place for investigating any reports of social harms following index testing services?	Y N	If N = Yellow If Y = Green
	SCORE		

CEE #: S_07_10 Secure Handling & Storage of Index Testing Data [HTS]			
STANDARD: Each site retains accurate, complete, and updated index testing records in a secure location and maintains a shared confidentiality agreement with any outside organization that assists with the testing of sex partner(s), drug-injecting partners, and biological child(ren) of index clients.			
Instructions: *Only assess this CEE at sites that provided index testing services*			
Comment			
	Question	**Response**	**Scoring**
Q1 👀	Are all index testing records/registers stored in a secure and locked location, this includes files being kept in a secure and confidential manner throughout the day (e.g., counselors do not leave person-identifying information on their desk or cabinet when stepping out of their room or admitting new clients)?	Y N	If N = Red
	If Y, then Q2		
Q2 👀	Have all index testing providers signed a patient confidentiality agreement stating that they pledge not to share information about index clients and their partner(s) and child(ren) with anyone outside the clinical care team without their consent?	Y N	If N = Red
	If Y, then Q3		
Q3 👀	Does the site have a written standard operating procedure (SOP) and/or data sharing agreement with other organizations, or community health workers supporting index testing services, on how to share and maintain the confidentiality of information about the index client and their contact(s) (i.e. sexual and drug-injecting partners and biological children)?	Y N	If N = Yellow If Y = Green
	SCORE		

CEE #: S_07_11 Intimate Partner Violence Risk Assessment and Support [HTS]			
STANDARD: Sites offering index testing services have an appropriate system in place for testing service providers to identify and respond to clients who disclose their fear of or experience with Intimate Partner Violence (IPV) from (a) named partner(s).			
Instructions: *This CEE should be assessed at sites offering HIV partner testing services (including both sexual and needle-sharing partner(s)) as part of index testing.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are IPV questions asked in private settings by providers with confidentiality ensured? *Note: Private means conducted in a space where no one else can hear or see the conversation. Confidentiality ensured means that information discussed during the HTS session will not be disclosed to anyone else without the consent of the beneficiary/client. Evidence of ensuring confidentiality can include: confidentiality or consent agreements, notices of confidentiality.*	**Y N**	If N = Red
	If Y, then Q2		
Q2	Have all providers who conduct index testing services been trained on both of the following before providing index testing services: (1) how to ask about IPV; and (2) how to offer first-line support (such as LIVES) following IPV disclosure? *Note: LIVES stands for Listen; Inquire about needs and concerns; Validate; Enhance Safety; Support. It is the immediate psychosocial support and safety check that is provided to someone who discloses violence. Consult Health care for women subjected to intimate partner violence or sexual violence: A Clinical Handbook (WHO, 2014) for further information.*	**Y N**	If N = Red
	If Y, then Q3		
Q3	Does the site have a written Standard Operating Procedure (SOP) or equivalent for asking clients about their experience or fear of violence? *Note: The SOP should outline the roles/responsibilities of site staff. For example, if a client discloses violence the testing provider provides immediate psychosocial support, does an immediate safety check, and then may refer to another staff member for referrals and follow up to other services. The SOPs outline these roles so it is clear for everyone at the site.*	**Y N**	If N = Red

	If Y, then Q4		
Q4 	Does the site have a standard set of questions providers use to ask clients about IPV and a place (e.g., IPV screening form, client file or register) to document responses? *Note: The standard questions help to minimize the potential for personal biases to shape how a provider asks questions.*	**Y N**	If N = Red
	If Y, then Q5		
Q5 	Do providers offer first-line support (such as LIVES) to clients who disclose violence?		If N = Yellow If Y = Green
	SCORE		

SET 8: TB TREATMENT SERVICE POINT			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_08_01	Routine PITC for Patients with TB and Presumptive TB		X
S_08_02	ART Provision for HIV-Positive Adult TB Patients	X	

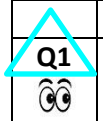
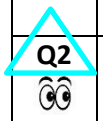
SET INSTRUCTIONS: The following CEEs are assessed at sites where TB treatment is the entry point for patients receiving HIV services and where these HIV services are PEPFAR supported.

