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TABLE OF CONTENTS

FOREWORD	4
INTRODUCTION	5
Purpose	5
How to use these guidelines	5
Background	6
2011 UN Political Declaration on HIV and AIDS – Targets and elimination commitments	6
Reporting History	7
Reporting Format	8
National indicators for high-income countries	9
IMPLEMENTATION OF PROGRESS REPORTING AT NATIONAL LEVEL INDICATOR CONSTRUCTION	10
Measurement tools and data sources	10
Numerators and denominators	11
Disaggregated Data: sex and age	11
Subnational-level data	12
Recent and representative survey data	13
Interpretation and analysis	14
Selection of indicators	14
Geo-coding surveillance and monitoring and evaluation information	15
Role of civil society	15
Report contents	17
Guidance on submission	18
Reporting tool	18
Joint reporting with WHO and UNICEF on health sector indicators	19
Data submission	19
The national-level reporting process: necessary actions	19
SUMMARY OF CHANGES FOR 2015 GLOBAL AIDS RESPONSE PROGRESS REPORTING	21
THE FUTURE OF GLOBAL AIDS RESPONSE PROGRESS REPORTING	23
LIST OF COMBINED SET OF GARPR AND UA INDICATORS	24

TARGET 1. REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015	29
1.1 Young people: Knowledge about HIV prevention	30
1.2 Sex before the age of 15	31
1.3 Multiple sexual partnerships	33
1.4 Condom use at last sex among people with multiple sexual partnerships	34
1.5 HIV testing in the general population	35
1.6 HIV prevalence in young people	36
1.7 Sex workers: prevention programmes	38
1.8 Sex workers: condom use	40
1.9 HIV testing in sex workers	42
1.10 HIV prevalence in sex workers	44
1.11 Men who have sex with men: prevention programmes	46
1.12 Men who have sex with men: condom use	48
1.13 HIV testing in men who have sex with men	50
1.14 HIV prevalence in men who have sex with men	52
TARGETS 1 AND 2. SIZE ESTIMATIONS FOR KEY POPULATIONS	55
TARGET 2. REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50% BY 2015	56
2.1 People who inject drugs: prevention programmes	56
2.2 People who inject drugs: condom use	58
2.3 People who inject drugs: safe injecting practices	60
2.4 HIV testing in people who inject drugs	62
2.5 HIV prevalence in people who inject drugs	64
TARGET 3. ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS	67
3.1 Prevention of mother-to-child transmission	67
3.1a Prevention of mother-to-child transmission during breastfeeding	72
3.2 Early infant diagnosis	74
3.3 Mother-to-child transmission of HIV (modelled)	77
TARGET 4. REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015	79
4.1 HIV treatment: antiretroviral therapy	79
4.2 Twelve-month retention on antiretroviral therapy	82

TARGET 5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50% BY 2015	86
5.1 Co-management of tuberculosis and HIV treatment	86
TARGET 6. CLOSE THE GLOBAL AIDS RESOURCE GAP BY 2015 AND REACH ANNUAL GLOBAL INVESTMENT OF US\$22–24 BILLION IN LOW- AND MIDDLE-INCOME COUNTRIES	88
6.1 AIDS spending	88
TARGET 7: ELIMINATING GENDER INEQUALITIES	91
7.1 Prevalence of recent intimate partner violence	91
TARGET 8: ELIMINATING STIGMA AND DISCRIMINATION	95
8.1 Discriminatory attitudes towards people living with HIV	95
TARGET 9: ELIMINATE TRAVEL RESTRICTIONS	100
TARGET 10: STRENGTHENING HIV INTEGRATION	101
10.1 Orphans school attendance	101
10.2 External economic support to the poorest households	103
GOVERNMENT HIV AND AIDS POLICIES	107
APPENDICES	108
Appendix 1. Country Progress Report template	108
Appendix 2. National Funding Matrix	110
Appendix 3. Sample checklist for Country Progress Report	118
Appendix 4. Selected bibliography	119
Appendix 5. Male circumcision indicators	120
Appendix 6. Geographic data collection in Surveillance, Monitoring and Evaluation	123
Appendix 7. Guidance on monitoring progress towards eliminating gender inequalities	125
ABBREVIATIONS	135
PART 2	
A GUIDE ON INDICATORS FOR MONITORING AND REPORTING ON THE HEALTH SECTOR RESPONSE TO HIV (ADDITIONAL WHO/UNICEF UNIVERSAL ACCESS HEALTH SECTOR INDICATORS)	137

FOREWORD

Intensive analysis and new data – much of it generated by countries through the use of this Global AIDS Progress Reporting mechanism – have enabled UNAIDS to release three critical reports in the past six months — the Gap Report, Fast-Track: Ending the AIDS Epidemic by 2030, and OUTLOOK: The Cities report. These three reports demonstrate just how dramatically we have succeeded in bending the trajectory of the AIDS epidemic. Since 2001, new HIV infections have fallen by 38%. Even better news is that new infections among children have fallen by 58%, dropping below 200 000 in 21 highly affected countries in Africa for the first time. This is a significant milestone on our journey towards 2020 and 2030 in order to end the AIDS epidemic as a public health threat.

We have just five years to break the trajectory of the AIDS epidemic. Our progress over the next five years will determine the impact we can have in the subsequent 10 years through 2030. This is new, compelling evidence that we must not ignore.

That is why UNAIDS is calling for new Fast-Track targets, which will enable us to focus on where the results can and need to be achieved: stepping up HIV treatment through 90-90-90 targets (90% of people living with HIV knowing their HIV status, 90% of people living with HIV who know their status on antiretroviral treatment, and 90% of people on treatment having suppressed viral loads), and reaching ambitious prevention and stigma reduction targets. We must close the gap to ensure that we leave no one behind in the AIDS response.

In September 2014, 127 countries were able to report their six-monthly ART and PMTCT data, and 57 countries broke it down by sub-national level. This illustrates the progress in national monitoring systems, and how countries are focusing their responses where smarter investments will bring greater programmatic gains.

These 2015 guidelines provide UN Member States with detailed information on how to collate the data and conduct the next round of global AIDS response progress reporting. I encourage all countries to use this opportunity to consult with key country constituents, including civil society, on how to focus the national AIDS response. This round of reporting is a further opportunity to concentrate our efforts on gathering and reporting more granular data, and to analyse sub-national data and make use of it for reprogramming.

Collecting and reporting high-quality results on the AIDS response are important elements of our agenda for shared responsibility and global solidarity. UNAIDS is determined to support you in this endeavour. I count on you to submit your monitoring data and HIV estimates for 2014 by 31 March 2015.

If you have any questions, or if you need additional support, please contact AIDSreporting@unaids.org.

I thank you for your continued engagement in the AIDS response.



Michel Sidibé
Executive Director
UNAIDS

INTRODUCTION

Purpose

The purpose of this document is to provide guidance to national AIDS programmes and partners actively involved in the country response to AIDS on use of core indicators to measure and report on the national response.

The “2011 UN Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS” (General Assembly resolution 65/277), which was adopted at the United Nations General Assembly High Level Meeting on AIDS in June 2011, mandated UNAIDS to support countries to report on the commitments in the 2011 UN Political Declaration on HIV and AIDS.

The Global AIDS Response Progress Reporting (GARPR) indicators (before 2012 known as UNGASS indicators) were until 2012 reported at the global level every second year. However, from 2013 data have been collected every year.

To assess progress made against the targets, the collection and reporting of indicator data is an important part. Countries are strongly encouraged to integrate these core indicators into their on-going monitoring and evaluation activities. These indicators are designed to help countries assess the current state of their national response and progress in achieving their national HIV targets. They will contribute to a better understanding of the global response to the HIV pandemic, including progress towards the global targets set in the 2011 UN Political Declaration on HIV and AIDS and the Millennium Development Goals.

How to use these guidelines

These guidelines have been developed to help countries collect data and report on their national HIV response as effectively as possible. In the section “Core indicators for Global AIDS Response Progress Reporting” readers will find pages devoted to each indicator, giving reasons for inclusion and methods for collecting, constructing and measuring the indicator. The indicator’s strengths and weaknesses are also discussed.

Help is available at every stage of the process. Key points and sources for additional information—including who to contact and how to reach them—is highlighted in this introductory section and pointed out with an blue arrow.



Background

We have now arrived at 2015, the end date of both the 2011 Political Declaration on HIV and AIDS and the Millennium Development Goals (MDGs). This will be an important opportunity to review progress and prepare for the final reporting towards these targets.

The 2011 UN Political Declaration on HIV and AIDS builds on two previous political declarations: the 2001 *Declaration of Commitment on HIV/AIDS* and the 2006 *Political Declaration on HIV/AIDS*. At the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), in 2001, the declaration was adopted unanimously by the member states. This declaration reflected global consensus on a comprehensive framework to achieve Millennium Development Goal 6: halting and beginning to reverse the HIV epidemic by 2015. It recognized the need for multisectoral action on a range of fronts and addressed global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. The 2006 declaration recognized the urgent need to achieve universal access to HIV treatment, prevention, care and support.

While the declarations have been adopted by governments, their vision extends far beyond the governmental sector to private industry and labour groups, faith-based organizations, nongovernmental organizations and other civil society entities, including organizations representing people living with HIV.

As indicated in the 2011 UN Political Declaration on HIV and AIDS, a successful AIDS response should be measured by the achievement of concrete, time-bound targets. It calls for careful monitoring of progress in implementing commitments and requires the United Nations Secretary-General to issue annual progress reports. These reports are designed to identify challenges and constraints and recommend action to accelerate achievement of the targets.

2011 UN Political Declaration on HIV and AIDS

Targets and elimination commitments



The guidelines in this document have been developed to enhance reporting of key indicators for the AIDS response. The reported data are used to monitor progress against the commitments and targets of the 2011 UN Political Declaration on HIV and AIDS and the AIDS related MDGs.

Reporting history

UNAIDS has collected country progress reports from Member States for the purpose of monitoring the various political declarations every two years since 2004 and every year since 2013. Response rates increased from 102 (53%) Member States in 2004 to 180 (93%) in 2014 (see graph for regional and global response rates).

Graph: Proportion of countries that have participated in the 2014 Global AIDS Response Progress Reporting



The information provided by country progress reports represents the most comprehensive data on both the status of, and response to the epidemic. The data from the previous reporting rounds are available online through AIDSinfo; aidsinfo.unaids.org. The full data base is available at www.aidsinfoonline.org, which can be used to produce charts, maps and tables. Unedited narrative country reports from the 2014 reporting are available at www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries. Full NCPI reports are available at www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2014countries.



The Global AIDS Response Progress Reporting indicator data should be submitted through the reporting website (<https://aidsreportingtool.unaids.org>) to enhance the completeness and quality of the data and to facilitate processing and analysis at both the country, regional and global levels.



The deadline for report submission using the reporting website is 31 March 2015.

Reporting format

2015 reporting only requires submission of the core indicators and the narrative country progress report. The National Commitments and Policy Instrument (NCPI) is not required.

When preparing Global AIDS Response Progress Reporting, countries should base their narrative reports on their national country reports. Where a recent national country report is available, this can be submitted as the narrative country progress report. A Country Progress Report template, with detailed instructions for completion of the different sections can be found in Appendix 1. The indicator data are considered an integral part of each Country Progress Report submission. Hence, both the narrative part of the Country Progress Report and the indicator data should be considered in the consultation and report preparation process as outlined in the section titled “Implementation of progress reporting at national level” in these guidelines.

Global AIDS Response Progress Reporting indicators are important for two reasons. First, they can help individual countries evaluate the effectiveness of their national response and second, when data from multiple countries are analysed collectively, the indicators can provide critical information on the effectiveness of the response at regional and global levels, and will be the basis for the regional and global analyses of progress towards the 2015 targets. At the same time this provides countries with insights into other national-level responses.

The changes in this round of reporting compared to the 2014 reporting round are summarized on page 20.

Countries should consider the applicability of each indicator to their epidemic. When countries choose not to report on a particular indicator, they should provide their reasons for choosing not to report as this enables differentiation between an absence of data and the inapplicability of specific indicators to particular country epidemics.

Most of the national indicators are applicable to all countries. The behaviour indicators for key populations at higher risk are relevant in all countries regardless of national HIV prevalence level. Similarly, countries with a low HIV prevalence are encouraged to collect data on sexual behaviours among young people as a means of tracking trends in behaviours that could influence the national response in the future. However, a few indicators are applicable to specific HIV epidemic contexts only.

UNAIDS strongly recommends that countries use these indicators within their national monitoring and evaluation systems. In accordance with specific needs, and if resources allow, countries may wish to include additional indicators in their national monitoring plans.

Five of the national indicators are also Millennium Development Goal indicators:

- percentage of young people who are living with HIV
- knowledge among young people about HIV
- condom use at last high-risk sex
- school attendance among orphans
- antiretroviral therapy coverage.

Data used by the UN Division of Statistics for reporting on the Millennium Development Goals are mainly sourced from data provided by Member States through Global AIDS Response Progress Reporting.

National indicators for high-income countries

In adopting the 2011 Political Declaration on HIV and AIDS, high-income countries have committed themselves to reporting on progress made in their national responses to HIV. It is recognized that high-income countries may use relatively complex information systems and a variety of data sources which can make the calculation of a single national indicator challenging. However, this does not remove the need for high-income country data for monitoring global progress towards the targets of the Political Declaration on HIV and AIDS. European Union/European Economic Area (EU/EEA) countries have used innovative ways to link global HIV monitoring systems more closely to regional circumstances.

UNAIDS encourages high-income countries to contact the UNAIDS Strategic Information and Monitoring Division (AIDSreporting@unaids.org) if they require further technical advice regarding reporting on their domestic programmes.



Full definitions for all indicators used for the Global AIDS Response Progress Reporting can be found in these guidelines. The indicators can also be found in the UNAIDS Indicator Registry at www.indicatorregistry.org. This online database provides complete definitions of the Global AIDS Response Progress Reporting indicators and clearly shows how these indicators relate to indicators used by WHO, UNAIDS, PEPFAR, the Global Fund and other key partners. The Indicator Registry also includes other HIV indicators used at country level. There are direct links from the online reporting tool to the indicators in the Indicator Registry. The indicators can also be exported from the Indicator Registry to Excel, Word or PDF.

IMPLEMENTATION OF PROGRESS REPORTING AT NATIONAL LEVEL

INDICATOR CONSTRUCTION

For each indicator this manual provides the information needed to construct the indicator, including:

- summary of what it measures
- rationale for the indicator
- numerator, denominator and calculation
- recommended measurement tools
- measurement frequency
- strengths and weaknesses of the indicator (including summary interpretation of the indicator).

Measurement tools and data sources

The primary measurement tools vary by indicator and include:

- nationally representative, population-based sample surveys
- behavioural surveillance surveys
- specially designed surveys and questionnaires, including surveys of specific population groups (e.g. specific service coverage surveys)
- patient tracking systems
- health information systems
- sentinel surveillance
- national HIV estimates from Spectrum software

Existing data sources, including records and programme reviews from health facilities and schools as well as specific information from HIV surveillance activities and programmes, should be used to supplement the primary measurement tools.

Another source for denominators used in the GARPR reporting is the Spectrum computer package that allows countries to create population-level estimates of people living with HIV, people in need of antiretroviral therapy, women in need of antiretroviral medicine and HIV-exposed children in need of virological testing.

In 2015 the process of completing the Spectrum file and submitting the GARPR data will be done: simultaneously to ensure the results are harmonized. Countries should participate in UNAIDS-sponsored estimates training workshops in February and March to construct and finalise the files.

Spectrum files should then be submitted by 31 March 2015. Countries will receive information in January 2015 on regional workshop dates and instructions for participation.

Spectrum files are created by a team of national experts who have been trained on how to populate and use the software. It is critical that the team completing the GARPR tool use the most-recent estimates developed by the national HIV estimates team.

Civil society organizations are valuable sources of data for many indicators, especially those that relate to interventions where nongovernmental, faith-based and community-based organizations play an active role. Examples include work with young people, key populations at higher risk and pregnant women.

In many countries, the bulk of the data required for the core national-level indicators may not be available from existing sources. Gathering such data is likely to require the adaptation of existing monitoring tools or the addition of specific surveys. Countries that conduct regular, nationally representative, population based surveys such as the Demographic and Health Surveys or AIDS Indicator Surveys will collect important information, including behavioural data on young people. In countries where other types of population-based surveys are conducted, including those for purposes other than HIV, it is possible to adapt these surveys to collect data for selected core indicators.

Numerators and denominators

For each core indicator, detailed instructions for measuring the national response are provided. Most core national-level indicators use numerators and denominators to calculate the percentages that measure the current state of the national response. Countries are strongly encouraged to pay close attention to the dates attached to specific data when calculating an indicator. If data used for the numerator and denominator are collected at different times, the accuracy and validity of that information will be compromised.

The methods described have been designed to facilitate the construction of global estimates from national-level data. While these methods can be applied at the subnational level, simpler, faster and more flexible approaches that are tailored to local conditions may be more appropriate to guide decision-making below the national level.

A number of indicators related to coverage of services require a denominator that is based on the full population, i.e. not just those people that are seen at health care clinics. To calculate population-level indicators it is necessary to estimate the total number of people eligible for the service. For example, to estimate how close a country is to reaching 100% MTCT coverage it is necessary to estimate the total number of pregnant women living with HIV. UNAIDS recommends that countries use the Spectrum computer package to calculate the denominators needed for GARPR reporting.

Disaggregated data: sex and age

One of the key lessons learnt from previous rounds of reporting was the importance of obtaining disaggregated data, for example, breaking it down by sex and age. It is vital that countries collect data in their component parts and not simply in summary form. Without disaggregated data, it is difficult to monitor the breadth and depth of the response to the epidemic at both national and global levels. It is equally difficult to monitor access to



The Global online reporting tool (<https://aidsreportingtool.unaids.org>) clearly identifies the disaggregated data that are required to accurately report on the numerator and denominator for each indicator (see the preceding subsection entitled “Numerators and Denominators” for additional information). In general, where appropriate, all data should be disaggregated by sex and age. Where collecting disaggregated data has proved difficult, entry of partial data is possible, where necessary.

activities, the equity of that access, the appropriateness of focusing on specific populations, and meaningful change over time.

Countries are strongly encouraged to make the collection of disaggregated data, especially by sex and age, one of the cornerstones of their monitoring and evaluation efforts. If possible, equity analyses should also be done. Gender dynamics may become evident through sex- and age-disaggregated epidemiological data as well as through the behavioural indicators. Please see Appendix 6 for further suggestions on broader monitoring of progress towards gender equality through GARPR. Key ministries should review their information systems, surveys and other instruments for collecting data to ensure that they capture disaggregated data at subnational levels, including facility and project levels. Special efforts should be made to follow disaggregated data up to the national level. In addition, the private sector and/or civil society organizations involved in the country’s AIDS response must be advised of the importance of disaggregated data and make the collection and dissemination of the data a priority in their on-going operations.

In situations where disaggregated data are not readily available, it may be possible to extract the information needed for core indicators from larger data sets, although the location of the data will vary from country to country. Countries should seek technical assistance from the United Nations System (including the UNAIDS, WHO and UNICEF country offices) and its partners for help with accessing the disaggregated data needed to properly complete the measurements of core indicators.

Governments are encouraged to look beyond their internal information resources to both collect and validate data. In many cases, civil society organizations may be able to provide valuable primary and secondary data.

Countries are encouraged to report available complementary data that reflects gender dimensions of the indicators from other sources, including quantitative and qualitative data collected by civil society, in the comment boxes on each indicator page. This additional data will permit a more comprehensive situational analysis of the indicators from a gender perspective.

Subnational-level data

Many countries are improving the use of data at the subnational level to better understand the epidemic and the response. Such data will help all stakeholders to better understand the geographic distribution of HIV epidemics and the responses in each community. In 2014 UNAIDS

launched a Local Epidemics Issues Brief, which discusses the advantages of localised data (http://www.unaids.org/sites/default/files/media_asset/JC2559_local-epidemics_en.pdf). In 2015, the online reporting tool makes provision for sub-national level data to be submitted specifically for indicators 3.1, 4.1 and key populations related data (see next paragraph for details on sub-national data on key populations).

Recent and representative survey data

Use the most-recently available nationally representative survey to calculate indicators that are based on general population surveys.

You will be requested to report any new data available. If you have already reported the latest available data in a previous round of reporting, you will not have to report this again.

Ensuring that survey samples of key populations are truly representative is a great technical challenge.

Methods are being developed to try to achieve representative sampling of these populations (e.g. respondent-driven sampling). While these are being refined, it is recognized that countries may not be confident that samples used for surveys of key populations at higher risk of HIV exposure are representative. Countries are advised to use the most-recent survey of key populations that has been reviewed and endorsed by local technical experts, such as monitoring and evaluation technical working groups or national research councils. Countries are encouraged to report all recent, quality surveys of key populations, by site, with numerator, denominator and methods in the provided Excel spread sheets.

One of the challenges in developing burden of disease estimates and planning for programme needs is understanding the size of key populations. Countries are asked to report the size estimates for key populations, providing methods and any city/province-specific estimates calculated empirically. Some countries with empirical national size estimates for key populations are also able to aggregate prevention programme data. If a country can report against an indicator with national programme data, they may do so in the comment fields this year.



Countries needing additional information on implementation should seek technical assistance from their UNAIDS Strategic Information Advisers, UNICEF or WHO offices and HIV monitoring and evaluation working groups. Technical support is also available from the UNAIDS Regional Strategic Information Advisers based at the Regional Support Team and from the Strategic Information and Monitoring Division Team at the UNAIDS Secretariat who can be reached via email at AIDSreporting@unaids.org.

Interpretation and analysis

As each core indicator is discussed later in this manual, so too are their strengths and weaknesses. Countries should carefully review this section before they begin collecting and analysing data as it explains how to interpret each indicator and any potential issues related to it. The points raised in this section should be reviewed before finalization of the reporting and the writing of the narrative report to confirm the appropriateness of the findings for each indicator.

The sections on the strengths and weaknesses of each core indicator are designed to improve the accuracy and consistency of the data submitted to UNAIDS. Other points in this section provide additional information on the value of a particular indicator. The section acknowledges that variations may occur from country to country on issues as diverse as the relationship of costs to local income, standards for quality and variations in treatment regimens.

After compiling their data countries are strongly encouraged to continue analysing their findings. This will enable them to better understand their national response and identify opportunities to improve that response. Countries should be looking closely at the linkages between policy, implementation of HIV programmes, verifiable behaviour change and changes in the epidemic. For example, if a country has a policy on the reduction of mother-to-child transmission of HIV, does it also have field programmes that make prevention of mother-to-child transmission available to pregnant women? If these field programmes are in place, are women using them in sufficient numbers to have an impact on the number of HIV-infected infants born in that country?

These linkages exist in every facet of a national response and many of the most important ones are reflected in the core national-level indicators included in this manual. To effectively analyse these linkages, countries must draw on the widest range of data available, including quantitative and qualitative information from both the public and private sectors.

An over-reliance on data of any one type or from any one source is less likely to provide the perspective or insights required to understand such linkages and to identify any existing or emerging trends.

Selection of indicators

Based on knowing the local HIV epidemic, countries should review all of the indicators to determine which ones are applicable in their situation. For example, a country with a concentrated epidemic among sex workers and men who have sex with men may not need to report on the core indicators related to people who inject drugs. However, they should regularly assess the situation to see whether injecting drug use is emerging as an issue that needs attention. They should calculate both the specific indicators for sex workers and men who have sex with men as well as broader indicators (e.g. young people's knowledge of HIV, higher-risk sex in women and men, and condom use during higher-risk sex), which are relevant in tracking the spread of HIV into the general population.

Similarly, countries with a generalized epidemic should include data on as many indicators as possible for key populations at higher risk. For example, a country with a higher-prevalence epidemic may also have a concentrated sub-epidemic among people who inject drugs. It would therefore be valuable to also calculate and report on the indicators that relate to the key populations at higher risk.

For each indicator, countries are requested to state the indicator relevance in the on-line reporting tool, depending on the epidemic situation in the country and if data is available. If it is felt that the area is relevant to the epidemic and response, but that the indicator itself is not relevant or appropriate for monitoring this issue, this should be stated in the online reporting tool comment boxes.

If a country is using an alternative indicator to effectively monitor the issue in question the comment boxes may be used to describe it (including a full definition and method of measurement), along with any available data for the indicator.

Geo-coding surveillance and monitoring and evaluation information

Through the Global AIDS Response Progress Reporting mechanism countries are asked to submit nationally representative data. However at the national level identifying geographic areas where localized HIV epidemics or specific populations most affected by the epidemic are not being reached by services is a key opportunity to strengthen the efficiency and effectiveness of national HIV responses. This is possible by attaching geographic information to indicator data. Geo-coding links surveillance and programmatic data from various sources to produce more detailed understandings of the HIV epidemic, facilitating implementation of focused and adapted interventions where they are most needed. To implement this approach, data collection must shift to sub-national levels that are programmatically relevant. Data disaggregation is already expanding in many countries to lower geographical levels and among key populations. Confidentiality and ethical considerations must always be maintained in data collection, analysis and dissemination, to ensure geo-coded data are used to bring HIV-related services closer to the people who need them and not expose people to harm. Please see Appendix 6 for more information about geo-coding surveillance and M&E information.

Since the 2014 mid-year reporting, countries are asked to report any available subnational data for indicators 3.1 and 4.1.

Role of civil society

Civil society plays a key role in the response to the AIDS epidemic in countries around the world. The wide range of expertise within civil society organizations makes them ideal partners in the process of preparing Country Progress Reports. Specifically, civil society organizations are well positioned to provide quantitative and qualitative information to augment the data collected by governments. National AIDS councils/commissions committees or their equivalents should seek input from the full spectrum of civil society, including

nongovernmental organizations, networks of people living with HIV, faith-based organizations, women, young people, trade unions and community-based organizations, for their reports on the core national-level indicators underlying the 2011 UN Political Declaration on HIV and AIDS. The importance of securing input from the full spectrum of civil society, including people living with HIV, cannot be overstated. Civil society speaks with many voices and represents many different perspectives, all of which can be valuable in the monitoring and evaluation of a country's AIDS response.

National AIDS Committees or their equivalents should provide civil society organizations with easy access to their plans for data collection and denominator data. A straightforward mechanism for submitting and evaluating information should be developed. As part of this effort, civil society organizations should also be invited to participate in workshops at the national level to determine how they can best support the country's reporting process. In every country civil society representatives should be given sufficient opportunity to review and comment on data before it is finalized and submitted. The report that is submitted to UNAIDS should be widely disseminated to ensure that civil society has ready access to it.

Country-level UNAIDS staff are available to assist with civil society input throughout the process. In particular, UNAIDS country-level staff should:

- brief civil society organizations on the indicators and the reporting process
- provide technical assistance on gathering, analysing and reporting data, including focused support to people living with HIV
- ensure the dissemination of reports including, whenever possible, reports in national languages.

Shadow reports by civil society will be accepted by UNAIDS as they were in previous rounds. It must be noted that shadow reports are not intended as a parallel reporting process for civil society. Wherever possible UNAIDS encourages civil society integration into national reporting processes, as described above. Shadow reports are intended to provide an alternative perspective where it is strongly felt that civil society was not adequately included in the national reporting process, where governments do not submit a report, or where data provided by government differs considerably from data collected by civil society monitoring government progress in service delivery.

Report contents

In 2015, countries are expected to submit data on all of the national indicators that are applicable to their response (except NCPI). National governments are responsible for reporting on national-level indicators with support from civil society and, where applicable, development partners. The procedures outlined in this manual should be used for collecting and calculating the necessary information for each indicator.

Countries are also requested, when possible, to submit copies of or links to primary reports from which data is drawn for the different indicators. These reports can be submitted through the online reporting tool. This will facilitate the analyses of the data including trend analyses and comparisons between countries.

As discussed previously, and as required by the 2011 UN Political Declaration on HIV and AIDS, civil society, including people living with HIV, should be involved in the reporting process. The private sector at large should have a similar opportunity to participate in the reporting process. UNAIDS strongly recommends that national governments organize a workshop or forum to openly present and discuss the data before it is submitted. Joint United Nations Teams on AIDS are available in many countries to facilitate this discussion process.

The indicator data will be made available after a process of data cleaning, validation and reconciliation at www.aidsinfoonline.org.



If there are any questions, countries are advised to consult with UNAIDS locally or in Geneva at AIDSreporting@unaids.org. Updated information on Global AIDS Response Progress Reporting is available on the UNAIDS web site at: <http://www.unaids.org/en/data-analysis/knowyourresponse/globalaidsprogressreporting>.



Countries are asked to submit their data using the online global reporting tool found at <http://AIDSreportingtool.unaids.org>. Each country has an assigned national focal point that will be responsible for accessing this tool and entering their country information for submission. Countries may add/assign multiple rapporteurs in case data is provided from several sources and reporting structures.

Guidance on submission

Countries needing additional information on the reporting tool and the submission mechanisms should seek technical assistance from their UNAIDS Strategic Information Advisers and HIV monitoring and evaluation working groups in country. The Strategic Information and Monitoring Division at the UNAIDS Secretariat is also available to provide support and can be reached via email at AIDSreporting@unaids.org.

To facilitate contact with UNAIDS Geneva during the reporting process and follow-up, countries are requested to provide the name and contact details of the individual responsible for submitting the data as early as possible to AIDSreporting@unaids.org.

Reporting tool

Country rapporteurs may access the reporting tool using the same credentials that they used in the previous reporting round. New country rapporteurs are requested to create their username and password. Based on official communication with the country, one data editor is initially assigned per country, but the country rapporteur can extend these rights to others if he/she wishes to do so. Editors are able to add and make changes to the information to be submitted. As in the past years, the country rapporteur can also enable other people to view the data, allowing for broader country consultation. Viewers are able to see the information that will be submitted, yet make no changes to it. More details on this are provided in the E-tutorials on how to use the reporting tool in the Global AIDS Response Progress Reporting page (<http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting>).

As mentioned above, where countries do not submit data on an indicator, they should indicate whether this was due to an absence of appropriate data or because the indicator was not considered relevant to the epidemic. The comment boxes should be used for short explanatory notes stating how the numerator and denominator were calculated and assessing the accuracy of the composite and disaggregated data. For country level review, the data can also be printed out as one file if needed.

Progress in the reporting can be assessed in the main page, viewing the percentage or number of indicators being responded to. In addition to entering the current year data, countries may request to modify their past year's data if necessary. This will also be done through the online tool.

At the end, the data entry is finished by clicking the "submit" button. This closes the country's session in the online global reporting tool. The country

will no longer be able to make editing changes or additions to its submission using this tool. UNAIDS will review the data and ask for clarifications if necessary. If there are queries to the data, the site will be opened again for the countries to edit their responses.

Problems with the online global reporting tool can be reported to AIDSreporting@unaids.org.

Joint reporting with WHO and UNICEF on health sector indicators

To minimize the reporting burden and facilitate the reporting process the Global AIDS Response Progress Reporting and the WHO and UNICEF health sector indicators will, as in the previous reporting round, be collected through the same online reporting tool.

The additional health sector indicators can be found in Part II of the guidelines.

For specific questions regarding these additional indicators, please e-mail: hivstrategicinfo@who.int.

Data submission

The indicator data should be submitted online by 31 March 2015. The national HIV estimates team should upload the Spectrum file to the designated folder (supplied by UNAIDS HIV Estimates team) by 31 March 2015. For any questions related to where to upload the file please contact estimates@unaids.org.

The indicator data should be entered online and the narrative report uploaded using the global reporting website <https://aidsreportingtool.unaids.org>. This will facilitate data processing and minimize errors.

The national-level reporting process: necessary actions

Complete reporting on the core indicators is essential if the reporting is to contribute to the global response to the epidemic. Countries are strongly encouraged to establish timetables and milestones for completing the necessary tasks. Listed below are necessary actions to facilitate completion of the report.

Under the direction of the National AIDS Committee or its equivalent, countries need to:

1. Identify the focal point for the reporting process and submit his/her name and contact details to UNAIDS Geneva through AIDSreporting@unaids.org;
2. Identify data needs in line with the national strategic plan requirements and these Global AIDS Response Progress Indicator guidelines; develop and disseminate a plan for data collection, including timelines and the roles of the National AIDS Committee or equivalent, other government agencies and civil society;
3. Identify relevant tools for data collection including meeting with national HIV estimates team;

4. Secure required funding for the entire process of collecting, analysing and reporting the data;
5. Collect and collate data in coordination with partner organizations from government, civil society and the international community;
6. Analyse data in coordination with partner organizations from government, civil society and the international community;
7. Work on draft Spectrum files to finalise denominator data;8. Calculate ART and PMTCT coverage estimates using denominators from updated Spectrum files;
8. Allow stakeholders, including government agencies and civil society, to comment on the draft data;
9. Enter the data into the Global online reporting website (<https://AIDSreportingtool.unaids.org>);
10. Upload the Spectrum file to the designated national estimates folder;
11. Submit the indicator data before **31 March 2015**;
12. Respond in a timely manner to queries on the submissions from UNAIDS, WHO or UNICEF.

It is important that the data that are reported are validated and reconciled between all partners in country. This process is supported in the online reporting tool through the ability to share the viewer credentials with national stakeholders. Several countries have reported that this feature enabled numerous civil society and other partners to view and provide inputs during the reporting process, hence allowing faster and wider stakeholder consultation and validation.

A summary checklist which may be used in the preparation and submission of the Country Progress Report is included as Appendix 3.

SUMMARY OF CHANGES FOR 2015 GLOBAL AIDS RESPONSE PROGRESS REPORTING

2015 reporting only requires submission of the core indicators and a narrative country progress report. The National Commitments and Policy Instrument (NCPI) is not required.

Changes compared to the 2014 reporting round are summarized below:

- For all key population indicators (Indicators 1.7-1-14 and 2.1 - 2.5) a request to provide the disaggregation by administrative area in the comment field has been added if the data are subnational. Please submit the digital version of any available survey reports using the upload tool.
- Since the 2014 mid-year reporting, countries are asked to report any available subnational data for Indicators 3.1 and 4.1. Please see under disaggregation for details for these indicators.
- Indicator 6.1 has a refined conceptual framework of the National Funding Matrix, with revised classification of AIDS programmes and a new National Funding Matrix. These changes have been made to provide information of greater relevance for policy and better information on the core indicators built to embrace the 10 targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS.
- An additional comment box is included under Indicator 7.1 in the online reporting tool for countries to submit any data on gender-based violence towards women, men and key populations, including people living with HIV, that may be available for their country.
- Indicator 8.1 provides an important measure of prevalence of discriminatory attitudes towards people living with HIV. To have a more complete assessment of progress towards eliminating HIV-related stigma and discrimination and of the success or failure of stigma reduction efforts, it is important to also measure other domains of stigma and discrimination. Therefore references to other new indicators that could support this effort have been added under Indicator 8.1, although they are not part of the formal GARPR reporting.
- Indicator 10.2 has been updated with more information about the method of measurement.
- An appendix on “Guidance on monitoring progress towards eliminating gender inequalities” (Appendix 7) has been added.
- A narrative report is requested (please see Appendix 1 for more details).
- The National Commitments and Policy Instrument (NCPI) is not requested.

Key issues new in the 2013 and 2014 reporting rounds that remain the same in the 2015 reporting round

- As in the last three reporting rounds survey data that have not been updated since the last reporting round (i.e. 2012, 2013 or 2014 depending on when the last time reporting submitted) do not need to be re-entered (i.e. Indicators 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 1.22, 2.2, 2.3, 2.4, 2.5, 7.1, 8.1 10.1, 10.2).
- The two indicators about prevalence of male circumcision and number of men circumcised that were added in 2013 for the 16 countries with high HIV-prevalence and low prevalence of male circumcision are still included (GARPR Indicators 1.22 and 1.23 and can be found in Appendix 5).
- Transgender as a possible disaggregation for sex-workers (Indicators 1.7, 1.8, 1.9 and 1.10), introduced in the 2014 reporting round is still available.
- In the 2014 reporting round the prevention of mother-to-child indicator (Indicator 3.1) had updated language to clarify the disaggregations and the links to Spectrum. The indicator to measure coverage of PMTCT during breastfeeding was added directly after this indicator (labelled Indicator 3.1a),
- The indicator for ART coverage (Indicator 4.1) has the same denominator as in 2014, including all people living with HIV, not only those eligible for treatment. Further, the disaggregation of those newly initiated on ART (in the last 12 months) is still available as in 2014
- As in the 2014 reporting, the 12-month ART retention indicator (Indicator 4.2) includes possible disaggregations for pregnancy status and breastfeeding status at initiation.
- The change in 2014 reporting remains on the indicator for co-management of tuberculosis and HIV treatment (Indicator 5.1) where “adults” was changed to “adults and children” in the numerator and “advanced” deleted from “advancedHIV infection”.
- The indicator Discriminatory attitudes towards people living with HIV (Indicator 8.1) is kept under target 8.
- Joint reporting of the Global AIDS Response Progress Reporting indicators and additional health sector indicators from WHO and UNICEF are included in these guidelines. The additional health sector indicators can be found in Part II of these guidelines.

THE FUTURE OF GLOBAL AIDS RESPONSE PROGRESS REPORTING

2015 is the target year for most targets of both the 2011 Political Declaration on HIV and AIDS and the Millennium Development Goals (MDGs). The world is preparing for the broader process of setting Sustainable Development Goals, and a new goal to end the AIDS epidemic was already adopted by the UNAIDS Programme Coordinating Board in June 2014; several programmatic targets have already been set (see Fast Track - Ending the AIDS epidemic by 2030, UNAIDS 2014).

To ensure continuing relevance and usefulness of the data, the global monitoring framework for the AIDS epidemic and the response will be reviewed in 2015 to assess its utility for the future and make recommendations for a new framework towards 2020 (and 2030). The review will also be informed by the “Consolidated HIV Strategic Information Guide for the Health Sector” developed by the WHO HIV department. This process will conclude by the end of 2015, informing decisions on future monitoring mechanisms and targets for 2016 and onwards.

LIST OF COMBINED SET OF GARPR AND UA INDICATORS

(GARPR; Global AIDS Response Progress Reporting, UA; Universal Access, DD; Dublin Declaration)

Individual indicators may be used to track more than one target.

