UNAIDS 2024

GUIDANCE

Global AIDS Monitoring 2025

Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS

Contents

Modelled HIV estimates using the updated Spectrum software are due by 31 March 2025.

Please use the Global AIDS Monitoring website (aidsreportingtool.unaids.org) to submit your indicator data by 31 March 2025.

Summary of components for 2025 Global AIDS Monitoring

Commitments of the 2021 Political Declaration on AIDS

Indicator number | Short indicator name

Reduce the annual number of people newly infected with HIV

1.1 HIV incidence

Reduce the annual number of people dying from AIDS-related causes

2.7 AIDS mortality

Commitment 1. Effective implementation of combination HIV prevention

1.2 Estimates of the size of key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings)

1.3 HIV prevalence among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings)

1.4 HIV testing and status awareness among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

1.5 Condom use among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

1.6 Coverage of HIV prevention programmes among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

1.7 HIV prevention programmes in prisons

1.8 Safe injecting practices among people who inject drugs

1.9 Needles and syringes distributed per person who injects drugs

1.10 Coverage of opioid agonist maintenance therapy

1.11 People who received PrEP

1.12 Prevalence of male circumcision

Indicator number | Short indicator name

1.13 Annual number of males voluntarily circumcised

1.14 Condom use at last high-risk sex

1.15 Annual number of condoms distributed

1.16 Young people: knowledge about HIV prevention

Commitment 2. HIV testing, treatment and viral suppression

2.1 People living with HIV who know their HIV status

2.2 People living with HIV on antiretroviral therapy

2.3 People living with HIV who have suppressed viral loads

2.4 Advanced HIV disease and late HIV diagnosis

2.5 HIV testing volume and positivity

2.6 Antiretroviral therapy coverage among people living with HIV in key populations

2.8 Management of cryptococcal infection

Commitment 3. Vertical transmission of HIV, syphilis and hepatitis B

3.1 HIV testing in pregnant women

3.2 Early infant diagnosis

3.3 Vertical transmission of HIV

3.4 Preventing vertical transmission of HIV.1

3.5 Syphilis among pregnant women

3.6 Congenital syphilis rate

3.7 Hepatitis B among pregnant women

Commitment 4. Gender equality, and empowerment of women and girls

4.1 Physical and/or sexual violence experienced by key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

4.2 Attitudes towards violence against women

4.3 Gender-responsiveness of HIV services

[1] The In this document, vertical transmission includes transmission to the child that occurs during pregnancy, delivery or breastfeeding. "Vertical transmission" in this document is used as a neutral, non-stigmatising alternative to "mother-to-child" transmission.

Indicator number
Short indicator name

Commitment 5. Community leadership

A measure of community leadership in combination prevention programmes for key populations is captured in Indicator 1.6, and for specific elements of harm reduction programmes for people who inject drugs in Indicators 1.9 and 1.10.

Commitment 6. Realizing human rights and eliminating stigma and discrimination

6.1 Discriminatory attitudes towards people living with HIV

6.2 Internalized stigma reported by people living with HIV

6.3 Stigma and discrimination experienced by people living with HIV in community settings

6.4 Experience of HIV-related discrimination in health-care settings

6.5 Stigma and discrimination experienced by key populations

6.6 Avoidance of health care among key populations because of stigma and discrimination (Sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

6.7 People living with HIV seeking redress for rights violations

6.8 Discriminatory attitudes towards people living with HIV among health facility staff

6.9 Discriminatory attitudes towards people from key populations among health facility staff (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

6.10 Discriminatory attitudes towards people from key populations among police (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)

Commitment 7. Universal health coverage and integration

7.1 Viral hepatitis among key populations

7.2 Management of viral hepatitis C

7.3 Syphilis prevalence among key populations (sex workers, gay men and other men who have sex with men, transgender people)

7.4 Men with urethral discharge

Indicator number
Short indicator name

7.5 Gonorrhoea among men

7.6 Co-management of tuberculosis and HIV treatment

7.7 People living with HIV with tuberculosis disease

7.8 People living with with HIV on ART who started tuberculosis preventive treatment

7.9 People living with HIV on antiretroviral therapy who completed a course of tuberculosis preventive treatment

7.10 Cervical cancer screening among women living with HIV

7.11 Treatment for pre-cervical cancer for women living with HIV

7.12 Treatment for invasive cervical cancer for women living with HIV

7.13 Coverage of multimonth dispensing of antiretroviral medicine

7.14 Coverage of DSD ART models among people living with HIV on ART

7.15 Viral suppression among people living with HIV engaged in DSD ART models

Commitment 8. Investments and resources

8.1 Domestic public budget for HIV

8.2 Antiretrovirals: unit prices and volume

8.3 HIV expenditure by origin of resources

National Commitments and Policy Instrument
Information on national policies and their implementation is collected through the National Commitments and Policy Instrument (NCPI).

WHO/UNAIDS Medicines and Diagnostics Service Survey
Information on antiretroviral regimens collected through the AIDS Medicines and Diagnostics Survey on the Use of ARV Medicines and Laboratory Technologies, and through monitoring of the WHO guidelines, hosted on the Global AIDS Monitoring online tool.