CEE #: S_08_01 Routine PITC for Patients with TB and Presumptive TB [TB]			
STANDARD: Routine HIV provider-initiated testing and counseling (PITC) is provided to all patients with tuberculosis (TB) and presumptive TB.			
Instructions: What age bracket is served by this site? Select ONE: ☐ **Pediatric patients only (<15 years of age)** ☐ **Adult patients only (≥15 years of age)** ☐ **Both pediatric and adult patients (mixed)**			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does this site provide routine provision of PITC for presumptive TB and TB patients?	Y N	If N = Red
	If Y, then Q2		
Q2 	*Review the last 10 entries in a line list/register of patients with presumptive TB. If this site serves pediatric patients and adult patients, choose 5 charts for pediatrics (<15 years of age) and 5 charts for adult and adolescent patients (≥15 years of age).* What percent of the reviewed presumptive TB patients have documented HIV-testing status? ***Numerator** = _____# of presumptive TB patients entries with documented HIV-testing status (e.g., positive, negative, declined)* ***Denominator** = _____#Total presumptive TB patient entries reviewed*	_____%	If <70% = Red If ≥70 and <90% = Yellow If ≥90% Green
	SCORE		

CEE #: S_08_02 ART Provision for HIV-Positive TB Patients [TB]			
STANDARD: All tuberculosis (TB) and presumptive TB patients diagnosed with HIV are initiated on ART regardless of CD4 count.			
Instructions: What age bracket is served by this site? Select ONE: ☐ **Pediatric patients only (<15 years of age)** ☐ **Adult patients only (≥15 years of age)** ☐ **Both pediatric and adult patients (mixed)**			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is there a standardized practice to initiate HIV-positive TB patients and presumptive TB patients on ART?	Y N	If N = Red
	If Y, then Q2		
Q2	*Review the TB register to identify 10 TB patients diagnosed with HIV more than 3 months but less than 12 months prior to the SIMS assessment.* *If this site serves pediatric patients and adult patients, choose 5 register lines for pediatrics (<15 years of age) and 5 register lines for adult and adolescent patients (≥15 years of age).* What percent of HIV-positive TB patients reviewed have documentation of ART initiation? ***Note**: If **NO** HIV-positive TB patients were found in the specified period, enter '100%' in the form of 1/1 and make a note in the COMMENTS portion of this CEE.* ***Numerator** = _____# of reviewed records of HIV-positive TB patients with documentation of ART initiation* ***Denominator** = _____# reviewed records of HIV-positive TB patients diagnosed with HIV more than 3 months but less than 12 months prior to the SIMS assessment.*	_____%	If <70% = Red If ≥70 and <90% = Yellow If ≥90% = Green
	SCORE		

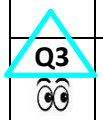
SET 9: METHADONE OR BUPRENORPHINE MEDICATION ASSISTED TREATMENT (MAT)			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_09_01	Intake Treatment Plan Development	X	
S_09_02	TB screening and Management in MAT Facilities		X
S_09_03	Dose Reduction and Termination	X	
S_09_04	HIV Testing	X	
S_09_05	Supply Chain Reliability (methadone and buprenorphine)		X

CEE #: S_09_01 Intake Treatment Plan Development [MAT]			
STANDARD: During a client intake assessment, a METHADONE OR BUPRENORPHINE MEDICATION ASSISTED TREATMENT (MAT) plan is developed for every client that lists his/her physical and mental health- and social- needs.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there written standard operating procedures (SOPs) to guide the intake assessment at this site?	Y N	If N=Red
	If Y, then Q2		
Q2	Does the patient intake assessment at the site include **ALL** of the following? *Tick Yes to all that apply:* ☐ 1) Drug use history ☐ 2) Mental health history ☐ 3) Comorbid medical conditions ☐ 4) Psychosocial circumstances ☐ 5) Medical examination and laboratory tests	Y N	If 0-4=Red
	If 5, then Q3		
Q3	*Review 10 randomly selected charts of clients who started METHADONE OR BUPRENORPHINE MEDICATION ASSISTED TREATMENT (MAT) within the past 12 months.* What percent of charts document development of treatment plans at intake? ***Numerator**: ____# of charts with documented development of treatment plan at intake* ***Denominator**: ____# of charts of clients who started METHADONE OR BUPRENORPHINE MEDICATION ASSISTED TREATMENT (MAT) within the past 12 months*	_____%	If <90%=Yellow If ≥90%= Green
	SCORE		