Target 1. Reduce sexual transmission of HIV by 50% by 2015

Indicators for the general population

- 1.1 Young People: Knowledge about HIV Prevention (GARPR)
- 1.2 Sex Before the Age of 15 (GARPR)
- 1.3 Multiple sexual partners (GARPR)
- 1.4 Condom use at last sex among people with multiple sexual partnerships (GARPR)
- 1.5 HIV Testing in the General Population (GARPR)
- 1.6 HIV prevalence in young people (GARPR)

Indicators for sex workers

- 1.7 Sex Workers: Prevention programmes (GARPR)
- 1.8 Sex Workers: Condom Use (GARPR, UA,DD)
- 1.9 HIV testing in sex workers (GARPR, UA,DD)
- 1.10 HIV prevalence in sex workers (GARPR, UA,DD)

Indicators for men who have sex with men

- 1.11 Men who have sex with men: Prevention programmes (GARPR)
- 1.12 Men who have sex with men: Condom Use (GARPR, UA,DD)
- 1.13 HIV testing in men who have sex with men (GARPR, UA,DD)
- 1.14. HIV prevalence in men who have sex with men (GARPR, UA,DD)

Testing and counselling

- 1.15 Number of health facilities that provide HIV testing and counselling services (UA)
- 1.16 HIV Testing and counselling in women and men aged 15 and older (UA)
- 1.16.1 Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months (UA)

Sexually transmitted Infections

- 1.17 Sexually Transmitted Infections (STIs) (UA)
- 1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis (UA)

- 1.17.2 Percentage of antenatal care attendees who were positive for syphilis (UA)
- 1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment (UA)
- 1.17.4 Percentage of sex workers with active syphilis (UA)
- 1.17.5 Percentage of men who have sex with men with active syphilis (UA)
- 1.17.6 Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months (UA)
- 1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months (UA)
- 1.17.8 Number of men reported with gonorrhoea in the past 12 months (UA)
- 1.17.9 Number of men reported with urethral discharge in the past 12 months (UA)
- 1.17.10 Number of adults reported with genital ulcer disease in the past 12 months (UA)
- 1.18 Percentage (%) of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis (PAHO only)
- 1.19 Diagnosis of HIV/AIDS cases (UA)
- 1.19.1 Number of HIV cases diagnosed by age and sex from 2010-2014 (UA)
- 1.19.2 Number of AIDS cases diagnosed by age and sex from 2010-2014 (UA)

Male circumcision

- 1.22 Male circumcision, prevalence (GARPR,UA)
- 1.23 Number of men circumcised last year (GARPR,UA)

Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015

- 2.1 People who inject drugs: prevention programmes (GARPR, UA, DD)
- 2.2. People who inject drugs: condom Use (GARPR, UA)
- 2.3 People who inject drugs: safe injecting practices (GARPR, UA)
- 2.4 HIV testing in people who inject drugs (GARPR, UA, DD)
- 2.5 HIV prevalence in people who inject drugs (GARPR, UA, DD)
- 2.6 People on opioid substitution therapy (UA)
- 2.7 NSP and OST sites (UA)

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

- 3.1 Prevention of Mother-to-Child Transmission (GARPR, UA)
- 3.1a Prevention of mother-to-child transmission during breastfeeding (GARPR, UA)
- 3.2 Early infant diagnosis (GARPR, UA)
- 3.3 Mother-to-child transmission of HIV (modelled) (GARPR, UA)
- 3.3a Mother-to-child transmission rate (based on programme data)
- 3.4 Pregnant women who were tested for HIV and received their results (UA)
- 3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months (UA)
- 3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing (UA)
- 3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks (UA)
- 3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth (UA)
- 3.10 Distribution of outcomes of HIV-Exposed Infants (UA)
- 3.11 Number of pregnant women attending ANC at least once during the reporting period (UA)
 - 3.11.1 Percentage of HIV-positive pregnant women who had their pregnancy terminated (EURO8)
 - 3.11.2 Percentage of HIV-positive pregnant women who delivered during the reporting year (EURO9)
- 3.12 ANC and EID facilities (UA)
- 3.13 EURO-specific PMTCT Indicator (pregnant women who inject drugs)
 - 3.13.1 Percentage of HIV-positive pregnant women who were injecting drug users (IDUs) (EURO11)
 - 3.13.2 Percentage of HIV-positive pregnant IDU women who received OST during pregnancy (EURO12)
- 3.13 Percentage of HIV-positive pregnant IDU women who received ARVs to reduce the risk of mother-to-child transmission during pregnancy (EURO13)

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

- 4.1 HIV treatment: antiretroviral therapy (GARPR, UA,DD)
- 4.2a Twelve-month retention on antiretroviral therapy (GARPR, UA)
- 4.2b Twenty-four month retention on antiretroviral therapy (UA)
- 4.2c Sixty-month retention on antiretroviral therapy (UA)
- 4.2.1 Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months, 24 months and 60 months after initiation of antiretroviral therapy (EURO4)
- 4.3 Health facilities that offer antiretroviral therapy (UA)
- 4.4 ARV stock-outs (UA)
- 4.5 Late HIV diagnoses (UA)
- 4.6 HIV care (UA)
- 4.7 Viral Load (UA)

Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

- 5.1 Co-Management of Tuberculosis and HIV Treatment (GARPR, UA)
- 5.2 Percentage of people living with HIV newly enrolled in HIV care with active TB disease (UA)
- 5.3 Percentage of people living with HIV newly enrolled in HIV care, started on isoniazid preventive therapy (IPT) (UA)
- 5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit (UA)

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22–24 billion in low- and middle-income countries

- 6.1 AIDS Spending (GARPR,DD)

Target 7. Eliminating gender inequalities

7.1 Prevalence of recent intimate partner violence (IPV) (GARPR)

Target 8. Eliminating stigma and discrimination

8.1 Discriminatory attitudes towards people living with HIV (GARPR)

Target 9. Eliminate Travel restrictions

Target 10. Strengthening HIV integration

10.1 Orphans school attendance (GARPR)

10.2 External economic support to the poorest households (GARPR)

Government HIV and AIDS policies

P.1b Policy and Programmatic Questions (UA)



TARGET 1. REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015

General population

- 1.1 Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*
- 1.2 Percentage of young women and men who have had sexual intercourse before the age of 15
- 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months
- 1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*
- 1.5 Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results
- 1.6 Percentage of young people aged 15–24 who are living with HIV*

Sex workers

- 1.7 Percentage of sex workers reached with HIV prevention programmes
- 1.8 Percentage of sex workers reporting the use of a condom with their most recent client
- 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results
- 1.10 Percentage of sex workers who are living with HIV

Men who have sex with men

- 1.11 Percentage of men who have sex with men reached with HIV prevention programmes
- 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
- 1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results
- 1.14 Percentage of men who have sex with men who are living with HIV

*Millennium Development Goals indicator

1.1 Young people: Knowledge about HIV prevention

Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

What it measures

It measures progress towards universal knowledge of the essential facts about HIV transmission

Rationale

HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV and AIDS is an essential prerequisite—albeit, often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

Numerator:	Number of respondents aged 15–24 years who gave the correct answer to all five questions
Denominator:	Number of all respondents aged 15–24
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?
Measurement frequency:	Preferred: every two years; minimum: every 3–5 years
Disaggregation:	• Sex • Age (15–19 and 20–24)

Explanation of numerator

The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples

include: “Can a person get HIV by hugging or shaking hands with a person who is infected?” and “Can a person get HIV through supernatural means?”

Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of “don’t know” should be recorded as an incorrect answer.

Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.

Strengths and weaknesses

The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behaviour, while belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with HIV.

This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it can be used to ensure that pre-existing high levels of knowledge are maintained.

Further information

For further information on DHS/AIS methodology and survey instruments, visit www.measuredhs.com.

1.2 Sex before the age of 15

Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

What it measures

It measures progress in increasing the age at which young women and men aged 15–24 first have sex.

Rationale

A major goal in many countries is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV. There

is also evidence to suggest that first having sex at a later age reduces susceptibility to infection per act of sex, at least for women.

Numerator:	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
Denominator:	Number of all respondents aged 15–24 years
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: How old were you when you first had sexual intercourse for the first time?
Measurement frequency:	Every 3–5 years
Disaggregation:	• Sex • Age (15-19 and 20-24)

Strengths and weaknesses

Countries where very few young people have sex before the age of 15 might opt to use an alternative indicator: percentage of young women and men aged 20-24 who report their age at sexual initiation as under 18 years. The advantage of using the reported age at which young people first had sexual intercourse (as opposed to the median age) is that the calculation is simple and allows easy comparison over time. The denominator is easily defined because all members of the survey sample contribute to this measure.

It is difficult to monitor change in this indicator over a short period because only individuals entering the group, i.e. those aged under 15 at the beginning of the period for which the trends are to be assessed, can influence the numerator. If the indicator is assessed every two to three years, it may be better to focus on changes in the levels for the 15-17 age group. If it is assessed every five years, the possibility exists of looking at the 15-19 age group.

In countries where HIV-prevention programmes encourage virginity or delaying of first sex, young people's responses to survey questions on this issue may be biased, including a deliberate misreporting of age at which they first had sex.

Further information

For further information on DHS/AIS methodology and survey instruments, visit www.measuredhs.com.

1.3 Multiple sexual partnerships

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months

What it measures

It measures progress in reducing the percentage of people who have multiple sexual partnerships.

Rationale

The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners have a higher risk of HIV transmission than individuals that do not link into a wider sexual network.

Numerator:	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	Number of all respondents aged 15–49
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents' sexual histories are obtained. Analysis of sexual history is used to determine whether the respondent has had more than one partner in the preceding 12 month period
Measurement frequency:	Every 3–5 years
Disaggregation:	• Sex • Age (15-19, 20-24 and 25-49)

Strengths and weaknesses

This indicator gives a picture of levels of higher-risk sex. If people have only one sexual partner, the change will be captured by changes in this indicator. However, if people simply decrease the number of sexual partners they have, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a programme success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.

Further information

For further information on DHS/AIS methodology and survey instruments, visit www.measuredhs.com.

1.4 Condom use at last sex among people with multiple sexual partnerships

Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse

What it measures

It measures progress towards preventing exposure to HIV through unprotected sexual intercourse among people with multiple sexual partners.

Rationale

Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners.

Numerator:	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
Denominator:	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months.
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents' sexual histories are obtained. Analysis of sexual history is used to determine whether the respondent has had more than one partner in the preceding 12 month period, and if so whether a condom was used the last time the respondent had sexual intercourse
Measurement frequency:	3-5 years
Disaggregation:	• Sex • Age 15-19, 20-24 and 25-49 years

Strengths and weaknesses

This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly). However, the broader significance of any given indicator value will depend upon the extent to which people engage in such relationships.

Thus, levels and trends should be interpreted carefully using the data obtained on the percentages of people that have had more than one sexual partner within the last year.

The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide the level of consistent condom use. However, the alternative method of asking whether condoms were always/sometimes/never used in sexual encounters with non-regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use during the most recent sex act will generally reflect the trend in consistent condom use.

Further information

For further information on DHS/AIS methodology and survey instruments, visit www.measuredhs.com.

1.5 HIV testing in the general population

Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

What it measures

It measures progress in implementing HIV testing and counselling.

Rationale

In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Numerator:	Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of all respondents aged 15-49 The denominator includes respondents who have never heard of HIV or AIDS
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents are asked: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you get the results of that test?

Measurement frequency: Every 3 to 5 years

Disaggregation:

- Sex
- Age (15-19, 20-24 and 25-49)

Strengths and weaknesses

The introductory statement by the interviewer “I don’t want to know the results [of any testing], but...” allows for better reporting and reduces the risk of underreporting of HIV testing among people who do not wish to disclose their serostatus.

Knowledge of HIV test results in the past 12 months does not guarantee that a respondent knows their current HIV status. A respondent may have contracted HIV in the time since their last HIV test.

Further information

For further information on DHS/AIS methodology and survey instruments, visit www.measuredhs.com.

1.6 HIV prevalence in young people

Percentage of young people aged 15–24 who are living with HIV

What it measures

It measures progress towards reducing HIV infection.

Rationale

The goal in the response to HIV is to reduce HIV infection. However, given current inability to reliably measure HIV incidence in a cross-sectional survey, proxy measures of HIV incidence are required.

HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable, and rising mortality, rather than behaviour change. Increases in HIV prevalence can reflect increasing numbers of individuals receiving

antiretroviral therapy, and living longer. However at younger ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour since young people are likely to only recently have initiated sexual or injecting drug behaviours. In addition, young people who have recently been infected with HIV are not likely to have started antiretroviral therapy. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in trends in HIV prevalence figures for 15–24 years olds (or even earlier in 15–19-year-olds if this age breakdown is available). Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence.

Epidemic Type:	Countries with generalized epidemics
Numerator:	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive
Denominator:	Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status
Calculation:	Numerator / Denominator
Method of measurement:	UNAIDS/WHO guidelines for HIV sentinel surveillance This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement frequency:	Annual
Disaggregation:	None

Strengths and weaknesses

In countries where the age at which young people first have sexual intercourse is late and/or levels of contraception use are high, HIV prevalence among pregnant women of 15–24 years of age will differ from that among all women in the age group. If fertility patterns are changing this trend might be biased if women living with HIV make different fertility choices.

This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV-epidemic trends in locations where most infections are primarily among key populations.

To supplement data from antenatal clinics, an increasing number of countries have included HIV testing in population-based surveys. If a country has produced HIV prevalence estimates from survey data, these estimates should be included in the comments box for this indicator in order to allow for comparisons between multiple surveys. Survey-based estimates should be disaggregated by sex.

The addition of new sentinel sites will increase the samples' representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to use consistent sites when undertaking trend analyses.

As more children who were infected through mother to child transmission live into their reproductive years this indicator becomes more difficult to interpret. Countries should collect information on timing of infection for women with known HIV-positive sero-status to exclude these women from analyses of trends.

Further information

For further information, please consult the following links:

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/20131118_Methodology.pdf

1.7 Sex workers: prevention programmes

Percentage of sex workers reached with HIV prevention programmes

What it measures

It measures progress in implementing basic elements of HIV prevention programmes for sex workers.

Rationale

Sex workers are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV and AIDS among sex workers as well as into the general population, it is important that they access these services.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations at higher risk. If so, they should calculate and report this indicator for those populations.

Numerator: Number sex workers who replied "yes" to both questions

Denominator: Total number of sex workers surveyed

Calculation: Numerator / Denominator

Method of measurement:	Behavioural surveillance or other special surveys Sex workers are asked the following questions: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic) Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field Access to sex workers as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Sex (female, male, transgender) • Age (<25/25+)

Strengths and weaknesses

The data obtained may not be based on a representative national sample of the sex worker population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

The inclusion of these indicators for reporting purposes should not be interpreted to mean that these services alone are sufficient for HIV prevention programmes for the populations. The set of key interventions described above should be part of a comprehensive HIV prevention programme, which also includes elements such as provision of HIV prevention messages, (e.g. through outreach programmes and peer education), treatment of sexually transmitted diseases, and others. For further information on the elements of comprehensive HIV prevention programmes for sex workers please see the Practical guidelines for intensifying HIV prevention: towards universal access.

This indicator asks about services accessed in the past 12 months. If you have data available on another time period, such as the last three or six months or the last 30 days, please include this additional data in the comments section of the reporting tool.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

Several countries have in previous reporting rounds reported HIV prevalence among subpopulations of transgender women through the additional comments field in the GARPR online reporting tool. This demonstrates that the data are feasible to obtain in different settings.

In addition to the above requested data, please report programme data if available for this indicator using the text box provided in the online reporting platform.

Further information

For further information, please consult the following references:

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation (www.cpc.unc.edu/measure/publications/ms-11-49a).

1.8 Sex workers: condom use

Percentage of sex workers reporting the use of a condom with their most recent client

What it measures

It measures progress in preventing exposure to HIV among sex workers through unprotected sex with clients.

Rationale

Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, through consistent and correct condom use.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among sex workers. If so, it would be valuable for them to calculate and report on this indicator for this population.

Numerator: Number of sex workers who reported that a condom was used with their last client

Denominator:	Number of sex workers who reported having commercial sex in the last 12 months
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys Respondents are asked the following question: Did you use a condom with your most recent client? Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field Access to sex workers as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Sex (female, male, transgender) • Age (<25/25+)

Strengths and weaknesses

Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.

This indicator asks about commercial sex in the past twelve months. If you have data available on another time period, such as the last three or six months, please include this additional data in the comments section of the reporting tool.

Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Several countries have in previous reporting rounds reported HIV prevalence among subpopulations of transgender women through the additional comments field in the GARPR online reporting tool. This demonstrates that the data are feasible to obtain in different settings.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

Further information

For further information, please consult the following references:

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation (www.cpc.unc.edu/measure/publications/ms-11-49a).

1.9 HIV testing in sex workers

Percentage of sex workers who received an HIV test in the past 12 months and know their results

What it measures

It measures progress in implementing HIV testing and counselling among sex workers.

Rationale

In order to protect themselves and to prevent infecting others, it is important for sex workers to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more Key populations at higher risk. If so, they should calculate and report this indicator for those populations.

Numerator:	Number of sex workers who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of sex workers included in the sample
Calculation:	Numerator / Denominator

Method of measurement:	Behavioural surveillance or other special surveys Sex workers are asked the following questions: 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test? Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field Access to sex workers as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Sex (female, male, transgender) • Age (<25/25+)

Strengths and weaknesses

The data obtained may not be based on a representative national sample of the sex workers being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Tracking sex workers over time to measure progress may be difficult due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time.

Several countries have in previous reporting rounds reported HIV prevalence among subpopulations of transgender women through the additional comments field in the GARPR online reporting tool. This demonstrates that the data are feasible to obtain in different settings.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

This indicator is most meaningful in settings where testing scale-up is relatively recent. People who tested more than 12 months ago and know they are positive will be considered “uncovered” by this indicator construction. Ideally, surveys should ask why respondents did not test in the past 12 months. If they report that they know their HIV status to be positive,

they should not be included in the denominator. This indicator will be formally changed post-2015; we ask countries that can to report against this indicator while omitting known HIV-positive persons from the denominator and state that they've done this in the comment field.

Further information

For further information, please consult the following references:

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation (www.cpc.unc.edu/measure/publications/ms-11-49a).

1.10 HIV prevalence in sex workers

Percentage of sex workers who are living with HIV

What it measures

It measures progress on reducing HIV prevalence among sex workers.

Rationale

Sex workers typically have higher HIV prevalence than the general population in both concentrated and generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among sex workers is a critical measure of a national-level response to HIV.

Countries with generalized epidemics may also have a concentrated sub-epidemic among sex workers. If so, it is valuable to calculate and report on this indicator for this population.

Numerator: Number of sex workers who test positive for HIV

Denominator: Number of sex workers tested for HIV

Calculation: Numerator / Denominator

Method of measurement:	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011) This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement frequency:	Annual
Disaggregation:	• Sex (female, male, transgender) • Age (<25/25+)

Strengths and weaknesses

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available. In analyzing prevalence data of sex workers for the assessment of prevention programme impact, it is desirable not to restrict analysis to young people but to report on those persons who are newly initiated to behaviours that put them at risk for infection (e.g. by restricting the analysis to people who have or participated in sex work for less than one year) This type of analysis also has the advantage of not being affected by the effect of ART in increasing survival and thereby increasing prevalence.

If prevalence estimates are available disaggregated by greater than and less than one year in sex work countries are strongly encouraged to report this disaggregation in their Country Progress Report, and to use the comments field in the reporting tool for this indicator to present disaggregated estimates.

Due to difficulties in accessing sex workers, biases in sero-surveillance data are likely to be far more significant than in data from a more general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the interpretation.

An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. The period during which people belong to a key population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.

Trends in HIV prevalence among sex workers in the capital city will provide a useful indication of HIV prevention programme performance in that city. However, it will not be representative of the situation in the country as a whole.

The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new

sentinel sites reduces the comparability of values. As such it is important to use consistent sites when undertaking trend analyses.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Several countries have in previous reporting rounds reported HIV prevalence among subpopulations of transgender women through the additional comments field in the GARPR online reporting tool. This demonstrates that the data are feasible to obtain in different settings.

Further information

For further information, please consult the following links:

http://www.unaids.org/en/HIV_data/Methodology/default.asp

Revised guidelines on HIV surveillance for key populations at higher risk: WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. Guidelines on surveillance among populations most at risk for HIV. Geneva, UNAIDS, 2011

(<http://www.unaids.org/en/media/unaids>)

[contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf)

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation
(www.cpc.unc.edu/measure/publications/ms-11-49a).

1.11 Men who have sex with men: prevention programmes

Percentage of men who have sex with men reached with HIV prevention programmes

What it measures

It measures progress in implementing basic elements of HIV prevention programmes for MSM.

Rationale

Men who have sex with men (MSM) are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV and AIDS among MSM as well as into the general population, it is important that they access these services.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations at higher risk. If so, they should calculate and report this indicator for those populations.

Numerator:	Number MSM who replied “yes” to both questions
Denominator:	Total number of MSM surveyed
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys Respondents are asked the following questions: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic) Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator Whenever possible, data for MSM should be collected through civil society organizations that have worked closely with this population in the field Access to MSM as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	Age (<25/25+)

Strengths and weaknesses

The data obtained may not be based on a representative national sample of the MSM population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

The inclusion of these indicators for reporting purposes should not be interpreted to mean that these services alone are sufficient for HIV prevention programmes for the population. The set of key interventions described above should be part of a comprehensive HIV prevention programme, which also includes elements such as provision of HIV prevention messages, (e.g. through outreach programmes and peer education), treatment of sexually transmitted diseases, and others. For further information on the elements of comprehensive HIV prevention programmes for key populations at higher risk please see the Practical guidelines for intensifying HIV prevention: towards universal access.

This indicator asks about services accessed in the past 12 months. If you have data available on another time period, such as the last three or six months or the last 30 days, please include this additional data in the comments section of the reporting tool.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

In addition to the above requested data, please report programme data if available for this indicator using the text box provided in the online reporting platform.

Further information

For further information, please consult the following references:

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation (www.cpc.unc.edu/measure/publications/ms-11-49a).

1.12 Men who have sex with men: condom use

Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

What it measures

It measures progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.

Rationale

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with their most recent male partner is considered a reliable indicator of longer-term behaviour.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among men who have sex with men. If so, it would be valuable for them to calculate and report on this indicator for this population.

Numerator:	Number of MSM who reported that a condom was used the last time they had anal sex
Denominator:	Number of MSM who reported having had anal sex with a male partner in the last six months
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys In a behavioural survey of a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field Access to MSM as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	Age (<25/25+)

Strengths and weaknesses

For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. This indicator does not give any idea of risk behaviour in sex with women among men who have sex with both women and men. In countries where men in the sub-population surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for female and male partners.

This indicator asks about male to male sex in the past six months. If you have data available on another time period, such as the last three or twelve months, please include this additional data in the comments section of the reporting tool.

The data obtained may not be based on a representative national sample of the men who have sex with men being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

Further information

For further information, please consult the following references:

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation (www.cpc.unc.edu/measure/publications/ms-11-49a).

1.13 HIV testing in men who have sex with men

Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results

What it measures

It measures progress in implementing HIV testing and counselling among men who have sex with men.

Rationale

In order to protect themselves and to prevent infecting others, it is important for men who have sex with men to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key population at higher risk. If so, they should calculate and report this indicator for those populations.

Numerator:	Number of men who have sex with men who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of men who have sex with men included in the sample
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys Respondents are asked the following questions: 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test? Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field Access to MSM as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Age (<25/25+)

Strengths and weaknesses

The data obtained may not be based on a representative national sample of the men who have sex with men being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Tracking men who have sex with men over time to measure progress may be difficult due to mobility and the often hard-to-reach nature of these populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

This indicator is most meaningful in settings where testing scale-up is relatively recent. People who tested more than 12 months ago and know they are positive will be considered “uncovered” by this indicator construction. Ideally, surveys should ask why respondents did not test in the past 12 months. If they report that they know their HIV status to be positive,

they should not be included in the denominator. This indicator will be formally changed post-2015; we will ask countries that can to report against this indicator while omitting known HIV-positive persons from the denominator and state that they've done this in the comment field.

Further information

For further information, please consult the following references:

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation (www.cpc.unc.edu/measure/publications/ms-11-49a).

1.14 HIV prevalence in men who have sex with men

Percentage of men who have sex with men risk who are living with HIV

What it measures

It measures progress on reducing HIV prevalence among men who have sex with men.

Rationale

Men who have sex with men typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among men who have sex with men is a critical measure of a national-level response to HIV.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key population at higher risk. If so, it would be valuable for them to calculate and report on this indicator for those populations.

Numerator: Number of MSM who test positive for HIV

Denominator: Number of MSM tested for HIV

Calculation:	Numerator / Denominator
Method of measurement:	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011) This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement frequency:	Annual
Disaggregation:	• Age (<25/25+)

Strengths and weaknesses

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available.

In analyzing prevalence data of men who have sex with men for the assessment of prevention programme impact, it is desirable not to restrict analysis to young people but to report on those persons who are newly initiated to behaviours that put them at risk for infection (e.g. by restricting the analysis to people who first had sex with another man within the last year). This type of analysis also has the advantage of not being affected by the effect of ART in increasing survival and thereby increasing prevalence.

If prevalence estimates are available disaggregated by greater than and less than one year of sexual activity with other men countries are strongly encouraged to report this disaggregation in their Country Progress Report, and to use the comments field in the reporting tool for this indicator to present disaggregated estimates.

Due to difficulties in accessing men who have sex with men, biases in sero-surveillance data are likely to be far more significant than in data from a more general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the interpretation.

An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. The period during which people belong to a key population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.

Trends in HIV prevalence among men who have sex with men in the capital city will provide a useful indication of HIV-prevention programme performance in that city. However, it will not be representative of the situation in the country as a whole.

The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to use consistent sites when undertaking trend analyses.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Further information

For further information, please consult the following links:

http://www.unaids.org/en/HIV_data/Methodology/default.asp

Revised guidelines on HIV surveillance for key populations at higher risk: WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. Guidelines on surveillance among populations most at risk for HIV. Geneva, UNAIDS, 2011

(<http://www.unaids.org/en/media/unaids>)

[contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf)

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. MEASURE Evaluation

(www.cpc.unc.edu/measure/publications/ms-11-49a).



TARGETS 1 AND 2. SIZE ESTIMATIONS FOR KEY POPULATIONS

Rationale

Programme planning for key populations can be much more efficient if there are accurate estimates of the size of these populations. The figures provide the MOH and UNAIDS with the ability to understand the scope of the potential HIV epidemic as well as the resources that will be needed to adequately meet the prevention needs of the at-risk populations.

1. Have you performed population size estimations for key populations?

Key population	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a) Men who have sex with men			
b) People who inject drugs			
c) Sex workers			
d) Other key populations—please specify which key population in the comments box.			
e) Comments:			

To get a better understanding of the size estimates submitted, we request the following additional information about each estimate, to be included in the comment box:

1. the definition used of the population;
2. the method used to derive the size estimate;
3. site specific estimates for all available estimates.

In keeping with on-going effort to provide more granular data presentations, the latter will offer the opportunity for mapping denominator data with programme data if they are collected in the same survey areas.

Please submit the digital version of any available size estimation reports using the upload tool.



TARGET 2. REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50% BY 2015

-
- | | |
|-----|--|
| 2.1 | <i>Number of syringes distributed per person who injects drugs per year by needle and syringe programmes</i> |
| 2.2 | <i>Percentage of people who inject drugs who report the use of a condom at last sexual intercourse</i> |
| 2.3 | <i>Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected</i> |
| 2.4 | <i>Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results</i> |
| 2.5 | <i>Percentage of people who inject drugs who are living with HIV</i> |
-

2.1 People who inject drugs: prevention programmes

Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes

What it measures

It measures progress in improving coverage of an essential HIV prevention service for people who inject drugs.

Rationale

Injecting drug use is the main route of transmission for approximately 10% of HIV infections globally and 30% of infections outside of sub-Saharan Africa. Preventing HIV transmission through injecting drug use is one of the key challenges to reducing the burden of HIV.

Needle and syringe programmes (NSPs) are one of nine interventions in the WHO, UNODC and UNAIDS comprehensive package for the prevention, treatment and care of HIV among people who inject drugs.

Needle and syringe programmes greatly affect HIV prevention for people who inject drugs, and there is a wealth of scientific evidence supporting its efficacy in preventing the spread of HIV (see <http://www.who.int/hiv/topics/idu/needles/en/index.html>).

Numerator:	Number of needles and syringes distributed in past 12 months by NSPs
Denominator:	Number of people who inject drugs in the country
Calculation:	Numerator / Denominator
Method of measurement:	Programme data used to count the number of needles and syringes distributed (numerator) Size estimation of the number of people who inject drugs in the country (denominator)
Measurement frequency:	Every two years
Disaggregation:	None

Strengths and weaknesses

Some difficulties regarding how to count needles and syringes are reported. Some commonly used syringes are 1 or 2ml needle and syringe units while others are syringes to which additional needles need to be fitted. In most cases only data on the number of syringes distributed via NSPs but not pharmacy sales will be available.

Estimating the size of PWID populations at country level is not without its challenges. Many different definitions of people who inject drugs exist in the literature and there are ranges of estimates. UNODC publishes size estimates of people who inject drugs in the World Drug Report. These estimates may be used. If there is a reason NOT to use them, please provide rationale in the comment box.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Countries can monitor this indicator against the following coverage levels:

- Low: <100 syringes per PWID per year
- Medium: >100–<200 syringes per PWID per year
- High: >200 syringes per PWID per year

These levels are based upon studies in developed country settings investigating the levels of syringe distribution and impact on HIV transmission. Note that the levels required for the prevention of hepatitis C are likely to be much higher than those presented here.

Further information

A full description of this indicator can be found in: WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2012
http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html.

For further information, please consult the following references:

Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among IDUs. Geneva, World Health Organization, 2004
(<http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html>).

UNODC Global Assessment Programme on Drug Abuse. *Estimating prevalence: indirect methods for estimating the size of the drug problem*. Vienna, UNODC, 2003.

Hickman M et al. Estimating the prevalence of problematic drug use: a review of methods and their application. *Bulletin on Narcotics*, 2002, 54:15–32.

Most at risk populations sampling strategies and design tool. Atlanta, United States Department of Health and Human Services, Centers for Disease Control and Prevention, GAP Surveillance Team, 2009 (<http://www.igh.org/surveillance>).

<http://www.idurefgroup.unsw.edu.au/IDURGWeb.nsf/page/publications> (for more details on the Reference Group and to access reported country-level and global-level estimates of injecting drug use and HIV among injectors).

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/2011_Estimating_Populations_en.pdf (the WHO/UNAIDS working group on global HIV/AIDS and STI surveillance 2010 guidelines on estimating the size of populations most at risk to HIV).

WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. *Guidelines on surveillance among populations most at risk for HIV*. Geneva, UNAIDS, 2011
(http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf).

2.2 People who inject drugs: condom use

Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse

What it measures

It measures progress in preventing sexual transmission of HIV among people who inject drugs.

Rationale

Safer injecting and sexual practices among people who inject drugs are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) people who inject drugs can spread HIV (e.g. through sexual transmission) to the wider population.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among people who inject drugs. If so, it would be valuable for them to calculate and report on this indicator for this population.

Numerator:	Number of people who inject drugs who reported that a condom was used the last time they had sex
Denominator:	Number of people who inject drugs who report having injected drugs and having had sexual intercourse in the last month
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys people who inject drugs are asked the following sequence of questions: 1. Have you injected drugs at any time in the last month? 2. If yes: Have you had sexual intercourse in the last month? 3. If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse? Whenever possible, data for people who inject drugs should be collected through civil society organizations that have worked closely with this population in the field Access to survey respondents as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Sex • Age (<25/25+)

Strengths and weaknesses

The data obtained may not be based on a representative national sample of the people who inject drugs being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey

data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which people who inject drugs use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among people who inject drugs and between people who inject drugs and the wider population. This indicator provides partial information on the fourth factor.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

Further information

For further information, please consult the following references:

WHO, UNODC and UNAIDS. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization, 2012

http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html.

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

2.3 People who inject drugs: safe injecting practices

Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected

What it measures

It measures progress in preventing injecting drug use-associated HIV transmission.

Rationale

Safer injecting and sexual practices among people who inject drugs are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) people who inject drugs can spread HIV (e.g., through sexual transmission) to the wider population.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among people who inject drugs. If so, it would be valuable for them to calculate and report on this indicator for this population.

Numerator:	Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs
Denominator:	Number of people who inject drugs who report injecting drugs in the last month
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys Respondents are asked the following questions: 1. Have you injected drugs at any time in the last month? 2. If yes: The last time you injected drugs, did you use a sterile needle and syringe? Whenever possible, data for people who inject drugs should be collected through civil society organizations that have worked closely with this population in the field Access to people who inject drugs as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Sex • Age (<25/25+)

Strengths and weaknesses

Surveying people who inject drugs can be challenging. Consequently, data obtained may not be based on a representative national sample of the people who inject drugs being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which people who inject drugs use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among people who inject drugs and between people who inject drugs and the wider population. This indicator provides information on the third factor. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

Further information

For further information, please consult the following references:

WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2012

http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html.

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

2.4 HIV testing in people who inject drugs

Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results

What it measures

It measures progress in implementing HIV testing and counselling among people who inject drugs.

Rationale

In order to protect themselves and to prevent infecting others, it is important people who inject drugs to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations at higher risk. If so, they should calculate and report this indicator for those populations.

Numerator:	Number of people who inject drugs respondents who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of people who inject drugs included in the sample
Calculation:	Numerator / Denominator
Method of measurement:	Behavioural surveillance or other special surveys Respondents are asked the following questions: 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test? Whenever possible, data for people who inject drugs should be collected through civil society organizations that have worked closely with this population in the field Access to people who inject drugs as well as the data collected from them must remain confidential
Measurement frequency:	Every two years
Disaggregation:	• Sex • Age (<25/25+)

Strengths and weaknesses

The data obtained may not be based on a representative national sample of the people who inject drugs being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool

Tracking people who inject drugs over time to measure progress may be difficult due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

This indicator is most meaningful in settings where testing scale-up is relatively recent. People who tested more than 12 months ago and know they are positive will be considered “uncovered” by this indicator construction. Ideally, surveys should ask why respondents did not test in the

past 12 months. If they report that they know their HIV status to be positive, they should not be included in the denominator. This indicator will be formally changed post-2015; we will ask countries that can to report against this indicator while omitting known HIV-positive persons from the denominator and state that they've done this in the comment field.

Further information

For further information, please consult the following references:

WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance.

Guidelines on surveillance among populations most at risk for HIV. Geneva, UNAIDS, 2011 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/2011_Estimating_Populations_en.pdf).

Guidelines for using HIV testing technologies in surveillance: selection, evaluation and implementation. Geneva, World Health Organization, 2010 (http://www.who.int/hiv/pub/surveillance/hiv_testing_technologies_surveillance_.pdf).

WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2012 http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html.

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva, UNAIDS, 2007.

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva, UNAIDS, 2007.

2.5 HIV prevalence in people who inject drugs

Percentage of people who inject drugs who are living with HIV

What it measures

It measures progress on reducing HIV prevalence among people who inject drugs.

Rationale

People who inject drugs typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among people who inject drugs is a critical measure of a national-level response to HIV.

Countries with generalized epidemics may also have a concentrated sub-epidemic among people who inject drugs. If so, it is valuable for them to calculate and report on this indicator for those populations.

Numerator:	Number of people who inject drugs who test positive for HIV
Denominator:	Number of people who inject drugs tested for HIV
Calculation:	Numerator / Denominator
Method of measurement:	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011) This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites or in the context of a surveillance survey The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement frequency:	Annual
Disaggregation:	• Sex • Age (<25/25+)

Strengths and weaknesses

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available.

In analysing prevalence data of people who inject drugs for the assessment of prevention programme impact, it is desirable not to restrict analysis to young people but to report on those persons who are newly initiated to behaviours that put them at risk for infection (e.g. by restricting the analysis to people who have initiated injecting drug use within the last year). This type of analysis also has the advantage of not being affected by the effect of ART in increasing survival and thereby increasing prevalence.

If prevalence estimates are available disaggregated by greater than and less than one year of injecting drugs countries are strongly encouraged to report this disaggregation in their Country Progress Report, and to use the comments field for this indicator in the reporting tool to present disaggregated estimates.

Due to difficulties in accessing people who inject drugs, biases in sero-surveillance data are likely to be far more significant than in data from a more general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the interpretation.

An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. The period during which people belong to a key population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.

Trends in HIV prevalence among people who inject drugs in the capital city will provide a useful indication of HIV-prevention programme performance in that city. However, it will not be representative of the situation in the country as a whole.

The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to use consistent sites when undertaking trend analyses.

If the data are subnational, please provide the disaggregation by administrative area in the comment field. Please submit the digital version of any available survey reports using the upload tool.

Further information

For further information, please consult the following links:
http://www.unaids.org/en/HIV_data/Methodology/default.asp

Revised guidelines on HIV surveillance for key populations at higher risk: WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. *Guidelines on surveillance among populations most at risk for HIV*. Geneva, UNAIDS, 2011
([http://www.unaids.org/en/media/unaids](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf))

[contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf)).



TARGET 3. ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS

-
- 3.1 *Percentage of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of mother-to-child transmission*
 - 3.1a *Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period (formerly indicator 3.8)*
 - 3.2 *Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth*
 - 3.3 *Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months*
-

3.1 Prevention of mother-to-child transmission

Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission

What it measures

This indicator measures progress in preventing mother-to-child transmission of HIV during pregnancy and delivery through the provision of antiretroviral medicine.

This indicator allows countries to monitor the coverage of antiretroviral medicines to HIV-positive pregnant women to reduce the risk for transmission of HIV to infants during pregnancy and delivery. When disaggregated by regimen, this indicator can show increased access to more effective antiretroviral drug regimens for pregnant women living with HIV. As the indicator usually measures antiretroviral drugs initially dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases.

The postpartum regimen, including ARV to reduce the risk of transmission during breastfeeding, is captured in indicator 3.1a. In addition, indicator 3.7 measures the percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks.

Rationale

The risk of mother-to-child transmission can be significantly reduced by providing antiretroviral medicine (as lifelong therapy or as prophylaxis) for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretrovirals to the mother or child during breastfeeding (if breastfeeding), and use of safe delivery practices and safer infant feeding. The data will be used to track progress toward global and national goals towards elimination of mother-to-child transmission; to inform policy and strategic planning; for advocacy; and leveraging resources for accelerated scale up. It will help measure trends in coverage of antiretroviral prophylaxis and treatment, and when disaggregated by regimen type, will also assess progress in implementing more effective regimen and ART.

Numerator:	Number of HIV-positive pregnant women who received antiretroviral medicine during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery. Global reports summarizing coverage of ARV for PMTCT will exclude women who received single dose nevirapine as it is considered a sub-optimal regimen. However the number of women who received only a single dose of nevirapine should be reported by the country.
Denominator:	Estimated number of HIV-positive women who delivered within the past 12 months
Calculation:	Numerator / Denominator
Method of measurement:	For the numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms For the denominator: estimation models such as Spectrum, or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to coverage of ANC surveys
Measurement frequency:	Annual or more frequently, depending on a country's monitoring needs
Disaggregation:	The numerator should be disaggregated by the six general regimens described below. Please provide subnational data as disaggregated by administrative areas. The data entry sheet has separate space for these data. You may also submit the digital version of any available related reports using the upload tool.

Explanation of numerator

The numerator should be disaggregated by the six categories below (the first three regimens are currently recommended by WHO) for HIV-positive pregnant women for the prevention of mother-to-child transmission:

1. Newly initiated on ART during the current pregnancy
2. Already on ART before the current pregnancy
3. Maternal triple ARV prophylaxis
(prophylaxis component of WHO Option B)
4. Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines)
5. Single dose nevirapine (with or without tail) ONLY
6. Other (please comment: e.g. specify regimen, uncategorized, etc.)

Disaggregation of regimen definitions

Categories	Further clarification	Common examples
The first two options include women receiving lifelong antiretroviral therapy (including Option B+) 1. newly initiated on treatment during the current pregnancy 2. already on treatment before the pregnancy	A three-drug regimen intended to provide ART for life 1. Number of HIV-positive pregnant women identified in the reporting period newly initiated on ART for life 2. Number of HIV-positive pregnant women identified in the reporting period who were already on ART at their first ANC visit. If a woman is initiating ART for life during labour, she would be counted in category 1. If the number of women on antiretroviral is not available by the timing of when they started ART the number can be included in the cell titled Total number of pregnant women on life-long ART.	Standard national treatment regimen, for example: • TDF+3TC+EFV • AZT+3TC+NVP

Categories	Further clarification	Common examples
3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	A three-drug regimen provided for MTCT prophylaxis started during pregnancy or as late as during labour or delivery with the intention of stopping at the end of the breastfeeding period (or stopping at delivery if not breastfeeding) If a woman is receiving triple ARVs for the first time at labour or delivery then she should still be counted in this category if the facility is implementing Option B.	• TDF+3TC+EFV • AZT+3TC+EFV • AZT+3TC+LPV/r
4. Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	A prophylactic regimen that uses AZT (or another NRTI) started as early as 14 weeks or as late as during labour or delivery to prevent HIV transmission If a woman is receiving ARVs for the first time at labour or delivery, then she should still be counted in this category if the facility is implementing Option A.	• AZT at any point before labour + intra-partum NVP • AZT at any point before labour + intra-partum NVP +7 day post-partum tail of AZT/3TC
5. Single-dose nevirapine (sd-NVP) to the mother during pregnancy or delivery	• Nevirapine is the ONLY regimen provided to an HIV-positive pregnant woman during pregnancy, labour or delivery Do NOT count as sd-NVP if: • Nevirapine is provided as part of Option A during pregnancy or • An HIV+ pregnant woman is initiated on Option A, B, or B+ at labor and delivery	• sd-NVP for mother ONLY at onset of labour • sd-NVP + 7 day AZT/3TC tail ONLY • sd-NVP for mother at onset of labour and sd-NVP for baby ONLY

The numerator must match the values included in Spectrum or an automated query will be sent requesting that the team make the values consistent.