Introduction

Background

United Nations Member States adopted the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 at the United Nations General Assembly High-Level Meeting on AIDS in June 2021.[1] The 2021 Political Declaration on AIDS highlights the importance of identifying inequalities in order to end AIDS as a public health threat by 2030. If the international community achieves the full range of targets in the Declaration in all geographic areas and across all populations, then the global AIDS response will be on track to prevent 3.6 million new HIV infections and 1.7 million AIDS-related deaths by 2025.

The 2021 Political Declaration on AIDS is based on the Global AIDS Strategy 2021–2026: End Inequalities, End AIDS, a bold new approach that uses an inequalities lens to identify and close the gaps that are preventing progress towards ending AIDS.[2] Shifting to an inequalities lens aims to ensure that the global HIV response works for everyone and leaves no one behind. The focus of the Global AIDS Strategy 2021–2026 is to reduce the inequalities that drive the AIDS epidemic by prioritizing people who are not yet fully benefitting from life-saving HIV services and to remove the structural barriers that create or maintain those inequalities and prevent access to services. The Strategy sets out evidence-informed priority actions with ambitious 2025 targets to reduce inequalities and get every country and every community on track to end AIDS as a public health threat by 2030.

A successful AIDS response should be measured by the achievement of concrete, timebound targets, accompanied by careful monitoring of the progress in implementing the commitments of the 2021 Political Declaration on AIDS. The Global AIDS Monitoring (GAM) framework helps to structure and organize collective global monitoring efforts. It is based on the structure of the Political Declaration, using eight core focus areas, linked to three global AIDS strategic priorities (see Table 1).

[1] The 2021 Political Declaration on AIDS can be found at https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf

[2] For more on the Global AIDS Strategy 2021–2026, see https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf

Table 1.
Global AIDS Monitoring organizing framework

Strategic focus areas of the 2021 Political Declaration on AIDS used for the GAM monitoring framework		AIDS strategic priorities
1	Combination HIV prevention for all	Maximize equitable and equal access to HIV services and solutions
2	95–95–95 for HIV testing and treatment	
3	End paediatric AIDS and eliminate vertical transmission	
4	Gender equality and empowerment of women and girls	Break down barriers to achieving HIV outcomes
5	Community leadership	
6	Realize human rights and eliminate stigma and discrimination	
7	Universal health coverage and integration	Fully resource and sustain efficient and integrated HIV responses
8	Investments and resources	

Purpose

The indicators and questions in this document are designed for use by national AIDS programmes, other government entities and partners to assess the state of a country's HIV and AIDS response, and to measure progress towards achieving national HIV targets. Countries are encouraged to integrate these indicators and questions into their ongoing monitoring efforts and to report comprehensive national data through the GAM process. In this way they will contribute to improving understanding of the global response to the HIV epidemic, including progress that has been made towards achieving the commitments and global targets set out in the 2021 Political Declaration on AIDS and the linked Sustainable Development Goals.[3]

This document is a detailed compilation of indicators, including on financing, and a suite of questions on national policies and their implementation. The indicators and policy questions are designed to enable the best use of available data at the national level, to standardize reporting from different HIV epidemics and sociopolitical contexts, and to enable aggregation at the global level. UNAIDS is working with key organizations under the umbrella of the Monitoring Technical Advisory Group (MTAG) to harmonize the indicators to match international standards. Members of this group include international, country and community representatives, human rights experts and technical experts in HIV monitoring. Over the past 20 years, the indicators used for global monitoring have evolved as our collective knowledge of effective HIV responses and the barriers to this have improved. This will continue in the coming years. The indicators are reviewed annually and revised by the UNAIDS MTAG.

Data reported through GAM will be used to describe progress towards the 2025 targets, including in UNAIDS annual publications on the HIV response, and to hold

[3] Details of the Sustainable Development Goals can be found at Make the SDGs a reality. New York: United Nations Department of Economic and Social Affairs; 2021 (https://sustainabledevelopment.un.org/).

countries and global partners to account on desired improvements. The monitoring framework is also used by the United Nations Secretary-General when issuing annual progress reports to the United Nations General Assembly that compile the results from country reports. The annual United Nations Secretary-General progress reports are designed to identify challenges and constraints, and to recommend actions to accelerate the achievement of targets.

The data will also be made available for grant and operational plan preparation and review for countries participating in resource mobilization from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Data reported through GAM can also be a valuable resource as countries develop sustainability roadmaps.

The GAM process has often been referenced as a benchmark for successful international accountability mechanisms. The lessons from past rounds serve us well for the upcoming reporting—providing an evidence-informed road map for timely, high-quality and complete reporting at an accelerated and streamlined pace. They include the following:

1. The national consultation process during the first quarter of the year speeds up consolidation and validation of the data. This can help avoid additional data validation steps later in the process, such as going back to the original sources of the data.
2. The involvement of civil society in the national consultation is critical, especially for responding to questions related to laws and policies, and for ensuring that all relevant partners are engaged and play their important roles in implementation and reporting.
3. Timely engagement of data providers from the beginning of the year (January) helps to ensure that the data are reported on time, and that they are of the highest quality and accuracy.