CEE #: S_09_02 TB screening and Management in MAT Facilities [MAT]			
STANDARD: All sites providing MAT perform and document screening for active tuberculosis (TB) on intake and at each clinical visit, and provide access to TB treatment either on site or through referral.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Is there a protocol in place for TB screening and documentation at each clinical assessment per national guidelines?	Y N	If N=Red
	If Y, then Q2		
Q2 	Does the TB screening protocol include all 4 of the following symptoms: cough, fever, night sweats, and weight loss AND procedures for the client to access TB treatment on site or through referral?	Y N	If N=Yellow
	If Y, then Q3		
Q3 	*Review 10 randomly selected charts of clients who started MAT within the past 12 months*. What percent of reviewed charts document TB screening results at the last clinical visit? ***Numerator**: ____# of client charts with documented TB screening results at the last clinical visit* **Denominator**: ____*# of clients who started MAT within the past 12 months*.	_____%	If <80%=Yellow If ≥80%= Green
	SCORE		

CEE #: S_09_03 Dose Reduction and Termination [MAT]			
STANDARD: Clinical staff guide clients who decide voluntarily to discontinue MAT through standardized tapering and termination procedures, including provision of on-going counseling and client-clinician agreement on a decreasing dosage schedule.			
Comment:			
	Question	**Response**	**Scoring**
Q1 	Are written standard procedures available to guide standardized tapering and termination procedures for clients who decide voluntarily to discontinue MAT?	Y N	If N = Red
	If Y, then Q2		
Q2 	Is there documentation to demonstrate standard counseling procedures on relapse prevention are provided to clients who decide voluntarily to discontinue MAT?	Y N	If N = Yellow
	If Y, then Q3		
Q3 	Are there standard procedures to demonstrate client-clinician agreement on a decreasing dosage schedule for clients who decide voluntarily to discontinue MAT?	Y N	If N = Yellow If Y= Green
	SCORE		

CEE #: S_09_04 HIV Testing [MAT]			
STANDARD: All MAT clients are offered voluntary HIV testing during the client intake assessment. HIV uninfected clients are offered voluntary retesting at least every 12 months**.**			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are there standard procedures in place to promote voluntary HIV testing at MAT intake, including at least annual re-testing among clients who test HIV negative?	Y N	If N=Red
	If Y, then Q2		
Q2 	*Review 10 of the most recent charts of clients on MAT for ≥12 months*. What percent of reviewed charts document HIV testing within the last 12 months? ***Numerator****: ____# of charts with HIV testing documented* ***Denominator****: _____# of the most recent charts of clients on MAT for ≥12 months*	_____%	If <90%=Yellow If ≥90% = Green
	SCORE		

CEE #: S_09_05 Supply Chain Reliability (methadone and buprenorphine) [MAT]			
STANDARD: Each site has a reliable supply of methadone and/or buprenorphine.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Has there been a stock-out of methadone or buprenorphine in the past 3-months that interfered with medication for existing clients (e.g., could not receive minimum dose or scale up dose per treatment plan)?	Y N	If Y=Red
	If N, then Q2		
Q2	Has there been a stock-out of methadone or buprenorphine in the past 3 months that resulted in halting new enrollment?	Y N	If Y=Yellow
	If N, then Q3		
 **Q3**	Is there documentation of a contingency plan in place in the event of a stock-out?	Y N	If N=Yellow If Y= Green
	SCORE		

SET 10A: LABORATORY			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_10_01	Quality Management Systems	X	
S_10_02	Laboratory Biosafety		X
S_10_03	Test SOP		X
S_10_04	Quality Testing Monitoring		X
S_10_05	Testing Interruptions		X
S_10_06	Waste Management		X
S_10_07	Injection Safety		X
S_10_08	HIV Viral Load Laboratory Capacity	X	
S_10_09	HIV Viral Load Specimen Referral and Results Management	X	

CEE #: S_10_01 Quality Management Systems (QMS) [LAB]			
STANDARD: Each laboratory is implementing a Quality Management System (QMS) program for continuous quality improvement and/or accreditation. As part of a QMS, each facility laboratory provides and documents routine personnel training, performs and documents routine equipment maintenance, has an inventory control system for supplies and reagents, and conducts regular quality improvement activities.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is documentation of **ALL** of the following available? *Tick all that apply:* ☐ 1) Personnel training records ☐ 2) Routine equipment maintenance ☐ 3) Inventory system for supplies and reagents	# Ticked _____	If 0-2=Red
	If 3, then Q2		
Q2	Is the laboratory doing **EITHER** of the following? *Tick all that apply:* ☐ 1) Implementing a quality management/quality improvement program (e.g., SLMTA, SLIPTA, GLI, and LQMS-SIP)? ☐ 2) Applying for accreditation according to international standards (e.g., SANAS, CAP, ISO, and KENAS)?	# Ticked _____	If 0=Yellow If 1-2=Green
	SCORE		