GARPR	Spectrum
1. Newly initiated on treatment during the current pregnancy	ART started during current pregnancy
2. Already on treatment before the pregnancy	ART started before current pregnancy
3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	Option B – Triple prophylaxis from 14 weeks
4. Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	Option A—maternal AZT
5. Single-dose nevirapine (sd-NVP) to the mother during pregnancy or delivery	Single dose nevirapine
6. Other (usually limited to countries still providing maternal AZT started late in the pregnancy)	Maternal AZT according to 2006 WHO guidelines Spectrum requires data on historical regimens. This category is maintained to describe the regimens provided in previous years.

Explanation of denominator

Two methods can be used to estimate the denominator:

1. a projection model, such as Spectrum; use the output “number of pregnant woman needing PMTCT”; or
2. multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates of the central statistics office or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics and appropriate adjustments related to coverage of ANC surveys.) if Spectrum projections are unavailable.

To ensure comparability the Spectrum output will be used for the denominator when global analyses are done.

Strengths and weaknesses

Countries are encouraged to track and report the actual number of women receiving the various regimens, so that the impact of antiretroviral drugs on mother-to-child transmission

can be modelled on the basis of the efficacy of the regimens. If countries do not have a system for collecting and reporting data on the provision of different antiretroviral drug regimens for the prevention of mother-to-child transmission of HIV, they should establish such a system.

Further information

The prevention of mother-to-child transmission is a rapidly evolving programmatic area. Methods for monitoring coverage of this service are therefore also evolving. To access the most current information available please consult the following links:

www.who.int/hiv/pub/mtct/en/

www.who.int/hiv/pub/me/en/index.html

3.1a Prevention of mother-to-child transmission during breastfeeding

Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period (formerly indicator 3.8)

What it measures

While indicator 3.1 captures whether programmes are reaching mothers during pregnancy and delivery, indicator 3.1a captures whether women are receiving prophylaxis for themselves or for their babies during the breastfeeding period.

Rationale

For women who are breastfeeding and not on antiretroviral therapy, the risk of transmitting HIV to the child during breastfeeding remains substantial. This risk can be reduced by providing prophylaxis to the mother or the baby during the entire duration of breastfeeding. The data will be used to track progress toward global and national goals towards elimination of mother-to-child transmission, to inform policy and strategic planning, for advocacy, and leveraging resources for accelerated scale up.

Numerator:	Number of women living with HIV who were breastfeeding who received antiretroviral prophylaxis for themselves or their infants to reduce the risk of mother-to-child transmission during breastfeeding during the past 12 months
Denominator:	Estimated number of women living with HIV who were breastfeeding in the past 12 months
Calculation:	Numerator / Denominator

Method of measurement:

For the numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms. The data for the numerator can be collected at the infant's six-week Early Infant Diagnosis (EID) visit or DPT3 immunization visit (two to three months) and distinguished from ARV interventions given to prevent peripartum transmission. Data on whether maternal or infant antiretrovirals to reduce post-natal transmission were provided should be recorded for breastfeeding infants. HIV-infected pregnant women who are eligible for lifelong antiretroviral therapy, are receiving a treatment regimen and whose infants therefore benefit from the prophylactic effect of ART in reducing the risk of transmission through breastfeeding are also included in the numerator.

For the denominator: estimation models such as Spectrum, or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to coverage of ANC surveys. The denominator should represent the number of women living with HIV who are breastfeeding. In settings where most HIV positive women breastfeed, the estimated number of HIV-positive pregnant women could be a proxy for the denominator (with some adjustment of infant deaths before the time point for measurement if available). In other settings, where a sizable population of HIV-exposed infants may not be breastfeeding, it will be necessary to estimate the number of HIV-exposed infants who are breastfeeding.

Measurement frequency:

Annual or more frequently, depending on a country's monitoring needs

Strengths and weaknesses

This indicator allows countries to monitor the coverage of programmes to reduce transmission to children during breastfeeding. As the indicator measures antiretroviral drugs dispensed and not those consumed, it is not possible to determine adherence to the regimen.

This indicator should not be confused with indicator 3.7 (Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child transmission in the first six weeks).

It is important to assess antiretroviral coverage throughout the breastfeeding period, but in many settings there is significant loss to follow-up after the six-week visit so it is difficult to get an accurate estimate of antiretroviral coverage at a later time point. In breastfeeding populations, effort should be made to ensure antiretroviral coverage during the breastfeeding period beyond six weeks or DPT3 as captured by this indicator.

If the data submitted for this indicator are not nationally representative, please state this in the comments field and describe the sample.

Further information

The prevention of mother-to-child transmission is a rapidly evolving programmatic area. Methods for monitoring coverage of this service are therefore also evolving. To access the most current information available please consult the following links:

www.who.int/hiv/pub/mtct/en

www.who.int/hiv/pub/me/en/index.html

3.2 Early infant diagnosis

Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

What it measures

It measures progress in the extent to which infants born to HIV-positive women are tested within the first 2 months of life to determine their HIV status and eligibility for antiretroviral therapy disaggregated by test results.

Rationale

Infants infected with HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. WHO recommends national programmes to establish the capacity to provide early virological testing of infants for HIV at 6 weeks, or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progression is rapid in children; they need to be put on treatment as early as possible because without early treatment almost 50% of children would be dead by the second year.

Numerator:	Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once
Denominator:	Number of HIV-positive pregnant women giving birth in the last 12 months
Calculation:	Numerator / Denominator
Method of measurement:	Early Infant Diagnosis (EID) testing laboratories for the numerator, and Spectrum estimates, central statistical offices, and/or sentinel surveillance for the denominator
Measurement frequency:	Annual or more frequently, depending on a country's monitoring needs

Explanation of numerator

To be collected from databases held at early infant diagnosis testing laboratories. The numerator should represent the number of infants who received virologic testing within two months of birth; it should not represent the number of samples tested at the laboratory. Data should be aggregated from the laboratory data bases. Where possible, double counting should be minimized when aggregating data to produce national-level data. It is expected that the number of infants receiving more than one virologic test in the first 2 months of life will be low. Efforts should be made to include all public, private and NGO-run health facilities that are providing HIV testing for HIV-exposed infants.

The test results should be reported as positive, negative, indeterminate or rejected for testing by the laboratory. When reporting this information only the most recent test result for an infant tested in the first 2 months of life should be included.

Explanation of denominator

This is a proxy measure for number of infants born to HIV-positive women.

Two methods can be used to estimate the denominator:

- a) Using a projection model such as the one provided by Spectrum software use the output “the number of pregnant woman needing PMTCT” as a proxy,
- or;
- b) Multiplying the total number of women who gave birth in the last 12 months, (which can be obtained from central statistics office estimates of births or the UN Population Division estimates) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in ANC clinic and appropriate adjustments related to coverage of ANC surveys), if Spectrum projections are unavailable.

To ensure comparability the Spectrum output will be used for the denominator when global analyses are done.

Strengths and weaknesses

This indicator allows countries to monitor progress in providing early HIV virologic testing to HIV-exposed infants aged two months or less, critical for appropriate follow-up care and treatment. By limiting the age to two months of life or less, the chance of repeat tests for the same infant which can lead to double counting is also eliminated. The only three fields needed for this indicator: date of sample collection, age at collection (actual or calculated based upon date of birth), and results are systematically entered into central EID testing databases at testing laboratories.

Due to the small number of testing laboratories, and the electronic format of testing databases, this indicator should not have a heavy collection burden. Data quality at the laboratories is generally high, resulting in a robust indicator. The indicator does not capture the number of children with a definitive diagnosis (i.e. of HIV infection), or measure whether appropriate follow-up services were provided to the child based on interpretation of test results. It also does not measure the quality of testing nor the system in place for testing. A low value of the indicator could, however, signal systemic weaknesses, including poor country-level management of supplies of HIV virologic test kits, poor data collection, poor follow-up and mismanagement of testing samples.

Disaggregation by test results cannot be used as a proxy for overall MTCT transmission rates. If either the EID coverage of national need or the EID testing coverage in the first two months of life is low, low positivity rates among infants tested will not necessarily mean program success, as many other infants who are likely positive are not represented in this sample.

While early virological testing is a critical intervention for identifying infected infants, it is also important for countries to strengthen the quality of HIV-exposed infant follow-up and to train health providers to recognize signs and symptoms of early HIV infection among exposed infants, particularly where access to virological testing is limited. Inappropriate management of supplies can negatively affect the value of the indicator and significantly reduce access to HIV testing for infants born to HIV-positive women. Countries should ensure that appropriate systems and tools, particularly tools for LMIS, are in place to procure, distribute and manage supplies at facility, district and central level.

Further information

For further information, please consult the following reference and website:

WHO, UNICEF and UNAIDS. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report, September 2010*. Geneva, World Health Organization, 2010 (<http://www.who.int/hiv/pub/2009progressreport/en/index.html>).

Next generation indicators reference guide. Washington, DC, United States President's Emergency Plan for AIDS Relief, 2009.

Monitoring and evaluation toolkit. Part 2. Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening. Geneva, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2009.

Measuring the impact of national PMTCT programmes: towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. A short guide on methods. Geneva, World Health Organization, 2012.

3.3 Mother-to-child transmission of HIV (modelled)

Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months

What it measures

It measures progress towards eliminating mother-to-child HIV transmission.

Rationale

Efforts have been made to increase access to interventions that can significantly reduce mother-to-child transmission, including combination antiretroviral prophylactic and treatment regimens and strengthened infant-feeding counselling. It is important to assess the impact of PMTCT interventions in reducing new paediatric HIV infections through mother-to-child transmission.

The percentage of children who are HIV-positive should decrease as the coverage of interventions for PMTCT and the use of more effective regimens increases.

Numerator:	The numerator is the estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women
Denominator:	Estimated number of HIV positive women who delivered in the previous 12 months
Calculation:	Numerator / Denominator
Method of measurement:	The mother-to-child transmission probability differs with the antiretroviral drug regimen received and infant-feeding practices. The transmission can be calculated by using the Spectrum model. The Spectrum computer programme uses the information on: a. the distribution of HIV-positive pregnant women receiving different antiretroviral regimens prior to and during delivery (peripartum) by CD4 category of the mother b. the distribution of women and children receiving antiretrovirals after delivery (postpartum) by CD4 category of the mother. c. the percent of infants who are not breastfeeding in PMTCT programmes by age of the child d. mother-to-child transmission of HIV probabilities based on various categories of antiretroviral drug regimen and infant feeding practices The estimated national transmission rate is reported in the PMTCT summary display in Spectrum. This variable can also be calculated using the variables in Spectrum on "New HIV infections" for children 0-14 years and dividing this by the variable "Women in need of PMTCT"

There is not enough information available about other HIV transmission routes for children to include such infections in the model. In addition other modes of transmission are believed to be a small fraction of the overall infections among children. The Spectrum output variable "New HIV infections for children 0-1 years" is not used because some infections due to breastfeeding will take place after age 1 year

Measurement frequency: Annual

Disaggregation: None

To ensure comparability the Spectrum output will be used for calculating this indicator when global analyses are done.

Strengths and weaknesses

Over time, this indicator assesses the ability of PMTCT programmes by estimating the impact of increases in the provision of antiretroviral drugs and the use of more efficacious regimens and optimal infant feeding practice. This indicator is generated from a model, which provides estimates of HIV infection in children. The estimated indicator is reliant on the assumptions and data used in the model. The indicator may not be a true measure of mother-to-child transmission. For example, in countries where other forms of PMTCT (e.g. Caesarean section) are widely practised, the indicator will overestimate mother-to-child transmission. It also relies on programme data that often captures antiretroviral drug regimens provided rather than taken, thus could underestimate mother-to-child transmission.

This indicator allows countries to assess the impact of PMTCT programmes by estimating the HIV transmission rate from HIV positive women to their children. It is difficult to follow up mother–children pairs, particularly at national level, because of the lag in reporting and the multiple health facility sites that mother-child pairs can visit for the wide range of PMTCT and child care interventions delivered over a timespan. In countries where data are available, facility attendance is high, and confirmatory tests are conducted systematically, efforts should be made to monitor the impact through directly assessing the percentage of children found to be HIV-positive among those born to HIV-positive mothers. All countries should make efforts to monitor the HIV status and survival of children born to HIV-positive women, gathered during follow-up health care visits.

Further information

<http://www.who.int/hiv/pub/me/en/index.html>



TARGET 4. REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015

-
- 4.1 *Percentage of adults and children currently receiving antiretroviral therapy**
 - 4.2 *Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy*
-

*Millennium Development Goals indicator

4.1 HIV treatment: antiretroviral therapy

Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV

What it measures

Progress towards providing antiretroviral therapy to all people for treatment.

Rationale

Antiretroviral therapy (ART) has been shown to reduce HIV-related morbidity and mortality amongst those living with HIV and to reduce transmission of HIV. In recent years the guidelines on eligibility for antiretroviral therapy have changed a number of times. In addition national guidelines do not always match global guidelines. As a result, antiretroviral therapy coverage has been reported in numerous ways including being based on global guidelines, on national guidelines or both. When the guidelines are modified to include more people who are living with HIV, the coverage values for countries decrease. To avoid multiple antiretroviral therapy coverage values the number of people on antiretroviral therapy will be presented in relation to the total number of people living with HIV. The estimated coverage using all people living with HIV as a denominator is similar to the denominator been all people eligible for antiretroviral therapy under the 2013 antiretroviral therapy guidelines. Approximately 85% of people living with HIV are eligible under the 2013 WHO criteria for antiretroviral therapy provision.

Numerator:	Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period
Denominator:	Estimated number of adults and children living with HIV National criteria for ART eligibility varies by country. To make this indicator comparable across countries global reports will present the ART coverage for adults and children as a percentage of all people living with HIV.
Calculation:	Numerator / Denominator
Additional information:	Although coverage will be calculated using the total number of people living with HIV, please also provide the number eligible for ART under your national ART criteria guidelines.
Method of measurement:	Data should be collected continuously at the facility level. Data should be aggregated periodically. The most recent full year of data should be used for annual reporting. For the numerator: facility-based antiretroviral therapy registers and corresponding cross-sectional forms. For the denominator: HIV estimation models such as Spectrum
Measurement frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting
Disaggregation:	• Sex • Age (less than 15 years, 15 years and older, 15-49, <1 year, 1-4 years, 5-9, 10-14, 15-19, 20-24, 25-49, 50+) • Public/Private • persons newly initiating antiretroviral therapy during the last reporting year (this indicator should be available from the same sources as the total number of people receiving antiretroviral therapy) Please provide subnational data as disaggregated by administrative areas. The data entry sheet has separate space for these data. You may also submit the digital version of any available related reports using the upload tool.

Explanation of numerator

The numerator can be generated by counting the number of adults and children who received antiretroviral therapy at the end of the reporting period.

The numerator should equal the number of adults and children who ever started antiretroviral therapy minus those patients who are not currently on treatment prior to the end of the reporting period.

Patients not currently on treatment at the end of the reporting period, in other words, those who are excluded from the numerator, are patients who died, stopped treatment or are lost to follow-up.

Some patients pick up several months of antiretroviral drugs at one visit, which could include antiretroviral medicine received for the last months of the reporting period, but not be recorded as visits for the last months in the patient register. Efforts should be made to account for these patients, as they need to be included in the numerator.

Antiretroviral medicines taken only for the purpose of prevention of mother-to-child transmission and postexposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are on lifelong antiretroviral therapy are included in this indicator.

The number of adults and children currently receiving antiretroviral therapy can be obtained through data collected from facility-based antiretroviral therapy registers or drug supply management systems. These are then tallied and transferred to cross-sectional monthly or quarterly reports which can then be aggregated for national totals.

Patients receiving antiretroviral therapy in the private sector and public sector should be included in the numerator where data are available.

Explanation of denominator

The denominator is generated by estimating the number of people living with HIV. In previous years UNAIDS and WHO have reported on the percentage eligible based on the number eligible according to WHO criteria. In 2014 this will change to include all people living with HIV. This does not endorse the concept that all people living with HIV should receive antiretroviral therapy; instead this is a simpler measure that will not change over time and will result in coverage values that are consistent when compared globally and when calculated for national purposes.

Denominator estimates are most often based on the latest data available from sentinel surveillance used with a HIV modeling programme such as Spectrum. For further information on estimates of HIV need and the use of Spectrum please refer to the UNAIDS/WHO Reference Group on Estimates, Modelling and Projections methodology.¹⁵

Strengths and weaknesses

This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of antiretroviral therapy or to measure the cost, quality or effectiveness of, or adherence to the treatment regimen provided. These will each vary within and between countries and are liable to change over time.

The degree of utilization of antiretroviral therapy will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of testing and counselling services, and perceptions of effectiveness and possible side effects of treatment.

The indicator measures the number of people provided with medication but does not measure whether the individual imbibed the medication thus it is not a measure of adherence.

Further information

<http://www.who.int/hiv/topics/treatment/en/index.html>

4.2 Twelve-month retention on antiretroviral therapy

Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

What it measures

It measures progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.

Rationale

One of the goals of any antiretroviral therapy programme is to increase survival among infected individuals. As antiretroviral therapy is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. These data can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

Numerator:	Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment
Denominator:	Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period, including those who have died since starting antiretroviral therapy, those who have stopped antiretroviral therapy, and those recorded as lost to follow-up at month 12
Calculation:	Numerator / Denominator
Method of measurement:	Programme monitoring tools; cohort/group analysis forms Antiretroviral therapy registers and antiretroviral therapy cohort analysis report form: The reporting period is defined as any continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. The pre-defined number of months can be determined by national reporting requirements. If the reporting period is January 1 to December 31, 2014, countries will calculate this indicator by using all patients who started antiretroviral therapy any time during the 12-month period from January 1 to December 31, 2013.

If the reporting period is July 1, 2013 to June 30, 2014, countries will include patients who started antiretroviral therapy from July 1, 2012 to June 30, 2013

A 12-month outcome is defined as the outcome (i.e., whether the patient is still alive and on antiretroviral therapy, dead or lost to follow-up) at 12 months after starting antiretroviral therapy. For example, patients who started antiretroviral therapy during the 12-month period from January 1 to December 31, 2012 will have reached their 12-month outcomes for the reporting period of January 1 to December 31, 2014

Measurement frequency: As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated

Disaggregation:

- Sex
- Age (<15, 15+)
- Pregnancy status at start of therapy
- Breastfeeding status at start of therapy

Explanation of numerator

The numerator requires that adult and child patients must be alive and on antiretroviral therapy 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected:

- Number of adults and children in the antiretroviral therapy start-up groups initiating antiretroviral therapy at least 12 months prior to the end of the reporting period;
- Number of adults and children still alive and on antiretroviral therapy at 12 months after initiating treatment.

The numerator does not require patients to have been on antiretroviral therapy continuously for the 12-month period. Patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment during the 12 months since initiating treatment but are recorded as still being on treatment at month 12 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 12 months since starting treatment are not included in the numerator.

For example, for those patients who started antiretroviral therapy in May 2013, if at any point during the period May 2013 to May 2014 these patients die, are lost to follow-up (and do not return) or stop treatment (and do not restart), then at month 12 (May 2014), they are not on antiretroviral therapy, and not included in the numerator. Conversely, a patient who started antiretroviral therapy in May 2013 and who missed an appointment in June 2013, but is recorded as on antiretroviral therapy in May 2014 (at month 12) is on antiretroviral therapy and will be included in the numerator. What is important is that the patient who has started antiretroviral therapy in May 2013 is recorded as being alive and on antiretroviral therapy after 12 months, regardless of what happens from May 2013 to May 2014.

ART registries should include a number of variables describing the patients – for example the age of the patient at the start of ART. In addition many registries will include information indicating whether the patient was pregnant or was breastfeeding at the start of ART. ART retention for these sub-sets of women should be calculated to determine ART retention at 12 months for pregnant women and for breastfeeding women.

Explanation of denominator

The denominator is the total number of adults and children in the antiretroviral therapy start-up groups who initiated antiretroviral therapy at any point during the 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome.

For example, for the reporting period January 1 to December 31, 2014, this will include all patients who started antiretroviral therapy during the 12-month period from January 1 to December 31, 2013. This includes all patients, both those on antiretroviral therapy as well as those who are dead, have stopped treatment or are lost to follow-up at month 12.

At the facility level, the number of adults and children on antiretroviral therapy at 12 months includes patients who have transferred in at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. In other words, at the facility level, patients who have transferred out will not be counted either in the numerator or the denominator. Similarly, patients who have transferred in will be counted in both the numerator and denominator. At the national level, the number of transferred-in patients should match the number of transferred-out patients. Therefore, the net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior.

Strengths and weaknesses

Using this denominator may underestimate true “survival”, since a proportion of those lost to follow-up are alive. The number of people alive and on antiretroviral therapy (i.e. retention on antiretroviral therapy) in a treatment cohort is captured here.

Priority reporting is for aggregate survival reporting. If comprehensive cohort patient registries are available then it is encouraged for countries to track retention on treatment at 24, 36, and 48 months and yearly thereafter. This will enable comparison over time of survival on ART. As it stands, it is possible to identify whether survival at 12 months increases or decreases over time. However, it is not possible to attribute cause to these changes. For example, if survival at 12 months increases over time, this may reflect an improvement in care and treatment practices or earlier initiation of ART. The retention on antiretroviral therapy at 12 months therefore needs to be interpreted in view of the baseline characteristics of the cohort of patients at the start of antiretroviral therapy: mortality will be higher in sites where

patients accessed antiretroviral therapy at a later stage of infection. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term effectiveness of ART.

Further information

<http://www.who.int/hiv/topics/treatment/en/index.html>



TARGET 5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50% BY 2015

5.1 *Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV*

5.1 Co-management of tuberculosis and HIV treatment

Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

What it measures

It measures progress in detecting and treating TB in people living with HIV.

Rationale

Tuberculosis (TB) is a leading cause of morbidity and mortality in people living with HIV, including those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

Numerator: Number of adults and children with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year

Denominator: Estimated number of incident TB cases in people living with HIV
Annual estimates of the number of incident TB cases in people living with HIV in high TB burden countries are calculated by WHO. The 2014 denominator estimates (provided by countries on notification and ART coverage) will only be available in August of this year and do not need to be provided at the time of the reporting. For your reference, the estimate for 2013 can be found at: <http://www.who.int/tb/country/en>.

Calculation:	Numerator / Denominator
Method of measurement:	Facility antiretroviral therapy registers and reports; programme monitoring tools Programme data and estimates of incident TB cases in people living with HIV
Measurement frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here

Strengths and weaknesses

Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. WHO provides annual estimates of the burden of TB among people living with HIV, based on the best available country estimates of HIV prevalence and TB incidence. All TB cases among people living with HIV should be started on TB treatment and ART, within eight weeks of starting TB treatment, regardless of CD4 count. Those HIV-positive TB patients with profound immunosuppression (e.g. CD4 counts of less than 50 cells/mm³) should receive ART within the first two weeks of initiating TB treatment. TB treatment should be started in accordance with national TB programme guidelines.

This indicator provides a measure of the extent to which collaboration between the national TB and HIV programmes is ensuring that people with HIV and TB disease are able to access appropriate treatment for both diseases. However, this indicator will also be affected by low uptake of HIV testing, poor access to HIV care services and ART, and poor access to TB diagnosis and treatment. Separate indicators exist for each of these factors and should be referred to when interpreting the results of this indicator.

It is important that those providing HIV care and antiretroviral therapy record TB diagnosis and treatment, as this information has important implications for antiretroviral therapy eligibility and choice of antiretroviral regimen. It is therefore recommended that the date of starting TB treatment is recorded in the ART register.

Further information

For further information, please consult the following reference:

Global tuberculosis control: surveillance, planning, financing. Geneva, World Health Organization, 2009 (<http://www.who.int/tb/country/en>).

A guide to monitoring and evaluation for collaborative TB/HIV activities. Geneva, World Health organization, 2009 (http://www.who.int/hiv/pub/tb/hiv_tb_monitoring_guide.pdf)



TARGET 6. CLOSE THE GLOBAL AIDS RESOURCE GAP BY 2015 AND REACH ANNUAL GLOBAL INVESTMENT OF US\$22–24 BILLION IN LOW- AND MIDDLE-INCOME COUNTRIES

6.1 Domestic and international AIDS spending by categories and financing sources

6.1 AIDS spending

Domestic and international AIDS spending by categories and financing sources

What it measures

It measures how funds are spent at the national level and where those funds are sourced in an accurate and consistent manner.

Rationale

Resource commitments for the AIDS response continue to scale up in order to end the epidemic by 2030. Combined with resource scarcity, it is increasingly important to accurately track in detail: i) the use of available resources for various HIV and AIDS-related programmes at the national level; and ii) where the funds originate. The data are being used as evidence to track changes in national policy priorities, and to determine the introduction of reforms and new programmes has resulted in changes in resources allocation and expenditure. The data are also being used to measure annual global AIDS spending, which is an important component of monitoring the 2011 United Nations Political Declaration on HIV and AIDS.

In this reporting cycle we introduce a refined conceptual framework of the National Funding Matrix, with revised classification of AIDS programmes. These changes have been made in order to provide information of greater relevance for policy and better information on the core indicators built to embrace the ten targets of the 2011 Declaration.

The National Funding Matrix reflects an investment approach and fully incorporates the “fast-track” strategy to end the AIDS epidemic by 2030. The new framework gives extra emphasis to tracking expenditure on basic prevention and treatment programmes, and related critical enablers and development synergies. In this regard, programme categories have been renamed and restructured although the content of the programmes remains unchanged.

The classifications of programmes and services are designed to be self-explanatory. In order to guide countries in adopting the new classification, we provide its correspondence to previous codes.

The simplification of reporting categories in GARPR does not preclude the collection of disaggregated data in the country spending analysis. Quite on the contrary, it is recommended that countries with disaggregated or granular information continue to collect and analyze such information for country purposes but report it aggregated at country level.

The classification framework of AIDS programmes is structured around the 10 targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS and is divided into eight AIDS core programme areas. Each programme area comprises a set of specific spending categories, including basic prevention and treatment programmes, as well as critical enablers and development synergies.

The full list of AIDS programme areas and spending categories is provided in Appendix 2. To simplify the use and view of the matrix there is an option to hide and unhide spending categories of each HIV and AIDS programme area by pressing “+” to hide or “-” to unhide the categories of each programme area on the left side of the table. The same option is available to hide and unhide the columns of funding sources. Appendix 2 provides further instructions on how to complete the National Funding Matrix and submit the report.

Measurement Tool:	Primary tool/method: 1. National AIDS Spending Assessment (NASA) Alternative tool/method: 2. System of Health Accounts (SHA)
Method of measurement:	Since countries can choose among different methodologies and tools to monitor the flow of expenditure on HIV and AIDS, we recommend applying NASA as a primary and SHA as an alternative tool and methodology. There should not be any difference in the AIDS health spending measured by NASA or by SHA. However, some activities performed outside the health sector might not be included in SHA. The outputs from any of these measurement tools are to be used to complete the National Funding Matrix, which is to be submitted as part of the Country Progress Report. If the suggested measurement tools were not implemented, countries may perform ad-hoc data collection with an explicit description of the way expenditures were captured.
Measurement frequency:	Preferred: every defined period of time, i.e. every calendar or fiscal year In this reporting cycle we suggest that countries submit as many country year reports as they consider necessary, including estimates for 2012, 2013, and 2014. Countries are not limited to the most recent three years to report on Indicator 6.1 and are able to submit the data for the time frame starting from 2001. If previously submitted National Funding Matrixes have not undergone any adjustments, countries do not need to resubmit the same data. If the data for the previous reporting cycles were inaccurate, countries are invited to resubmit updated versions.

Strengths and weaknesses

NASA and SHA are internationally recognized methodologies and are suggested as primary and alternative tools, respectively, for data collection. NASA allows a comprehensive level of disaggregation of data by programme and provides the information required to complete the National Funding Matrix. SHA does not allow the same level of data disaggregation by programme, but it allows the total health expenditure on AIDS to be defined by funding source. Additionally NASA tracks non-health expenditures such as social mitigation, education, labour, justice and other sectors related to the multisectoral HIV response.

Development of NASA or SHA may be resource-consuming and require a certain level of capacity to be implemented. Access to quality data on actual expenditure tends to be difficult. Therefore, the approach needs a high degree of political support and the good will of many stakeholders to provide the necessary data. At the same time, it is essential that the data be collected regularly and in a consistent and comprehensive manner, and it is preferable that this activity be institutionalised at the national level using one of the recommended tools.

Further information:

1. UNAIDS. National AIDS Spending Assessment (NASA): Classification and Definitions http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916_nasa_classifications_edition_en.pdf
2. UNAIDS. Guide to Produce National AIDS Spending Assessment (NASA) http://data.unaids.org/pub/BaseDocument/2009/20090406_nasa_notebook_en.pdf
3. UNAIDS. National AIDS Spending Assessment (NASA) country reports <http://www.unaids.org/en/dataanalysis/knowyourresponse/nasacountryreports/>
4. WHO. Producing national health accounts <http://www.who.int/SHA/create/en/>
5. OECD. Eurostat. WHO. A system of health accounts. 2011 Edition <http://www.who.int/health-accounts/methodology/sha2011.pdf?ua=1>
6. WHO. Guidelines on the Implementation of the System of Health Accounts 2011 http://www.who.int/health-accounts/documentation/system_of_health_accounts_2011/en/
7. USAID, Health Systems 20/20 and UNAIDS. Linking NASA and SHA concepts and mechanics http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/dataimport/pub/globalreport/2009/SHA_nasa_crosswalk_final_en.pdf



TARGET 7: ELIMINATING GENDER INEQUALITIES

7.1 *Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months*

7.1 Prevalence of recent intimate partner violence

Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

What it measures

It measures progress in reducing prevalence of intimate partner violence against women (as an outcome itself and as a proxy for gender inequality).

An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated.

Rationale

Globally, and particularly in sub-Saharan Africa, the observed high rates of HIV infection in women have brought into sharp focus the problem of violence against women. There is growing recognition that women and girls' risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. Violence and HIV have been linked through both direct and indirect pathways. Studies conducted in many countries indicate that a substantial proportion of women have experienced violence in some form or another at some point in their life. WHO estimates that globally one in three women have experienced intimate-partner violence and/or non-partner sexual violence in their lifetime. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not. Please see Appendix 7 for further information on monitoring progress towards gender equality beyond Indicator 7.1.

Numerator:	Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of these partners in the past 12 months. (Please see the numerator explanation below for specific acts of physical or sexual violence to include).
Denominator:	Total women surveyed aged 15-49 who currently have or had an intimate partner
Calculation:	Numerator / Denominator
Method of measurement:	Population based surveys that are already being used within countries, such as WHO multi-country surveys, DHS/AIS (domestic violence module), International Violence against Women Surveys (IVAWS) Data collection on violence against women requires special methodologies that adhere to the ethical and safety standards to ensure that information is gathered in an ethical manner that does not pose a risk to study subjects, and in a way that maximizes data validity and reliability
Measurement Frequency	3-5 years
Disaggregation:	• Age (15-19, 20-24 and 25-49) • HIV status (if available)

Explanation of numerator

Ever married or partnered women aged 15-49 include women who have ever been married or had an intimate partner. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. These women are asked if they experienced physical or sexual violence from a male intimate partner in the past 12 months. Physical or sexual violence is determined by asking women if their partner did any of the following:

- Slapped her or threw something at her that could hurt her
- Pushed her or shoved her
- Hit her with a fist or something else that could hurt
- Kicked her, dragged her or beat her up
- Choked or burned her
- Threatened her with or used a gun, knife or other weapon against her
- Physically forced her to have sexual intercourse against her will
- Forced her to do something sexual she found degrading or humiliating
- Made her afraid of what he would do if she did not have sexual intercourse with him

Those reporting at least one incident corresponding to any one of these items in the last 12 months are included in the numerator.

Explanation of denominator

Total women surveyed aged 15-49 who currently have or had an intimate partner.

Strengths and weaknesses

This indicator assesses progress in reducing the proportion of women who have experienced recent IPV, as an outcome in and of itself. Further, the indicator should also be interpreted as a proxy for gender equality. A change in the prevalence level of recent violence over time will indicate a change in the level of gender equality—which is one of the structural factors driving the HIV epidemic. Gender equality has a clear, inverse relationship with IPV: In countries where IPV is high, gender equality, women's rates of education, and women's reproductive health and rights are low.

The indicator focuses on recent IPV, rather than ever experience of IPV, in order to enable monitoring and evaluating progress over time. Ever experience of IPV would show little change over time, no matter what the level of programming, since the numerator would include the same women for as long as they fell into the target age group. Sustained reductions in IPV are not possible without fundamental changes in unequal gender norms, gender relations at the household and community level, women's legal and customary rights, gender inequalities in access to health care, education, and economic and social resources, and male involvement in reproductive and child health. They are also not possible without promoting male responsibility for HIV prevention. Thus, changes in this one IPV indicator will be a bellwether for changes in the status and treatment of women in all the different societal domains, which in turn directly and indirectly contributes to reduced risk of HIV.

Even after adhering to the WHO ethical and safety guidelines and providing a good setting in which to conduct interviews, there will always be some women who will not disclose this information. This means that estimates will likely be more conservative than the actual level of violence which has taken place in the surveyed population.

The complex relationship between violence against women and HIV has been conceptually illustrated in a comprehensive review of the current state of evidence and practice in developing and implementing interventions and strategies to address the intersection of violence against women and HIV. For over a decade, research world-wide has documented the undeniable link between violence against women (VAW) and HIV. Studies have demonstrated an links between VAW and HIV as both a contributing factor for infection as well as a consequence of infection. This relationship operates through a variety of direct and indirect mechanisms. For example:

- fear of violence may keep women from insisting on condom use by a male partner whom they suspect is HIV infected;
- fear of IPV may keep women from disclosing their HIV status or seeking treatment;
- forced vaginal penetration increases the likelihood of HIV transmission;

For reporting on this indicator in 2015, an additional comment box is included for countries to provide any data that may be available on gender-based violence towards women, men and key populations, including women living with HIV. Gender-based violence beyond IPV also increases vulnerability of men, boys and key populations to HIV. This additional data will allow a more comprehensive understanding of the situation to be captured, as well as progress towards gender equality aligned to the epidemic context of each country.

- rape is one manifestation of gender inequality and can result in HIV infection, although this represents a minority of cases; and
- rape, other sexual and physical abuse can result in psychological distress that is manifested in risky sexual behaviour, with the result of becoming infected with HIV.

Further information

Investing in gender equality: ending violence against women and girls.

UNIFEM Brief, October 2010. Geneva, World Health Organization, 2010.

Addressing violence against women and HIV/AIDS: what works? Geneva, World Health Organization.

Dunkle KL, Head S, Garcia Moreno C. *Current intervention strategies at the intersection of gender-based violence and HIV: a systematic review of the peer-reviewed literature describing evaluations of interventions addressing the interface between gender, violence and HIV.* Geneva, World Health Organization, 2009.

Gender-based violence and HIV. Cambridge, MA, Program on International Health and Human Rights, Harvard School of Public Health, 2009.

Maman S et al. The intersections of HIV and violence: directions for future research and interventions. *Social Science and Medicine*, 2000, 50:459–478.

Global and regional estimates of violence against women. Geneva, World Health Organization, 2013.

16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool. Geneva, World Health Organization, 2013.

Unite with women, unite against violence and HIV. Geneva, UNAIDS, 2014.

World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010.

Dunkle KL, Decker MR. Gender-based violence and HIV: reviewing the evidence for links and causal pathways in the general population and high-risk groups. *Am J Reprod Immunol* 2013; 69 (Suppl. 1): 20–26.

The Gap Report” Chapter 2: Adolescents and Young women, pp 132-145, UNAIDS, 2014.



TARGET 8: ELIMINATING STIGMA AND DISCRIMINATION

8.1 Discriminatory attitudes towards people living with HIV

8.1 Discriminatory attitudes towards people living with HIV

Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV

What it measures

It measures progress towards reducing discriminatory attitudes, and support for discriminatory policies.

Rationale

Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or an omission) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fuelling the HIV epidemic.

This indicator is not a direct measure of discrimination but rather a measure of discriminatory attitudes which may result in discriminatory actions (or omissions). One item in this indicator measures the potential support by the respondents for discrimination that takes place at an institution while the other measures social distancing or behavioural expressions of prejudice. The composite indicator can be monitored as a measure of a key manifestation of HIV-related stigma and the potential for HIV-related discrimination within the general population. This indicator could provide further understanding and improve interventions in the area of HIV discrimination by: (1) showing change over time in the percentage of people with discriminatory attitudes, (2) allowing comparisons between national, provincial, state and more local administrations, and (3) pointing to priority areas for action.

Numerator:	Number of respondents (aged 15–49 years) who respond “No” to any of the two questions.
Denominator:	Number of all respondents aged 15–49 years who have heard of HIV
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) This indicator is constructed from responses of respondents in a general population survey who have heard of HIV to the following set of prompted questions: • Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV? (Yes; No; Don't know/ Not sure/It depends)) • Do you think children living with HIV should be able to attend school with children who are HIV negative? (Yes; No; Don't know/ Not sure/It depends))
Measurement Frequency	Every 3–5 years
Disaggregation:	Age (15-19, 20-24, 25-49) Sex Responses for each of the individual questions (based on the same denominator) are required as well as the consolidated response for the composite indicator.

Explanation of numerator

Those who have never heard of HIV and AIDS should be excluded from the numerator and denominator. Participants who respond “Don’t Know/Not sure/It depends” and those who refuse to answer should also be excluded from the analyses.

It is important to assess the proportion of eligible survey participants who respond “Don’t Know/Not sure/It depends” or who refuse to answer the questions. A high proportion of Don’t Know/Not sure/It depends responses and refusals will reduce the precision of the results and may indicate problems with applicability of the question within the survey setting.

Strengths and weaknesses

This indicator directly measures discriminatory attitudes and support for discriminatory policies.

The question about buying vegetables is virtually identical to the question that has been used in DHS surveys for monitoring “accepting attitudes” towards people living with HIV, thereby enabling continued monitoring of trends; however, the question focuses on “no” (discriminatory attitudes) rather than “yes” (accepting attitudes) responses. These measures improve upon

the previously used measures for the “accepting attitudes” indicator as they are applicable in both high and low HIV prevalence settings, in both high and low income countries and are relevant across a wide cultural range. Individual measures and the composite indicator do not rely on the respondent having observed overt acts of discrimination against people living with HIV, which in many contexts are rare and difficult to both characterize and quantify. Rather, the individual measures and the composite indicator assess individuals’ attitudes, which may have a more direct role in influencing behaviour.

The recommended questions assess agreement with hypothetical situations rather than measuring events of discrimination witnessed, and therefore social desirability bias may occur, leading to under-reporting of discriminatory attitudes. There is no mechanism for examining the frequency with which discrimination occurs, or the severity of the forms of discrimination.

In addition to conducting surveys that measure the prevalence of discriminatory attitudes in a community, where possible it would be ideal to collect qualitative data to inform the origins of discrimination. It would also be advisable to routinely collect data from people living with HIV about actual experiences of stigma and discrimination via the PLHIV Stigma Index process (www.stigmaindex.org) and compare findings with the data derived from the discriminatory attitudes indicator.