Summary of changes to the indicator set for 2025 reporting

The 2025 reporting requires submitting data on indicators, the interim National Commitments and Policy Instrument (NCPI), and the AIDS Medicines and Diagnostics Survey. The narrative report is optional.

Based on the recommendations of the MTAG following its review of the GAM and taking into account inputs from other stakeholders, some indicator definitions have been modified to reflect updates in guidance and for clarification based on feedback from previous GAM reporting rounds.

The changes for the 2025 reporting round are as follows:

- 3.5 Syphilis among pregnant women: to provide information on context for data interpretation, the additional information requested has been modified to include tests used for screening; the proportion of women who have a confirmatory test done (if confirmatory tests are done); and whether information from private providers is included in the data reported.
- 7.2 Hepatitis C testing and 7.3 People coinfected with HIV and hepatitis C virus starting hepatitis C virus treatment: these indicators have been combined into one indicator on management of hepatitis C virus infections among people living with HIV on antiretroviral therapy, to enable assessment of the full cascade of testing and treatment for hepatitis C virus among people living with HIV.

- 7.4 Men with urethral discharge: an additional item is included in the additional information requested on whether information from private providers is also included in the data reported.
- 7.4 Gonorrhea among men: an additional item is included in the additional information requested on whether information from private providers is also included in the data reported.
- 7.6 Co-management of tuberculosis and HIV treatment: the request to disaggregate numerator data by sex and age has been removed to reduce the reporting burden. The denominator is an estimate that is not available by these disaggregations.
- 7.14 Coverage of differentiated service delivery (DSD) antiretroviral therapy models among people living with HIV currently on antiretroviral therapy: the text in the rationale section has been updated to reflect approved language on types of DSD antiretroviral therapy models to consider in data reported for this indicator. A clarification has also been added regarding the two options for reporting on the denominator, specifying that it is recommended for countries to report on the number of people on antiretroviral therapy eligible for DSD antiretroviral therapy models if these data are available, or otherwise on the number of people on antiretroviral therapy at the end of the reporting period.
- 7.15 Viral suppression among people living with HIV engaged in DSD antiretroviral therapy models: the text in the method of measurement section has been updated to reflect approved language on types of DSD antiretroviral therapy model to consider in the data reported.
- WHO/AIDS medicines and diagnostics survey: Questions included for 2025 reporting refer to Dolutegravir-based, Protease Inhibitor-based and other treatment regimens, rather than first-line, second-line and third-line/salvage regimens. Questions have been added on the number of sexually transmitted infection, advanced HIV and hepatitis tests done in 2024.

The NCPI for 2025 reporting is an interim questionnaire consisting of a subset of questions from Part A of the full questionnaire included in the 2024 GAM that refer to policies considered to change more rapidly. The wording of some of the questions retained from previous rounds has been refined further. These modifications are based on experiences in previous reporting and to reflect developments in policy recommendations and available technologies.

Reporting process

A multisectoral process

Although governments have adopted the 2021 Political Declaration on AIDS, its vision extends far beyond the government sector, reaching community-led organizations led by people living with HIV, key populations, women in all their diversity and young people, private industry and labour groups, and faith-based organizations and other nongovernmental organizations. Their involvement ensures that the inequalities in the AIDS response are identified, noted and addressed.

The community of people living with and affected by HIV plays a key role in the response to the AIDS epidemic in countries around the world, and the wide range of expertise within community-led organizations makes them ideal partners in the process of preparing country progress reports. Specifically, community-led organizations are well positioned to provide information for GAM reporting, including through qualitative input to NCPI reporting, in order to augment the data collected by governments and to interpret the data collected.

National AIDS councils, commissions and committees (or their equivalents) should seek input from the full spectrum of communities living with and affected by HIV and their community-led organizations for GAM reporting. Community-led organizations should include those led by women in all their diversity, key populations and people living with HIV. In addition to community-led organizations, it will be useful to reach out to other civil society players, including faith-based organizations, trade unions and other nongovernmental organizations (NGOs).

The importance of securing input from the full spectrum of the community affected by HIV, including people living with HIV and members of key populations, cannot be overstated. Communities speak with many voices, including through quantitative and qualitative reporting, and represent many different perspectives, all of which can be valuable when monitoring and evaluating a country's AIDS response. Focused support to different groups, including key populations, may be required to enable their full participation throughout the process.

National AIDS committees or their equivalents should ensure opportunities for community-led organizations to engage with and contribute to data collection plans, including for denominators, and for the necessary space and resources so they can convene and coordinate their inputs. A straightforward multidisciplinary mechanism for submitting and evaluating information also should be developed. As part of that effort, community-led organizations and any relevant civil society representation should be invited to participate in workshops at the national level to determine how they can best support the country's reporting process.

Community-led organizations in every country should be given sufficient opportunity to review and comment on the data before they are finalized and submitted. The report that is eventually submitted to UNAIDS should also be widely disseminated to ensure that community-led organizations have ready access to it.