CEE #: S_10_02 Laboratory Biosafety [LAB]			
STANDARD: Each laboratory has a biosafety program that includes the following elements: availability and proper use of Personal Protective Equipment (PPE) and waste containers, training on biosafety for laboratory personnel and laboratory biosafety SOPs and/or biosafety manual. •			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are **ALL** of the following available in the laboratory? *Tick all that apply:* ☐ 1) Gloves ☐ 2) Lab Coats ☐ 3) Clean water/soap or hand sanitizer ☐ 4) Sharps containers ☐ 5) Biohazard waste containers	# Ticked	If 0-4=Red
	If 5, then Q2		
Q2	Are there written laboratory biosafety standard operating procedures or manuals available?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Is there documentation that **all** laboratory personnel have received ***annual*** biosafety training?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: S_10_03 Test SOPs [LAB]			
STANDARD: Each laboratory has current written standard operating procedures (SOPs) available and accessible for all the core HIV-related tests that are performed.			
Comment:			
	Question	**Response**	**Scoring**
Q1	What percentage of the HIV-related tests offered at this laboratory have written SOPs available at the point of testing? ***Numerator***= _____*# of HIV-related tests performed at the facility laboratory with SOPs available* ***Denominator*** = _____*# of HIV-related tests performed at facility laboratory*	_____**%**	If <50%=Red If ≥50 and ≤90%=Yellow
	If >90%, then Q2		
Q2	Are ALL SOPs current? *Note: "Current" refers to approval or effective dates within the last 2 years*	Y N	If N=Yellow If Y=Green
	SCORE		

CEE #: S_10_04 Quality Testing Monitoring [LAB]			
STANDARD: Each laboratory performs and monitors routine Quality Control (QC) testing on all core HIV-related tests and participates in proficiency testing (PT) or external quality assessment (EQA) programs for all core HIV-related tests that they perform. PT/EQA results and feedback are available onsite.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the laboratory perform and monitor the results of routine QC testing for **All** (100%) HIV-related core tests offered? ***Numerator*** *=_____ # of HIV-related core tests with QC test results* ***Denominator*** *= _____# of HIV-related core tests performed at facility laboratory*	_____%	If ≤90% =Red
	If >90%, then Q2		
Q2	In the past 12 months, has the lab participated in PT/EQA for **All** (100%) core HIV-related tests offered and are PT/EQA result reports available onsite? ***Numerator*** *= _____# of HIV-related core tests participating in PT/EQA* ***Denominator*** *= _____# of HIV-related core tests performed at facility laboratory*	_____%	If ≤90% =Yellow
	If >90%, then Q3		
Q3	*Evaluate the results reports for PT/EQA panels.* Did the laboratory's result reports demonstrate satisfactory/passing scores for **ALL** PT/EQA panels submitted within the past 12 months? *Tick **one** of the following:* ☐ 1) No PT results were returned to the site ☐ 2) Unsatisfactory results and no evidence of corrective action ☐ 3) Unsatisfactory results and evidence of corrective action ☐ 4) All satisfactory results	Answer #: _____	If #1 or #2=Yellow If #3 or #4=Green

	SCORE		

CEE #: S_10_05 Testing Interruptions [LAB]			
STANDARD: Each laboratory provides continuous and reliable services, in which there are minimal to no testing interruptions due to supply or reagent stock outs, expired supplies or reagents, equipment failures, staff shortages, or infrastructure issues.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Within the past 3 months, have there been **any** testing interruptions of >2 days for **any** HIV-related core test for any of the reasons below? *Tick all that apply:* ☐ 1) Supply or reagent stock out ☐ 2) Expired supplies or reagents ☐ 3) Equipment failure ☐ 4) Staff shortages ☐ 5) Power supply, water or temperature conditions ☐ 6) Other (please note in the comments)	_____ # Ticked	If ≥4= Red If 1 – 3=Yellow
	If <1, then Q2		
Q2	Have there been any testing interruptions at all?	Y N	If Y=Yellow If N=Green
	SCORE		