Further information

For further information on stigma and discrimination, and efforts to measure their prevalence, please see:

Thematic Segment on Non-Discrimination, 31st meeting of the UNAIDS Programme Coordinating Board. Background Note.

(www.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121111_PCB%2031_Non%20Discrimination_final_newcoverpage_en.pdf)

Stangl, A., Brady, L., Fritz, K. Technical Brief: Measuring HIV Stigma and Discrimination. Washington DC and London: International Center for Research on Women and London School of Tropical Medicine; STRIVE, 2012 (http://strive.lshtm.ac.uk/system/files/attachments/STRIVE_stigma%20brief-A4.pdf).

Stangl, A., Lloyd, J., Brady, L. et al. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? Journal of the International AIDS Society. 2013, vol 16 Supplement

(www.jiasociety.org/index.php/jias/issue/view/1464).
www.stigmaactionnetwork.org

For further information on DHS/AIS methodology and survey instruments, please visit: www.measuredhs.com

Special Note for the 2015 Reporting Round:

- As this indicator is relatively new, it is likely that many countries will not be able to report on the indicator during the 2015 reporting round;
- Instead countries are requested to report data from the previous version of question 1, 'Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?'. This question has been routinely collected in DHS in many countries.
- When using data from this DHS question to respond to question 1 of Indicator 8.1, the numerator should only include "No" responses. Please note that the indicator currently available in DHS StatCompiler and in final DHS country reports is the percentage who respond "Yes". "Yes" and "No" responses may not add up to 100% if there are any "Don't know" responses or missing values. Therefore it would not be accurate to calculate the percentage of persons responding "No" to this question by subtracting the percentage of "Yes" responses from 100%. DHS data for this question can be accessed by clicking on "Load data" in the GARPR online reporting tool under Indicator 8.1.
- In future reporting rounds, countries should report on the full indicator.

Additional ways of measuring Stigma and Discrimination

Indicator 8.1 provides an important measure of prevalence of discriminatory attitudes towards people living with HIV. To have a more complete assessment of progress towards eliminating HIV-related stigma and discrimination and of the success or failure of stigma reduction efforts, it is important to also measure other domains of stigma and discrimination. The following new indicators that could support this effort have been added to the Indicator Registry. For detailed information, please consult the following link: <http://www.indicator-registry.org/?q=taxonomy/term/677>.

- Negative manifestations of HIV-related stigma (not final)
Percentage of people who report negative individual- and population-level manifestations of HIV-related stigma
- Fear of HIV transmission through casual contact with a person living with HIV (not final)
Percentage of people who report fear of HIV infection through non-invasive contact with a person living with HIV
- Health Facility Staff: Institutional Policies (Tier 1)
Percent of health facility staff who report that their facility has written guidelines to protect patients living with HIV from discrimination
- Health Facility Staff: Enforcement of Institutional Policies (Tier 2)
Percent of health facility staff who report that they will get into trouble at work if they discriminate against patients living with HIV
- Health Facility Staff: Fear of HIV Infection (Tier 1)
Percent of health facility staff who worry about getting HIV when providing care or services to patients living with HIV
- Health Facility Staff: Attitudes and Opinions (Tier 1)
Percent of health facility staff who hold stigmatizing views about people living with HIV
- Health Facility Staff: Observed Enacted Stigma (Tier 1 for High HIV Prevalence and Tier 2 for Low HIV or Concentrated Prevalence Settings)
Percent of health facility staff who have observed unjust treatment of patients living with HIV in their facility
- Health Facility Staff: Unnecessary Precautions and Measures (Tier 2)
Percent of health facility staff who use unnecessary precautions when providing care or services to a patient living with HIV
- Health Facility Staff: Staff Needs and Support (Tier 2)
Percent of health facility staff who report an unsupportive working environment to protect staff from work-related HIV exposure



TARGET 9: ELIMINATE TRAVEL RESTRICTIONS

Travel restriction data are collected directly by the Human Rights and Law Division at UNAIDS and no reporting is therefore needed.



TARGET 10: STRENGTHENING HIV INTEGRATION

-
- 10.1 *Current school attendance among orphans and non-orphans aged 10–14**
- 10.2 *Proportion of the poorest households who received external economic support in the last 3 months*
-

10.1 Orphans school attendance

Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)

What it measures

It measures progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans.

The indicator is split up in two parts so comparisons can be made between orphans and non-orphans:

Part A: current school attendance rate of orphans aged 10–14 primary school age, secondary school age.

Part B: current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent.

Rationale

AIDS deaths in adults occur just at the time in their lives when they are forming families and bringing up children. Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can jeopardize children's chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important therefore to monitor the extent to which AIDS support programmes succeed in securing the educational opportunities of orphaned children.

Numerator:	Part A: Number of children who have lost both parents and who attend school aged 10-14, primary school age, secondary school age Part B: Number of children both of whose parents are alive, who are living with at least one parent and who attend school aged 10-14, primary school age, secondary school age
Denominator:	Part A: Number of children who have lost both parents Part B: Number of children both of whose parents are alive who are living with at least one parent
Calculation:	For both part A and B: Numerator / Denominator
Method of measurement:	Population-based survey (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) For every child aged 10-14, of primary school age, and secondary school age, living in a household, a household member is asked: 1. Is this child's natural mother still alive? If yes, does she live in the household? 2. Is this child's natural father still alive? If yes, does he live in the household? 3. Did this child attend school at any time during the school year?
Measurement frequency:	Preferred: every two years Minimum: every 4–5 years
Disaggregation:	• Sex

Explanation of numerator

The definition of primary school age and secondary school age should be consistent with the UNESCO definition and as currently used for calculating other education-specific indicators such as net primary school enrolment/attendance rate and net secondary school enrolment/attendance rate for each country. The primary school age and secondary school age populations may vary slightly from country to country. Therefore this indicator uses the terms 'primary school age' and 'secondary school age' as currently applied in standard international measurements including in major survey programmes such as DHS or MICS to allow each country to apply its own national age ranges for primary and secondary school. The important point is to compare current school attendance of orphans and non-orphans across primary school and secondary school rather than by specific ages.

Strengths and weaknesses

The definitions of orphan/non-orphan used here—i.e., child aged 10–14 years as of the last birthday both of whose parents have died/are still alive—are chosen so that the maximum effect of disadvantage resulting from orphanhood can be identified and tracked over time. The age-range 10–14 years is used because younger orphans are more likely to have lost their parents recently so any detrimental effect on their education will have had little time to materialize. However, orphaned children are typically older than non-orphaned children (because

the parents of younger children have often been HIV-infected for less time) and older children are more likely to have left school.

Typically, the data used to measure this indicator are taken from household-based surveys. Children not recorded in such surveys—e.g., those living in institutions or on the street—generally, are more disadvantaged and are more likely to be orphans. Thus, the indicator will tend to understate the relative disadvantage in educational attendance experienced by orphaned children.

This indicator does not distinguish children who lost their parents due to AIDS from those whose parents died of other causes. In countries with smaller epidemics or in the early stages of epidemics, most orphans will have lost their parents due to non-HIV-related causes. Any differences in the treatment of orphans according to the known or suspected cause of death of their parents could influence trends in the indicator. However, to date there is little evidence that such differences in treatment are common.

The indicator provides no information on actual numbers of orphaned children. The restrictions to double orphans and to 10–14 year-olds mean that estimates may be based on small numbers in countries with small or nascent epidemics.

Further information

For further information, please consult the following website:
http://www.unicef.org/aids/index_documents.html

10.2 External economic support to the poorest households

Proportion of the poorest households who received external economic support in the last 3 months

What it measures

It measures progress in providing external economic support to poorest households affected by HIV and AIDS.

Rationale

Economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programmes. This indicator reflects the growing international commitment to HIV-sensitive social protection. It recognizes that the household should be the primary unit of analysis since many of the care and support services are directed to the household level. Tracking coverage of households with orphans and within the poorest quintile remains a developmental priority.

Numerator:	Number of the poorest households that received any form of external economic support in the last 3 months <i>External economic support</i> is defined as free economic help (cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter) that comes from a source other than friends, family or neighbours unless they are working for a community-based group or organization. This source is most likely to be the national government or a civil society organization
Denominator:	Total number of poorest households <i>Poorest households</i> are defined as a household in the bottom wealth quintile. Countries should use the exact indicator definition and method of measurement for standardized progress monitoring and reporting at national and global levels. This will allow monitoring of changes over time and comparisons across different countries. However, countries can add or exclude other categories locally (for example, other wealth quintiles) depending on the country needs with respect to national programme planning and implementation
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys such as Household Income and Expenditure Surveys, Household Budget Surveys, Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey. National Statistics Offices carry out Household Income and Expenditure Surveys and questions include "current transfers received (cash and goods) and current transfers received (services)". An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile to identify the poorest 20% of households. However, since it is not possible to identify the poorest households at the time of data collection, questions on economic support should be asked to all households. Only those who fall in the lowest wealth quintile will be included in the indicator As part of a household survey, a household roster should be used to list all members of the household together with their ages, and identify all households with children less than 18 years of age, and with orphans, in the last year before the survey. Questions are then asked for each such household about the types of economic support received in the last 3 months, and the primary source of the help The household heads or respondents are asked the following questions about the type of external economic support they have received in the last 3 months Has your household received any of the following forms of external economic support in the last 3 months: a) Cash transfer (e.g., pensions, disability grant, child grant, to be adapted according to country context) b) Assistance for school fees c) Material support for education (e.g., uniforms, school books etc)

- d) Income generation support in cash or kind e.g. agricultural inputs
 - e) Food assistance provided at the household or external institution (e.g., at school)
 - f) Material or financial support for shelter
 - g) Other form of economic support (specify)
- An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile at which point it will be possible to assess the extent to which the poorest households are receiving external support

Measurement frequency:

Every 4–5 years

Disaggregation:

It is recommended that the indicator is disaggregated by type of external economic support in order to track the different types of economic support provided – particularly to be able to distinguish between access to free social assistance such as cash transfers (often specifically for poor labour-constrained households) and livelihoods support, which is often targeted at poor households which are less labour-constrained. It is also recommended that the indicator is disaggregated by whether or not households have orphans as orphaning remains a major determinant of vulnerability, particularly in relation to access to services. Where possible, data should also be disaggregated by rural versus urban residence. For countries which opt to add data collection on households in other wealth quintiles in addition to those in the bottom quintile, the indicator can also be compared with other wealth quintiles to track whether external economic support is reaching the bottom quintile compared to wealthier quintiles

Strengths and weaknesses

This indicator reflects new evidence of the need for a greater focus on wealth dimensions of vulnerability and the fact that targeting on the basis of extreme poverty in high prevalence contexts ensures good coverage of poor households affected by HIV. Proxy indicators of AIDS affectedness (such as “chronic illness”) have often been poorly associated with HIV, have weak associations with adverse developmental outcomes, and have proven difficult to define in household questionnaires.

This indicator demonstrates changing levels of economic support for the poorest households. In high prevalence contexts, in particular, the majority are likely to be HIV affected. The indicator also demonstrates changes in the composition of external support (e.g. cash, food, livelihoods) received by poor households.

The indicator does not measure directly economic support to HIV infected and affected households, which is difficult to establish during a survey, but implicitly suggests that households living in the bottom wealth quintile in high prevalence contexts are more likely to be negatively impacted by HIV and AIDS and in need of economic assistance. In order to keep

measurement as simple as possible, the indicator does not attempt to identify the different sources of support to households but this should be partly captured in National AIDS Spending Assessments (NASA).

The collection of data through population-based surveys, particularly DHS and MICS, means that the indicator does not capture the status of people living outside of households such as street children, children in institutions and internally displaced populations. Separate surveys are needed to track coverage for such vulnerable populations.

Further information

For further information, please consult the following website:
http://www.unicef.org/aids/index_documents.html

GOVERNMENT HIV AND AIDS POLICIES

Every two years GARPR includes completion of the National Commitments and Policy Instrument (NCPI) to measure progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws. Most recent reporting on the NCPI was in 2014; therefore the NCPI will not be reported in 2015. A review of the NCPI is currently being undertaken in order to assess the purpose of the NCPI tool in the post-2015 environment and propose a new instrument towards 2020/2030.

It is expected that a revised version of the NCPI will be included in the 2016 GARPR.

APPENDICES

Appendix 1. Country Progress Report template

Appendix 2. National Funding Matrix

Appendix 3. Sample checklist for Country Progress Report

Appendix 4. Selected bibliography

Appendix 5. Male circumcision indicators

Appendix 6 Geographic data collection in Surveillance, Monitoring and Evaluation

Appendix 7. Guidance on monitoring progress towards eliminating gender inequalities

Appendix 1. Country Progress Report template

The following provides the full template of the narrative part of the Country Progress Report and detailed instructions for completion of the different sections included in it. It is highly recommended that the indicator data are submitted through the recommended online reporting tool.

COUNTRY PROGRESS REPORT [Country Name]

Submission date: fill in the date of the formal submission of the country report to UNAIDS.

Table of Contents

I. Status at a glance

Instructions: this section should provide the reader with a brief summary of

- (a) the inclusiveness of the stakeholders in the report writing process;
- (b) the status of the epidemic;
- (c) the policy and programmatic response;
- (d) Indicator data in an overview table.

II. Overview of the AIDS epidemic

Instructions: This section should cover the detailed status of the HIV prevalence in the country in 2014 based on sentinel surveillance, national surveys and specific studies. The source of information for all data provided should be included.

III. National response to the AIDS epidemic

Instructions: This section should reflect the change made in national commitment and programme implementation broken down by prevention, care, treatment and support; knowledge and behaviour change; and impact alleviation during 2014.

Countries should specifically address the linkages between the existing policy environment, implementation of HIV programmes, verifiable behaviour change and HIV prevalence as supported by the indicator data. Where relevant, these data should also be presented and analysed by sex and age groups. Countries should also use data from previous rounds of the National Commitments and Policy Instrument (NCPI) to describe progress made in policy/strategy development and implementation. Countries are encouraged to report on additional data to support their analysis and interpretation of the reported data.

IV. Best practices

Instructions: This section should cover detailed examples of what is considered a best practice in-country in one or more of the key areas (such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity-building; infrastructure development. The purpose of this section is to share lessons learned with other countries.

V. Major challenges and remedial actions

Instructions: This section should focus on:

- (a) progress made on key challenges reported in the 2013 Country Progress Report;
- (b) challenges faced throughout the reporting period (–2014) that hindered the national response, in general, and the progress towards achieving targets, in particular;
- (c) concrete remedial actions that are planned to ensure achievement of agreed targets.

VI. Support from the country's development partners (if applicable)

Instructions: This section should focus on (a) key support received from, and (b) actions that need to be taken by development partners to ensure achievement of targets.

VII. Monitoring and evaluation environment

Instructions: This section should provide (a) an overview of the current monitoring and evaluation (M&E) system; (b) challenges faced in the implementation of a comprehen-

sive M&E system; and (c) remedial actions planned to overcome the challenges, and (d) highlight, where relevant, the need for M&E technical assistance and capacity-building.

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

Please submit your complete Global AIDS Progress Report before 31 March 2015 using the recommended reporting tool.

Please direct all enquiries related to Global AIDS Reporting to the UNAIDS Secretariat at: AIDSreporting@unaids.org,

Appendix 2. National Funding Matrix

To report on Indicator 6.1 the countries are required to fill in and submit the National Funding Matrix, which reflects AIDS expenditure in a given country over a defined period of time. The National Funding Matrix is available on the Global AIDS Progress reporting tool at: <http://AIDSreportingtool.unaids.org>.

Cover sheet

On the cover sheet of Excel file the countries are required to provide:

- The name of the country. The drop-down menu allows the name of the country to be selected.
- Date of data entry in the following format: day/month/year.
- Institution responsible for filling out the indicator forms, along with the name and contact details of the person responsible for submission and follow-up on the National Funding Matrix.
- Reporting cycle for each reported country year. The drop-down menu allows a calendar or a fiscal year for each reporting cycle to be selected.
- Start and end date for each reporting cycle in the following format: from: mm/yyyy to: mm/yyyy.
- Currency of each reporting cycle. The drop-down menu allows local currency or US dollars to be selected.

- Monetary units reported amounts expressed in. The drop-down menu allows units, thousand, or million to be selected for each reporting cycle.
- Reporting period average exchange rate, e.g. local currency to 1 US dollar for each reporting cycle.
- Data measurement methodology/tool used to report on Indicator 6.1. The drop-down menu allows National AIDS Spending Assessment (NASA), System of Health Accounts (SHA), or other to be selected, along with a text box to provide an explicit reference to the way data were captured for each reporting cycle.
- Unaccounted expenditure for each reporting cycle. Provided text boxes allow activities that were not captured in the National Funding Matrix to be listed, along with the reason.
- Amounts of general budget support provided within each reporting cycle from an international source, and reported under “Public sources” of financing. If general budget support was provided and included under the Central/National and/or Subnational sub-categories, for each reporting cycle please indicate the donor, the amount and the type of currency.

Structure of the matrix

The core accounting framework is organised around a two-axis system for recording HIV and AIDS- related expenditure: classifications of the programmes; and financing sources. They address the two basic questions:

- What kinds of programmes and services are implemented?
- Which financing sources pay for these programmes and services?

Responses to these questions will come from collecting and analysing data on AIDS-related expenditure from donors, non governmental organizations, private companies, insurance providers, government entities and households. Data from all of these financing sources are to be cross-checked to avoid double-counting and to produce an accurate estimate of current and capital spending in a country over a fixed time period. Detailed descriptions of funding sources are provided in *National AIDS Spending Assessment (NASA): Classification Taxonomy and Definitions*¹. Note that the data on Private Sources are optional. However, countries are strongly encouraged to collect and report available data in this area, providing an explicit reference on the methodology used and a description of AIDS-related programmes that were captured within the exercise.

The classification framework of AIDS programmes is structured around the 10 targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS and is divided into eight AIDS core programme areas. Each programme area comprises a set of specific spending categories, including basic prevention and treatment programmes, as well as critical enablers and development synergies.

¹ UNAIDS. National AIDS Spending Assessment (NASA): Classification and Definitions
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090916_nasa_classifications_edition_en.pdf

The full list of AIDS programme areas and spending categories is provided below.

Target 1. Reduce sexual transmission of HIV by 50 percent by 2015

1. Prevention of sexual transmission of HIV

- 1.1 Behaviour change programmes
- 1.2 Condom promotion
- 1.3 Voluntary medical male circumcision
- 1.4 Post-exposure prophylaxis
- 1.5 Programmes for men who have sex with men
- 1.6 Programmes for sex workers and their clients
- 1.7 Programmes for transgender people
- 1.8 Pre-exposure prophylaxis for serodiscordant couples
- 1.9 Programmes for children and adolescents
- 1.10 Community mobilization
- 1.11 Cash transfers to girls

Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015

2. HIV prevention for people who inject drugs

- 2.1 Needle and syringe exchange and other prevention programmes for people who inject drugs
- 2.2 Substitution therapy

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

3. Prevention of mother-to-child transmission

- 3.1 ARVs for PMTCT
- 3.2 Non-ARV-related component of PMTCT

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

4. Universal access to treatment

- 4.1 HIV testing
- 4.2 Pre-ART care and palliative care

- 4.3 Adult antiretroviral treatment
- 4.4 Paediatric antiretroviral treatment
- 4.4 Support and retention

Target 5. Reduce tuberculosis (TB) deaths in people living with HIV by 50 percent by 2015

5. TB

- 5.1 TB screening and diagnostics for PLHIV
- 5.2 TB treatment for PLHIV

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22-24 billion in low- and middle-income countries

6. Governance and sustainability

- 6.1 Strategic information
- 6.2 Planning and coordination
- 6.3 Procurement and logistics
- 6.4 Health systems strengthening

Target 8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

Target 9. Eliminate HIV-related restrictions on entry, stay and residence

7. Critical enablers

- 7.1 Policy dialogue
- 7.2 Stigma reduction
- 7.3 Law reform and enforcement
- 7.4 AIDS-specific institutional development/community mobilization

Target 7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

Target 10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

8. Synergies with development sectors

- 8.1 Social protection
- 8.2 Gender programmes
- 8.3 Education
- 8.4 Workplace
- 8.5 Synergies with health sector

Addendum items/Noncore global/other

Please list below and specify any essential programmes outside suggested system of classifications

Instructions

- Financing under Public Sources should only include revenue generated by the government and allocated to the AIDS response. It should not include development assistance of any type from international sources. If the total amount of budget support can be identified, it should appear under the proper International Sources sub-category (e.g. PEPFAR or “Other Bilaterals”). If any budget support is included in the Public Sources sub-category, please indicate this on the cover sheet.
- Financing provided by individual bilateral donors does not need to be disaggregated by donor agency in the funding matrix, with the exception of PEPFAR.
- Financing provided by a development bank should be designated either as Reimbursable (e.g. loans), which appears under Public Sources, or Non-reimbursable (e.g. grants), which appears under International Sources. Countries that receive both loans and grants from development banks should be careful to allocate these funds to the correct categories.
- Financing provided by international foundations should be listed in the “Other International Aid “ sub-category.
- Providing information on financing from Private Sources is optional. However, countries are strongly encouraged to collect and report available data in this area in order to provide a more complete picture of the funds available for the AIDS response.
- Countries are requested to include as much detail in the National Funding Matrix as possible, including a breakdown by all applicable AIDS Spending and Funding Source Categories and sub-categories. Any categories or sub-categories that are not applicable in a country should be clearly identified; explanations for categories or sub-categories that do not include estimates for any other reason should be provided as part of the cover sheet to the matrix.
- The correspondence between new programme classifications and former categories is provided in the column “Programme codes of the previous National Funding Matrix.
- There are a number of new programme categories – these are self-explanatory.

- Expenditure should only be counted and attributed to a single programme category or sub-category to avoid double-counting.
- Note that all of the spending categories are AIDS-specific and should include only HIV and AIDS-related expenditure. This holds true for Enablers and Synergies, which should only be those that are directly attributable to the AIDS response.
- If countries are required to report on essential programmes that happen to be outside the suggested system of core HIV and AIDS programmes, these programmes may be listed in the “Addendum items/Noncore global/other” category at the end of the table. In this case, we ask that a description of these additional programmes be provided, along with expenditures that occurred within each reporting cycle.
- To simplify the use and view of the matrix there is an option to hide and unhide spending categories of each HIV and AIDS programme area by pressing “+” to hide or “-” to unhide the categories of each programme area on the left side of the table. The same option is available to hide and unhide the columns of funding sources.
- The matrix provides automated sub-totals and totals where necessary. The formulas for these cells are protected and provide the aggregated indicators only when the data for the components are entered accordingly.
- Once the National Funding Matrix is filled in, it has to be submitted through the Global AIDS Progress Reporting online tool.
- If you do not have access to the Global AIDS Progress Reporting tool, please submit the National Funding Matrix by email to UNAIDS (AIDSreporting@unaids.org).

The UNAIDS Secretariat strongly recommends that the NAC or equivalent organize a one-day workshop of relevant stakeholders to review the National Funding Matrix before it is submitted as part of the Global AIDS Progress Reporting process. Relevant stakeholders should include federal and provincial/regional/state government ministries and departments, local and international civil society organizations, multilateral agencies, bilateral donors, foundations and commercial sector entities, as well as representatives from other relevant resource-tracking initiatives.

NATIONAL FUNDING MATRIX

Country:						
Reporting cycle (calendar or fiscal year):						
Start of the reporting cycle (mm/yyyy):						
End of the reporting cycle (mm/yyyy):						
Currency of the report (local currency or US dollars):						
Amounts expressed in (units, thousand or million):						
Reporting period average exchange rate (local currency to 1 US dollar):						
Data measurement methodology / tool:						
TEN TARGETS: 2011 United Nations General Assembly Political Declaration on HIV/AIDS	HIV and AIDS programmes	Programme codes of the previous National Funding Matrix	Public Sources	Private Sources	International Sources	TOTAL
			Total Public	Total Private	Total International	
Target 1. Reduce sexual transmission of HIV by 50 percent by 2015	1. Prevention of sexual transmission of HIV					
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015	2. HIV prevention for people who inject drugs					
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths	3. Prevention of mother to child transmission					
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	4. Universal access to treatment					
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	5. TB					

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22-24 billion in low- and middle-income countries	6. Governance and sustainability						
	7. Critical enablers						
Target 7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV Target 10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems	8. Synergies with development sectors						
	Addendum items / Non-core global / Other						

Appendix 3. Sample checklist for Country Progress Report

Reporting process established, including timelines and milestones, and roles of NAC, government agencies, UN agencies, civil society and other relevant partners.

Funding secured for all aspects of the reporting process.

Data collection, vetting and analysis process established, including:

- Identification of relevant tools (including Spectrum) and sources for data collection for each indicator
- Timeline for data collection in line with other data collection efforts, including those via funding agencies such as the Global Fund, PEPFAR and UN agencies
- Reporting timeline for facility-based indicators for national level aggregation
- Data vetting and triangulation workshops with the aim of reaching consensus on the correct value for each indicator

Protocols established for data processing and management, including:

- Basic data cleaning and validation
- One database for analysis and reporting purposes

Relevant data analysed in coordination with partner organizations from government, civil society and the international community

Consensus reached with stakeholders, including government agencies and civil society, on the final report to be submitted

Data entered into and narrative report attached to the online reporting tool by 31 March 2015

Data queries answered (sent from AIDSreporting@unaids.org or directly in the online reporting tool).

Appendix 4. Selected bibliography

UNAIDS (2010) *12 Components M&E System Assessment - Guidelines to support preparation, implementation and follow up activities*. Geneva: UNAIDS

UNAIDS (2010) *12 Components M&E System Strengthening Tool*. Geneva: UNAIDS

UNAIDS (2011) *Glossary of M&E Terminology*. Geneva: UNAIDS

UNAIDS (2010) *Guidance HIV M&E Capacity-building*. Geneva: UNAIDS

UNAIDS (2010) *Indicator Standards and Assessment Tool*. Geneva: UNAIDS

UNAIDS (2010) *Monitoring and Evaluation Fundamentals: A National Evaluation Agenda for HIV*. Geneva: UNAIDS

UNAIDS (2010) *Monitoring and Evaluation Fundamentals: An Introduction to Triangulation*. Geneva: UNAIDS

UNAIDS (2010) *Monitoring and Evaluation Fundamentals: An Introduction to Indicators*. Geneva: UNAIDS

UNAIDS (2010) *Monitoring and Evaluation Fundamentals: Basic Terminology and Frameworks for Monitoring and Evaluation*. Geneva: UNAIDS

UNAIDS (2008) *Organizing Framework for a Functional National HIV Monitoring and Evaluation System*. Geneva: UNAIDS

UNAIDS (2014) *UNAIDS Report on the Global AIDS Epidemic*. Geneva: UNAIDS

UNAIDS (2014) *The Gap Report* Geneva: UNAIDS

UNAIDS (2011) *Securing the future today – Synthesis of Strategic Information on HIV and Young People*; Geneva, UNAIDS

UNAIDS (2010) *Strategic Guidance for the Evaluation of HIV prevention programmes*. Geneva: UNAIDS

WHO (2013) *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Geneva: WHO

UNICEF (2014). *The State of the World's Children Report*. New York: UNICEF

UNICEF (2009) *Country-led Monitoring and Evaluation Systems*. New York; UNICEF

Appendix 5. Male circumcision indicators

These two indicators are only required from 16 countries with high HIV prevalence, low levels of male circumcision and generalized heterosexual epidemics i.e. Botswana, Ethiopia, Central African Republic, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

1.22 Proportion of males circumcised

Percentage of men 15-49 that are circumcised

What it measures

It measures progress towards increased coverage of male circumcision.

Rationale

There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Three randomized controlled trials have shown that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of HIV acquisition. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence.

Numerator:	Number of male respondents aged 15-49 years who report that they are circumcised.
Denominator:	Number of all male respondents aged 15-49 years
Calculation:	Numerator / Denominator
Method of measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Surveys or other representative survey)
Measurement frequency:	Every 3-5 years
Disaggregation:	• Age 15-19, 20-24 and 25-49 years • Source/practitioner of circumcision procedure: formal healthcare system or traditional

Strengths and weaknesses

Changing rates of male circumcision may or may not be the result of a programme. For example, changing societal norms not due to a programme may be leading to changing rates of male circumcision. This indicator measures total change in the population, whatever the reason(s).

Existing population-based surveys (such as DHS) may not accurately measure true male circumcision status because of a lack of knowledge of what male circumcision is, confusion about circumcision status, or perceived social desirability of circumcision status. Other approaches to determining circumcision status might be used, e.g. the use of pictures or drawings (drawings may be more culturally appropriate), prompts or even direct examination. Modelling the potential impact of changing rates of male circumcision on HIV incidence requires accurate knowledge of male circumcision status over time.

Further information

For further information on Male Circumcision indicators, see
A guide to indicators for male circumcision programmes in the formal health care system, WHO, UNAIDS, 2009
http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf

1.23 Number of male circumcisions performed

Number of male circumcisions performed according to national standards during the last 12 months

What it measures

It measures progress in scaling up male circumcision services.

Rationale

There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Three randomized controlled trials have shown that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of HIV acquisition. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence.

Numerator:	Number of males circumcised during the past 12 months according to national standards
Denominator:	Not applicable
Method of measurement:	Health facility recording and reporting forms
Measurement frequency:	Yearly
Disaggregation:	Age: <1, 1-9, 10-14, 15-19, 20-24, 25- 49, and 50+ years

Strengths and weaknesses

The total number of male circumcisions carried out indicates either change in the supply of services or change in demand. Comparing the results against previous values shows where male circumcision services have been newly instituted or where male circumcision volume has changed.

Further disaggregations are recommended at country level:

- i. iHIV positive by test(s) on site; HIV negative by test(s) on site; HIV indeterminate result by test(s) on site; Unknown/refused HIV test;
- ii. Type and location of health facility
- iii. Cadre of provider

When the number of male circumcisions is disaggregated by HIV status and age it will be possible to determine the impact of male circumcision programmes on HIV incidence using models. If a country has prioritized particular age groups this disaggregation will help determine whether age-specific communication strategies are creating demand. Further if the data are available by type and location of health-care facility where the circumcision was performed resource allocation needs can be assessed. Finally by disaggregating these data by the cadre of health-care provider will determine if task-shifting efforts are succeeding and determine resource allocation.

Some programmes will work closely with voluntary HIV counselling and testing services to provide HIV testing. A patient desiring male circumcision may have been recently tested, in which event an on-site HIV test may be unnecessary. In these cases, a written 'verified result' may be requested at the facility to verify HIV status. There is no specific length of time before male circumcision that the test should have been done, but within three months is suggested (the purpose of testing is not to identify every man who might be infected but to provide HIV testing to men seeking health care and to identify HIV-positive men who, if they choose to be

circumcised, are likely to be at higher risk of surgical complications, i.e. men who are chronically infected and with low CD4 counts).

Further information

For further information on Male Circumcision indicators, see

A guide to indicators for male circumcision programmes in the formal health care system, WHO, UNAIDS, 2009

http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf Appendix 4.

Appendix 6. Geographic data collection in Surveillance, Monitoring and Evaluation

There is a programmatically relevant geographic aspect to virtually every element of surveillance and Monitoring and Evaluation (M&E) systems. Many input, output, and outcome indicators can be represented in a Geographic Information System (GIS) for analysis and presentation. As a result, geographic data can be leveraged for epidemic assessment, monitoring and evaluation. Epidemiology has an obvious geographic dimension, and the range of prevention, care and treatment services also come together in specific places. Geography therefore has a key role in integrating data from surveillance and different programmatic streams. A standards-based approach to spatial data can support country systems where operational guidance directs programmes to take account of geographic aspects of interventions. Such an approach will also promote consistency of geospatial data between data sources, facilitating sharing and use of geospatial data by countries and partners, as well as the bringing together of all available data sources to inform analysis and decision-making at local level.

Spatial data inputs to surveillance and M&E

To facilitate data integration and analysis, geographic markers for data should be maintained with indicators at the appropriate level of precision and using standardized geographic references and naming conventions. The appropriate level of precision may be as general as a health district, province or even a national administrative boundary. However, attaching geographic information to the more granular data that compose aggregate indicators can enable a wide array of analysis, such as geographic coverage of services, spatial distribution of human resource and expenditures, and the estimation of change over time for small areas.

For many surveillance applications, geographic representativeness dictates the scale at which data can be used. For example, population-based surveys are typically representative of populations at the province level. ANC sentinel surveillance data is usually linked to specific health facilities or more rarely to a cluster of rural health facilities. The geographic localization of the ANC site or cluster of ANC sites should be attached to the HIV prevalence data from these sites. As surveillance systems transition to using HIV prevalence data generated by PMTCT

programmes, the prevalence data should be accompanied by the geo-location of the PMTCT sites. Sentinel surveillance data for key populations (e.g. collected through integrated bio-behavioural surveys – IBBS) can either be located to the central facility at which the surveillance is conducted (e.g. when using respondent-driven sampling or clinic-based surveillance), or to the actual location where respondents are encountered during the surveillance (e.g. when using time-location sampling).

For indicator data that characterize a health facility, the finest geographic representation is a point based on the latitude and longitude of the facility, which is information that should be maintained as part of a Ministry of Health's master list of health facilities, where that exists, or possibly in a GIS unit within a central statistical agency. Key monitoring data that should be geographically tagged include people tested for HIV, new HIV diagnoses, pregnant women tested for HIV, people initiated on ART, people on ART, pregnant women receiving antiretrovirals and early infant diagnoses.

Many community-based activities whether for key populations or for supporting treatment programmes may also be located with latitude and longitude, although the geography of non-facility based activities in the continuum of response can be diffuse or complex.

Spatial data standards and metadata

Most countries have National Spatial Data Infrastructure (NSDI) initiatives or an explicit spatial data component in a larger national information and communication infrastructure. NSDI includes the technology, policies, standards, human resources and related activities necessary to acquire, process, distribute, use, maintain and preserve spatial data.” A data management plan for spatial data is recommended to reduce duplication and to support country ownership and sustainability by ensuring that these data become part of the NSDI of the country.

To the extent possible, databases should include international naming standards in addition to any local naming standards and place codes. For country-specific data where metadata standards are specified by NSDI policy, spatial data can follow the FGDC Metadata Standard and include any additional metadata elements enumerated in the local standard. Adherence to spatial data standards is necessary for alignment with national programmes and systems.

Unique identification of individuals

Place can uniquely identify individuals, especially when linked with other data elements Care must be taken in determining whether the release of specific spatial data could be inappropriately leveraged with other data to violate confidentiality. Extreme care should be taken when developing maps of stigmatized key populations or the places where key populations congregate.

Geospatial tools

A variety of commercial and free and open-source tools to support geographic mapping are available. Elementary spatial analysis can be conducted in spreadsheets or using digital globes. More advanced spatial analysis, management of spatial data, and displays of spatial data can be accomplished using a GIS. The right tool should be matched with the right data, the right analysis and at the right scale. Skills that potentially already exist in countries to conduct geospatial analysis should be sought. Analysis using geographic mapping tools can be complemented through participatory methodologies involving community stakeholders.

Appendix 7 Guidance on monitoring progress towards eliminating gender inequalities

Background

Through the United Nations 2011 Political Declaration on HIV and AIDS, Member States made a “pledge to eliminate gender inequalities and gender-based abuse and violence.” This commitment is reflected in Target 7, which refers to eliminating gender inequalities and gender-based abuse and violence and increasing the capacity of women and girls to protect themselves from HIV.

Progress towards Target 7 is measured through annual Global AIDS Response Progress Reporting (GARPR) on Indicator 7.1 on the proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months. In addition to measuring an outcome in itself, this indicator is also considered a proxy for gender inequality.

Gender equality and HIV

Gender “entails the concept that all human beings... are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs... are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person’s gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.”²

Although discussions of this target often assume a reference to women and girls, it is recognized that there is a spectrum of gender identity, beyond the binary view of male and female. Gender identity “refers to a person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means, and other expressions of gender, including dress, speech, and mannerisms.”³

² UNAIDS Terminology Guidelines, October 2011 (http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-guidelines_en_0.pdf).

³ UNAIDS Terminology Guidelines, October 2011 (http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-guidelines_en_0.pdf), page 11

Harmful gender norms and practices related to what is considered feminine and masculine, and stigma and discrimination based on gender identity, may increase a person's vulnerability to HIV⁴ and cause differentials in health services uptake, the ability to adhere to medical regimens, and other factors that contribute to HIV-related risks and outcomes.

Purpose of this guidance note

Although gender equality is addressed by Target 7 specifically, it is cross-cutting across the 2011 Political Declaration targets and GARPR indicators. Indicator 7.1 is a proxy measure for progress towards gender equality. However it only addresses one of the three components of Target 7. Countries have expressed challenges in assessing progress towards Target 7, in particular in the context of epidemics in which key populations are most affected.

This appendix aims to provide additional guidance to countries on how to strengthen monitoring of progress towards gender equality through the GARPR framework, highlighting ways in which progress on target 7 can be more comprehensively monitored to gain a better understanding of the situation around gender equality in a country – reflecting an inclusive concept of gender that involves women and girls, as well as women and girls in key populations,⁵ transgender persons and men and boys.

Violence and HIV

Gender-based violence “describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with ‘violence against women.’ The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they don't conform to or challenge prevailing gender norms and expectations (e.g. may have feminine appearance) or heterosexual norms.”⁶

Violence against women is defined as “any public or private act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty with the family or general community.”⁷ Intimate partner violence towards women, as measured by Indicator 7.1, is a form of violence against women. Please see Indicator 7.1 for a list of behaviours that are forms of intimate partner violence.

Globally, one out of every three women have experienced intimate partner violence and/or non-partner sexual violence in their lifetime.⁸ Intimate partner violence—a manifestation of gender inequality and a violation of women's human rights—has been linked with HIV

⁴ WHO and UNAIDS (2013). 16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool.

⁵ Depending on the country context, female key populations may include female sex workers, female drug users, transgender women, female intimate partners of men with high-risk behaviours, adolescent/young women from key populations, women migrant workers, women in closed settings/prisons, etc.