Country-level UNAIDS staff members are available to assist with input from community-led organizations and other community representatives throughout the process. In particular, UNAIDS country-level staff members support the national rapporteurs to do the following:

- Brief community-led organizations on the indicators, the NCPI questions and the reporting process.
- Provide technical assistance on gathering, analysing and reporting data, including focused support for people living with and affected by HIV.
- Facilitate the dissemination of data reported and narrative reports, where available, including (whenever possible) reports in national languages.

As in previous reporting rounds, UNAIDS will accept shadow reports, but they are not intended to be a parallel reporting process for communities living with and affected by HIV. Whenever possible, UNAIDS encourages integrating community-led organizations into national reporting processes, as described above. Shadow reports are instead intended to provide an alternative perspective if: (a) it is strongly felt that communities and community-led organizations were not adequately included in the national reporting process; (b) governments do not submit a report; or (c) the data provided by government differ considerably from the data collected by community-led organizations monitoring government progress in service delivery, and it is not possible to reconcile those differences or reflect them satisfactorily in the national reporting.

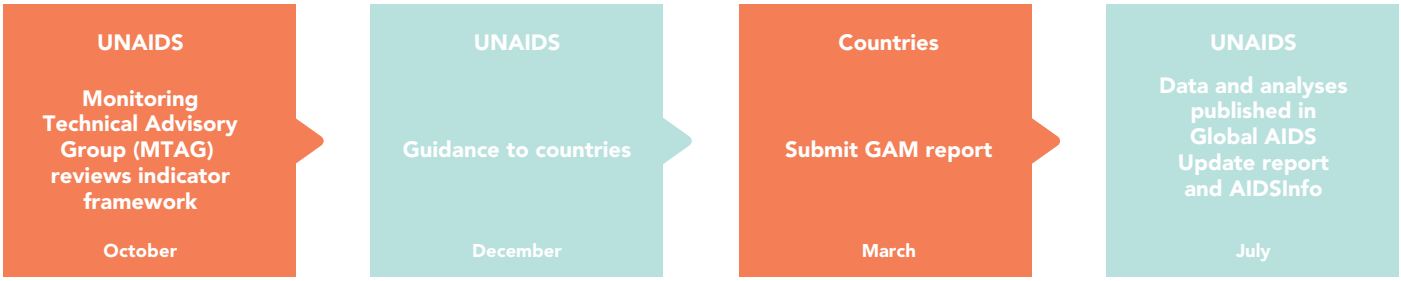
Shadow reports can be submitted through aidsreporting@unaids.org.

Reporting steps and timelines

The annual GAM cycle follows specific, well-established steps. This enables different stakeholders, both national and international, to rely on the availability of recent data and to use them to assess progress towards the established global and national AIDS targets. At the end of each year, UNAIDS provides countries with updated information on the indicators to use. This enables countries to coordinate and manage the national reporting process, submitting their AIDS reporting by 31 March each year. Based on the data reported, in July, UNAIDS publishes the Global AIDS Update report, which is used in different international fora and for programmatic and financial decisions (such as by the Global Fund to Fight AIDS, Tuberculosis and Malaria [the Global Fund], the United States President's Emergency Plan for AIDS Relief [PEPFAR] and others).

One of the key factors to setting up a successful national AIDS reporting structure is to have clarity on roles and responsibilities within a comprehensive group of partners. This will reduce the burden on individuals and ensure timely reporting. In the following section, the specific steps of monitoring and reporting on the national AIDS response are shown in three main phases – preparation, reporting and follow-up. To understand the full reporting process, reference is also made to the complementary global actions and to the production of the HIV epidemiological estimates data. These steps are presented in the form of a flowchart representing the actions at different levels, with some explanatory notes on each step.