CEE #: S_10_06 Waste Management [LAB]			
STANDARD: Each laboratory implements procedures for collection, storage, and disposal of infectious waste to prevent exposures to workers, patients, and the public. Procedures include segregation of infectious waste, posted waste disposal guidance, and secure storage of infectious waste inside and outside the facility.			
*Instructions: Assess this CEE **only** at a stand-alone laboratory that is not connected to a clinical facility OR a stand-alone blood bank/blood center.* *Is this a stand-alone laboratory OR a stand-alone blood bank/blood center?* *If **NO**, check NA, and* **SKIP** *CEE*: **NA** ☐ If **YES,** *assess all the components of this CEE at the applicable testing areas, then complete the CEE scoring based on **any** instance where the observations do not meet the requirements.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Is infectious waste segregated from general waste and correctly stored in separate, labeled, color-coded waste containers?	Y N	If N=Red
	If Y, then Q2		
Q2	Is infectious waste securely stored and not accessible to the public (*regardless if stored inside or outside the facility*)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Does the facility have **BOTH** of the following? *Tick all that apply:* ☐ 1) Written procedures for infectious waste management and disposal? ☐ 2) Posted guidance or job aides describing the types of waste and the process for waste segregation?	# Ticked _____	If 0-1=Yellow If 2=Green
	SCORE		

CEE #: S_10_07 Injection Safety [LAB]			
STANDARD: Appropriate injection and phlebotomy equipment supplies and written, standardized safety procedures are available to reduce risk of blood borne pathogen transmission to patients and healthcare workers.			
*Instructions: Assess this CEE **only** at a stand-alone laboratory or blood bank/blood center that performs phlebotomy.* *Does this site provide injections or phlebotomy services to patients?* *If **NO**, check NA, and **SKIP** CEE.* ☐*NA* If **YES,** *assess all the components of this CEE at the applicable areas, then complete the CEE scoring based on **any** instance where the observations do not meet the requirements.*			
Comment:			
	Question	**Response**	**Scoring**
Q1	Are **ALL** of the following available in the areas where blood is drawn? *Tick all that apply:* ☐ 1) Disposable gloves ☐ 2) Hand washing materials ☐ 3) Rigid World Health Organization-approved sharps containers	# Ticked ____	If ≤2=Red
	If 3, then Q2		
Q2	Is appropriate size equipment available for all applicable patient ages (example: pediatric venous and capillary blood collection)?	Y N	If N=Yellow
	If Y, then Q3		
Q3	Are there written procedures for safe blood collection and post-exposure prophylaxis (PEP) protocol for health care staff working at the site? ***Note:** Guidelines do not qualify as a specific site protocol.*	Y N	If N=Yellow
	If Y, then Q4		
Q4	Are post-exposure prophylaxis drugs or starter packs available at the site?	Y N	If N=Yellow If Y= Green
	SCORE		

CEE #: S_10_08 HIV Viral Load Laboratory Capacity [LAB]			
STANDARD: The laboratory has the capacity and systems to meet the testing demands for HIV viral load scale-up.			
Instructions: Does this laboratory perform HIV viral load testing? *If **NO**, check NA, and **SKIP** this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the laboratory have sufficient capacity to meet HIV viral load testing demands in regards to: *Tick all that apply:* ☐ 1) Personnel: Including qualified technician for testing, supervisory/monitoring, and support staff ☐ 2) HIV viral load instruments and ancillary equipment ☐ 3) Infrastructure: Reliable electricity and adequate space for: lab testing, specimen processing and storage, and reagent and supply storage. ☐ 4) Keeping up with demand: The backlog for testing of HIV viral load specimens is < 1 month.	# Ticked _____	If ≤3=Red
	If 4, then Q2		
Q2	Does the laboratory have sufficient systems to meet HIV viral load testing demands in regards to all of the following? *Tick all that apply:* ☐ 1) The laboratory uses specimen/result transport system(s) to serve all designated facility. ☐ 2) The laboratory has a turn-around-time for HIV viral load testing of ≤ 14 days. ☐ 3) The laboratory has procedures available to notify Care and Treatment facilities of specimens that show virological non-suppression as defined by country's guidelines (e.g. ≥ 1000 cp/mL). ***Note:** Laboratory turn-around-time is defined as time from specimen reception to results reported.*	# Ticked _____	If ≤2= Yellow If 3= Green
	SCORE		