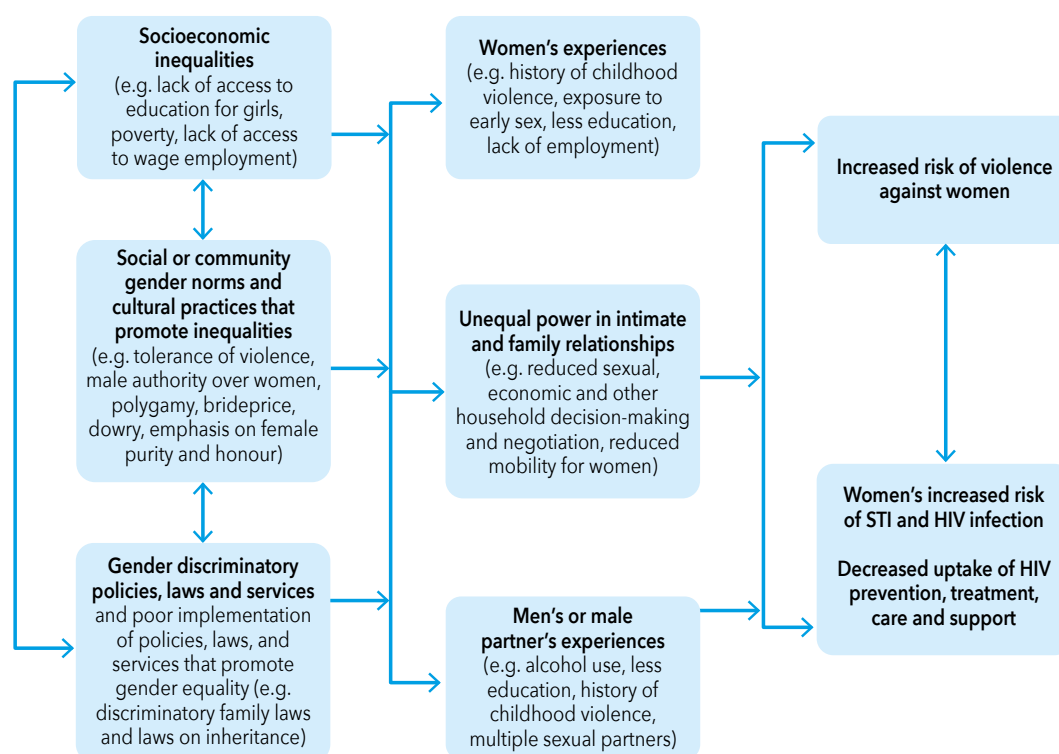
⁶ WHO and UNAIDS (2013). 16 ideas for addressing violence against women in the context of the HIV epidemic, p. 3 (http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf)

⁷ WHO and UNAIDS (2013). 16 ideas for addressing violence against women in the context of the HIV epidemic, p. 3 (http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf)

⁸ WHO, LSHTM, SAMRC. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, WHO, 2013.

through multiple pathways, including as a contributing risk factor and as a consequence of living with HIV. Several studies have found that exposure to intimate partner violence is associated with approximately a 1.5-fold increase in the risk of STI and HIV infection.^{9, 10, 11} Please see diagrams below of pathways between gender inequality and violence against women and HIV, and indirect and direct links between violence against women, HIV risk and service uptake.¹²

Pathways between gender inequality and violence against women and HIV



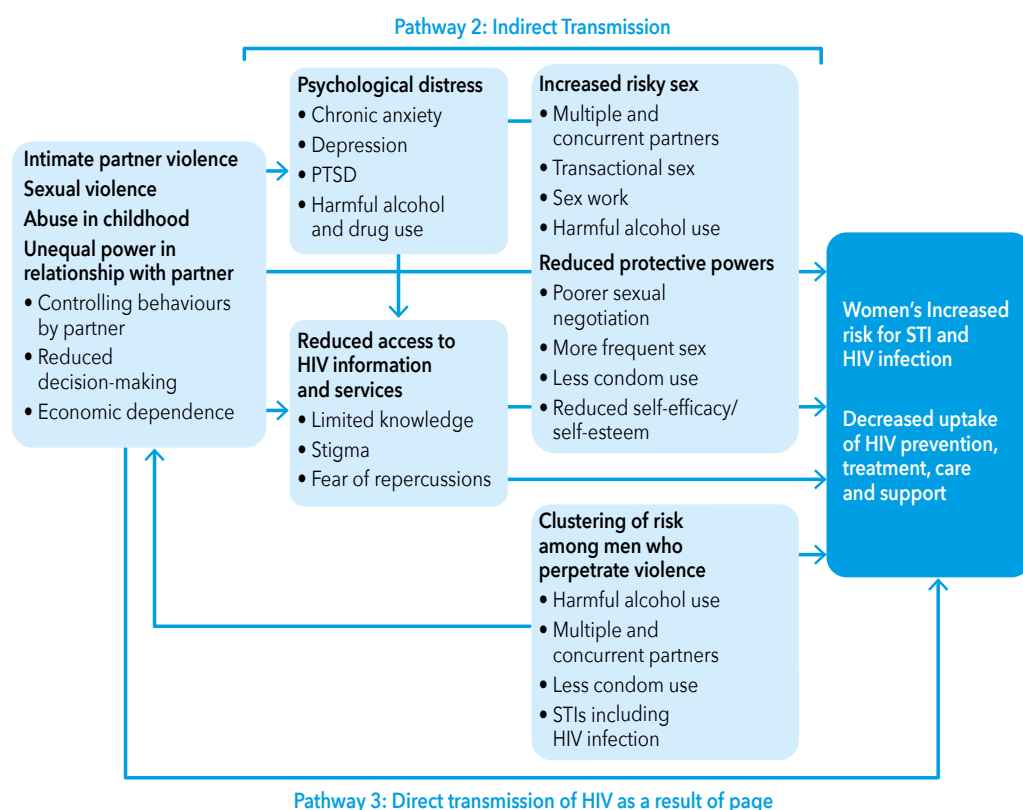
⁹ WHO, LSHTM, SAMRC. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, WHO, 2013.

¹⁰ Jewkes R et al. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *The Lancet*, 2010, 376(9734):41–48.

¹¹ Kouyoumdjiana FG et al. Intimate partner violence is associated with incident HIV infection in women in Uganda. *AIDS*, 2013, 27(8):1331–1338.

¹² WHO and UNAIDS (2013). 16 ideas for addressing violence against women in the context of the HIV epidemic, pp. 6–7. (http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf)

Indirect and direct links between violence against women, HIV risk and uptake of services



Broader monitoring of progress towards gender equality through GARPR

Through the various elements of GARPR, it is possible to obtain a more comprehensive view of progress towards gender equality:

Collecting and reporting data disaggregated by sex, key population and age by indicator:

As mentioned in the 2015 GARPR guidelines, “Without disaggregated data, it is difficult to monitor the breadth and depth of the response to the epidemic... Countries are strongly encouraged to make the collection of disaggregated data, especially by sex and age, one of the cornerstones of their monitoring and evaluation efforts. Gender dynamics may become evident through sex- and age-disaggregated epidemiological data as well as on the behavioural indicators.” Please refer to Tables 1 and 2 for a list of epidemiological estimates¹³ and GARPR indicators that should be disaggregated.

Countries are requested to submit copies or links to primary reports for data reported through GARPR for reference and to allow further analysis. Reports can be submitted through the “add file” button at the top of the indicator page in the online GARPR tool.

¹³ From national Spectrum files.

Indicator comment boxes: Indicator construction, measurement tools and data sources are detailed for each GARPR indicator in the GARPR guidelines. In the case of indicators that are considered relevant but for which data may not be readily available, countries are encouraged to:

- Indicate that the “indicator is relevant”; and
- Include in the comment box the reasons for which data are not currently available. If relevant data are available but do not fully respond to the indicator definition as detailed in the GARPR guidelines, they can be included in the comment box.

Countries are encouraged to report any available complementary data that reflect gender dimensions of the indicator from other sources, including quantitative or qualitative data collected by civil society, in the comment boxes on each indicator page. Such additional data will permit countries to conduct a more comprehensive situational analysis of the indicator from a gender perspective.

Prevalence of recent IPV: This is the core indicator included in GARPR for monitoring of progress towards target 7.

Data on other forms of gender-based violence: Under Indicator 7.1, an additional comment box is included in 2015 GARPR reporting for countries to provide any data that may be available on gender-based violence towards men and key populations, including women living with HIV. Gender-based violence beyond IPV also contributes to increased vulnerability of men, boys and key populations. This will permit a more comprehensive view of the situation to be captured, as well as progress towards elimination of gender inequalities aligned to the epidemic context of each country.

Policy questions: Every two years, GARPR reporting includes completion of the National Commitments and Policy Instrument (NCPI). The most recent reporting on the NCPI was in 2014; therefore it is not requested in 2015. The Instrument includes questions related to the inclusion of women and girls and men and boys and key populations in national strategic plans and activities, assignment of budget for activities with these groups, and questions around legislation that may positively or negatively influence the impact of HIV-related activities on these populations. The data provide key information to understand the environment within which actions to promote gender equality are implemented. A revised version of the NCPI is expected to be included for 2016 reporting. Although it is not required in 2015 GARPR reporting, countries are encouraged to consider data reported in the 2014 GARPR and other information on the legal and policy environment in their analysis of gender dimensions of the epidemic and its response.

Narrative report: Countries are asked to submit a narrative report as part of the GARPR. The narrative report is an opportunity to bring together the different elements of the GARPR (indicator data and comment boxes, policy questions) through analysis and interpretation. Complementary data from other sources (e.g. population-based surveys such as the Demographic and Health Surveys) can also be reflected in the narrative report to provide

a more comprehensive overview of progress towards gender equality in the country. The Compendium of Gender Equality and HIV Indicators¹⁴ is a useful reference and guide to identify other complementary indicators that can be used to monitor progress against the 10 targets. The Indicator Registry (www.indicatorregistry.org) is a repository of AIDS indicator information and may also be a useful reference.

Summary: Monitoring progress towards gender equality through GARPR

- Sex- and age-disaggregated data for all targets and indicators, as relevant
- Prevalence of IPV as a proxy for gender equality
- Gender-based violence towards men and women, and of key populations
- Legal and policy environment
- Analysis of all available data together
- Analysis including complementary data sources

Key recommendations

Countries are encouraged to increase availability of sex- and age-disaggregated indicator data, such as during data collection efforts (e.g. survey implementation) or in reports of surveys and other data collection tools that will be more widely available. UNAIDS and partners in country can provide technical assistance to support these efforts.

Disaggregated data, where available, should be used in advocacy efforts and in drafting reports, presentations, press releases and other similar tools in order to provide targeted, gender-responsive and gender-transformative messages to improve policy development and programming at national, regional and global levels.

GARPR data can be triangulated, including with complementary data from other sources (e.g. integrated HIV bio-behavioral surveillance surveys), to generate a broader analysis and understanding of the gender dynamics in relation to the HIV epidemic and response in countries.

Civil society is a key partner in the analysis and interpretation of information related to progress towards target 7 and gender aspects throughout all targets.

Countries are encouraged to conduct gender assessments¹⁵ to identify the needs of women and girls in the context of HIV in a country, and use this information to develop or review their national strategic plan. Gender assessment reports may be a useful reference when analysing GARPR data in order to identify gender aspects that may be relevant in assessing progress towards each of the targets.

¹⁴ <http://www.cpc.unc.edu/measure/publications/ms-13-82>.

¹⁵ http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2543_gender-assessment_en.pdf

Checklist for reporting and assessing progress towards the 2011 Political Declaration targets from a gender perspective

Consultations with relevant partners throughout the process

Engaging relevant organizations and institutions in the process:

Ministry of Health

State agencies beyond Ministry of Health (e.g. Ministry of Women's Affairs, Ministry of Education, Ministry of Interior, National Drug Law Enforcement Agencies)

Male, female and transgender key populations

Men, women and transgender people living with HIV, including adolescents

Women's rights groups and/or organizations working on gender equality issues, including men's organizations working for gender equality

Indicator data collection and reporting

Include sex- and age-disaggregated data for all indicators, as relevant

Include the most current, relevant data available for Indicator 7.1 on prevalence of IPV

Provide explanatory text/comments for Indicator 7.1 if the data provided were collected using a methodology different to that recommended in the GARPR guidelines

Provide any available data on gender-based violence towards women and men, including of key populations, in the corresponding comment box in the Indicator 7.1 indicator page

Attach relevant reports of data submitted through GARPR on each indicator page

Data analysis

Analyse sex- and age-disaggregated data throughout GARPR indicators to identify any differences between groups

Analyse age-disaggregated data for Indicator 7.1 and identify any differences in prevalence by age

Analyse available data on gender-based violence, other than IPV, towards women, jointly with data from other GARPR indicators (e.g. knowledge, condom use)

Jointly analyse sex- and age-disaggregated data for GARPR indicators with data for Indicator 7.1 and any available data on gender-based violence towards other population groups

Table 1: Selected epidemiological estimates and available disaggregation

Indicator	Disaggregated by sex	Disaggregated by age
HIV prevalence	Yes	Yes (0-14, 15-24, 15-49, 50+)
Number of people living with HIV	Yes	Yes (0-14, 15-24, 15-49, 50+)
Number of new HIV infections	Yes	Yes (0-14, 15-24, 15-49, 50+)
HIV Incidence	Yes	Yes (15-24, 15-49, 50+)
Percentage of all people living with HIV currently receiving antiretroviral therapy	Yes	Yes (0-14*, 50+)
Number of women in need of antiretroviral medicines to prevent mother-to-child transmission	N/A	No
Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	N/A	No
Annual number of AIDS deaths	Yes	Yes (0-14, 15-24, 15-49, 50+)

Epidemiological estimates should always be reported with upper and lower uncertainty bounds. Proportions should be calculated on the basis of unrounded estimates data.

*Sex disaggregation not presented for ages 0-14.

Table 2: Selected GARPR indicators and recommended disaggregation

	Indicator	Disaggregated by gender	Disaggregated by age
General population	Percentage of young people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Yes	Yes (15-19, 20-24)
	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Yes	Yes (15-19, 20-24)
	Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months	Yes	Yes (15-19, 20-24, 25-49)
	Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Yes	Yes (15-19, 20-24, 25-49)
	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.	Yes	Yes (15-19, 20-24, 25-49)
	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Yes	Yes (<15, 15+)
	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	Yes (15-19, 20-24, 25-49)
	The percent of respondents who say they would buy fresh vegetables from a vendor whom they knew was HIV+	Yes	Yes (15-19, 20-24, 25-49)
	Current school attendance rate of orphans aged 10-14	Yes	N/A

	Indicator	Disaggregated by gender	Disaggregated by age
Sex workers	Percentage of sex workers reached with HIV prevention programs	Yes (female, men, transgender)	Yes (<25, 25+)
	Percentage of sex workers reporting the use of a condom with their most recent client	Yes (female, men, transgender)	Yes (<25, 25+)
	Percentage of sex workers who received an HIV test in the past 12 months and know their results.	Yes (female, men, transgender)	Yes (<25, 25+)
	Percentage of sex workers who are living with HIV	Yes (female, men, transgender)	Yes (<25, 25+)
Men who have sex with men	Percentage of men who have sex with men reached with HIV prevention programs	N/A	Yes (<25, 25+)
	Percentage of men who have sex with men reporting the use of a condom the last time they had anal sex with a male partner.	N/A	Yes (<25, 25+)
	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	N/A	Yes (<25, 25+)
	Percentage of men who have sex with men who are living with HIV	N/A	Yes (<25, 25+)
People who inject drugs	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	Yes	Yes (<25, 25+)
	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected.	Yes	Yes (<25, 25+)
	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	Yes	Yes (<25, 25+)
	Percentage of people who inject drugs who are living with HIV	Yes	Yes (<25, 25+)

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic(s)
ART	Antiretroviral therapy
BSS	Behavioural Surveillance Survey
DHS	Demographic and Health Survey
EID	Early Infant Diagnosis
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user/people who inject drugs (latter preferred language)
ILO	International Labour Organization
IPV	Intimate Partner Violence
MC	Male circumcision
MTCT	Mother-to-Child Transmission
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MSM	Men who have sex with men
M&E	Monitoring and evaluation
NA	Not Applicable
NAC	National AIDS Committee(s)
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NGO	Nongovernmental Organization(s)
NSP	National Strategic Plan
NSP	Needle and Syringe Programmes
OECD	Organisation for Economic Co-operation and Development
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper

PWID	People who inject drugs
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection(s)
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization



PART 2

A GUIDE ON INDICATORS FOR MONITORING AND REPORTING ON THE HEALTH SECTOR RESPONSE TO HIV AND AIDS 2015



List of Abbreviations

3TC	lamivudine
ABC	abacavir
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral drug
AZT	zidovudine
CTX	co-trimoxazole
DHS	Demographic and Health Survey
DPT3	third dose of diphtheria, pertussis and tetanus vaccine
d4T	stavudine
EBF	exclusive breastfeeding
EIA	enzyme immunoassay
EID	early infant diagnosis
EFV	efavirenz
FDC	Fixed Dose Combination
FTC	emtricitabine
GARPR	Global AIDS Response Progress Reporting
HBV	hepatitis B virus
HBsAg	Hepatitis B surface antigen
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HIVDR	HIV drug resistance
HTC	HIV testing and counselling
IDP	internally displaced persons
IDU	Injecting drug users
IEC	Information, Education and Communication
IF	infant feeding
IPT	isoniazid preventive therapy. Also can be termed TBPT (TB preventive therapy)
L&D	labour and delivery
LMIS	logistics management information system
LPV/r	lopinavir
M&E	monitoring & evaluation
MC	male circumcision
MDG	Millennium Development Goal
MOH	Ministry of Health
MF	mixed feeding
MNCH	Maternal, Newborn and Child Health
MTCT	mother-to-child transmission
NAP	National AIDS Programme
NSP	needle and syringe programme
NNRTI	non-nucleoside reverse transcriptase inhibitors
NRTI	nucleoside reverse transcriptase inhibitors
OST	opioid substitution therapy
PAHO	Pan American Health Organization
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
RPR	rapid plasma reagin
RF	replacement feeding

SAM	Service Availability Mapping
SPA	Service Provision Assessment
SRH	Sexual and Reproductive Health
STI	sexually transmitted infections
SW	sex workers
TB	tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
T&C	testing and counselling
TDF	tenofovir
TPHA	<i>treponema pallidum</i> haemagglutination assay
TPPA	<i>treponema pallidum</i> particle agglutination assay
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNPD	United Nations Population Division
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counselling and testing
VDRL	venereal disease research laboratory test
VL	viral load

TABLE OF CONTENTS

I. INTRODUCTION

Introduction	5
Indicator descriptions in this guide	6
Technical support and contact for questions	7
Acknowledgements	7

II. INDICATOR DESCRIPTIONS

List of indicators	8
--------------------	---

Target 1. Reduce sexual transmission of HIV by 50% by 2015

Testing and counselling

1.15 Number of health facilities that provide HIV testing and counselling services (UA)	14
1.16 HIV Testing and counselling in women and men aged 15 and older (UA)	15
1.16.1 Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months (UA)	16

Sexually transmitted Infections

1.17 Sexually Transmitted Infections (STIs) (UA)	
1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis (UA)	16
1.17.2 Percentage of antenatal care attendees who were positive for syphilis (UA)	17
1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment (UA)	19
1.17.4 Percentage of sex workers with active syphilis (UA)	20
1.17.5 Percentage of men who have sex with men with active syphilis (UA)	21
1.17.6 Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months (UA)	22
1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months (UA)	22
1.17.8 Number of men reported with gonorrhoea in the past 12 months (UA)	23
1.17.9 Number of men reported with urethral discharge in the past 12 months (UA)	24
1.17.10 Number of adults reported with genital ulcer disease in the past 12 months (UA)	25
1.18 Percentage (%) of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis (PAHO only)	26
1.19 Diagnosis of HIV and AIDS cases (UA)	
1.19.1 Number of HIV cases diagnosed by age and sex from 2010-2014 (UA)	26
1.19.2 Number of AIDS cases diagnosed by age and sex from 2010-2014 (UA)	26

Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015

2.6 People on opioid substitution therapy (UA)	28
2.7 NSP and OST sites (UA)	28

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

3.3a Mother-to-child transmission rate (based on programme data) (UA)	31
3.4 Pregnant women who were tested for HIV and received their results (UA)	31
3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months (UA)	33
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing (UA)	34

3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks (UA)	36
3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth (UA)	38
3.10 Distribution of outcomes of HIV-Exposed Infants (UA)	39
3.11 Number of pregnant women attending ANC at least once during the reporting period (UA)	40
3.11.1 Percentage of HIV-positive pregnant women who had their pregnancy terminated (EURO8)	40
3.11.2 Percentage of HIV-positive pregnant women who delivered during the reporting year (EURO9)	41
3.12 ANC and EID facilities (UA)	41
3.13 EURO-specific PMTCT Indicator (pregnant women who inject drugs)	
3.13.1 Percentage of HIV-positive pregnant women who were injecting drug users (IDUs) (EURO11)	43
3.13.2 Percentage of HIV-positive pregnant IDU women who received OST during pregnancy (EURO12)	43
3.13.3 Percentage of HIV-positive pregnant IDU women who received ARVs to reduce the risk of mother-to-child transmission during pregnancy (EURO13)	44

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

4.1. Percentage of adults and children currently receiving antiretroviral therapy	45
4.2b Twenty-four month retention on antiretroviral therapy (UA)	46
4.2c Sixty-month retention on antiretroviral therapy (UA)	46
4.2.1 Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months, 24 months and 60 months after initiation of antiretroviral therapy (EURO4)	47
4.3.a Number of health facilities that offer antiretroviral therapy (UA)	49
4.3.b Number of health facilities that offer paediatric antiretroviral therapy (UA)	50
4.4 ARV stock-outs (UA)	51
4.5 Late HIV diagnoses (UA)	53
4.6 HIV care (UA)	53
4.7 Viral Load (UA)	54

Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

5.2 Percentage of people living with HIV newly enrolled in HIV care with active TB disease	56
5.3 Percentage of people living with HIV newly enrolled in HIV care, started on isoniazid preventive therapy (IPT) (UA)	57
5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit (UA)	58

P.1b Policy and Programmatic Questions (UA)	60
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Appendix 1. HIV/Hepatitis Indicators (EURO/PAHO)

Number of adults and children currently in HIV care who were screened for hepatitis B (EURO15/ PAHO1)	75
Percentage of HIV-positive hepatitis B cases eligible for hepatitis B treatment who received treatment for both hepatitis B and HIV (EURO16/ PAHO2)	75
Number of adults and children currently in HIV care who were screened for hepatitis C (EURO17/PAHO3)	76
Percentage of HIV-positive hepatitis C cases eligible for hepatitis C treatment who received treatment for hepatitis C (EURO18/ PAHO4)	77

I. Introduction

As countries scale up their national HIV/AIDS programmes towards the goal of universal access (UA) to prevention, treatment, care and support, it is increasingly important to strengthen strategic information on the epidemic and national responses to inform policies and programmes, improve the effectiveness of interventions and promote accountability.

At the international level, WHO is committed since the 59th World Health Assembly in 2006 to monitor and report annually on global progress in countries' health sector responses towards universal access to HIV prevention, treatment, care and support.¹ WHO is working with UNICEF and UNAIDS to harmonize the global monitoring and reporting on the health sector response to HIV/AIDS towards universal access. This joint work of the UN partners aims to harmonize data collection and minimize the reporting burden on countries.

In order to collect data from countries, WHO, UNAIDS and UNICEF have developed a Joint Online Reporting Tool. The reporting tool and guidance on the Global AIDS Response Progress Reporting indicators and the UA health sector indicators are available at <http://AIDSreporting.unaids.org>.

This part of the guide describes in detail the additional health sector indicators that are not described in the UNAIDS Global AIDS Response Progress Reporting. It can also be considered for use to monitor the health sector response at the national level, in addition with other information, to review progress. In summary:

- **Global Reporting:** This part of the guide complements the UNAIDS *Global AIDS Response Progress Reporting 2015: guidelines. Construction of core indicators for monitoring the 2011 Political Declaration on HIV/AIDS*. The overall recommended country reporting process is described in detail in the global reporting guidelines. This section aims to support and facilitate data collection using the Joint Online Reporting Tool with a focus on the additional indicators of the 2015 health sector reporting requested which are not part of the GARPR indicators. The online data collection tool, disseminated to all countries, is the main tool to enable annual global reporting on the health sector progress towards universal access to HIV prevention, care, and treatment.
- **National Monitoring:** This guide can also be used for national monitoring of the health sector's response to HIV/AIDS. It can be adapted to the epidemic context of each country. For example, countries should select indicators that would support monitoring of their own nationally-set targets. They may also add or remove some of the indicators depending on the importance of intervention areas to their country epidemic.

¹ HIV/AIDS. *WHO's contribution to universal access to HIV/AIDS prevention, treatment and care: report by the Secretariat*. Geneva, WHO, 2006.

The indicator number is the number in the 2015 GARPR/UA reporting tool

II. Indicator descriptions in this guide

The indicator descriptions follow this format:

X. INDICATOR TITLE	
Rationale	Why this indicator is important
What it measures	What the indicator measures
Numerator	Definition of the numerator
Denominator	Definition of the denominator (sources of information must be specified: for some indicators, estimates only are possible and/ or required)
How to Measure and Measurement Tools	What is included in the numerator and denominator Method of measurement Tools used for measurement
Disaggregation	Recommended disaggregation. Even if not included for breakdown in the Reporting Tool, disaggregation is recommended to be collected for national monitoring and reporting as appropriate.
Strengths and weaknesses	Description of the strengths and weaknesses of the indicator
Additional considerations	Other points for countries to note
Data utilization	How this indicator can be used and some implications
Data Quality Control and Notes for the Reporting Tool	Additional information on issues to consider when filling in the reporting tool. Includes elements of: ▪ <i>Double Reporting:</i> What to pay attention to in order to assess possible double reporting. ▪ <i>National Representativeness:</i> What to pay attention to in order to assess the national representativeness of the value reported. ▪ <i>Denominator Issues:</i> Issues to note about the denominator ▪ <i>Triangulation Options:</i> Other data sources that can be reviewed to assess the validity of the indicator value
Other References	References related to the indicator, e.g.: <i>PMTCT:</i> Indicator in the updated Monitoring and Evaluating the PMTCT of HIV A guide for national programmes (2011) <i>HIV/TB:</i> Indicators in the updated A guide to monitoring and evaluation for collaborative TB/HIV M&E activities, 2014 Revision <i>People who inject drugs:</i> WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (2012)

Technical Support and Contact for Questions

WHO, UNICEF and UNAIDS are committed to support countries improve their strategic information system, including and not limited to the review of health sector M&E systems; data quality and validation; evaluating impact; surveillance; operational research; and training in various aspects of strategic information.

Please do not hesitate to contact WHO at hivstrategicinfo@who.int for any questions or requests, or to send any comments and suggestions for improving this guidance.

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WHO and UNICEF appreciate the contribution of MACRO-DHS to provide the latest DHS (Demographic and Health Survey) results available.

II. INDICATOR DESCRIPTIONS

The present table gives an overview of the indicators described in the Global AIDS Response Progress Reporting 2015 guidelines and those described in this guide for the 2015 health sector reporting for universal access (UA2015).

GARPR	UA	
Target 1. Reduce sexual transmission of HIV by 50% by 2015		
<i>Indicators for the general population</i>		
x		1.1 Young people: Knowledge about HIV prevention
x		1.2 Sex before the age of 15
x		1.3 Multiple sexual partners
x		1.4 Condom use at last sex among people with multiple sexual partnerships
x		1.5 HIV Testing in the general population
x		1.6 HIV prevalence in young people
<i>Indicators for sex workers</i>		
x		1.7 Sex workers: prevention programmes
x	x	1.8 Sex workers: condom use
x	x	1.9 HIV testing in sex workers
x	x	1.10 HIV prevalence in sex workers
<i>Indicators for men who have sex with men</i>		
x		1.11 Men who have sex with men: prevention programmes
x	x	1.12 Men who have sex with men: condom Use
x	x	1.13 HIV testing in men who have sex with men
x	x	1.14 HIV prevalence in men who have sex with men
<i>Testing and Counselling</i>		
	x	1.15 Number of health facilities that provide HIV testing and counselling services

GARPR	UA	
	x	1.16 HIV testing and counselling in women and men
	x	1.16.1 Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months
		<i>Sexually Transmitted Infections</i>
	x	1.17 Sexually Transmitted Infections (STIs)
	x	1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis
	x	1.17.2 Percentage of antenatal care attendees who were positive for syphilis
	x	1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment
	x	1.17.4 Percentage of sex workers with active syphilis
	x	1.17.5 Percentage of men who have sex with men with active syphilis
	x	1.17.6 Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months
	x	1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months
	x	1.17.8 Number of men reported with gonorrhoea in the past 12 months
	x	1.17.9 Number of men reported with urethral discharge in the past 12 months
	x	1.17.10 Number of adults reported with genital ulcer disease in the past 12 months
	x	1.18 Percentage of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis (PAHO only)
	x	1.19 Diagnosis of HIV and AIDS cases
	x	1.19.1 Number of HIV cases diagnosed by age and sex from 2010–2014
	x	1.19.2 Number of AIDS cases diagnosed by age and sex from 2010–2014
		<i>Male circumcision</i>
x	x	1.22 Male circumcision, prevalence
x	x	1.23 Number of men circumcised last year
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015		

GARPR	UA	
x	x	2.1 People who inject drugs: prevention programmes
x	x	2.2. People who inject drugs: condom use
x	x	2.3 People who inject drugs: safe injecting practices
x	x	2.4 HIV testing in people who inject drugs
x	x	2.5 HIV prevalence in people who inject drugs
	x	2.6 People on opioid substitution therapy
	x	2.7 NSP and OST sites
		Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths
x	x	3.1 Prevention of mother-to-child transmission
x	x	3.1a Prevention of mother-to-child transmission during breastfeeding
x	x	3.2 Early infant diagnosis
x	x	3.3 Mother-to-child transmission of HIV (modelled)
	x	3.3a Mother-to-child transmission rate (based on programme data)
	x	3.4 Pregnant women who were tested for HIV and received their results
	x	3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months
	x	3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing
	x	3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks
	x	3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth
	x	3.10 Distribution of outcomes of HIV-Exposed Infants
	x	3.11 Number of pregnant women attending ANC at least once during the reporting period
	x	<i>3.11.1 Percentage of HIV-positive pregnant women who had their pregnancy terminated (EURO8)</i>
	x	<i>3.11.2 Percentage of HIV-positive pregnant women who delivered during the reporting year (EURO9)</i>

GARPR	UA	
	x	3.12 ANC and EID facilities
	x	3.13 EURO-specific PMTCT Indicator (pregnant women who inject drugs)
	x	3.13.1 Percentage of HIV-positive pregnant women who were injecting drug users (IDUs) (EURO11)
	x	3.13.2 Percentage of HIV-positive pregnant IDU women who received OST during pregnancy (EURO12)
	x	3.13 Percentage of HIV-positive pregnant IDU women who received ARVs to reduce the risk of mother-to-child transmission during pregnancy (EURO13)
		Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
x	x	4.1 HIV treatment: antiretroviral therapy
x	x	4.2 Twelve-month retention on antiretroviral therapy
	x	4.2b Twenty-four month retention on antiretroviral therapy
	x	4.2c Sixty-month retention on antiretroviral therapy
	x	4.2.1 Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months, 24 months and 60 months after initiation of antiretroviral therapy (EURO4)
	x	4.3 Health facilities that offer antiretroviral therapy
	x	4.4 ARV stock-outs
	x	4.5 Late HIV diagnoses
	x	4.6 HIV care
	x	4.7 Viral Load
		Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015
x	x	5.1 Co-Management of Tuberculosis and HIV Treatment
	x	5.2 Percentage of people living with HIV (PLHIV) newly enrolled in HIV care who are detected having with active TB disease
	x	5.3 Percentage of people living with HIV and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT))
	x	5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$22–24 billion in low- and middle-income countries

x

6.1 AIDS Spending

Target 7. Eliminating gender inequalities

x

7.1 Prevalence of recent intimate partner violence (IPV)

Target 8. Eliminating stigma and discrimination

x

8.1 Discriminatory attitudes towards people living with HIV

Target 9. Eliminate Travel restrictions

Target 10. Strengthening HIV integration

x

10.1 Orphans school attendance

x

10.2 External economic support for eligible to the poorest households

x

P.1 Policy and Programmatic Questions

Appendix

Appendix 1. HIV/Hepatitis Indicators (EURO/PAHO)

x

Number of adults and children currently in HIV care who were screened for hepatitis B (EURO15/ PAH01)

x

Percentage of HIV-positive hepatitis B cases eligible for hepatitis B treatment who received treatment for both hepatitis B and HIV (EURO16/ PAH02)

x

Number of adults and children currently in HIV care who were screened for hepatitis C (EURO17/ PAH03)

x

Percentage of HIV-positive hepatitis C cases eligible for hepatitis C treatment who received treatment for hepatitis C (EURO18/ PAH04)

Note on Defining “Health Facility”

A frequently asked question is what we are defining as a **health facility**. For the purposes of this reporting process, we are excluding health facilities that provide specialized care which would never provide any HIV services (e.g. an eye clinic). If you have difficulties trying to define what is counted as a health facility for this exercise, please provide any comments you have in the Comment box or e-mail WHO at hivstrategicinfo@who.int.

Target 1: Reduce Sexual transmission of HIV by 50% by 2015

Testing and Counselling

1.15 Number of health facilities that provide HIV testing and counselling services

Rationale	Knowledge of HIV status is critical to expand access to HIV treatment, care and support, and prevention. Availability of testing and counselling (TC) services is the pre-requisite for scaling up TC coverage so that more people know their HIV status, which can be expanded through client-initiated testing and counselling (CITC) and provider initiated testing and counselling (PITC) models.
What it measures	Availability of TC services in health facilities.
Numerator	Number of health facilities that provide HIV testing and counselling services
How to Measure and Measurement Tools	Numerator: Two possible sources of information, either: 1. Central register of all T&C sites; 2. Central test kit procurement records for the number of facilities requesting kits. If both are available, then provide the information from both <i>Please include data on all facilities providing services in the country, whether private, public, NGO, or other.</i> Information on availability of certain services are usually summarized at the national or sub-national level. National TC programs should have a record of facilities that provide TC services. Effort should be made to include facilities providing services in the private and NGO sectors, especially where they are a significant provider of TC services. A recent health facility census can also provide this information as well as much more in-depth information on availability of services. All sites where TC is offered should be counted. Thus sites that offer testing and refer out samples to a lab elsewhere, get test results back, and relay results to the client, are included. All sites will be included in the numerator.
Disaggregation	<i>If possible, by:</i> 1. <i>Type of health facility (e.g., government health facilities, NGOs, CBOs, mission hospitals, and private health facilities)</i> 2. <i>Type of services offered (e.g., TB clinic, STI clinic, etc.)</i>
Strengths and weaknesses	This indicator is intended to monitor availability of TC services as countries continue to expand TC. It does not intend to capture quality of TC services provided.
Data utilization	To look at progress in the number of health facilities which provide testing and counselling. Analysing the data geographically and by type of health facilities, and triangulating it with population data, can provide insight into where there is a need to increase availability of TC services.
Additional considerations	It is recommended that every health facility has the capacity to offer testing and counselling in generalized epidemics ² . In low-level and concentrated epidemics, the goal may not be to have TC services available in every facility
Data Quality Control and Notes for the Reporting Tool	<i>National Representativeness: Effort should be made to include all public, private and NGO-run health facilities.</i> The numerator matters in the comparison of trends in service availability over time.

² Guidance of provider-initiated testing and counselling in health facilities, WHO/UNAIDS, 2007.

1.16 Number of people who received HIV testing and counselling in the last 12 months and know their results

Rationale	Knowledge of HIV status is critical for access to HIV treatment, care and support, and prevention. There are different models for delivery of the testing and counselling services such as client-initiated testing and counselling (CITC) and provider-initiated testing and counselling (PITC). The essential elements of TC are that those who are tested are appropriately counselled and know the results.
What it measures	Number of people aged 15 and older who received HIV T&C through any method or setting (excluding mandatory T&C) in the past 12 months and know their results (Note: Although not required for the purposes of this indicator the denominator may be gauged by using the general population as the denominator in generalized epidemics, and the key populations at higher risk and other groups for low-level and concentrated epidemics. These data can be reviewed along with an estimate of what percentage of the HIV+ population already know their status, and what the recommended HIV testing policy or frequency is. Programmatic progress for testing and counselling. Tracking the number of individuals who are tested and counselled and know their status provides an indication of uptake of T&C in the country.
How to Measure and Measurement Tools	Programme service statistics compiled from routine reports of the number of people tested and know the results from all service points, including clinics, hospitals, VCT sites, other NGO sites and outreach points, mobile testing, home and community testing, testing delivered in the workplace, schools, testing as part of special campaigns, and all other forms of testing (excluding mandatory T&C) which are often aggregated at the district levels and subsequently at the national level. This indicator is not measured through population-based surveys.
Disaggregation	Sex: male, female, pregnancy Serostatus: HIV positive, HIV negative If possible: Age: <15, <1, 1–9, 10–14, 15+, 15–19, 20–24, 25–49, 50+ Test: New test , Repeated test HIV transmission mode: injecting drug use, sex between men, heterosexual contact, mother-to-child transmission, other and unknown (European Region only)
Strengths and weaknesses	This indicator permits comparison of trends of the quantity of TC services delivered and the strength of scaling up TC services over time. This indicator may provide information on the number of times T&C occurred, and not necessarily the number of people who received T&C services unless countries have a mechanism to avoid double-counting of repeat testers. The indicator does not provide information on whether those who were tested were adequately referred to and receiving follow-up services to benefit from knowing their status.
Data utilization	To review the number of tests conducted in the country, data can be compared with previous years to look at trends while considering the percentage of the population that may have already been tested recently. It can be useful to

explore any patterns in testing, for example whether there were more tests conducted in a particular season or month when there were campaigns, or whether many more people are being tested in particular health facilities or in the communities.

Additional considerations for countries

In some countries, a significant proportion of testing and counselling services are provided by community-based organizations or unregistered organizations, which often may not be included as part of national statistics. These organizations should be encouraged to register with national authorities so all data on testing and counselling could be reflected in the national statistics.

Data Quality Control and Notes for Reporting

Double Reporting: Countries will need to estimate the extent of repeat testers in order to determine the true number of persons tested over the period. If countries have a mechanism to make such a meaningful assessment (e.g. record of the number of repeat tests or re-testers within a year), please do so and note how this was done. Otherwise, please report the total number of tests reported and clarify that repeat tests are likely included.

National Representativeness: Try to ensure information from non-governmental and private facilities is also available at the central level. If significant information is missing, note it down in the comments section.

Denominator Issues: Although not required for the purposes of this indicator the validity of the numerator may be gauged by comparing the general population as the denominator in generalized epidemics, and the size of the key populations at higher risk and other groups for low-level and concentrated epidemics.

Triangulation Options: In generalized epidemics, data from population-based surveys asking for the number (and calculating the percentage) of people tested can be compared to with this indicator value to assess and discuss any major differences.

1.16.1 Percentage of health facilities dispensing rapid HIV test kits that experienced a stock-out in the last 12 months

Numerator	Number of health facilities dispensing rapid HIV test kits (if applicable) that experienced a stock-out in the last 12 months
Denominator	Total number of health facilities dispensing rapid HIV test kits

Sexually Transmitted Infections

1.17.1 STIs: Percentage of women accessing antenatal care (ANC) services who were tested for syphilis

Rationale	Testing pregnant women for syphilis early in pregnancy is important both for their health and the health of the fetus, and contributes to monitoring of the quality of ANC services and services to prevent HIV among pregnant women. It is also a core process indicator for assessment of validation of elimination of mother-to-child transmission (MTCT) of syphilis.
What it measures	Coverage of syphilis testing in women attending first ANC services
Numerator	Number of women attending ANC services who were tested for syphilis
Denominator	Number of women attending ANC services
How to Measure and Measurement Tools	How to measure: All pregnant women should be tested ("screened") for syphilis at their first antenatal care visit. Ideally countries will report on testing at any visit as well as testing at first visit. Countries unable to distinguish first visit from testing at any visit should still report data on this indicator, but should make sure that it is clearly reported as data for "any visit". This indicator should be measured annually.

Either non-treponemal tests that measure reaginic antibody (e.g., VDRL or RPR) or treponemal tests that measure treponemal antibody (e.g., TPHA, TPPA, EIA or rapid treponemal tests) may be used for screening. For this indicator simply being tested by either type of test is sufficient, although being tested with both is preferred. Please indicate in the "Comments" section what test type is generally used in your country.

Measurement tools: Ideally national programme records aggregated from health facility data should be used. However, if national programme data are not available, data from sentinel surveillance or special studies can be reported if the data are felt to be representative of the national situation. Please specify the source and coverage of your data (for example, national programme data from all 12 provinces) in the "Comments" section.

Disaggregation

Tested at any visit, tested at first visit

Additional considerations

Countries may wish to also monitor the week of pregnancy that each woman is tested. Preventing congenital syphilis requires testing early in pregnancy, as stillbirth may occur in the second trimester. Knowing that women are being tested late in pregnancy will indicate either that women are not accessing ANC early or that testing is not occurring early in pregnancy.

Programmes that test pregnant women for syphilis and those that test pregnant women for HIV should work together to enhance the effectiveness of their individual programme work.

Data utilization

Global: Examine trends over time to assess progress towards target levels of testing coverage required for elimination of mother-to-child transmission of syphilis. Knowledge of testing policies and practices should be used to assist with interpretation of trends in coverage. Data on testing of ANC attendees can later be combined with data on ANC attendance to estimate overall coverage of syphilis testing among pregnant women.