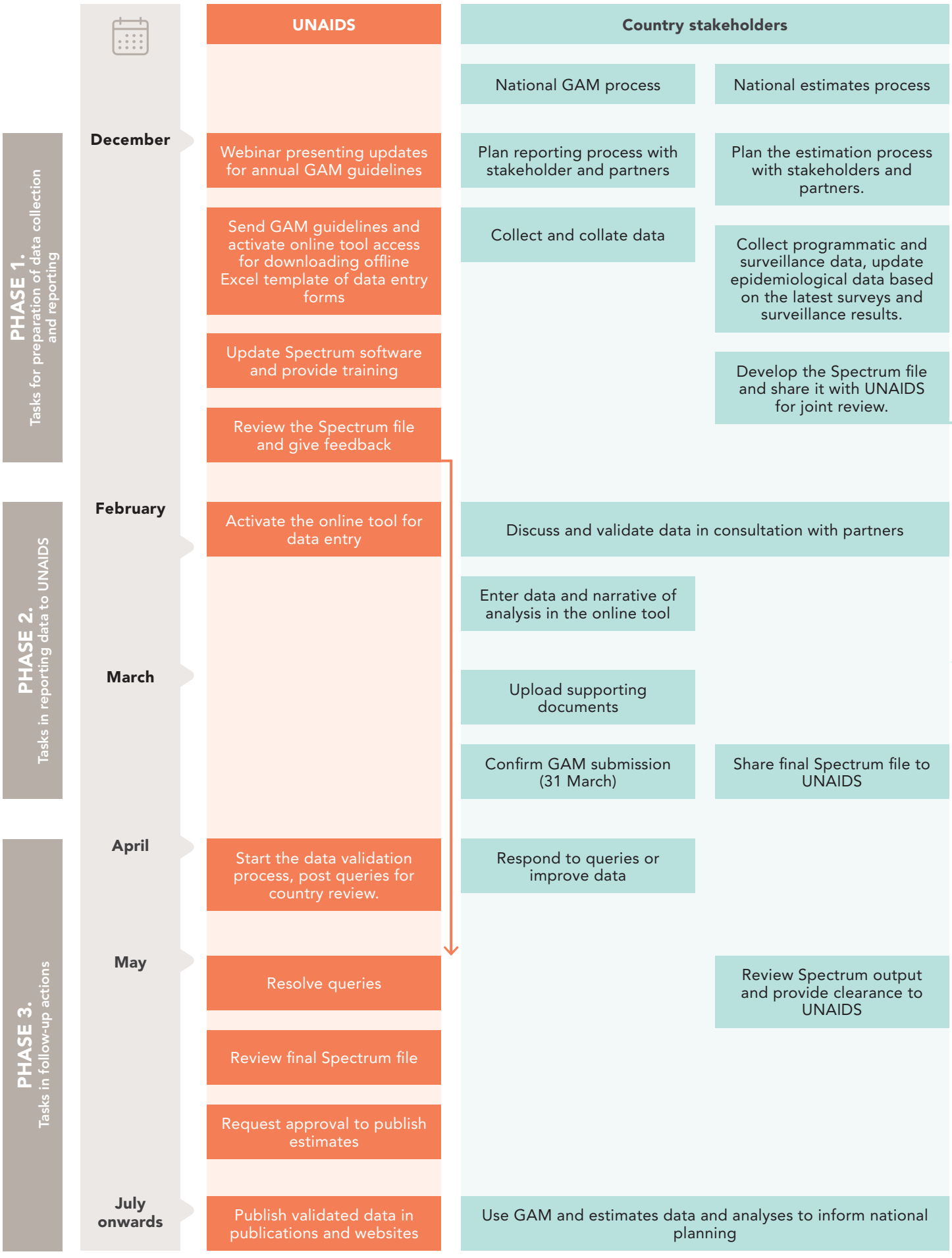
Figure 1
Principal activities in data reporting and use by UNAIDS



National rapporteur's tasks in preparing for the reporting with partners (December–March)

1. In December, the national rapporteur receives a confirmation message from UNAIDS on the reporting process (through AIDSreporting@unaids.org).
2. Identify the indicators where data are available for reporting.
3. Identify a focal point to coordinate completion of the NCPI. In alternate years when both NCPI Parts A and B are included, identify a focal point for each part. Ensure access to the guidance provided on reporting the NCPI, especially for questions on laws and policies. Encourage engagement through explaining the significance and use of reported data.
4. Develop and disseminate a plan for collecting data for GAM indicators, the NCPI and the AIDS Medicines and Diagnostics Survey, including timelines and the roles of the national AIDS committee (or equivalent), other government agencies, community and other relevant partners.
5. Identify relevant tools for data collection and sources for each report component, including by:
   - Meeting with the national HIV estimates team.
   - Aligning the data collection timeline with the following as feasible:
     - That of other data collection efforts, including those through funding agencies such as the Global Fund, PEPFAR and United Nations agencies.
     - The timeline for the aggregation of data at the national level for facility-based indicators.
6. Collect and collate data in coordination with partner organizations from government, communities and international partners, including:
   - Establishing protocols for data processing and management:
     - Basic data cleaning and validation.
     - One database for analysis and reporting purposes.
   - Data vetting.
   - Completing the NCPI.

Figure 2
Tasks for completing GAM and estimates processes



Note: Tasks included in this flowchart may continue beyond the start date reflected in the figure and involve iterative processes.

National rapporteur's tasks in reporting (March)

1. Enter the indicator, NCPI and AIDS Medicines and Diagnostics Survey data into the GAM online reporting tool (https://AIDSreportingtool.unaids.org).
2. Enable stakeholders, including government agencies and communities living with and affected by HIV, to comment on the draft data. Use the online reporting tool ability to share credentials for data viewers.
3. Conduct a validation workshop to analyse indicator data, including on AIDS expenditure and the NCPI, jointly with partner organizations from government, community-led organizations, civil society, and international partners. This is done in order to: (a) identify progress, gaps, challenges and next steps towards achieving each of the commitments and expanded targets to end AIDS by 2030; and (b) reach consensus on the national GAM submission.
4. Summarize the results of this analysis to use when producing the narrative report in the online reporting tool.
5. Submit all indicator data, NCPI responses, AIDS Medicines and Diagnostics Survey responses, and narrative summaries by commitment on or before 31 March.