CEE #: S_10_09 HIV Viral Load Specimen Referral and Results Management [LAB]			
STANDARD: Laboratories that do not perform HIV viral load have capacities and tools in place for referred specimen and handling results to ensure specimen integrity and achievement of established acceptable turnaround time for referral testing services.			
Instructions: Does this laboratory offer specimen referral services for HIV viral load testing? *If **NO**, check NA, and **SKIP** this CEE.* **NA** ☐			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the laboratory have sufficient capacity to manage referred HIV viral load specimens and results in regards to **ALL** of the following? *Tick all the apply:* ☐ 1) Personnel: Including trained laboratory staff for specimen handling, storage, packaging, and VL Focal Person/ Roster of staff in-charge ☐ 2) Registers/ Logs: Including HIV viral load specimen referral, rejected specimens, and dispatched results registers/ logs ☐ 3) Guidelines/SOPs: Containing instructions of safe handling and packaging of biological specimen, specimen referral laboratory network for HIV viral load testing, contact information for referral laboratories and Itinerary of specimen transport system ☐ 4) Infrastructure and Materials: Reliable specimen reception area and adequate space for, specimen and lab request verification, specimen packaging materials and containers, and lockable cabinet for results	# Ticked _____	If ≤3=Red
	If 4, then Q2		

Q2 	Does the laboratory have sufficient systems to monitor HIV viral load testing services in regards to: *Tick all the apply:* ☐ 1) The laboratory reviews all registers at least weekly to identify rejected specimen and missing VL results for corrective action(s) to be taken ☐ 2) The laboratory monitors turn-around-time and alerts the hub of HIV viral load testing going beyond ≤14 days ☐ 3) The laboratory has procedures available to notify Care and Treatment facilities of delayed VL results ***Note:*** *Laboratory turn-around-time is define as time from specimen dispatch to results reported.*	# Ticked _____	If ≤2= Yellow If 3= Green
	SCORE		

SET 10B: BLOOD SAFETY			
CEE #	*Abbreviated Title*	*Required*	*Elective*
S_10_10	Access to Safe Blood		X
S_10_11	Blood Center/Blood Bank Linkage to Care		X

Instructions: Only assess this Set if PEPFAR supports blood safety at this facility.

CEE #: S_10_10 Access to Safe Blood [LAB-BLOOD]
STANDARD: Clinical service delivery sites that conduct blood transfusions (e.g., via comprehensive emergency obstetric care) provide access to transfusion services that are delivered in a consistent and quality-assured manner.
Instructions: Are ANY blood transfusions -performed at this site? *If **NO**, check NA, and **SKIP** CEE.* **NA** ☐
Comment:

	Question	Response	Scoring
Q1	Do **ALL** of the following apply to blood units at this facility? *Tick all that apply:* ☐ 1) Transfusion in compliance with National Blood Transfusion Service (NBTS) guidelines ☐ 2) Stored separately in a temperature-monitored blood storage refrigerator and/or freezer for transfusion blood units/components ☐ 3) Blood storage refrigerators are monitored by a functional temperature monitoring system to detect temperature variations	# Ticked	If 0-2=Red
	If 3, then Q2		
Q2	Does the site have or use all of the following? *Tick all that apply.* ☐ 1) Standardized form for all requests for blood ☐ 2) Adequate supply of blood products to meet the demand ☐ 3) Conduct at least 75% of transfusions with blood components rather than whole blood	# Ticked _____	If 0-2=Yellow If 3=Green
	SCORE		

CEE #: S_10_11 Blood Center/Bank/Linkage to HIV Testing and Treatment [LAB-BLOOD]			
STANDARD: Blood donors are screened using a behavioral questionnaire to identify high-risk HIV behavior and their donations are tested for HIV. HIV-positive blood donors receive their test results, post-donation counseling, and are linked to HIV testing and treatment services.			
Comment:			
	Question	**Response**	**Scoring**
Q1	Does the facility use a standardized behavioral questionnaire to screen all blood donors?	Y N	If N = Red
	If Y, then Q2		
Q2	Does the facility provide HIV test results to all HIV-positive blood donors? ***Note:*** *This information may come from client forms or other documents.*	Y N	If N = Red
	If Y, then Q3		
Q3	Does the facility link HIV-positive blood donors to HIV testing and treatment services? ***Note****: This information may come from the general or referral register, client forms, or other documents.*	Y N	If N = Yellow If Y = Green
	SCORE		