Local: Data can be used to identify clinics not fully implementing national policy.

Data Quality Control and Notes for the Reporting Tool

Please comment on if the data you are providing is routine programme data, and if it is felt to be representative of the entire country.

Other References

Recommended indicator in "National-Level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and practical considerations and related indicators", "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems", and "Criteria and Processes for Validation of Elimination of Mother-to-Child Transmission of HIV and Syphilis"

1.17.2 STIs: Percentage of antenatal care attendees who were positive for syphilis

Rationale

Syphilis infection in antenatal care attendees can be used to guide STI prevention programme needs, and may provide early warning of potential changes in HIV transmission in the general population.

What it measures

The percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology

Numerator

Number of antenatal care attendees who tested positive for syphilis

Denominator

Number of antenatal care attendees who were tested for syphilis

How to Measure and Measurement Tools

How to measure: Syphilis positivity can be measured using either non-treponemal tests (e.g., RPR or VDRL), treponemal tests (e.g. TPHA, TPPA, EIA, or a variety of available rapid tests), or ideally a combination of both. A reactive non-treponemal test, particularly if the titre is high, is suggestive of active infection, whereas positivity with a treponemal test indicates any previous

infection even if treated successfully. For the purposes of this indicator (intended to measure seropositivity), it is acceptable to report positivity based on a single test result. If both treponemal and non-treponemal test results on an individual patient are available, then syphilis positivity should be defined as having positive results on both tests. Use of rapid treponemal test has allowed syphilis testing to occur in settings without laboratory capacity, greatly increasing the number of women who can be tested and treated for syphilis in pregnancy. Data should be collected annually.

Measurement tools: National programme records aggregated from health facility data, sentinel surveillance, or special surveys, using serologic tests to detect reagenic and/or treponemal antibody may be used. Please specify the source and coverage of your data (for example, sentinel surveillance of all ANC attendees in 2 of 10 provinces) as well as what test type is generally used in your country to define positivity in pregnant women in the "Comments" section (e.g., non-treponemal (RPR, VDRL), treponemal (rapid tests, TPPA), patients positive on both, or unknown).

Disaggregation

Age groups: Total, 15–24 years, 25 years and over

Strengths and weaknesses

Strengths: Data on syphilis positivity in pregnant women are available in most countries through routine health system reporting.

Weaknesses: Differences in test type used or changes in testing practices may affect data. Knowledge of testing practices within the country (e.g., proportion of treponemal vs. non-treponemal testing used) should be used to assist with interpretation of disease trends.

Additional considerations

- Countries are encouraged to use unique identifiers or registers that separate first and subsequent tests so that the data reflect syphilis true prevalence or incidence rather than test positivity.
- Since most countries will have data from a variety of test types, sub-analysis (disaggregation) in 15 to 24 year old women may increase the likelihood that test positivity reflects recent infection.

Data utilization

Global/regional: Estimate perinatal mortality and morbidity caused by syphilis that could be averted with effective programmes to eliminate MTCT of syphilis. Identify areas at greatest need of comprehensive congenital syphilis prevention interventions.

Local: Follow trends over time to assess changes in burden of disease and STI prevention programme needs.

All levels: Compare data on trends of syphilis and HIV to look for early warning of increased risk of HIV transmission.

Data Quality Control and Notes for the Reporting Tool

Please comment on if the data you are providing is routine programme data, if it is felt to be representative of the entire country, and what test type was used to define positivity in ANC attendees (e.g., non-treponemal, treponemal, patients positive on both, or mixed/unknown).

Other References

Recommended indicator in "National-Level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and practical considerations and related indicators" and "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems".

1.17.3 STIs: Percentage of antenatal care attendees positive for syphilis who received treatment

Rationale	Treatment of antenatal care attendees positive for syphilis is a direct measure of the elimination of mother-to-child transmission of syphilis programme efforts and efforts to strengthen primary HIV prevention. It is also a core process indicator for validation of EMTCT of syphilis.
What it measures	Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately.
Numerator	Number of antenatal care attendees with a positive syphilis serology who received at least one dose of benzathine penicillin 2.4 mU IM
Denominator	Number of antenatal care attendees with a positive syphilis serology
How to Measure and Measurement Tools	How to measure: Data should be collected annually. Seropositivity on either treponemal or non-treponemal test is sufficient for being considered positive for syphilis for this indicator. Measurement tools: Ideally national programme records aggregated from health facility data should be used. However, if national programme data are not available, data from sentinel surveillance or special studies can be reported <i>if it is felt to be representative of the national situation</i>. Please specify the source and coverage of your data (for example, national programme data from all 12 provinces) in the "Comments" section.
Disaggregation	None
Strengths and weaknesses	Strengths: Data on treatment of syphilis in antenatal care attendees is often routinely monitored in health facilities. Weaknesses: Collection of treatment data may require collaboration with MCH programmes to ensure that it is available at a national level.
Additional considerations	For purposes of this indicator, documentation of a single dose of penicillin is sufficient. Treatment of a pregnant woman positive for syphilis with a single injection of 2.4 mU benzathine penicillin prior to 24 weeks gestational age is sufficient to prevent transmission of syphilis from mother to infant. However, three injections spaced at weekly intervals are recommended to treat latent syphilis and prevent tertiary syphilis in the mother.
Data utilization	Global/regional/local: Estimate programme effectiveness in reducing syphilis-associated perinatal morbidity and mortality. Local: Identify areas in need of assistance with programme implementation or additional resources. All levels: Knowledge of treatment policies and practices should be used to assist with interpretation of trends in treatment.
Data Quality Control and Notes for the Reporting Tool	If the data you are providing does not cover the entire country, please comment.
Other References	Recommended indicator in "National-Level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and practical considerations and related indicators"; recommended indicator in "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems"; core process indicator in "Criteria and Processes for Validation of Elimination of Mother-to-Child Transmission of HIV and Syphilis"

1.17.4 STIs: Percentage of sex workers (SWs) with active syphilis

Rationale	Testing sex workers (SWs) for syphilis is important for their health, and for second generation surveillance purposes.
What it measures	Progress in decreasing high-risk sexual behaviour, and intervention efforts to control syphilis among sex workers.
Numerator	Number of sex workers who tested positive for active syphilis
Denominator	Number of sex workers who were tested for active syphilis
How to Measure and Measurement Tools	Measurement tools: Data from routine health information systems, sentinel surveillance or special surveys may be used. How to measure: The traditional approach to determining seroprevalence has been to screen with a non-treponemal test that measures reaginic antibody (e.g., VDRL or RPR) and confirm positive results with a treponemal test that measures treponemal antibody (e.g., TPHA, TPPA, EIA, or rapid treponemal test). Newer, rapid treponemal tests are comparatively easy to use, a feature which encourages the use of these tests for screening, ideally paired with a non-treponemal test that detects reaginic antibody. Whichever approach is used, the proposed indicator requires both a positive non-treponemal test AND a positive treponemal test to give a proxy for active infection. Just a non-treponemal test, or just a treponemal test, while useful in some situations for therapeutic purposes, is not sufficiently specific for surveillance of sex workers. The requirement for both a positive non-treponemal test and a positive treponemal test in sex workers differs from the indicator on syphilis testing in antenatal care attendees because sex workers are more likely to have a history of previous infection. A positive treponemal test measures lifetime exposure, whereas the non-treponemal test is a better indicator of active infection.
Disaggregation	Sex: total, male, female
Strengths and weaknesses	Strengths: Requiring testing by both tests enhances specificity of the reported numbers of positive tests. In addition, requiring testing by both tests will increase the likelihood of identifying active disease. Weaknesses: Requiring testing by both tests increases the difficulty of acquiring data for this indicator.
Additional considerations	Quality assurance and quality control should be an integral part of syphilis testing to ensure reliable results.
Data utilization	Look at trends in comparable groups over time. Compare with data on trends of syphilis and HIV where available.
Data Quality Control and Notes for the Reporting Tool	Please describe in “Comments” what type of sex workers the data represent and what setting the data were collected in. It is important NOT to count multiple tests run on the same patient. That is, if a person has been tested more than once in the past 12 months, they should not be counted more than once.

1.17.5 STIs: Percentage of men who have sex with men with active syphilis

Rationale	Testing of syphilis among men who have sex with men is important for their health, and for second generation surveillance purposes.
What it measures	Progress in decreasing high-risk sexual behaviour, and intervention efforts to control syphilis among men who have sex with men.
Numerator	Number of men who have sex with men who tested positive for active syphilis
Denominator	Number of men who have sex with men who were tested for active syphilis
How to Measure and Measurement Tools	Measurement tools: Routine health information systems, sentinel surveillance or special surveys. How to measure: The traditional approach to determining seroprevalence has been to screen with a non-treponemal test that measures reagenic antibody (e.g., VDRL or RPR) and confirm positive results with a treponemal test that measures treponemal antibody (e.g., TPHA, TPPA, EIA, or rapid treponemal test). Newer, rapid treponemal tests are comparatively easy to use, which encourages the use of these tests for screening, ideally paired with a non-treponemal test that detects reagenic antibody. Whichever approach is used, the proposed indicator requires both a positive non-treponemal test AND a positive treponemal test to give a proxy for active infection. Just a non-treponemal test, or just a treponemal test, while useful in some situations for therapeutic purposes, is not sufficiently specific for surveillance of men who have sex with men. The requirement for both a positive non-treponemal test and a positive treponemal test in men who have sex with men differs from the indicator on syphilis testing in antenatal care attendees because men who have sex with men are more likely to have a history of previous infection. A positive treponemal test measures lifetime exposure, whereas the non-treponemal test is a better indicator of active infection.
Disaggregation	None
Strengths and weaknesses	Strengths: Requiring testing by both tests enhances specificity of the reported numbers of positive tests. In addition, requiring testing by both tests will increase the likelihood of identifying active disease. Weaknesses: Requiring testing by both tests increases the difficulty of acquiring data for this indicator.
Additional considerations	Quality assurance and quality control should be an integral part of syphilis testing to ensure reliable results.
Data utilization	Look at trends in comparable groups over time. Compare with data on trends of syphilis and HIV where available.
Data Quality Control and Notes for the Reporting Tool	It is important NOT to count multiple tests run on the same patient. That is, if a person has been tested more than once in the past 12 months, they should not be counted more than once. Please describe in "Comments" what setting the data were collected in.

1.17.6 STIs: Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months

Rationale	Infection with an acute bacterial STI such as primary/secondary syphilis is a marker of unprotected sexual intercourse and facilitates HIV transmission and acquisition. Therefore, surveillance for primary/secondary syphilis contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated syphilis causes stillbirths and neonatal disease, and can progress to debilitating or fatal outcomes in adults.
What it measures	Progress in reducing unprotected sex in the general population.
Numerator	Number of adults reported with syphilis during the reporting period
Denominator	Number of individuals aged 15 and older
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	Sex, Primary/secondary vs. latent/unknown: Total, Total Female, Total Male, Female primary/secondary, Male primary/secondary
Strengths and weaknesses	Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.
Additional considerations	It is important that countries when reporting on syphilis communicate on the extent to which the data are felt to be representative of the national population. If a country is unable to report on the denominator, WHO will use denominator per UNPD.
Data utilization	Look at trends in comparable groups over time.
Data Quality Control and Notes for the Reporting Tool	Recommended indicator in: "Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012"

1.17.7 STIs: Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months

Rationale	Untreated syphilis infection in pregnancy can not only increase risk of HIV transmission and acquisition in the mother and the infant, but also lead to stillbirth, neonatal death, and congenital disease (collectively defined as "congenital syphilis"). Given the high efficacy, simplicity, and low cost of syphilis testing and treatment, global and regional initiatives to eliminate mother-to-child transmission (MTCT) of syphilis have been launched. The rate of congenital syphilis is a measure of the impact of programmatic interventions to eliminate MTCT of syphilis.
What it measures	Progress in elimination of MTCT of syphilis.
Numerator	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months
Denominator	Number of live births
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	None

Strengths and weaknesses	Diagnosis of congenital syphilis is most reliable when using specific diagnostic tests that are seldom available even in developed countries. Therefore, in most countries diagnosis of congenital syphilis relies on clinical history and examination, making surveillance challenging. Although WHO has a global case definition for surveillance purposes, actual case definition may vary between and within countries and regions.
Additional considerations	It is important that countries when reporting on syphilis communicate on the extent to which the data are felt to be representative of the national population. If a country is unable to report on the denominator, WHO will use denominator per UNPD.
Data utilization	Given the difficulties in diagnosing congenital syphilis, and depending on the case definition used, either underreporting or overreporting can be a problem. The likely magnitude of such reporting errors should always be considered when looking at rates of congenital syphilis. However, with use of a consistent case definition, trends over time may be useful.
Data Quality Control and Notes for the Reporting Tool	Countries should comment on any major differences between the national case definition and the global surveillance case definition (available on page 15 of: http://www.who.int/reproductivehealth/publications/rtis/9789241505895/en/index.html). In particular, countries should note if stillbirths are counted in their national case definition or not. Recommended indicator in "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems" and core impact indicator in "Criteria and Processes for Validation of Elimination of Mother-to-Child Transmission of HIV and Syphilis"

1.17.8 STIs: Number of men reported with gonorrhoea in the past 12 months

Rationale	Infection with an acute bacterial STI such as gonorrhoea is a marker of unprotected sexual intercourse and facilitates HIV transmission and acquisition. Therefore, surveillance for gonorrhoea contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated gonorrhoea can result in pelvic inflammatory disease, ectopic pregnancy, infertility, blindness, and disseminated disease. Increasing resistance to currently recommended treatment options may render this infection untreatable.
What it measures	Progress in reducing unprotected sex in men.
Numerator	Number of men reported with gonorrhoea during the reporting period
Denominator	Number of males aged 15 and older
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	None
Strengths and weaknesses	Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.
Additional considerations	It is important that countries when reporting on gonorrhoea communicate on the extent to which the data are felt to be representative of the national population. Data on gonorrhoea among women, although useful for monitoring purposes at

a local and national level, are not requested at the global level because the majority of women infected with *Neisseria gonorrhoeae* are asymptomatic and sensitive diagnostic tests for gonorrhoea in women are not widely available in developing countries. Therefore data on gonorrhoea among women are felt to be too dependent on diagnostic resources and screening practices to be monitored appropriately at the global level.

If a country is unable to report on the denominator, WHO will use denominator per UNPD.

Data utilization

Look at trends in comparable groups over time.

Data Quality Control and Notes for the Reporting Tool

Recommended indicator in: "Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012"

1.17.9 STIs: Number of men reported with urethral discharge in the past 12 months

Rationale

Urethral discharge in men is an STI syndrome generally most commonly caused by *Neisseria gonorrhoeae* or *Chlamydia trachomatis*. Presentation with an acute STI syndrome such as urethral discharge is a marker of unprotected sexual intercourse and urethral discharge facilitates HIV transmission and acquisition. Therefore, surveillance for urethral discharge contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated urethral discharge can result in infertility, blindness, and disseminated disease. Increasing resistance to currently recommended treatment options for *Neisseria gonorrhoeae* may render this infection untreatable.

What it measures

Progress in reducing unprotected sex in men.

Numerator

Number of men reported with urethral discharge during the reporting period

Denominator

Number of males aged 15 and older

How to Measure and Measurement Tools

Routine health information systems.

Disaggregation

None

Strengths and weaknesses

Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, clinical diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.

Additional considerations

It is important that countries when reporting on urethral discharge communicate on the extent to which the data are felt to be representative of the national population.

Following trends in urethral discharge is a feasible means to monitor incident STI in a population. Data on vaginal discharge among women, although useful for monitoring purposes at a local and national level, are not requested at the global level because in many settings the majority of vaginal discharge cases are not due to sexually transmitted infections.

Countries should conduct periodic assessments of the etiology of urethral discharge syndrome in order to understand the predominant causes of urethral discharge and therefore appropriate therapy.

If a country is unable to report on the denominator, WHO will use denominator per UNPD.

Data utilization

Look at trends in comparable groups over time.

Data Quality Control
and Notes for the
Reporting Tool

Recommended indicator in: “Strategies and laboratory methods for
strengthening surveillance of sexually transmitted infection 2012”

1.17.10 STIs: Number of adults reported with genital ulcer disease in the past 12 months

Rationale

Genital ulcer disease is an STI syndrome generally most commonly caused by syphilis, chancroid, or herpes simplex virus. Presentation with an acute STI syndrome such as genital ulcer disease is a marker of unprotected sexual intercourse and facilitates HIV transmission and acquisition. Therefore, surveillance for genital ulcer disease contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated genital ulcer diseases can cause stillbirths and neonatal disease, and can progress to debilitating or fatal outcomes in adults.

What it measures

Progress in reducing unprotected sex in the general population.

Numerator

Number of adults reported with genital ulcer disease during the reporting period

Denominator

Number of individuals aged 15 and older

How to Measure and
Measurement Tools

Routine health information systems

Disaggregation

Sex: total, men, women

Strengths and
weaknesses

Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, clinical diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.

Additional
considerations

It is important that countries when reporting on genital ulcer disease communicate on the extent to which the data are felt to be representative of the national population.

Countries should conduct periodic assessments of the etiology of genital ulcer disease in order to ensure appropriate drug selection for syndromic management and to understand the extent to which genital ulcer disease reflects incident infection due to recurrent HSV infection versus acute infection with syphilis, chancroid, or HSV.

If a country is unable to report on the denominator, WHO will use denominator per UNPD.

Data utilization

Look at trends in comparable groups over time.

Data Quality Control
and Notes for the
Reporting Tool

Recommended indicator in: “Strategies and laboratory methods for
strengthening surveillance of sexually transmitted infection 2012”

1.18 Percentage (%) of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis

Numerator	The number of pregnant women who tested positive for syphilis and whose sexual contacts were identified and treated.
	This numerator calls for providing counselling for each pregnant woman and identifying all her sexual contacts. Only if all her reported sexual partners are being treated, can that woman be included in this numerator.
Denominator	Number of pregnant women who tested positive for syphilis during pregnancy.

Diagnosis of HIV and AIDS cases

1.19.1 Number of HIV cases diagnosed by age and sex from 2010–2014

Rationale	HIV infection is detected in VCT, PHC, TB clinics or other services and is the first step to link PLHIV to care and treatment centres. It is part of the strategy to increase the number of people tested.
What it measures	Number of HIV cases diagnosed by age and sex from 2010–2014
Numerator	Number of people reported with HIV diagnosis
Denominator	Number of people living in the country
How to Measure and Measurement Tools	Regular programme reporting data from health services, routine health information systems
Disaggregation	Age: adults 15+ and children < 15 years Sex: males and females
Strengths and weaknesses	The underreporting, delays of reporting and duplication are possible problems in Health Information systems
Additional considerations	Please refer to the WHO/UNODC/UNAIDS Technical Guide for HIV case reporting and SGS package.
Data utilization	This data can be used for triangulation of data with HIV estimates, see the distribution of HIV cases by population and geographical location and access to services
Other References	HIV second generation surveillance guidelines http://who.int/hiv/pub/surveillance/2013package/module1/en/

1.19.2 Number of AIDS cases diagnosed by age and sex from 2010–2014

Rationale	HIV infection is detected in VCT, PHC, TB clinics or other services and is the first step to link PLHIV to care and treatment centres. It is part of the strategy to increase the number of people tested. AIDS case surveillance was set up by countries since the mid-1980s.
What it measures	Number of AIDS cases diagnosed by age and sex from 2010–2014
Numerator	Number of people reported with AIDS diagnosis
Denominator	Number of people living in the country
How to Measure and Measurement Tools	Regular programme reporting data from health services
Disaggregation	Age: adults 15+ and children < 15 years Sex: males and females

Strengths and weaknesses

The underreporting, delays of reporting and duplication are possible problems in Health Information systems

Additional considerations

Please refer to the WHO/UNODC/UNAIDS Technical Guide for AIDS reporting and SGS package .

Data utilization

This data can be used for triangulation of services, the clinical stage of diagnosis shows how soon people get to services and start ART

Other References

WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children
<http://who.int/hiv/pub/vct/hivstaging/en/>

HIV second generation surveillance guidelines
<http://who.int/hiv/pub/surveillance/2013package/module1/en/>

Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

2.6 Number of people on opioid substitution therapy (OST)

Rationale	Opioid substitution therapy represents a commitment to treat opioid dependence and to reduce the frequency of injecting, preferably to zero. OST is the most effective public health tool for reducing injecting drug use among opioid injectors. OST also provides a crucial support for the treatment of other health conditions, including HIV, TB and viral hepatitis.
What it measures	National commitment and progress towards the treatment of opioid dependence and reduction of HIV transmission probabilities among people who inject drugs.
How to Measure and Measurement Tools	Programme data
Disaggregation	Administrative units: urban, rural
Strengths and weaknesses	Number of people on OST should be readily available and valid since they are typically licensed by the relevant authorities.
Additional considerations	Please refer to the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html) for a proposed complete set of globally agreed indicators for people who inject drugs.
Data utilization	Try to assess whether sufficient OSTs are available for the number and distribution of people who are dependent on opioids in the country.
Other References	WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html)

2.7.a Number of NSP and OST sites:

- Number of needle and syringe programme (NSP) sites

Rationale	Needle and syringe distribution programmes are among the most effective interventions for preventing transmission of HIV among people who inject drugs. Sufficient access to clean needles for the injecting population is measured with this indicator.
What it measures	Number of NSP sites (including pharmacy sites providing at no cost needles and syringes). Availability of sites that can provide clean needles and syringes to injection drug users.
How to Measure and Measurement Tools	National programme data
Disaggregation	Administrative unit Urban, rural
Strengths and weaknesses	Many NSPs are not "official" and therefore not counted among national programme data
Additional considerations	Needle and syringe programmes (NSPs) are any programmes that include access to clean equipment and safe disposal through fixed or mobile exchange programmes and/or through pharmacies where equipment is available free of charge. In many countries pharmacy sales of injecting equipment are an important and sometimes the most significant source of clean injecting equipment accessible to drug users. However, pharmacies that sell needles and syringes are typically not counted in a retrievable database as part of a public health or harm reduction programme. If they are available, they should be

counted and highlighted, if possible. Pharmacies that distribute needles and syringes free of cost typically do maintain records of needles distributed as part of the programme and should be included.

Please refer to the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (<http://www.who.int/hiv/topics/idu/en/index.html>) for a proposed complete set of globally agreed indicators for people who inject drugs.

Data utilization

Get an idea of the availability of NSP sites, and trends over time. Also try to analyse data based on geographical location of the NSP sites and geographical distribution and population density of people who inject drugs in the country. Try to assess whether sufficient NSPs are available for the number and distribution of people who inject drugs in the country.

Data Quality Control and Notes for the Reporting Tool

National Representativeness: Many NSP sites are not "official" and may be run by NGOs, which the government may not have information on. Please try to assess the national representativeness of the number you are reporting.

Other References

WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (<http://www.who.int/hiv/topics/idu/en/index.html>)

2.7.b Number of NSP and OST sites:

- Number of opioid substitution therapy (OSP) sites

Rationale

Opioid substitution therapy represents a commitment to treat opiate users and to reduce the frequency of injection, preferably to zero. OST is the single most effective public health tool for reducing injection drug use.

What it measures

National commitment and progress towards the treatment of opiate users and reduction of HIV transmission probabilities among people who inject drugs. The number of OST sites and the availability of sites that can provide OST to injecting drug users.

How to Measure and Measurement Tools

National programme data

Disaggregation

Administrative unit

Urban, rural

Strengths and weaknesses

OST sites should be readily available and valid since they are typically licensed by the relevant authorities. However, the number of sites does not indicate the number of *slots* that may be available.

Obtaining subgroup population size estimates will be difficult and add extra uncertainty.

Additional considerations

Please refer to the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (<http://www.who.int/hiv/topics/idu/en/index.html>) for a complete set of globally agreed indicators for people who inject drugs.

Data utilization

Get an idea of the availability of OST sites and trends over time in relation to the population size of opiate injectors in the country. Also try to analyse data based on geographical location of the OST sites and geographical distribution and population density of people who inject opioid drugs in the country. If possible, try to interpret this indicator considering information available on the number of OST slots in various sites. Try to assess whether sufficient OSTs are available for the number and distribution of opiate injectors in the country.

Data Quality Control
and Notes for the
Reporting Tool

Other References

National Representativeness: Many OST sites are not "official" and may be run by NGOs, which the government may not have information on. Please try to assess the national representativeness of the number you are reporting.

WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf)

Target 3: Eliminate mother-to-child transmission on HIV by 2015 and substantially reduce AIDS-related maternal deaths

3.3a Mother-to-child transmission rate (based on programme data)

What it measures	Please report the MTCT rate observed in your country, and provide details of the data source and any assumptions made for the estimation. The modelled MTCT rate is indicator 3.3 (often from Spectrum estimation). Please include here other estimates of MTCT rate – for example, through surveys, programme data, special studies etc. Please make sure to write the data source in the additional information section. If the data source is a special study or from a sample of mother-child pairs, please provide information on the sample size, time period and at what age the child infection was measured.
Numerator	Number of children newly infected with HIV due to mother-to-child transmission among children in the previous 12 months to HIV positive women (or a different period for which you have data. Please specify on the additional information section.)
Denominator	Number of HIV positive women who delivered in the previous 12 months

3.4. Percentage of pregnant women who know their HIV status (tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status)

Rationale	Identification of a pregnant woman's HIV serological status provides an entry point for other services for PMTCT and to tailor prevention, care and treatment to her needs.
What it measures	This indicator assesses efforts to identify the HIV serological status of pregnant women in the previous 12 months.
Numerator	Number of pregnant women of known HIV status. This is compiled from the number of women of unknown HIV serological status attending antenatal care, labour and delivery and postpartum services, who have been tested for HIV and know their results and women with known HIV infection attending antenatal care for a new pregnancy in the past 12 months. Pregnant women with known HIV infection: women who were tested and confirmed to be HIV-positive at any time before the current pregnancy, who are attending antenatal care for a new pregnancy. These women may not need to be retested if there is documented proof of their positive status³, and in line with national guidelines on testing pregnant women. These women do, however, need services for PMTCT and are counted in the numerator. Pregnant (and postpartum) women of unknown serological status: women who were not tested during antenatal care or at labour and delivery for this pregnancy or do not have documented proof of having been tested during this pregnancy. The numerator is the sum of categories a–c below: (a-1) pregnant women who have an HIV test and receive their result during antenatal care;

³ Documentation of HIV infection (care and treatment card, maternal card from previous pregnancy or other reliable written documentation of HIV status) is generally required in most settings. Without proof of existing HIV infection, women are usually considered as being of 'unknown' status and are often retested. National guidelines should be consulted.

- (a-2) pregnant women with known HIV infection attending antenatal care for a new pregnancy;
- (b) pregnant women of unknown HIV serological status attending labour and delivery who were tested and received results; and
- (c) women of unknown HIV serological status attending postpartum services within 72 hours of delivery who were tested and received results.

Categories a-1, b and c include all women who were tested and received results, irrespective of the HIV test result. Category a-2 includes women with previously known HIV-positive status.

Data reported from facilities may be disaggregated into:

- (a) women with known (positive) HIV infection at antenatal care;
- (b) women newly identified as HIV positive; and
- (c) women testing HIV negative (the remainder).

See below for Disaggregation for Global Reporting.

Denominator

Estimated number of pregnant women in the past 12 months

How to Measure and Measurement Tools

The numerator is calculated from national programme records aggregated from facility registers for antenatal care, labour and delivery and postpartum care. In countries with high rates of facility attendance for labour and delivery, data can be collected from labour and delivery registers only, as the results of HIV testing will be available for most pregnant women from this one source.

Health facility registers should record known HIV infection in pregnant women coming to antenatal care clinics for a new pregnancy, so that they receive services for PMTCT.

All public, private and nongovernmental organization-run health facilities that are providing testing and counselling for pregnant women should be included.

The denominator is derived from a population estimate of the number of pregnant women giving birth in the past 12 months. This can be obtained from estimates of births from the central statistics office or from the United Nations Population Division or pregnancy registration systems with complete data.

Disaggregation

Pregnancy stages: ANC, L&D, postpartum

Receipt of results: tested, tested and received results

HIV serostatus: number HIV+

Strengths and weaknesses

This indicator enables a country to monitor trends in HIV testing among pregnant women. The points at which drop-outs occur during the testing and counselling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counselling. It also does not capture the number of women who received pre-test counselling.

Additional considerations for countries

Health facility registers should reflect known HIV infection among HIV-infected pregnant women coming to the ANC for a new pregnancy (even if they are not tested at that site), such as through a code, circle, or other method, in order for them to receive subsequent PMTCT interventions.

Not all categories will be applicable or significant to all settings (e.g. women of unknown status tested within 72 hours postpartum). Countries may want to prioritize investment of resources (revision of tools, time, money) for measuring the categories that are appropriate to their country context.

It may be important for programme managers to use additional sub-national and facility level indicators to measure trends and progress in the testing and

counselling process, such as uptake of testing and receipt of results.

It is also important to know the number of women whose HIV status has been identified at each service, i.e. % ANC attendees whose HIV status is known; % L&D attendees whose HIV status is known, etc.

This indicator could be triangulated and validated using population-based surveys, such as the DHS, which generally occurs every five years, or the AIDS Indicator Survey, a population-based survey that can be done on a more periodic basis.

Data utilization

Look at trends over time. If disaggregated data is available by region, see whether any lower performing areas can be identified. Review if data is available on % of ANC attendees who know their status (including those with previously confirmed HIV status and those tested) and % of L&D attendees who know their status.

Data Quality Control and Notes for the Reporting Tool

Double Reporting: There is a risk of double counting with this indicator, as a pregnant woman can be tested a few times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, countries should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place.

Please do not add *all* the number of women tested from ANC *and* L&D to get the *total* number of women tested. We are interested in knowing the number of *women* tested, and not the total number of tests (i.e. if a women is tested at ANC and again at L&D, try to only count her once). It is important to include those with previously known HIV infection in the numerator – even if they do not receive an HIV test, their HIV infection is identified for subsequent PMTCT interventions.

Number tested, as well as tested and received results: If available, please report the number of pregnant women tested, as well as the number of pregnant women tested and received results (latter should not exceed the former).

If your data collection system does not currently separate those with known and unknown HIV status and you are unable to provide the specific disaggregated data, please review the data available, and derive the best data for the number of *pregnant women whose HIV status has been identified* during pregnancy, L&D, or during the post-partum period within 72 hours.

Please provide any details that would help to interpret your data in the *Comment* section.

Please comment on the source of your denominator.

Other References

PMTCT M&E Core Indicator #3

3.5 Percentage of pregnant women attending antenatal care (ANC) whose male partner was tested for HIV in the last 12 months

Rationale

Male involvement is a critical element in providing family-focused services to HIV-infected pregnant mothers, their infants and family members. It is also important in the prevention of HIV infection and can help couples who are seronegative to remain seronegative.

Partner testing is the first step in involving the male partner, regardless of the couple's HIV status.

What it measures

The percentage of pregnant women attending antenatal care whose male partner was tested during their female partner's pregnancy in the past 12 months.

Numerator	Number of pregnant women attending antenatal care whose male partner was tested in the last 12 months
Denominator	Number of pregnant women attending antenatal care
How to Measure and Measurement Tools	The numerator can be calculated from national programme records compiled from facility registers. Male partners can be tested with the woman at the first antenatal care visit or at a follow-up visit or tested alone on a separate visit, such as a day reserved for male partner testing. Data can be aggregated from antenatal care or testing and counselling register, depending on the context. All public, private and nongovernmental organization-run health facilities that provide antenatal care services should be included. If feasible, programmes may consider collecting data on whether or not the male and female partner disclosed their HIV status to each other in the presence of a clinic staff member.
Strengths and weaknesses	This indicator allows countries to monitor efforts at increasing testing of male partners of pregnant women attending ANC services. It does not measure whether the male partner received his result or any follow-up services. The indicator does not take into account ANC clients that have more than one partner or that may change partners over time. It also may not include partners that received HIV testing at non-ANC settings and which are not linked to ANC (e.g. general VCT or provider initiated testing). Not all sites may be collecting data on male partner testing or routinely aggregating and reporting the data. Measuring this indicator may require additional investment and resources to revise data collection tools and summary reporting forms.
Additional considerations	Although testing male partners is an important tool for increasing male involvement and preventing infection during pregnancy, it is also a critical entry point into on-going and family-focused care for the man. Health providers should ensure and document that appropriate follow-up services are provided to all male partners who test HIV-positive, as part of a comprehensive care and treatment programme.
Data utilization	Interpret based on country context and applicability. Discuss how to increase coverage.
Data Quality Control and Notes for the Reporting Tool	Please provide any comments that would help to interpret the representativeness of the data. If the number of discordant couples is easily available, please provide data in the comments section with any supporting comments.
Other References	PMTCT Additional Indicator # A-3

3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing

Rationale	HIV-infected pregnant women who meet the clinical and (when available) immunological criteria for antiretroviral therapy should receive it. Antiretroviral therapy preserves maternal health and reduces the risk for mother-to-child transmission. Services for the prevention of mother-to-child transmission of HIV should undertake such assessments. Women who are not yet eligible for antiretroviral therapy should receive antiretroviral drug prophylaxis for PMTCT according to the national guidelines and recommendations.
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What it measures	Coverage of eligibility assessment for antiretroviral therapy among HIV-infected pregnant women, either clinically by WHO clinical staging criteria or immunologically by CD4 testing. Assessments can be made on site or by referral.
Numerator	Number of HIV-infected pregnant women assessed for eligibility for antiretroviral therapy by either clinical staging or CD4 testing, on site or by referral, in the past 12 months. ‘On site’ means that the service is offered in a health facility structure or compound. For instance, HIV clinical staging may be available in the antenatal care unit, while blood drawn for CD4 testing is available at the HIV care and treatment unit in the same health facility. Both these services are considered to be on site. Referral can be made on site or off site and is defined as sending a patient to a different service unit, health provider or health facility. Often, patients return to the original health facility, service unit or provider, where the services received at the referral site are fed back to the original site, and the patient continues with follow-up care. Referral facilities should document the services provided and patient outcomes. This indicator should be disaggregated by type of assessment (clinical staging or CD4 testing). Women who were assessed by CD4 testing and clinical staging should be counted only once as having been assessed by CD4 testing.
Denominator	Estimated number of HIV-infected pregnant women in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Assessment can be conducted in antenatal care clinics and HIV care and treatment units, on site or by referral. Data should be aggregated from the appropriate register, with consideration of which registers capture the data, where the assessment actually took place, possible double-counting or under-counting and the need for accurate data for the national level. All public, private and nongovernmental organization-run health facilities that assess eligibility of HIV-infected pregnant women for antiretroviral therapy, either on site or by referral, should be included. Two methods can be used to calculate the denominator: ▪ a projection model such as that provided by Spectrum software: use the output “number of pregnant woman needing prevention of mother-to-child transmission of HIV”; or ▪ multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates of the central statistics office or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics), if Spectrum projections are unavailable.
Disaggregation	Method of ART eligibility assessment: Clinical staging, CD4 testing
Strengths and weaknesses	The strength of this indicator is that it enables countries to monitor the extent to which HIV-infected pregnant women are receiving an intervention that is critical for accessing ART for their own health. It does not capture whether HIV-infected pregnant women who were eligible for ART actually received it. Although each category is mutually exclusive, there is a risk of double counting this indicator where HIV-infected pregnant women have been assessed both clinically and immunologically, as well as where women are assessed in

	different units or in a different facility. Countries should ensure systems are in place to minimize the risk of double counting.
	This indicator does not capture women who may have been identified HIV-positive at labour and delivery and subsequently assessed for ART eligibility.
Additional considerations	It is recommended that countries disaggregate by eligibility status for additional information on national trends in the percentage of pregnant women who are eligible for ART.
	In settings where HIV-infected pregnant women are referred out to another health facility or another service unit within the same health facility, health providers should make an effort to document referrals made and services received for these women in the ANC/PMTCT register for better patient tracking and monitoring of HIV-infected pregnant women.
Data utilization	The goal would be to aim for 100%; once 100% is reached routinely, this indicator may become obsolete. Explore further information on disaggregated data on whether eligibility was assessed through clinical staging or CD4 tests and any data available on how long it takes to receive a CD4 test result in various places.
Data Quality Control and Notes for the Reporting Tool	Please provide any comments that would help to interpret the data.
Other References	PMTCT M&E Core Indicator #4

3.7 Percentage of infants born to HIV-infected women provided with antiretroviral (ARV) prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks (i.e. early postpartum transmission around 6 weeks of age)

Rationale	The risk for mother-to-child transmission can be significantly reduced by the complementary approaches of providing antiretroviral drugs (as treatment or as prophylaxis) for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretrovirals to the mother or child during breastfeeding (if breastfeeding), and use of safe delivery practices and safer infant feeding.
What it measures	Progress in the prevention of early postpartum mother-to-child transmission by the provision of antiretroviral prophylaxis for HIV-exposed infants
Numerator	Number of infants born to HIV-infected women during the past 12 months who received antiretroviral prophylaxis to reduce early mother-to-child transmission (i.e. early postpartum, in the first 6 weeks).
Denominator	Estimated number of live births to pregnant HIV-infected women in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Antiretroviral drugs can be given to HIV-exposed infants shortly after delivery, at facilities for labour and delivery for infants born at facilities, at outpatient postnatal care or child clinics for infants born at home and brought to the facility, or at HIV care and treatment or other sites, depending on the country. Three methods for calculating the numerator can be considered: Counting at the point of antiretroviral drug provision: In settings with low facility delivery rates, data for the numerator should be compiled from the sites where antiretroviral drugs are dispensed and where the data are recorded. There is a risk of double-counting when antiretroviral drugs are provided during more than one visit or at different health facilities. Countries should establish data collection and reporting systems to minimize double-counting.

- **Counting around time of delivery:** In settings where a high proportion of women give birth in health facilities, countries can estimate the numerator from only the labour and delivery register by counting the number of HIV-exposed infants who received a specific antiretroviral drug regimen before discharge from the labour and delivery ward. This may be the most reliable and accurate method for calculating this indicator in settings with a high proportion of facility deliveries and low follow-up, as the corresponding antiretroviral drug regimen dispensed is counted at the time of provision to the infant.
- **Counting at postnatal or child health sites:** Countries can also count and aggregate the number of HIV-exposed infants who received antiretroviral prophylaxis recorded at postnatal or child health clinics if attendance is high and the exposure status of the child is likely to be known (e.g. from postnatal registers, stand-alone registers or integrated HIV-exposed infant registers).

All public, private and nongovernmental organization-run health facilities that provide antiretroviral drugs to HIV-exposed infants for the prevention of mother-to-child transmission of HIV should be included.

Two methods can be used to estimate the denominator:

- a projection model, such as that provided by Spectrum software; use the output “number of pregnant woman needing prevention of mother-to-child transmission of HIV” as a proxy; or
- multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates by central statistics office or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics), if Spectrum projections are unavailable.
- If there are data on the number of live births, they should be adjusted to derive a better proxy.

Disaggregation

None requested

Strengths and weaknesses

This indicator allows countries to monitor the coverage of antiretrovirals regimens dispensed or initiated among HIV-exposed infants to reduce the risk of early maternal HIV transmission.

The indicator measures the extent to which ARVs were dispensed for infants as prophylaxis. It does not capture whether the ARVs were consumed; thus it is not possible to determine adherence to the ARV regimen, nor whether ARV regimens were completed.

Additional considerations

Countries that have developed mechanisms for reaching HIV-exposed infants at the community level with ARVs will want to ensure a system of data collection is in place for reporting infants receiving ARV regimens at the community level.

Data utilization

Compare the indicator value with coverage of the maternal ARV regimen (Indicator I-10) and discuss what the data may mean in the country context. Some countries may want to explore further and do a linked review of the infant ARV prophylaxis regimen vis-à-vis the maternal ARV regimen can be assessed.

Data Quality Control and Notes for the Tool

Please provide any comments that would help to interpret the data.