National rapporteur's tasks in follow-up actions (April–July)

1. Respond to queries on the submission that are posted in the online reporting tool by UNAIDS, the World Health Organization (WHO) or the United Nations Children's Fund (UNICEF), or those sent by AIDSreporting@unaids.org to the national rapporteur.
2. Use extracts from the online tool to inform any public national events, forums or programme reviews on progress towards ending AIDS by 2030.
3. Guide any programme review discussions in order to encourage prioritization and evidence-informed decisions for programme improvement.

As part of the finalization process, reported data should be validated and reconciled between all partners in the country, including community-led organizations. The online reporting tool supports this process through the option to share viewer credentials with national stakeholders. Several countries have reported that this feature enabled community-led organizations and other partners to view and provide input during the reporting process, enabling wider and more rapid stakeholder consultation and validation.

Data validation process

After countries submit GAM reports through the online reporting tool, UNAIDS, UNICEF and WHO will review the data submitted to do the following:

- Support countries in reviewing any errors in entering data.
- Verify that the data submitted respond to the indicator definitions (as outlined in these guidelines).
- Compare the results to data submitted to the Global Fund and to PEPFAR.

Data submitted through GAM will be published through AIDSInfo and used for global and regional analyses. For this reason, data must be comparable across countries and respond to the globally agreed definitions of the indicators used for monitoring global political commitments.

If countries do not have data that correspond exactly to the indicator definition available, they are encouraged during the reporting process to consider other data that may be relevant to the commitment area in order to assess progress. However, for the reasons mentioned above, these data will not be published in AIDSInfo or included in the global analysis.

During the review, UNAIDS liaises with national GAM focal points to request clarification or revise the data submitted in the tool. Data validation is conducted in several steps:

- The indicator focal points from UNICEF, WHO and UNAIDS headquarters conduct an initial review and note preliminary queries.
- Queries are entered in the online tool.
- UNAIDS, WHO and UNICEF indicator focal points follow up with countries about queries.

The validation process considers the following points across indicators:

For indicators sourced from surveys:

- Verify the consistency of reported numbers, including whether the disaggregated data add up to the total.
- Verify for substantial variation from previously reported data.
- Verify that the data were not previously reported through GAM. If the data were previously reported, ask the country to remove the data and indicate that no new data are available for the indicator.
- Compare numerators, denominators and disaggregated data with the survey data available.
- Check the survey years and data collection dates entered in the online reporting tool.
- Check the survey methods and sample sizes for representativeness.
- Review the reports.
- If data apply to a composite indicator, verify that the same source was used for all questions, and that the composite values correspond to the sum of individual questions.

For indicators produced from Spectrum or with estimate-based denominators:

- Verify that the country has selected for data to be taken from the final Spectrum file.
- Verify as applicable against comparable data.

The comments from countries are reviewed for all indicators.

Technical preparations for reporting

The GAM reporting consists of providing data on the following:

- The quantitative indicators, including the financial data.
- The NCPI questionnaire.
- The AIDS Medicines and Diagnostics Survey.
- Narrative progress summaries by commitments or national report (optional).

GAM reporting 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 the country, regional and global levels.

Countries are encouraged to submit a narrative progress report when submitting GAM data. The online tool incorporates a template for creating a narrative report that consists of brief narrative summaries for each area in the 2021 Political Declaration on AIDS. If readily available, countries can instead submit a recent national epidemiology and response overview report.

The data will be published in AIDSinfo.unaids.org, and it will be included in the Global AIDS Update report.

Measurement tools and data sources

The primary measurement tools vary by indicator and include the following:

- Nationally representative population-based surveys.
- Behavioural surveillance surveys.
- Specially designed surveys and questionnaires, including surveys of specific population groups (such as specific service coverage surveys).
- Patient tracking systems.
- Health information systems.
- Sentinel surveillance.
- National HIV estimates from Spectrum software (mathematical models).
- Community-led data gathering, for example the People Living with HIV Stigma Index.

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

Data collected by community-led organizations will be necessary to provide a complete picture in many cases, particularly around societal enablers or programme data. Some civil society organizations may contribute data for indicators relating to interventions in which NGOs and faith-based organizations play an active role. Examples include work with young people, key populations at higher risk and pregnant women. For the NCPI sections, it will be necessary to also work across sectors, involving ministries of justice, home affairs, gender and youth among others.

In many countries, much of the data required for the national-level indicators may not be available from routine sources. Gathering indicator data may require adapting existing monitoring tools or adding specific surveys. Countries that conduct regular, nationally representative population-based surveys—such as Demographic and Health 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, surveys can be adapted, in collaboration with community, to collect data for selected indicators.

Spectrum estimates

A major tool for generating denominators used in GAM reporting is the Spectrum computer package. Spectrum allows countries to create population-level estimates of people living with HIV, pregnant women who need antiretroviral medicine to prevent vertical HIV transmission and children with perinatal HIV exposure who need virological testing.[4] In addition, Spectrum allows countries to estimate difficult to measure indicators such as new HIV infections, HIV incidence (the SDG indicator), deaths from AIDS-related illness and the vertical transmission rate. It is also a tool for collecting programmatic data. Country teams update their Spectrum files every year using the most recent programmatic and surveillance data. Once completed some of the indicators from this process correspond to GAM indicators. Spectrum files are created by a team of national experts trained on the software. These files are then reviewed

[4] For more on the national HIV estimates file and Spectrum, see http://www.unaids.org/en/dataanalysis/datatools/spectrum-epp.

by UNAIDS for quality control. Country teams receive information on the estimates process by early December each year.