Other References

PMTCT M&E Core Indicator #6

3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth

Rationale	Co-trimoxazole prophylaxis is a simple, cost-effective intervention to prevent <i>Pneumocystis jiroveci</i> pneumonia in HIV-infected infants. This infection is the leading cause of serious respiratory disease in these infants in resource-constrained countries and often occurs before HIV infection can be diagnosed. Owing to resource and logistical constraints in diagnosing HIV infection in young infants, all infants born to HIV-infected women should receive co-trimoxazole prophylaxis, starting 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
What it measures	The provision and coverage of co-trimoxazole prophylaxis for HIV-exposed infants in line with international guidelines ⁴
Numerator	Number of infants born to HIV-infected women started on co-trimoxazole prophylaxis within 2 months of birth in the past 12 months
Denominator	Estimated number of HIV-infected pregnant women who gave birth in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Data should be aggregated from the appropriate facility registers, such as a stand-alone or integrated HIV-exposed infant register. The register used may depend on where services are offered. For example, where HIV-exposed infants are followed by health workers in HIV care and treatment facilities, countries could aggregate information from a register based at that site. All public, private and nongovernmental organization-run health facilities that provide co-trimoxazole prophylaxis for HIV-exposed infants should be included. Two methods can be used to estimate the denominator: ▪ a projection model such as that provided by Spectrum software; use the output “number of pregnant woman needing PMTCT (prevention of mother-to-child transmission of HIV)” as a proxy; or ▪ multiply the total number of women who gave birth in the past 12 months (which can be obtained from central statistics offices or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women⁵ (which can be derived from HIV sentinel surveillance in antenatal care clinic), if Spectrum projections are unavailable. If there are data on the number of live births, they should be adjusted to derive a better proxy.
Disaggregation	None requested
Strengths and weaknesses	This indicator allows countries to monitor progress in the early follow-up of exposed infants by measuring provision of co-trimoxazole in line with international guidelines. It can also be used as a proxy indicator for early follow-up visits of exposed infants within the recommended first 4–6 weeks of life. The indicator captures only those infants who return for HIV-exposed infant follow-up services within two months of birth. It does not measure <i>actual</i>

⁴ WHO. Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults: Recommendations for a public health approach. Geneva, World Health Organization, 2006.

⁵ National estimates of HIV-infected pregnant women should be derived by adjusting surveillance data from sentinel sites at antenatal clinics and other sources, taking into consideration characteristics such as age distribution and rural and urban patterns of HIV prevalence.

	coverage of co-trimoxazole prophylaxis for HIV-exposed infants as some infants may have been started on treatment after 2 months. A low value of the indicator could signal potential bottlenecks in the system, including poor management of CTX supplies in the country, poor data collection, and inadequate distribution systems.
Additional considerations	Countries may also wish to document provision of CTX for HIV-exposed infants older than 2 months as a way to monitor overall progress of the programme, identify existing challenges with early initiation of CTX, and to monitor consumption for procurement needs. Inappropriate management of supplies can negatively affect the value of the indicator and significantly reduce access to CTX for HIV-exposed infants. Countries should ensure appropriate systems and tools, particularly tools for LMIS, are in place to adequately procure, distribute, and manage supplies at facility, district and central levels.
Data utilization	Data can also be reviewed as an indication of the number of exposed infants who are seen at a facility within 2 months of birth. If indicator value is low, explore reasons why (e.g. whether exposed-infants are not attending facilities within 2 months, or if there are stock-outs of CTX, etc.).
Data Quality Control and Notes for the Reporting Tool	National Representativeness: If this indicator is obtained from a sub-set of facilities, comments should be added regarding the representativeness. Triangulation Options: pharmacy registers If the data reported represents CTX provided in infants beyond 2 months of age, please note it in the Comments section.
Other References	PMTCT M&E Core Indicator #8

Distribution of outcomes of HIV-Exposed Infants

3.10.1 Number of infants born to HIV positive mothers ("HIV-exposed infants") born in 2013 (or latest data available)

What it measures	Reported number of infants born to HIV-positive mothers within a defined calendar year (2013). For breastfeeding settings, report number of infants born to HIV-positive mothers in 2012 (or latest data available) For non-breastfeeding settings, report number of infants born to HIV-positive mothers in 2013 (or latest data available) Specify the year
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3.10.2 Number of infants, born in 2013 (or latest data available) to HIV positive mothers, classified as indeterminate (i.e.: all lost to follow up, death before definitive diagnosis, indeterminate lab results)

What it measures	Number of infants born during the defined calendar year (2013) to HIV-positive women, who did not complete diagnostic testing to evaluate their HIV status due to their being lost to follow-up, to their death, or to their transfer to another facility and/or were not tested. For breastfeeding settings, report number of infants born to HIV-positive mothers in 2012 (or latest data available) For non-breastfeeding settings, report number of infants born to HIV-positive mothers in 2013 (or latest data available)
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3.10.3 Number of infants born in 2013 (or latest data available) to HIV + mothers that are diagnosed as positive for HIV

What it measures	Number of infants born to HIV-positive mothers in 2013 , who were diagnosed as HIV positive. For breastfeeding settings, report number of infants born to HIV-positive mothers in 2012 (or latest data available) For non-breastfeeding settings, report number of infants born to HIV-positive mothers in 2013 (or latest data available)
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3.10.4 Number of infants born to HIV + mothers in 2013 (or latest data available) that are diagnosed as negative for HIV

What it measures	Number of infants born to HIV-positive mothers in 2013, who were diagnosed as HIV negative. For breastfeeding settings, report number of infants born to HIV-positive mothers in 2012 (or latest data available) For non-breastfeeding settings, report number of infants born to HIV-positive mothers in 2013 (or latest data available)
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3.11 Number of pregnant women attending ANC at least once during the reporting period

Notes for the Reporting Tool	Please report the number of ANC attendees with at least one visit during the reporting period. Please note that this counts the number of <i>people</i>, and not the number of <i>attendances</i>, meaning that a pregnant woman making 3 ANC visits will only be counted once. If the number does not represent the national number (e.g. if you only have data from 65% of the districts or facilities; or if the number represents multiple visits instead of "at least one visit"), please comment on the representativeness of the number you are reporting.
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EURO only

3.11.1 Percentage of HIV-positive pregnant women who had their pregnancy terminated (EURO8)

Rationale	Pregnancy termination is common in eastern European countries. HIV positive pregnant women who terminated their pregnancy do not need to take ARV drugs to prevent mother-to-child transmission. This indicator helps to assess access to effective contraceptive methods among HIV positive women, quality of counselling on reproductive health and family planning and reflects common medical practices.
What it measures	This indicator measures termination of pregnancy among pregnant HIV positive women.
Numerator	Number of pregnancy terminations among HIV-positive pregnant women during the reporting year.
Denominator	Number of diagnosed HIV-positive women who had pregnancy registered during the reporting year.
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from health care facility registers.
Disaggregation	None requested.
Strengths and weaknesses	Prevention of unintended pregnancies among HIV positive women and improved access to family planning and effective contraception is one of the key elements of a comprehensive PMTCT strategy.

This indicator helps for better planning reproductive health services for HIV positive women.

Data utilization

Look at trends over time. Although disaggregation is not required for this indicator, disaggregated data by geographical regions in the country (if available) is useful for in-country analysis allowing identification of lower performing areas.

This indicator will have impact on other indicators, including ARV coverage.

Data quality control and notes for the reporting tool

It is important to comment how the indicator was calculated. Variation could happen due to different HIV testing policies among pregnant women between countries, for example:

- HIV testing is offered to all pregnant women, including those who terminate pregnancy
- HIV testing is offered only for women who will continue pregnancy, excluding those who opt for termination

3.11.2 Percentage of HIV-positive pregnant women who delivered during the reporting year (EURO9)

Rationale

The number and percentage of HIV-positive pregnant women who delivered during the reporting period provides the basis for calculating reported rates of mother-to-child transmission of HIV. Further, elective Caesarean section is an intervention that reduces the risk of mother-to-child transmission. This indicator will help to monitor access to PMTCT interventions and calculate mother-to-child transmission rate and provides information about current health system practices.

What it measures

This indicator measures the proportion of HIV-positive women who delivered during the reporting year.

Numerator

Number of HIV-positive pregnant delivering women who delivered during the reporting year.

Denominator

Number of HIV-positive pregnant women who had pregnancy registered during the reporting year.

How to Measure and Measurement Tools

The numerator is calculated from national programme records aggregated from health care facility registers.

Disaggregation

Delivery mode: Normal delivery including acute Caesarean section versus elective Caesarian section (defined as Caesarian section conducted prior to uterus contractions started and foetal membranes ruptured)

Strengths and weaknesses

Elective Caesarean section among HIV positive women has been one of the key interventions prior to the use of ART for PMTCT. If ART is used and viral load at 36 weeks of gestation is less than 1000 copies/ml there is limited benefit of these interventions. Still there are countries in the Region that do not have access to routine monitoring of viral load. With unknown viral load status, elective Caesarean section is an important intervention for PMTCT.

Data utilization

This indicator will help to calculate mother-to-child transmission rates.

ANC and EID facilities

3.12.1. Number of antenatal care facilities providing HIV testing and counselling services

Notes for the Reporting Tool

Please report the number of antenatal care facilities that provide HIV and counselling services. If the number does not represent the national number (e.g. if you only have data from public facilities, although private facilities provide a significant percentage of healthcare to your population), please comment on the representativeness of the number you are reporting.

3.12.2 Number of antenatal care facilities providing HIV testing and counselling and dispensing antiretrovirals

Notes for the Reporting Tool	Please report the number of antenatal care facilities that provide HIV and counselling services and provide antiretrovirals. If the number does not represent the national number (e.g. if you only have data from public facilities, although private facilities provide a significant percentage of healthcare to your population), please comment on the representativeness of the number you are reporting.
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3.12.3 Percentage of health facilities that provide virological testing services (e.g. PCR) for diagnosis of HIV in infants on-site or from dried blood spots (DBS)

Rationale	Early diagnosis of HIV by on-site virological testing or through dried blood spots is critical for identifying HIV-infected infants for immediate referral to care and treatment, and to facilitate decision making by health providers
What it measures	The extent to which countries have scaled up and increased access to early diagnosis of HIV in infants born to HIV-infected women
Numerator	Number of health facilities that provide virological testing for HIV exposed infants by on-site testing or through dried blood spots.
Denominator	Total number of health facilities that provide follow-up for HIV exposed infants
How to Measure and Measurement Tools	The numerator could be calculated by one of three methods, depending on the availability of information at central institutions: a) national programme records of lists of facilities that perform virological testing on-site or through dried blood spots; b) lists of distribution of dried blood spot kits by site, in central medical stores, private or nongovernmental organization-run medical stores responsible for national distribution or national reference laboratory; and c) facility survey or questionnaire about whether the site is providing virological testing on site or through dried blood spots. In many countries, virological testing is performed only at a national reference laboratory or sent out of the country due to the cost of buying virological testing machines. Thus, the 'provision' of virological testing includes on-site testing as well as transport of dried blood spot filter papers to a virological testing laboratory. Sites that refer a mother and her infant to a site that provides virological testing on site or through dried blood spots are not included in the numerator. The denominator comprises all health facilities at any level that provide follow-up for HIV-exposed infants, including maternal and child health clinics, sites where a unit for PMTCT is responsible for the follow-up of HIV-exposed infants, nutritional centres, district hospitals and care and treatment sites. All public, private and nongovernmental organization-run health facilities that provide follow-up for HIV-exposed infants should be included.
Disaggregation	By availability of virological tests: On site; through DBS <i>Uncategorized/Other category exists if you know virological tests are provided, but you are unsure whether it is done onsite or through DBS.</i>
Strengths and weaknesses	This indicator does not measure the quality of the virological testing at sites, nor the quality of the system in place, including length of turnaround time, stock-outs of DBS or virological testing reagents, and other bottlenecks in the system.

Additional considerations for countries	In addition to monitoring the expansion of virological testing capacity at health facilities, countries may wish to periodically monitor bottlenecks in the system to expand testing capacity, including national, district level or facility level stock outs of testing materials; turnaround times for test results; human resource availability and trainings conducted; and tools available to appropriately track samples and receipt of results.
Data utilization	Look at trends overtime. Review where services are available and identify any gaps. Explore further data available on the average time it takes for test results.
Data Quality Control and Notes for the Reporting Tool	Double Reporting: If compiling data from multiple sources, ensure no facility is counted twice. National Representativeness: Try to ensure information from non-governmental and private facilities are also available at the central level. If significant information is missing, note it down. See Denominator explanation above - The total # of health facilities is sometimes used as a proxy, but if you have more accurate data on the denominator of this indicator (i.e. number of facilities where infant follow-up is possible), please report this number (or an estimate) in the Comment section.
Other References	PMTCT Additional Indicator A-2

3.13 EURO-specific PMTCT Indicator (pregnant women who inject drugs)

3.13.1 Percentage of HIV-positive pregnant women who were injecting drug users (IDUs) (EURO11)	
Rationale	HIV positive pregnant women who are injecting drugs remain the hardest to reach population by PMTCT interventions. Significant proportion of children who are HIV positive or/and abandoned were born to HIV positive women using drugs. It is a strategic focus for the Region to improve access of IDU women to PMTCT interventions and services.
What it measures	This indicator measures proportion of HIV-positive pregnant women who were actively injecting drugs during pregnancy.
Numerator	Number of HIV-positive pregnant women who were injecting drug users (IDUs).
Denominator	Number of diagnosed HIV-positive women who had pregnancy registered during the reporting year.
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from health care facility registers.
Disaggregation	None requested.
Strengths and weaknesses	Injecting drug use and substance use has always been associated with stigma and discrimination. Therefore some IDU women might not report their drug use to healthcare providers, or be less inclined to seek health care services and the true prevalence of drug injection could be underestimated while some IDU women might not access the services they need.
Data utilization	This indicator will help to monitor trends of IDU among pregnant HIV positive women and better plan interventions to address it.
Data quality control and notes for the reporting tool	It is important to put a note if numerator and denominator has all delivered IDU women, or also include those who terminated their pregnancies.

3.13.2 Percentage of HIV-positive pregnant IDU women who received OST during pregnancy (EURO12)	
Rationale	HIV positive pregnant women who are injecting drugs remain the hardest to reach population by PMTCT interventions. Opioid substitution therapy (OST) is a critical intervention to improve access of IDU women to PMTCT services.

What it measures	This indicator measures proportion of HIV-positive pregnant drug dependent women who were receiving OST (methadone, buprenorphin) during pregnancy.
Numerator	Number of HIV-positive pregnant IDU women who received OST during pregnancy.
Denominator	Number of diagnosed HIV-positive IDU women who had pregnancy registered during the reporting year.
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from health care facility registers.
Disaggregation	None requested.
Strengths and weaknesses	OST has been documented as an effective intervention to improve pregnancy outcome, including reduced rates of neonatal morbidity and mortality. Due to stigma and discrimination of IDU women, some of them could under report their injecting drug use, which may in turn have an impact on the indicator and overestimate coverage with OST.
Data utilization	This indicator will help to monitor trends and access of IDU pregnant HIV positive women to OST.
Data quality control and notes for the reporting tool	It is important to put a note clarifying if the numerator and denominator includes delivering IDU women only, or also include those who terminated their pregnancies.

3.13.3 Percentage of HIV-positive pregnant IDU women who received ARVs to reduce the risk of mother-to-child transmission during pregnancy (EURO13)

Rationale	HIV positive pregnant women who are injecting drugs remain the hardest to reach population by PMTCT interventions. Antiretroviral Treatment (ART) is a critical intervention to reduce the risk of mother-to-child transmission in HIV-positive pregnant IDU women.
What it measures	This indicator measures the proportion of HIV-positive pregnant women who inject drugs who were receiving ARVs during pregnancy.
Numerator	Number of HIV-positive pregnant IDU women who received ARVs during pregnancy.
Denominator	Number of diagnosed HIV-positive IDU women who had pregnancy registered during the reporting year.
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from health care facility registers.
Disaggregation	None requested.
Strengths and weaknesses	ANC data are often incomplete and might influence the indicator. Due to stigma and discrimination of IDU women, some of them could under report their injecting drug use, which may in turn have an impact on the indicator. The indicator does not assess adherence.
Data utilization	This indicator will help to monitor trends and access of IDU pregnant HIV positive women to ARVs.
Data quality control and notes for the reporting tool	It is important to put a note clarifying if the numerator and denominator includes delivering IDU women only, or also include those who terminated their pregnancies.

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015

4.1. Percentage of adults and children currently receiving antiretroviral therapy

Note that the above indicator is described in the first part of the Guidelines whereas the following indicator on people newly initiating ART is additional to section 4.1 and not included in the GARPR Guidelines:

4.1 – additional: HIV treatment: Antiretroviral therapy Number of eligible adults and children who newly initiated antiretroviral therapy (ART) during the reporting period (2014)

Rationale In addition to coverage it is important to monitor ART initiation. Comparing the evolution of the number of people on ART at the end of the years does not inform about the number newly initiated, especially since ART attrition is high in the first year and thus the patients newly initiating during the reporting year are not all continuing at the end of the year. Therefore this indicator captures the number of patients newly initiated on ART during a reporting year.

What it measures Number of eligible adults and children who newly initiated antiretroviral therapy during the reporting period (2014)

Yearly evolution of the number of patients newly enrolled in antiretroviral therapy

How to Measure and Measurement Tools Facility ART registers and drug supply management forms. By counting the number of patients who are newly enrolled in ART within the reporting period. Patients with records that transfer in from another facility or who temporarily stopped therapy and have started again in the reporting period should not be counted (risk of double counting).

ARV drugs taken for purpose of PMTCT (except ART for the mother's own health) and post-exposure prophylaxis are not included in this indicator.

Disaggregation Sex: male / female

Age groups: <1, 1-4, 5-14, 15+

Public and private

By mode of transmission, injecting status, OST recipient status, imprisonment status (European Region only)

These and other disaggregations to be included if available in the Comments box

Strengths and weaknesses This indicator permits monitoring trends in initiation but does not attempt to distinguish between different forms of antiretroviral therapy or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.

The degree of initiation of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, and perceptions of effectiveness and possible side effects of treatment.

Additional considerations This indicator should be analysed in view of the 'waiting list' i.e. patients eligible for ART and not initiated.

Data utilization In addition to the number of old patients retained on ART (retention on ART) the number of patients newly initiated is necessary for accurate planning of resources and drug stocks (avoiding shortage and wastage)

Data Quality Control and Notes for the Reporting Tool Double Reporting: If patients transferred in and out are not correctly registered and if patients followed in different ART sites are not identified, there is a risk for double reporting which could lead to an overestimation of ART initiation. If this is the case, please comment.

Similarly if patients temporarily stopping ART and restarting are coded as new patients, this will overestimate the true number of patients newly initiated.

National Representativeness: the numerator is a national cumulative indicator, usually produced by all health facilities, otherwise it may estimate ART initiation. Please comment on your data as necessary.

Triangulation Options: Pharmacy report, comparing the number of new patients in the pharmacy register and the ART register

Other References

PEPFAR indicator and guidelines

4.2 Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy (a) 12 months after initiating treatment among patients initiating antiretroviral therapy during 2013 (b) 24 months after initiating treatment among patients initiating antiretroviral therapy during 2012 (c) 60 months after initiating treatment among patients initiating antiretroviral therapy during 2009

Rationale	Antiretroviral is a life-long intervention. Measuring retention on ART is critical for determining the effectiveness of programmes, inferring their impact and to highlight obstacles to expanding and improving them.
What it measures	This indicator measures the retention on ART related to the increase in survival and willingness to continue ART. It should be produced at 12 months and for longer duration of follow-up; the 24 and 60 months retention are described here (the 12 months retention is included in the GARPR indicator guidance). It completes programme coverage as a measure of the effectiveness.
Numerator	Number of adults and children who are still alive and on ART at b) 24 months, c) 60 months, after initiating treatment (among those who initiated ART in b) 2012 and c) 2009).
Denominator	(b) at 24 months: Total number of adults and children who initiated ART in 2012 (or another specified period), who were expected to achieve 24-month outcomes within the 2014 reporting period (or 24 months after the specified initiation period), including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 24. (c) at 60 months: Total number of adults and children who initiated ART in 2009 (or another specified period), who were expected to achieve 60-month outcomes within the 2014 reporting period (or 60 months after the specified initiation period), including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 60.
How to Measure and Measurement Tools	Numerator and denominator: Programme monitoring tools; ART register; cohort analysis forms. In measuring retention, it is important to carefully select the patients according to the period they have initiated ART and to check their outcomes when they reached the expected duration of follow-up. Assessing outcomes at 24 months should include all patients started 2 years ago and at 60 months, all patients started 5 years ago. If the data available does not really fit this standard yearly period, it is important to specify the period the patients have initiated ART.
Disaggregation	Among the people who started (denominator), in addition to reporting the (1) number of people alive and on treatment (numerator), it is also important to report the number (2) lost to follow-up, (3) stopped therapy, and (4) died. These 4 outcomes should sum to the number of people who started ART. When generating information at site level, patients transferred in should be included in the statistics and patients transferred out should be excluded. From the compilation of site reports, if the number of patients transferred in and

transferred out is summed at the national level, these statistics should be reported for 12-month analysis.

Strengths and weaknesses

The continuation of ART is mostly related to survival (but also willingness to continue). Survival might reflect the services offered but also depends on the baseline characteristics of the patients started on ART. Clinical, immunological and virological staging are independent predictors of survival under ART. Baseline characteristics of the cohort of patients should help in interpreting the results and, in particular, comparing ART sites.

Additional considerations

If data on 24-month or 60-month retention are not available for patients that initiated antiretroviral therapy in 2012 or 2009, respectively, but available for patients that initiated antiretroviral therapy during an earlier time period (e.g. 2011 or 2008), please specify the period in the comment field: e.g. "Started antiretroviral therapy between [month]/[year] and [month]/[year]".

The numerator does not require patients to have been on antiretroviral therapy continuously for the 24 month or 60 month period. For example, patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment since initiating treatment but are recorded as still being on treatment at month 24 or 60 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 24 or 60 months since starting treatment are not included in the numerator.

In countries where this indicator is not produced in all ART sites but in a sub-set of facilities, data should be interpreted keeping in mind the representativeness and this should be stated in the *Comments* box.

Data utilization

Note any particularly low retention and assess reasons behind it, by analysing the distribution of those who are not on ART: dead, stopped, loss to follow up. If data is available, try to assess the lost-to-follow-up population to see if they are likely to be dead, stopped, or transferred out. Compare cohorts.

Data Quality Control and Notes for the Reporting Tool

National Representativeness: If this indicator is only produced in a sub-set of facilities, comment should be added on the source of information and whether the information is representative of all ART sites.

EURO only

4.2.1 Percentage of injecting drug users with HIV still alive and known to be on treatment a) 12 months, b) 24 months and c) 60 months after initiation of antiretroviral therapy (EURO4)

Rationale

ART is a lifelong therapy that increases survival and reduces transmission. In WHO European Region, where injecting drug users (IDUs) are most affected by the HIV/AIDS epidemic, access to and retention in ART is among key the interventions in health sector response.

What it measures

This indicator measures the retention on ART related to the increase in survival and willingness to continue ART. It should be produced at 12 months and then yearly after the beginning of ART. It completes program coverage by a measure of the effectiveness.

Numerator

Number of IDUs who are still alive and on ART a) 12 months, b) 24 months, c) 60 months after initiating treatment.

Denominator

a) At 12 months: Total number of injecting drug users who initiated ART in 2013 and so, who were expected to achieve 12-month outcomes within the reporting period (2014), including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 12.

b) at 24 months: Total number of injecting drug users who initiated ART in 2012 and so, who were expected to achieve 24-month outcomes within the reporting period (2014), including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 24.

c) at 60 months: Total number of injecting drug users who initiated ART in 2009 and so, who were expected to achieve 60-month outcomes within the reporting period (2014), including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 60.

How to Measure and Measurement Tools

Numerator and denominator: Programme monitoring tools; ART register and cohort analysis report form.

In measuring retention for the 3 different intervals, it is important to carefully select the IDU patients according the period they have started therapy and to check the outcomes when they reached the expected duration of follow-up.

Assessing outcomes at 12 months should include all IDU patients who started therapy in the last year, at 24 months, all IDU patients who started 2 years ago and at 60 months, all IDU patients who started 5 years ago. If the data available do not fit this standard yearly period it is important to specify the period used for calculation and when the patients initiated treatment.

IDU patients must be alive and on antiretroviral therapy at 12/24/60 months after their initiation of treatment. The numerator does not require patients to have been on antiretroviral therapy continuously for the 12/24/60-months period. IDU patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment during the 12/24/60 months since initiating treatment but are recorded as still being on treatment at month 12/24/60 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 12/24/60 months since starting treatment are not included in the numerator.

When generating information at site level, patients transferred in should be included in the statistics and patients transferred out should be excluded. From the compilation of site reports, if the number of patients transferred in and transferred out is summed at national level, these statistics should be reported for 12 months analysis.

Disaggregation

As much as possible, this indicator is to be disaggregated by sex, by age (<15, 15+), by 1st line and 2nd line regimens at the end point.

Strengths and weaknesses

The continuation of ART is mostly related to survival (but also willingness to continue treatment). Survival might reflect the services offered but also depends on the baseline characteristics of the IDU patients started on ART. Clinical, immunological and virological staging are independent predictors of survival under ART. For injecting drug users, various underlying health conditions may additionally affect survival rates. Baseline characteristics of the cohort of patients should help in interpreting the results and in comparing ART sites.

Additional considerations

In countries where this indicator is not produced in all ART sites but in a subset of facilities, data should be interpreted keeping in mind the representativeness.

Data utilization

Note any particularly low coverage and use the data to assess the reasons behind it. Try to get data on the distribution of those who are no longer on ART: dead, stopped, loss to follow up. If data are available, try to assess loss to follow-up population to see if they are likely to be dead, stopped, or transferred out. Compare cohorts.

4.3.a Number of health facilities that offer antiretroviral therapy (ART)

Rationale

Antiretroviral therapy is a cornerstone of effective HIV treatment, and measuring the percentage of health facilities that offer ART provides valuable information about ART availability.

What it measures

Number of health facilities that offer ART (i.e., prescribe and/or provide clinical follow-up).

Capacity of health facilities to provide antiretroviral therapy (ART), expressed as percentage of health facilities that offer ART (i.e., prescribe and/or provide clinical follow-up). Health facilities include public and private facilities, health centres and clinics (including TB centres), as well as health facilities that are run by faith-based or nongovernmental organizations.

How to Measure and Measurement Tools

The numerator is calculated by summing of the number of facilities reporting availability of ART services. Information on the availability of specific services is usually kept at the national or sub-national level. National AIDS Programmes should have a record of all health facilities offering ART services.

A health facility census or survey can also provide this information, along with more in-depth information on available services, provided the information is collected from a representative sample of health facilities in the country. Responses to a series of questions establish whether providers in that facility provide ART services directly (i.e., prescribe ART and/or provide clinical follow-up for ART patients) or refer patients to other health facilities for these services. In addition, facility records documenting the current status of service provision should be consulted. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years.

Countries should regularly update their programme records on health facilities offering ART services, and supplement these data with those obtained through a health facility survey or census every few years. For health facility surveys or censuses, tools such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) can be used.

Disaggregation

Sector: public, private

Type: hospital, health centre, ANC facility, TB facility, STI facility.

Strengths and weaknesses

This indicator provides valuable information about the availability of ART services in health facilities, but it does not capture information about the quality of services provided. Antiretroviral therapy itself is complex, and it should be delivered as part of a package of care interventions, including the provision of co-trimoxazole prophylaxis, the management of opportunistic infections and comorbidities, nutritional support and palliative care. Simple monitoring of ART availability does not ensure that all ART-related services are adequately provided to those who need them. Nevertheless, it is important to know what percentage of health facilities provide ART services in order to plan for service expansion as needed to meet universal access targets.

Additional considerations

One strategy to scale up ART services is to make ART available in more health facilities. This may be achieved by decentralizing ART services from tertiary facilities (e.g., hospitals) to primary or secondary-level health facilities. Greater availability of ART services provides crucial support to the goal of universal access to HIV treatment.

Depending on the country's epidemic type, the denominator may not be as relevant if the HIV programme strategy aims to target a limited number of sites to offer ART in.

Data utilization	To look at progress in the percentage of health facilities which provide antiretroviral therapy. Analyzing the data geographically and by type of health facilities, and triangulating the data with estimates of HIV density can provide insight into where there is a need to increase availability of ART services.
Data Quality Control and Notes for the Reporting Tool	Please comment on whether the data reported is from a national facility listing or census, or from a survey. If data from the private or other sectors is missing, please comment. If it is possible to easily report any additional information on the geographical distribution of facilities offering ART (e.g. urban/rural, % facilities with ART in areas with a high concentration of people living with HIV), please provide extra details.
Other References	Additional Recommended Indicators for NAP #5

4.3.b Health facilities

Number of health facilities that offer paediatric antiretroviral therapy (ART)

Rationale	Antiretroviral therapy is a cornerstone of effective HIV treatment, and measuring the percentage of health facilities that offer paediatric ART provides valuable information about capacity to address HIV care in children.
What it measures	Number of health facilities that offer paediatric ART. Capacity of health facilities to provide paediatric antiretroviral therapy (ART), expressed as percentage of health facilities that offer paediatric ART. Health facilities include public and private facilities, health centres and clinics (including TB centres), as well as health facilities that are run by faith-based or nongovernmental organizations.
How to Measure and Measurement Tools	The numerator is calculated by summing the number of facilities reporting availability of paediatric ART services. Information on the availability of specific services is usually kept at the national or subnational level. National AIDS Programmes should have a record of all health facilities offering ART services. A health facility census or survey can also provide this information, along with more in-depth information on available services, provided the information is collected from a representative sample of health facilities in the country. Responses to a series of questions establish whether providers in that facility provide paediatric ART services directly or refer patients to other health facilities for these services. In addition, facility records documenting the current status of service provision should be consulted. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years. Countries should regularly update their programme records on health facilities offering paediatric ART services, and supplement these data with those obtained through a health facility survey or census every few years. For health facility surveys or censuses, tools such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) can be used. A denominator is not requested in the UA reporting tool but some countries trying to expand paediatric ART nationally can consider total number of health facilities, excluding specialized facilities where paediatric ART services are/will never be relevant, which can be calculated by summing the total number of health facilities included in the sample. Information for construction of the denominator may come from programme records, facility listings, and/or national strategy or planning documents. It should exclude specialized facilities where paediatric ART services are/will never be relevant. (e.g. facilities specializing in eye care where ART will never be introduced)
Disaggregation	Sector: public, private

Strengths and weaknesses	This indicator provides valuable information about the availability of paediatric ART services in health facilities, but it does not capture information about the quality of services provided. Antiretroviral therapy itself is complex, and it should be delivered as part of a package of care interventions, including the provision of co-trimoxazole prophylaxis, the management of opportunistic infections and comorbidities, nutritional support and palliative care. Simple monitoring of ART availability does not ensure that all ART-related services are adequately provided to those who need them. Nevertheless, it is important to know what percentage of health facilities provide ART services in order to plan for service expansion as needed to meet universal access targets. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years and may not capture the latest information especially in setting with recent intensified scale-up.
Additional considerations	One strategy to scale up ART services is to make ART including paediatric ART services available in more health facilities. This may be achieved by decentralizing ART services from tertiary facilities (e.g. hospitals) to primary or secondary-level health facilities. Greater availability of paediatric ART services provides crucial support to the goal of universal access to HIV treatment. Depending on the country's epidemic type, the denominator may not be as relevant if the HIV programme strategy aims to target a limited number of sites to offer paediatric ART in.
Data utilization	Look at trends over time. Explore the number of facilities that provide ART in relation the estimated number of children in need of ART.
Data Quality Control and Notes for the Reporting Tool	Please comment on whether the data reported is from a national facility listing or census, or from a survey. If a survey, please remember to report the year of the survey. If data from the private or other sectors is missing, please comment. If it is possible to easily report any additional information on the geographical distribution of facilities offering paediatric ART (e.g. urban/rural, %facilities with ART in areas with a high concentration of people living with HIV), please provide extra details.
Other References	UNAIDS Additional Recommended Indicators for NAP #5

4.4 Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months

Rationale	As countries scale-up ART services, it is important to ensure that ARVs are available to those who need them. ART is a long-term treatment strategy for people living with advanced HIV infection, and treatment interruptions may lead to treatment failure and HIV drug resistance. Efficient supply management is needed to ensure an uninterrupted supply of ARVs.
What it measures	This indicator measures a key aspect of antiretroviral (ARV) drug supply management: whether health facilities dispensing ARV drugs have run out of stock of at least one required ARV in the last 12 months.
Numerator	Number of health facilities dispensing ARVs that experienced a stock-out of one or more required ARV drug in the last 12 months.
Denominator	Total number of health facilities dispensing ARVs.
How to Measure and Measurement Tools	This information is collected at central level, where health facilities submit their inventory control reports or requisition forms for ARVs. These forms have information on patients on ART, consumption data, and stock on hand with stock out information if any. This indicator requires the following tools: stock inventory control reports from health facilities indicating also the stock level of each item in the report;

- b) requisition forms submitted from facilities during a defined period of time (e.g. last order period, last quarter, last year) for ARVs; and
- c) list of ARVs that each facility is expected to dispense, if not already included in the inventory control reports or requisition forms.

All the above work if the national logistics management information systems (LMIS) is operational. If the national LMIS is not operational, or health facility surveys such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) may be used provided they include questions on ARV stock-outs.

If there is one national logistics management information system (LMIS) with details on ARV availability at the health facility level, information should be extracted from this system to construct this indicator. Alternatively, the information may need to be collected through a special survey or site visits. If there are only a limited number of health facilities where ARVs are dispensed in the country, all health facilities dispensing ARVs should be included in the survey or site visits. If the number of health facilities dispensing ARVs is large, it may be necessary to select a representative sample from the total number of health facilities dispensing ARVs (the full list should be available at the national level). When sampling, it is important to ensure that the sample includes facilities at different levels (such as central, district, and peripheral levels). In countries where ARV drugs are dispensed at pharmacies or other non-health facility delivery points, stock-outs should also be monitored in these venues; feasibility will depend on the coverage of the Logistics Management Information System.

Disaggregation

Sector: public, private

Strengths and weaknesses

This indicator captures a crucial component of the ART programme: whether or not there is a continuous, uninterrupted supply of ARV drugs at the health facility level.

This indicator does not, however, provide information on why stock-out problems occur; which ARV drug(s) are/were out of stock; or how long the stock-out lasted for a particular ARV drug. It also does not provide information on the quality of ARV drug storage, delivery, and distribution.

Additional considerations

In some situations, simply monitoring stock-outs could be misleading because a facility may keep reserve stock but maintains a policy of not issuing the reserve stock. These facilities would not be counted as having experienced a stock-out using this indicator definition, even though a patient would not be receiving a required ARV drug for treatment. In settings where reserve stock is not issued during ARV stock-outs, it is preferable to collect information on a functional stock-out (i.e., the inability to access or make use of a required ARV drug).

Data utilization

If stock-outs exist, assess whether the problem lies in the national distribution system or if it is a financial flow problem or a global ARV shortage problem. Find out whether the reason is due to projections of supply order or the distribution system or any other issue. Use this as an opportunity to see whether LMIS is functioning.

Data Quality Control and Notes for the Reporting Tool

Comment on whether the data is based on national data or survey data from a sample of facilities. Please provide any other comments that would help the interpretation of data (e.g. if only public or private sector data is included, and whether it may be an over- or underestimate).

Other References

Harmonized monitoring and evaluation indicators for procurement and supply management systems.

4.5 Late HIV diagnoses: Percentage of HIV positive persons with first CD4 cell count < 200 cells/μL in 2014

Rationale	As countries scale-up HIV services, it is important to monitor whether people are diagnosed at an earlier stage (or what percentage is still diagnosed at a late stage).
What it measures	This indicator measures the proportion of people with a CD4 cell count <200 cells/μl out of those who had a first CD4 count during the reporting period.
Numerator	Number of HIV-positive people with first CD4 cell count <200 cells/μl in 2014
Denominator	Total number of HIV-positive people with first CD4 cell count in 2014

4.6 HIV CARE:

4.6 a Total number of people enrolled in HIV care at the end of the reporting period

4.6.b Number of people newly enrolled in HIV care during the reporting period (2014)

Rationale	In addition to HIV testing it is important to monitor linking to HIV care and treatment. Comparing the evolution of the number of people tested for HIV at the end of the years does not inform about the number new people enrolled in HIV care especially since losses in HIV continuum of care cascade may be high with high attrition and lost to follow up. Therefore this indicator captures the number of patients that are either on HIV care waiting for ART initiation or on ART treatment during a reporting year.
What it measures	Number of adults and children who are being followed up by health services for HIV care, including those in antiretroviral therapy during the reporting period (2014). People in HIV care include those seen at the HIV clinic at least once during the reporting year. Yearly evolution of the number of HIV+ patients enrolled in the health services for HIV.
How to Measure and Measurement Tools	Health facility services that received patients for ART assessment needs and ART registers. By counting the number of patients who are linked to care and ART within the reporting period. Transfer-in patients, those who temporarily stopped therapy but continue to be monitored, pregnant women taking ARVs for PMTCT purpose should be included as linked to care but caution is required to avoid double counting
Disaggregation	Sex: : male/ female Age groups: <15, 15+ Mode of transmission (European Region only)
Strengths and weaknesses	This indicator permits monitoring trends of total patients linked to HIV health services but does not attempt to distinguish between HIV care and ART or to measure the cost, quality or effectiveness of treatment provided. The degree of ART initiation will depend on factors such as new policies, cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, and perceptions of effectiveness and possible side effects of treatment.
Additional considerations	This indicator should be analysed in view of the 'waiting list' i.e. patients eligible for ART and not initiated.
Data utilization	In addition to the number of people on ART, the number of patients on care is necessary for accurate planning of resources and drug stocks (avoiding shortage and wastage)

Data Quality Control and Notes for the Reporting Tool

Double Reporting: If patients transferred in and out are not correctly registered and if patients followed in different ART sites are not identified, there is a risk for double reporting which could lead to an overestimation of ART initiation. If this is the case, please comment.

Similarly if patients temporarily stopping ART and restarting are coded as new patients, this will overestimate the true number of patients newly initiated.

National Representativeness: the numerator is a national cumulative indicator, usually produced by all health facilities,. Please comment on your data as necessary.

Triangulation Options: Pharmacy report, comparing the number of people being tested, the number of patients in the pharmacy register and the ART register

Other References

PEPFAR indicator and guidelines

4.7 Viral Load suppression

a) percentage of people on ART tested for viral load (VL) who were virally suppressed in the reporting period (2014)

b) percentage of people on ART tested for viral load (VL) with VL level below $\leq 1,000$ copies after 12 months of therapy (2014)

c) percentage of people on ART tested for viral load with undetectable viral load in the reporting period (2014)

Rationale

Viral load is the recommended measure of ART efficacy and also provides an indication of treatment adherence and the risk of HIV transmission at the individual and population levels

Effective ART reduces transmission of HIV. Various study results provide strong support for the premise that treatment of the HIV-infected individual can significantly reduce sexual transmission of HIV. Thus suppression of viral load to undetectable levels should greatly reduce the risk of transmission to the uninfected partner. ART also prevents perinatal transmission of HIV. ART is considered effective when it consistently suppresses plasma viral load to undetectable levels.

Persons receiving antiretroviral therapy (ART) frequently develop treatment resistance. A key determinant of treatment failure is increase in viral load. Measurement of viral suppression (VL ≤ 1000 copies/ml) is key programmatic indicator related to effective treatment.

What it measures

Viral load is a measure of the effect of ART on viral replication. A viral load threshold of $>1,000$ copies/ml defines treatment failure according to the WHO 2013 ART guidelines.

The viral load of patients in care may be used as a quality of care indicator for the population engaged in care. If measured over time, it should reflect access to healthcare, acceptance and adherence to antiretroviral therapy, and adequate clinical monitoring of VL. For a particular healthcare system it can be used as a rough proxy measure of access to antiretrovirals, level of antiretroviral medication adherence, patient compliance with disease monitoring, and quality of care delivered to a patient population.

Numerator

4.7. a (cross sectional data)

number of people on ART tested for viral load in the reporting period with suppressed viral load (i.e. ≤ 1000 copies)

4.7. b (cohort data)

number of people tested after 12 months therapy for VL and have suppression (VL ≤ 1000 copies) during the reporting period

	4.7 c (cross sectional data) number of people on ART tested for viral load in the reporting period with undetectable viral load (i.e. ≤ 50 copies)
Denominator	4.7.a (cross sectional data) number of people on ART tested for viral load in the reporting period 4.7. b (cohort data) number of people tested after 12 months therapy for VL during the reporting period 4.7.c (cross sectional data) number of people on ART tested for viral load in the reporting period
How to Measure and Measurement Tools	Where viral load testing is done routinely, results will be recorded in patient files or in laboratory systems. Viral load test results may also be recorded electronically and reported as part of cohort monitoring studies as the percentage of patients who are virologically suppressed at defined time points.
Disaggregation	Age groups: <15, 15+ Sex : male/ female
Strengths and weaknesses	Strengths: viral load measurements provide information on adherence, treatment efficacy, and transmission risk at the individual and programme level Weaknesses: viral load monitoring capacity is scaling up but remains limited in low-income settings. Summary data from the viral load indicator may not be representative of the broader ART treatment population viral load, as results may only be attainable from a non-representative subset. <i>This applies in particular if viral load testing is not performed routinely for all ART patients, but only selectively for those with questionable treatment outcomes.</i> Cut-off VL values for treatment failure are not universally determined. Values to define suppressed undetectable viral load varies depending on the sensitivity of the assays used.
Additional considerations	For above reasons, this indicator is only applicable if VL is performed routinely (rather than on a “as needed” basis). It is important to restrict this indicator to <i>people</i> on ART (and not include all tests performed) in order to exclude re-testing in the reporting period. Some settings use dried blood spots for viral load measures; this approach is currently poorly accurate at lower thresholds and therefore a higher threshold for defining virological failure needs to be applied (>3000 copies/ml).
Data utilization	Viral load testing can help programmes to plan for second-line drug needs (in the case of treatment failure) and potential interventions to limit HIV transmission. The percentage of patients with undetectable viral load is a proxy measure of the program’s success.
Data Quality Control and Notes for the Reporting Tool	Patient monitoring system may yield both cross sectional and cohort data. Cohort data may also stem from special studies. If laboratory data is used, data needs to be adjusted to avoid double counting of patients with more than one VL test in the reporting period.
Other References	Early warning indicators for HIVDR

Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

5.2 Percentage of PLHIV newly enrolled in HIV care that have active TB disease

Rationale	The primary aim of the TB intensive case finding (ICF) activities is early detection of TB among PLHIV and provision of prompt TB treatment and ART which if optimally implemented along with provision of early ART, Isoniazid Preventive Therapy and Airborne Infection Control practices, reduce TB burden among the PLHIV. While ICF is to be implemented in all the PLHIV attending HIV-care and treatment facilities during every visit, it is critically important among the PLHIV newly enrolled in HIV care and treatment, as risk of undetected TB among them is greater than those already on ART. Also, newly enrolled people living with HIV may be less aware about TB symptoms and the importance of early detection and treatment, and hence may not seek care for general or specific TB symptoms. Intensified TB case finding thus offers an opportunity to educate people living with HIV and detect TB early. Hence this indicator measures both the burden of active TB disease among PLHIV newly enrolled in HIV care as well as the extent of effort to detect HIV-associated TB early.
What it measures	Total TB cases detected among HIV positive patients who are newly enrolled in HIV care (Pre-ART or ART) during the reporting period
Numerator	Total number of persons who have active TB disease during the reporting period out of those newly enrolled in HIV care
Denominator	Total number of persons newly enrolled in HIV care during the reporting period (pre-ART plus ART).
How to Measure and Measurement Tools	The outcome of TB investigations in presumptive TB cases among people living with HIV should be recorded on HIV care/ART card ("investigations" column in the "encounters" section) and in the pre-ART and ART registers (monthly and quarterly follow-up sections, respectively). Similarly, TB patients who are found HIV-positive should be enrolled into HIV care promptly and their TB status recorded on ART card and registers. Numerator: At the end of the reporting period, count the total number of people living with HIV newly enrolled in the HIV care (pre-ART and ART registers) who have active TB disease. Denominator: Count the total number of people living with HIV newly enrolled in HIV care, that is, enrolled in pre-ART care or starting ART during the reporting period. Double counting of the same individual in both pre-ART and ART registers should be avoided. Also, information on the TB status in the pre-ART and ART registers should be updated and reconciled with the TB registers in relevant basic management units before consolidation and reporting to higher levels.
Disaggregation	Data for this indicator should be disaggregated by sex and age (<15 years/15+)
Strengths and weaknesses	Review of the trend of TB among people living with HIV newly enrolled in care over a period of time may provide useful information on TB burden among them and thus the effectiveness of efforts to detect and treat HIV-associated TB early. This indicator may underestimate the actual burden of HIV associated TB as it may exclude patients detected through provider initiated HIV testing and counselling but not enrolled in HIV care or those who have disseminated forms of TB, remain asymptomatic and therefore missed during routine TB screening. Further a high indicator value may mean high TB rates or effective TB screening and HIV testing programmes whereas a low value may be because of poor

	implementation of TB screening and HIV testing activities or successful TB control efforts. Therefore indicator value needs carefully interpretation.
Additional Considerations	Data are to be collected continuously and reported to sub-national or national level as part of routine cross-sectional reporting quarterly. It should also be submitted annually to WHO.
Data Quality Control and Notes for the Reporting Tool	This indicator was introduced in 2014 and so countries are asked to provide comments on problems with reporting – particularly if they are unable to report it.

5.3 Percentage of people living with HIV newly enrolled in HIV care starting isoniazid preventive therapy (IPT)

Rationale	To ensure that eligible HIV-positive individuals are given treatment for latent TB infection and thus to reduce the incidence of TB in people living with HIV.
What it measures	Number of people living with HIV newly-enrolled in HIV care who started treatment for latent TB infection, isoniazid preventative therapy (IPT)) expressed as a proportion of the total number of adults and children newly-enrolled in HIV care over a given time period.
Numerator	Number of people living with HIV <u>newly</u> enrolled (i.e. started) in HIV care (pre-ART and ART) who <u>also</u> start (i.e. given at least one dose) isoniazid preventive therapy treatment during the reporting period <i>HIV care</i> includes pre-ART and ART.
Denominator	Number of people living with HIV newly enrolled (i.e. started) in HIV care during the reporting period.
How to Measure and Measurement Tools	HIV treatment card and modified HIV care register. The data needed for this indicator is collected from pre ART and ART registers at the HIV care service sites, depending on where isoniazid preventive therapy (IPT) is to be administered. HIV-positive clients should be screened for TB using a four symptom screening algorithm. Those clients found not to have any of the following four symptoms: a current cough, fever, weight loss and night sweats are unlikely to have active TB and should be offered IPT according to nationally determined guidelines. Similarly, children who do not have poor weight gain, fever or current cough should be offered this therapy to reduce the risk of developing active TB, both in persons on ART and without ART. All those accepting IPT and receiving at least the first dose of treatment should be recorded. This information is being recorded in an extra column in the HIV care registers. Accurately predicting drug requirements for supply management requires the collection of more detailed information.
Disaggregation	None
Strengths and weaknesses	This indicator measures the coverage of TB preventive therapy among persons newly enrolled in HIV care. However, it lacks the benchmark for acceptable performance. Scale-up of this intervention will assist development of such a benchmark at national level. Also, unless further data are collected this indicator provides no information on the number of individuals who adhere to or complete the course of treatment.
Additional considerations	A pharmacy based TB preventive therapy (INH) register should record client attendance to collect further drug supplies (usually monthly). Alternatively, the ART facility may maintain a latent TB infection treatment register in parallel with the ART register. Such a record may facilitate understanding of the number of new and continuing patients on latent TB infection treatment as well as the treatment completion rates and adverse events.

Data utilization	If low value, explore reasons why and compare disaggregated data with the national average to identify places needing special attention and reasons for suboptimal coverage. Explore further available data on completion of TBPT/IPT.
Data Quality Control and Notes for the Reporting Tool	Please provide any comments on whether the data you provide covers the entire country, or is from a selected sample (if so, please provide details on what the data represents, as well as any assumptions made to extrapolate the data to a national figure)
Other References	A guide to monitoring and evaluation for collaborative TB/HIV activities 2014 version

5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit

Rationale	This is a process indicator for an activity intended to reduce the impact of TB among people living with HIV. It will demonstrate the level of implementation of the recommendation that people living with HIV are screened for TB at diagnosis and at follow-up visits using their last visit as proxy measure.
What it measures	Number of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit.
Numerator	Number of adults and children in HIV care, who had their TB status assessed and recorded during their last visit. <i>HIV care</i> includes pre-ART and ART.
Denominator	Total number of adults and children in HIV care in the reporting period.
How to Measure and Measurement Tools	WHO recommends the use of a simplified screening algorithm for intensified TB case findings that includes 4 clinical symptoms: (1) current cough, (2) fever, (3) weight loss and (4) night sweats. Using this simplified algorithm assessment of TB status at every visit during the reporting period ('Yes' if 'no signs', 'suspect' or 'on treatment' and 'No' if TB status not assessed) should be recorded on the patient HIV care/ART card, and transferred onto the pre-ART or ART registers as appropriate at all facilities providing routine HIV care. Enrolled in care includes all those continuing in care and those newly enrolled during the reporting period. The value of this denominator should normally exceed the denominator provided for 5.2 TB detection and for 5.3 IPT coverage. This data should be analysed and reported together with other cross sectional data at national level. The numerator is taken from the pre ART and ART registers by counting the number of patients who had their TB status assessed during the reporting period. For patients who started on ART during the reporting period, care should be taken to count them in the ART register and not in the pre-ART register. The denominator for pre-ART patients will be those seen for care during the reporting period. The denominator for ART patients will be those current on ART during the reporting period. The denominator is taken from the pre-ART and ART registers by counting the number of patients with a visit during the reporting period. This is then recorded on the cross sectional reporting form. TB and HIV programmes should collaborate to ensure that agreed criteria for identifying a TB suspect and methods of TB screening are used that are consistent with TB control programme protocols.
Disaggregation	None

Strengths and weaknesses

TB status assessment among people living with HIV, followed by prompt referral for diagnosis and treatment, increases the chances of survival, improves quality of life and reduces transmission of TB in the community. TB status assessment identifies HIV-positive clients who show no evidence of active TB and would benefit from treatment with isoniazid for latent TB infection.

The indicator does not measure the quality of intensified TB case-finding nor does it reveal whether those identified as suspects are investigated further or effectively for TB. However, it does emphasize the importance of intensified TB case-finding for people living with HIV at diagnosis and at every contact they have with HIV treatment and care services.

Programmes should aim for a high value for this indicator (close to 100%) but should interpret it in conjunction with values of indicators related to the % of people in HIV care who are: a) on TB treatment and b) who were given treatment for latent TB infection, to ensure that appropriate action follows the screening process. A low value will demonstrate that Objective B - reducing the impact of TB among people living with HIV - is unlikely to be met.

Data utilization

See section on Strengths and Weaknesses for interpretation of data and further areas to explore. If low value, review disaggregated data and explore reasons why.

Data Quality Control and Notes for the Reporting Tool

Please provide any comments on how this data was collected and any assumptions made in establishing a national estimate.

Other References

A guide to monitoring and evaluation for collaborative TB/HIV activities

P.1 Policy and Programmatic questions

HIV testing and counselling

For each set of questions, please indicate: yes, no, don't know.

- 1) Populations. Does the current HTC guidelines address :
 - Children
 - Adolescents
 - Key populations⁶
- 2) PITC. Does the current HTC guidelines recommend PITC for:
 - all medical contacts
 - all pregnant women
 - all paediatric patients
 - all people in TB clinics
 - all people in STI clinics
 - all people in Hepatitis services
 - all key populations attending key population-specific clinical services
 - other populations- please specify:
- 3) Community-based testing. Does the current HTC guidelines recommend
 - community based HTC
 - use of rapid tests
 - rapid tests for same day results
 - rapid tests to be performed by lay providers
- 4) Couples/partner HTC. Does the current HTC guidelines recommend
 - Couples/partner HTC in all settings
 - Couples/partner HTC in PMTCT programmes

Antiretroviral therapy

- 1) What is the status of ARV guidelines?

Please provide month and year of last completed and published revision.
Please indicate if the guidelines are stand alone or consolidated

 - a) Adult ART guidelines
 - b) PMTCT guidelines:
 - c) Paediatric ART guidelines:
 - d) Operational guidelines:

Please upload a copy of the document/s if available.

⁶ Refer to men who have sex with men, people in prison, people who inject drugs, sex workers and transgender people.

- 2) Have recommendations of the WHO 2013 Guidelines on the use of ARVs for the Prevention and Treatment of HIV been adapted in a national process?
 - a) Adult ART guidelines: Yes, completed/On-going/No/Other Please provide a comment if you choose other:
 - b) PMTCT guidelines: Yes, completed/On-going/No/Other Please provide a comment if you choose other:
 - c) Paediatric ART guidelines: Yes, completed/On-going/No/Other Please provide a comment if you choose other:

- 3) What are the national ART targets:
 - a) Target number(s) of people on ART :

_____number and year

_____number and year
 - b) Among pregnant women what are the targets for: PMTCT ART coverage target⁷ (e.g. XX % by 2015)

_____percentage and year

_____percentage and year

- 4) What is the recommended CD4 threshold for initiating ART in adults and adolescents who are asymptomatic?
 - a) (as per MOH guidelines or directive)?

_____all regardless of CD4 count (test and treat)

_____≤ 500,

_____≤ 350,

_____other (specify): _____
 - b) What is the implementation and practice of initiating ART at a CD4 threshold of 500 among adults and adolescents?

___Not done in practice

___Done in a small number of treatment sites

___Done in a large number of treatment sites

___Done country-wide

___Other

Please provide comment if you choose other:
 - c) What is the implementation and practice of initiating ART regardless of CD4 count among adults and adolescents ?

___Not done in practice

___Done in a small number of treatment sites

___Done in a large number of treatment sites

⁷ Under Prong 4: The target for ART coverage among pregnant women is 90% for 2015.

- ___ Done country-wide
- ___ Other: Please provide comment if you choose other.
- 5) If national guidelines recommend a CD4 threshold of 500, is there prioritization given to persons with a CD4 < 350 or to those with advanced clinical disease?
- ___ Yes, specify: ___
- ___ No
- ___ Not applicable (e.g. country has not yet adopted CD4 threshold of 500)
- ___ Other: Please provide comment if you choose other.
- 6) What are the ART initiation criteria adopted in national guidelines for infants and children with HIV?
- a) Age cut-off to treat all children irrespective of symptoms as per MOH guidelines or directive:
- ___ < 2 years
- ___ < 5 years
- ___ < 15 years
- ___ Other : Please provide comment if you choose other.
- b) What is the implementation status of the policy adopted above ?
- ___ Not done in practice
- ___ Done in a small number of treatment sites
- ___ Done in a large number of treatment sites
- ___ Done country-wide
- ___ Other: Please provide comment if you choose other.
- c) CD4 cell count thresholds in children aged 5 years and older who are asymptomatic per MOH guidelines or directive:
- ___ regardless of CD4 count
- ___ ≤ 500
- ___ ≤ 350
- ___ other
- Please provide comment if you choose other.
- d) What is the practice in applying the CD4 threshold of 500 or regardless of CD4 count to initiate ART among children aged 5 years and older?
- ___ Not done in practice
- ___ Done in a small number of treatment sites
- ___ Done in a large number of treatment sites
- ___ Done country-wide
- ___ Other
- Please provide comment if you choose other.
- 7) Do national guidelines recommend ART for all HIV-infected patients

with active TB?

☐ Yes

☐ No

☐ Other

Please provide comment if you choose other.

- 8) Do national guidelines recommend ART for all HIV positive patients with Hepatitis B with severe liver disease?

☐ Yes

☐ No

☐ Other

Please provide comment if you choose other

- 9) Do national guidelines recommend ART for the HIV positive partner in sero-discordant couples?

☐ Yes

☐ No

☐ Other

Please provide comment if you choose other.

- 10) Do national guidelines recommend treating HIV positive persons identified as key populations* irrespective of CD4 cell count? (Note that this is not currently a recommendation in the 2013 Consolidated ARV Guidelines)

☐ Yes

☐ No

☐ If yes please specify the key population/s: _____

- 11) For which populations is nurse-initiated ART allowed?

☐ Non-pregnant Adults (men, women and transgender)

☐ Pregnant Women

☐ Adolescents (10-19 years old)

☐ Children < 10 years old

☐ None

Regimen

- 12) Is TDF/3TC or (FTC)/EFV the preferred 1st line ARV combination for treatment initiation in national guidelines among:

a) adults and adolescents: Yes / No/Other

Please provide comment if you choose other.

b) pregnant women: Yes / No/Other

Please provide comment if you choose other.

- 13) Does the country use fixed-dose ART combinations as the preferred first line therapy? (Possibility of multiple choice).

☐ Yes , one pill once a day

☐ Yes, 2 drug FDC + 1 drug

☐ No

☐ Other

Please provide comment if you choose other.

14) Is there a policy to phase out D4T?

a) adults and adolescents:

☐ Yes , fully phased out

☐ Yes, partially phased other

☐ Other

Please provide comment if you choose other.

b) children:

☐ Yes , fully phased out

☐ Yes, partially phased other

☐ Other

Please provide comment if you choose other.

15) Is AZT/3TC (or FTC)/ATV/r(or LPV/r) the preferred 2nd line ARV combination for adults and adolescents with HIV in the national guidelines?

☐ Yes

☐ No

☐ Other

Please provide comment if you choose other.

16) What is the preferred NRTI for treatment initiation for children with HIV less than 3 years of age?

☐ Abacavir (ABC)

☐ Zidovudine (AZT)

☐ Stavudine (d4T)

☐ Other (specify_____)

17) Are LPV/r based-regimens the preferred treatment option for all infants and children < 36 months with HIV (irrespective of NNRTI exposure) in the national guidelines?

☐ Yes, for all

☐ No, but recommended for NNRTI-exposed infants only

☐ Not recommended

18) Is Efavirenz (EFV) recommended as the preferred NNRTI for treatment initiation in children aged 3 years and older?

☐ Yes

☐ No

☐ Other (specify_____)

19) What is the recommended NRTI backbone for treatment initiation in children aged 3–10 years?

☐ TDF + 3TC (or FTC)

☐ AZT + 3TC (or FTC)

☐ ABC + 3TC (or FTC)

___ Other (specify_____)

20) What is the recommended NTRI backbone for treatment initiation adolescents > 35kg and at least 10 years of age?

___ TDF + 3TC (or FTC)

___ AZT + 3TC (or FTC)

___ ABC + 3TC (or FTC)

___ Other (specify_____)

Monitoring treatment response

21) Does the country use point-of-care CD4 technology?

___ Yes___ No

a) If yes, what proportion of district hospitals have CD4 testing capacity ?

Provide an estimate ----- %

b) What proportion of primary health care facilities have access to CD4 cell count for testing their patients, whether on-site or nearby referral)?

Provide an estimate -----%

22) What is the current national policy and level of implementation of viral load ?

a) Viral load policy for adults and the level of implementation:

___ Yes , phase-in, provide date

___ Yes, fully implemented, provide date

___ Not implemented

b) Viral load policy for adolescents and the level of implementation:

___ Yes , phase-in, provide date

___ Yes, fully implemented, provide date

___ Not implemented

c) The viral load policy for children and level of implementation:

___ Yes , phase-in, provide date

___ Yes, fully implemented, provide date

___ Not implemented

23) What is the viral load testing strategy for monitoring the treatment response?

For each :

a)adults:

Routine first test at : 3 months/6 months/12 months

Then follow up testing every: 3 months/6 months/12 months

Targeted (based on suspected non-response to ART): Yes/No

b)adolescents:

Routine first test at : 3 months/6 months/12 months

Then follow up testing every: 3 months/6 months/12 months

Targeted (based on suspected non-response to ART): Yes/No

c)children:

Routine first test at : 3 months/6 months/12 months

Then follow up testing every: 3 months/6 months/12 months

Targeted (based on suspected non-response to ART): Yes/No

24) What is the recommendation for viral load monitoring for:

a)adults ?

Routine VL Monitoring/Targeted VL /No recommendation/Other:

(Specify: _____)

b)adolescents ?

Routine VL Monitoring/Targeted VL /No recommendation/Other:

(Specify: _____)

c)children?

Routine VL Monitoring/Targeted VL /No recommendation/Other:

(Specify: _____)

Service Delivery:

25) Which of the following service provision modalities are included in the ART national policy for:

a) adults ?

___ART provision in TB clinics by TB providers

___TB treatment in ART settings by ART providers

___ ART provision in MNCH clinics by MNCH providers

___ ART provision in settings providing opioid substitution therapy

___Community health workers engaged in ART patient support

___Other , Please specify:

b)children ?

___ART provision in TB clinics by TB providers

___TB treatment in ART settings by ART providers

- ☐ ART provision in MNCH clinics by MNCH providers
- ☐ ART provision in settings providing opioid substitution therapy
- ☐ Community health workers engaged in ART patient support
- ☐ Other , Please specify:

26) Which of the following co-infection policies are in place?

a)adults

- ☐ Isoniazid preventive therapy (IPT) for people living with HIV
- ☐ Intensified TB case finding in PLHIV
- ☐ TB Infection control for PLHIV
- ☐ Co-trimoxazole prophylaxis
- ☐ Hepatitis C diagnosis and management as part of HIV care
- ☐ Hepatitis B and Hepatitis C testing in ART clinics
- ☐ Hepatitis B vaccination provided at ART clinics
- ☐ Hepatitis C treatment provided in ART clinics
- ☐ Other

Please specify:

b)children

- ☐ Isoniazid preventive therapy (IPT) for people living with HIV
- ☐ Intensified TB case finding in PLHIV
- ☐ TB Infection control for PLHIV
- ☐ Co-trimoxazole prophylaxis
- ☐ Hepatitis C diagnosis and management as part of HIV care
- ☐ Hepatitis B and Hepatitis C testing in ART clinics
- ☐ Hepatitis B vaccination provided at ART clinics
- ☐ Hepatitis C treatment provided in ART clinics
- ☐ Other

Please specify:

Prevention of mother-to-child transmission

- 1) Do you have national plan for the elimination of MTCT of HIV?
 - ☐ Yes
 - if yes specify the MTCT transmission rate target(s) and year: ____
 - if yes specify the elimination target(s) (eg. #cases/pop) and year: ____
 - ☐ No
- 2) Do you have a national plan for elimination of MTCT of syphilis?
 - (1) Yes, integrated with HIV or other elimination initiative
 - (2) Yes, stand-alone (not integrated with HIV or other elimination initiative)

(3) No national plan

3) What tests are used for screening pregnant women for syphilis in your country? Yes/ No

- a) Laboratory-based Non-treponemal (e.g., RPR/VDRL)
- b) Laboratory-based treponemal (e.g., TPPA, TPHA)
- c) Rapid syphilis treponemal tests (e.g., Bioline, Determine, Chembio, etc.)

4) What is the current nationally recommended PMTCT option ? (as per MOH guidelines or directive)?

Option A

Option B: if yes since ____

Option B+: if yes since ____

a) What is the practice in applying the Option B+ in the treatment of HIV positive pregnant women?

- ___Not done in practice
- ___Done in a small number of MCH sites
- ___Done in a large number of MCH sites
- ___Done country-wide
- ___Other

5) If currently implementing Option A, is transition to option B/B+ planned?

- (1) Yes
- (2) No
- (3) If yes, in what year: ____

6) What is the current nationally recommended first line ART regimen for pregnant and breastfeeding women with HIV?

- (1) TDF/3TC(FTC)/EFV
- (2) other, please specify _____

7) What is the current nationally recommended PMTCT regimen, and duration, for exposed infants?

Current nationally recommended PMTCT regimen for exposed infants:
Duration

8) Is there a national recommendation on infant feeding for HIV-exposed infants?

- 1) Yes – breastfeeding (duration ____ months or unspecified ____)
- 2) Yes – replacement feeding
- 3) Yes – both recommended, left to individual choice or different

settings

4) No

9) If breastfeeding is recommended for HIV positive women and exposed infants, is the duration specified?

___ Yes

___ No

If Yes, please specify the duration in months: ()

Sexually transmitted infections (STI)

1) Are there national STI treatment guidelines or recommendations?

If so, what year were they last updated?

___ Yes,

If yes, year updated (___)

___ No

2) Does your country have a national strategy or action plan for the prevention and control of STI?

___ Yes

___ No

3) Is gonococcal antimicrobial resistance monitoring conducted in your country?

___ Yes, annually

___ Yes, less than annually

___ No

Key populations

1) Which of the following key population or vulnerable groups are explicitly addressed in the national HIV policy or national plans? (Possibility of multiple choice)

___ adolescent key populations

___ men who have sex with men

___ people in prisons and other closed settings

___ people who inject drugs

___ sex workers (male and female)

___ transgender people

2) Do you have population size estimates for the following populations: (Possibility of multiple choice)

___ adolescent key populations

___ men who have sex with men

___ people in prisons and other closed settings

___ people who inject drugs

___ sex workers (male and female)

___ transgender people

- 3) People who inject drugs: Which of the following components of the comprehensive package of HIV prevention, diagnosis, treatment and care interventions for people who inject drugs are implemented in your country?

Indicate: Yes ___No

- a) Needle and syringe programmes (NSP)
- b) i. Opioid substitution therapy (OST)
- b)ii. Other drug dependence treatment
- c) Community provision of naloxone
- d) HIV testing and counselling
- e) Antiretroviral therapy
- f) Sexually transmitted infection (STI) prevention and treatment
- g) Comprehensive condom programming
- h) Targeted information, education and communication (IEC)
- i) Viral hepatitis prevention, diagnosis, treatment and vaccination
- j) Tuberculosis prevention, diagnosis and treatment

- 4) People in prisons and other closed settings: Which of the following components of the comprehensive package of HIV prevention, diagnosis, treatment and care interventions for key populations are implemented in your country?

Indicate: Yes ___No

- (a) Comprehensive condom and lubricant programming
- (b) harm reduction interventions for substance use (e.g. NSP and OST)
- (c) behavioural interventions
- (d) HIV testing and counselling
- (e) HIV treatment and care
- (f) Co-infection and co-morbidity (viral hepatitis, tuberculosis, mental health) prevention and management
- (g) sexual and reproductive health interventions

- 5) Sex Workers: Which of the following components of the comprehensive package of HIV prevention, diagnosis, treatment and care interventions for key populations are implemented in your country?

Indicate: Yes ___No

- (a) Comprehensive condom and lubricant programming
- (b) harm reduction interventions for substance use (e.g. NSP and OST)
- (c) behavioural interventions
- (d) HIV testing and counselling
- (e) HIV treatment and care

- (f) Co-infection and co-morbidity (viral hepatitis, tuberculosis, mental health) prevention and management
- (g) i. Symptomatic STI treatment
- (g)ii. Screening for asymptomatic STI
- (g)iii Periodic presumptive STI treatment

- 6) Men who have sex with men: Which of the following components of the comprehensive package of HIV prevention, diagnosis, treatment and care interventions for key populations are implemented in your country?

Indicate: Yes ___ No

- (a) Comprehensive condom and lubricant programming
- (b) harm reduction interventions for substance use (e.g. NSP and OST)
- (c) behavioural interventions
- (d) HIV testing and counselling
- (e) HIV treatment and care
- (f) Pre-exposure prophylaxis (PrEP)
- (g) Co-infection and co-morbidity (viral hepatitis, tuberculosis, mental health) prevention and management
- (h)i. Symptomatic STI treatment
- (h)ii. Screening for asymptomatic STI

- 7) Transgender people: Which of the following components of the comprehensive package of HIV prevention, diagnosis, treatment and care interventions for key populations are implemented in your country?

Indicate: Yes ___ No

- (a) Comprehensive condom and lubricant programming
- (b) harm reduction interventions for substance use (e.g. NSP and OST)
- (c) behavioural interventions
- (d) HIV testing and counselling
- (e) HIV treatment and care
- (f) Co-infection and co-morbidity (viral hepatitis, tuberculosis, mental health) prevention and management
- (g)i. symptomatic STI treatment
- (g)ii. screening for asymptomatic STI

Male circumcision
(only for 14 countries)

- 1) What is the current timeframe and target age and number of voluntary medical male circumcisions to achieve?

Target number of voluntary medical male circumcisions:

Target age: ___

Target year: ___

- 2) What is the status of operational planning and monitoring? (Possibility of multiple choice)

Operational plan for 2015 exists

Annual MC programme performance review conducted: ___ if yes please specify in what year ____

MC HIV Prevention Programme is linked/(has a working plan) with adolescent health

A MC TWG/committee to review adverse events is established

- 3) What are the recommended medical male circumcisions methods that are recommended/approved by the national programme?

Conventional surgical methods (dorsal slit, forceps guided, sleeve resection)

(specify any age precisions)

A prequalified device method has been approved for use, please specify:

PrEP and PEP

- 1) Is PreP being provided in the country?

___ Yes

If Yes, specify for whom:

___ No

- 2) Is PEP being provided in the country?

___ Yes

If Yes, specify for whom:

___ No

- 3) What drugs are recommended for

a) Adults and adolescents : Please specify

b) Children: Please specify

- 4) Number of prescriptions (for the reporting year)

a) Adults/adolescents

b) Children

- 5) Please provide reason/s for prescription (e.g. occupations, non-occupational etc)

Surveillance

- 1) Does the country carry out sentinel surveillance in special populations?

if yes every __ years; number of sites __, last survey in year __

(i) ANC attendees

(ii a) sex workers?

(ii b) people who inject drugs?

(ii c) men who have sex with men?

(ii d) transgender

(ii e) in prisons and other closed settings

(iii) Other specific populations (please specify _____)

Monitoring and evaluation

What is the current status of planning for M&E of the HIV/AIDS health sector response?

A national M&E plan exists: last update in year ____

A review of the M&E system was conducted: year of last review, specify ____

A review of the M&E system is planned:, in year ____, specify: ____

HIV Drug Resistance

In the last 2 years, has the country carried out HIV Drug Resistance (HIVDR) surveillance according to the following WHO protocols ?

for each: ____yes ____no

if yes, last started in year ____

- a) Pretreatment drug resistance surveys
- b) Acquired drug resistance surveys
- c) Paediatric drug resistance surveys
- d) Survey of clinic performance using Early warning indicators for HIV drug resistance

Toxicity monitoring surveillance

- 1) Excluding passive pharmacovigilance approaches, is there a systematic effort ongoing to monitor the toxicity of ARVs in the country?

____yes ____no

- 2) If answer to question is "YES", what approaches are currently used [possibility of multiple choices]

____ reporting of toxicities by sentinel sites

____ active surveillance within cohorts established to assess a range of treatment outcomes

____ active surveillance within cohorts established solely to monitor toxicity

____ pregnancy registry

____ birth defect surveillance

____ monitoring of mother-infant pairs during breastfeeding

Strategic planning and review

If applicable, please provide the dates for the following:

- 1) Epidemiologic analysis:
 - a) When was the last epidemiological analysis conducted?
 - b) When is the next epidemiological analysis planned?
- 2) Programmatic and financial gap analysis:
 - a) When was the last programmatic and financial gap analysis conducted?
 - b) When is the next programmatic and financial gap analysis planned?
- 3) What is the status of national HIV/AIDS Programme development (that includes HIV in the health sector)?
 - ____ The HIV national (health sector) strategic plan is in place, valid from: (year) to (year)
 - ____ The HIV (health sector) programme review was carried out in year ____ ;
please specify ____
 - ____ The next HIV (health sector) programme review is planned for year :
()

Reproductive Health
and Research

- 4) Does the current national HIV [health sector] strategy address the following elements:
- a) achieving universal access to ART
 - b) collaboration between HIV and other services including reproductive health
 - c) strengthening health systems
 - d) reducing inequities

In your country, do you have service delivery points providing appropriate medical and psychological care and support for women and men who have been raped & experienced incest?

Appropriate medical and psychological care and support includes and is in accordance with the recommendations of the WHO clinical and policy guidelines - Responding to intimate partner violence and sexual violence against women (2013):

- Provision of first-line support or what is known as psychological first aid
- Provision of emergency contraception to women who seek services within 5 days
- Offer safe abortion if a woman is pregnant as a result of rape, in accordance with the national law
- Provision of STI and HIV post-exposure prophylaxis (within 72 hours of a sexual assault) as needed

___ yes

___ no

Appendix 1. HIV/Hepatitis Indicators (EURO and PAHO)

EURO15/ PAHO1 Number of adults and children in HIV care who were screened for hepatitis B	
Rationale	HIV patients are often co-infected with HBV, notably in the WHO European Region, due to the same modes of transmission of HIV and HBV. Screening of HBV informs physician strategy on patient management (recommending vaccination against hepatitis B of uninfected and not vaccinated patients, or further evaluation and treatment of Hepatitis B). This is part of a comprehensive approach to the management of PLHIV promoted in the WHO European Region.
What it measures	This indicator measures the number of people living with HIV enrolled in HIV care who were screened for HBsAg with the purpose of addressing patient's health needs regarding hepatitis B.
Numerator	Number of HIV-positive adults and children in HIV care who were screened for hepatitis B using HBsAg tests during the reporting year.
How to Measure and Measurement Tools	Calculated from clinical records of health care facilities which provide HIV/AIDS treatment and care.
Disaggregation	Test result: HBsAg-positive
Strengths and weaknesses	The strength of this indicator is that it allows countries to monitor the extent to which HIV infected patients are being screened for hepatitis B – an intervention that is critical for assessing further needs related to the management of hepatitis B. Presence of HBsAg for a minimum of 6 months indicates chronic hepatitis B and informs clinicians on the need for further clinical and laboratory evaluation and treatment. Knowing HIV/Hepatitis B status allows prescribing ARVs which are effective against both HBV and HIV infections.
Additional considerations	Additional information regarding the number of adults and children in HIV care and screened for hepatitis B who were diagnosed with hepatitis B during the reporting period is also requested as part of this indicator. This data allows evaluating access to treatment among those who need it.
Data utilization	Look at trends over time. Useful information for clinical management and quality control in patient management.
Data quality control and notes for the reporting tool	National Representativeness: if this indicator is only produced in a sub-set of facilities, comment should be added on the source of information, sample size and whether the information is representative of all sites where HIV/AIDS treatment and care delivered.
EURO16/ PAHO2 Percentage of HIV-positive hepatitis B cases eligible for hepatitis B treatment who received treatment for both hepatitis B and HIV	
Rationale	HIV patients are often co-infected with HBV due to the same modes of transmission of HIV and HBV. Co-infection rates are particularly high in the WHO European Region where a large proportion of HIV infections are related to injecting drug use. Treatment of hepatitis B in PLHIV has an impact on patients' quality of life, life expectancy and mortality. Some antiretroviral drugs are effective against both HIV and HBV viruses, which simplifies treatment of coinfecting patients.
What it measures	This indicator measures the number of HBV/HIV co-infected patients receiving treatment for both hepatitis B and HIV with effective ARVs for both viruses among patients enrolled in HIV care who were evaluated on hepatitis disease progression and found eligible for treatment.
Numerator	Number of HIV-positive hepatitis B cases eligible for hepatitis B and HIV treatment who received treatment for both hepatitis B and HIV with effective ARVs for both viruses during the reporting year.

Denominator	Number of HIV-positive hepatitis B cases who were eligible for both hepatitis B and HIV treatment during the reporting year.
How to Measure and Measurement Tools	The numerator and denominator are calculated from clinical records of health care facilities providing HIV/AIDS treatment and care.
Disaggregation	None requested.
Strengths and weaknesses	The strength of this indicator is that it provides information on hepatitis B disease burden in PLHIV. It also allows monitoring access to hepatitis B treatment for PLHIV co-infected with HBV who are eligible for treatment.
Data utilization	Look at trends over time. Useful information for clinical management and quality control in patient management.
Data quality control and notes for the reporting tool	National Representativeness: if this indicator is only produced in a sub-set of facilities, comments should be added on the source of information, sample size and whether the information is representative of all sites where HIV/AIDS treatment and care delivered.

EURO17 PAHO3 Number of adults and children in HIV care who were screened for hepatitis C

Rationale	HIV patients are often co-infected with HCV, notably in the WHO European Region, due to the same modes of transmission of HIV and HCV. Screening of HCV informs physician strategy on patient management (further evaluation and treatment of Hepatitis C if indicated or counselling on how to minimize risk of HCV infection in the future). This is part of a comprehensive approach to the management of PLHIV promoted in the WHO European Region.
What it measures	This indicator measures the number of people living with HIV enrolled in HIV care who were screened for HCV a/b with the purpose of addressing patient's health needs regarding hepatitis C.
Numerator	Number of HIV positive adults and children in HIV care who were screened for hepatitis C using HCV a/b tests during the reporting year.
How to Measure and Measurement Tools	Calculated from clinical records of health care facilities which provide HIV/AIDS treatment and care.
Disaggregation	Test result: HCV-positive
Strengths and weaknesses	The strength of this indicator is that it allows countries to monitor the extent to which HIV infected patients are being screened for hepatitis B – an intervention that is critical for assessing further needs related to the management of hepatitis C. Presence of HCV a/b provides information on HIV/HCV co-infection rates, informs clinicians on need for further clinical and laboratory evaluation and treatment.
Additional considerations	Additional information regarding the number of adults and children in HIV care and screened for hepatitis C who were diagnosed with hepatitis C during the reporting year is also requested as part of this indicator. This data allows evaluating access to treatment among those who need it.
Data utilization	Look at trends over time. Useful information for clinical management and quality control in patient management.
Data quality control and notes for the reporting tool	National Representativeness: if this indicator is only produced in a sub-set of facilities, comment should be added on the source of information, sample size and whether the information is representative of all sites where HIV/AIDS treatment and care delivered.

EURO18 / PAHO4 Percentage of HIV-positive hepatitis C cases eligible for hepatitis C treatment who received treatment for hepatitis C

Rationale	HIV patients are often co-infected with HCV due to the same modes of transmission of HIV and HCV. Co-infection rates are particularly high in the WHO European Region where a large proportion of HIV infections are related to injecting drug use. Treatment of hepatitis C in PLHIV has an impact on patients' quality of life, life expectancy, and mortality.
What it measures	This indicator measures number of HCV/HIV co-infected patients receiving hepatitis C treatment among patients enrolled in HIV care who were screened, evaluated on hepatitis disease progression and found eligible for treatment.
Numerator	Number of HIV positive hepatitis C cases eligible for hepatitis C treatment who received hepatitis C treatment during reporting year
Denominator	Number of HIV positive hepatitis C cases who were eligible for hepatitis C treatment during the reporting year
How to Measure and Measurement Tools	The numerator and denominator are calculated from clinical records of health care facilities providing HIV/AIDS treatment and care.
Disaggregation	None requested.
Strengths and weaknesses	The strength of this indicator is that it provides information on hepatitis C disease burden in PLHIV. It also allows monitoring access to hepatitis C treatment for PLHIV co-infected with HCV who are eligible for treatment.
Data utilization	Look at trends over time. Useful information for clinical management and quality control in patient management.
Data quality control and notes for the reporting tool	National Representativeness: if this indicator is only produced in a sub-set of facilities, comments should be added on the source of information, sample size and whether the information is representative of all sites where HIV/AIDS treatment and care delivered.



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