In the GAM online reporting tool there is the option for countries to indicate that data should be taken from their final Spectrum file for indicators where Spectrum is the recommended source. This reduces both the data entry required and the chance for errors, and it improves the consistency of data.

Indicators for which countries can select for data to be taken by UNAIDS from their final Spectrum files are:

- 1.1 HIV incidence
- 2.1 People living with HIV who know their HIV status
- 2.2 People living with HIV on antiretroviral therapy
- 2.3 People living with HIV who have suppressed viral loads
- 2.7. AIDS mortality
- 3.1 HIV testing in pregnant women
- 3.2. Early infant diagnosis (denominator)
- 3.3. Vertical transmission of HIV
- 3.4. Preventing the vertical transmission of HIV

Numerators and denominators

For each indicator, detailed instructions are provided for measuring the national response. Most national-level indicators use numerators and denominators to calculate the percentages that measure the state of the national response. Countries are strongly encouraged to pay close attention to the dates attached to specific data when calculating an indicator: collecting data used for the numerator and denominator at different times will compromise the accuracy and validity of that information.
The methods described have been designed to facilitate the construction of global estimates from national-level data. Although these methods can be applied at the subnational level, simpler, faster and more flexible approaches tailored to local conditions may be more appropriate to guide decision-making below the national level.

Disaggregate the data, especially by age and gender

It is vital that countries collect data in their component parts and not simply in summary form. Without disaggregated data, monitoring the breadth and depth of the response to the epidemic at the population, national and global levels is difficult. It is equally difficult to monitor access to services, the equity of that access, the appropriateness of focusing on specific populations and meaningful change over time. The GAM online reporting tool clearly identifies the disaggregated data required to report accurately on the numerator and denominator for each indicator.

Countries are strongly encouraged to make collecting disaggregated data—especially by gender and age, and for specific key populations—one of the cornerstones of their monitoring and evaluation efforts where this can be done in ways that respect the rights and safety of members of key populations. If possible, equity analysis should also be conducted.[5]

Key ministries should review their information systems, surveys and other instruments for collecting data to ensure that they capture disaggregated data at the subnational levels, including facility and project levels. Special effort should be made to follow disaggregated data up to the national level. In addition, the private sector and all partners involved in the country's AIDS response should be advised of the importance of disaggregated data, and they must make collecting, disseminating and analysing data a priority in their ongoing operations.

Detailed age-disaggregated data are also requested for treatment-related targets (95–95–95). These detailed age groups can improve our understanding of the HIV epidemic. For example, disaggregated detailed age group data allow countries to assess the extent to which programme coverage, including the percentage of people living with HIV on treatment, differs between adolescents aged 10 to 19 years and older people aged 20 to 49 years. If collecting disaggregated data proves difficult, partial data may be entered.

When disaggregated data are not readily available, the information needed for indicators may be extracted from larger data sets, although the location of the data varies from country to country. Countries should seek technical assistance from the United Nations system (including the country offices of UNAIDS, WHO and UNICEF) and their partners for help with accessing the disaggregated data needed to properly complete the measurements of indicators.

Governments are encouraged to look beyond their internal information resources to collect and validate data. In many cases, community-led organizations may be able to provide valuable primary and secondary data, especially for key populations.

Countries are encouraged to report available complementary data that reflect the gender and behavioural dimensions of the indicators from other sources, including quantitative and qualitative data collected by community-led organizations. These additional data will permit a more comprehensive situational analysis of the indicators from a gender perspective. They may be entered in the box Data related to this topic, found in each indicator page in the online reporting tool.

Subnational data

Many countries are improving the use of data at the subnational level to help all stakeholders better understand the geographical distribution of the epidemic and the response in each community.

[5] See World Health Organization, Joint United Nations Programme on HIV/AIDS. A tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/9789241515788).

Since mid-2014, the online reporting tool has allowed users to submit subnational data or site-specific data for selected indicators. Countries that have produced sub-national estimates using Naomi can select for final sub-national data for indicators 2.1 and 2.2 to be taken directly from their Naomi files instead of entering the data in the GAM online reporting tool. For certain indicators, the tool also prompts users to submit data on high-burden cities or those identified as Fast-Track cities that have committed to ending AIDS by 2030. These data are used to assess progress in the HIV response in these cities. When gathering city-level data for submission, it is highly recommended that relevant city counterparts be consulted.

Recent and representative survey data

For survey data, countries are requested to report only newly available data. If the latest available data have already been reported in a previous round of reporting, they should not be reported again.

When calculating indicators based on general population surveys, countries should use the most recently available, nationally representative survey.

When calculating indicators based on key population surveys, ensuring that samples are representative of the broader group is a known technical challenge. Methods are being developed to achieve representative sampling of these populations (such as respondent-driven sampling), but while these are being refined, countries may not be confident that the samples used for surveying 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 high-quality surveys of key populations, by site, in the GAM online reporting tool, along with the numerator, denominator and sample size.

One of the challenges in developing estimates of the burden of disease and planning for programme needs is describing the size of key populations. Countries are asked to report the size estimates for key populations, providing methods and any estimates specific to cities or provinces that have been calculated empirically. Some countries that have empirical national size estimates for key populations can also aggregate prevention programme data. If a country can report against an indicator with national programme data, this should be noted in the box Region for which the last estimation was performed.

Guidance from WHO and UNAIDS suggests that size estimates for gay men and other men who have sex with men should not represent less than 1% of the adult male population.[6] If the size estimate is calculated as less than 1%, the results should be reviewed, as per the guidance.

[6] See Technical brief: recommended population size estimates of men who have sex with men. Geneva: World Health Organization and Joint United Nations Programme on HIV/AIDS; 2020 (https://www.who.int/publications/i/item/9789240015357).

Interpretation and analysis

Indicator definitions in these guidelines discuss each indicator, taking into account their strengths and weaknesses in ways designed to improve the accuracy and consistency of the data submitted to UNAIDS. Countries should carefully review this document before beginning to collect and analyse data, since it explains how to analyse each indicator and any potential issues related to interpretation. Specific guidance on responding to the NCPI is provided. The points raised in the guidance should be reviewed to confirm the appropriateness of the findings for each indicator before finalizing the reporting and writing the narrative report.

After compiling their data, countries are strongly encouraged to continue to analyse their findings in collaboration with communities. This will enable a more in-depth understanding of their national response and help identify opportunities to improve it. Countries should be looking closely at the links between policy, resource allocation and efficiency, HIV programme implementation, verifiable behaviour change and changes in the epidemic. For example, if a country has a policy for reducing vertical transmission of HIV, are the programmes sufficiently funded to make the services available to pregnant women? If these services are in place, are women using them in sufficient numbers to reduce the number of infants born with HIV in that country?

These links exist in every facet of a national response, and the national-level indicators included in this manual reflect many of the most important ones. To analyse these linkages effectively, countries must draw on the widest range of data available, including quantitative and qualitative information from the public and private sectors and from communities. Excessive reliance on data of a single type or from a single source is less likely to provide the perspective or insights required to understand such links and to identify any existing or emerging trends.

Further guidance on submitting data

Countries needing additional information on collecting data for GAM indicators, the reporting tool and/or submission mechanisms should seek technical assistance from their UNAIDS strategic information advisers, UNICEF or WHO offices, or the HIV monitoring and evaluation working groups in their country. The UNAIDS Data for Impact department is also available to provide support, and can be reached via email at AIDSreporting@unaids.org.

Reporting tool and submitting data

National rapporteurs may access the reporting tool using the same credentials they used in the previous reporting round; they also may extend these rights to others, if desired. New national rapporteurs are requested to register online as country editors, who can add and change the information to be submitted. Registrations are approved based on official communication with the country.

Similar to previous years, the national rapporteur can also allow other people to view the data, enabling broader country consultation. Viewers can see the information to be submitted, but they cannot change it.

Countries are encouraged to submit data for all indicators where data are available. If countries are not submitting data on an indicator, they should indicate whether it is because the indicator is not considered relevant to the epidemic or because recent, appropriate data are not available.

The behaviour indicators for key populations are relevant in all countries, regardless of the national HIV prevalence. For example, a country with a higher prevalence epidemic also may have a concentrated subepidemic among people who inject drugs. It would therefore also be valuable to calculate and report on the indicators that relate to the key populations at higher risk.

Similarly, countries with low HIV prevalence are encouraged to collect data on sexual behaviour among young people as a means of tracking trends in behaviour that could influence the national response in the future. However, a few indicators are solely applicable to specific HIV epidemic contexts. This is noted in the corresponding indicator definitions in these guidelines.

UNAIDS strongly recommends that countries use these indicators within their national monitoring and evaluation systems. If a country is using an alternative indicator to monitor the issue in question, the comment box for Data related to this topic in the online reporting tool may be used to describe it (including a full definition and method of measurement) and to provide any available data for the indicator.

Countries are requested, when possible, to submit copies of (or links to) primary reports from which data are drawn for the respective indicators. These reports can be submitted through the online reporting tool. This will facilitate interpretation of the data, including trend analysis and comparison between countries.

To facilitate country-level review, users may select Print all to PDF to combine all indicators into a single PDF file.

UNAIDS will review the data and ask for clarification, if necessary. If UNAIDS has queries about the data, specific indicators will be opened again for countries to respond to queries and edit their responses.

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

Key populations-led organizations and responses

GAM reporting is paying increased attention to identifying inequalities in the AIDS response. This is reflected, for example, in the growing number of indicators with disaggregation of data for key populations and requirements to report on stigma and discrimination experienced by key populations. Doing this helps focus attention on, and identify shortfalls in, the provision of (and access to) services for specific groups of people.

Monitoring the proportion of selected prevention services that are key population-led in GAM

Indicators on the provision of prevention services for key populations may also be sourced from programme data to indicate the proportion of total services delivered by different types of provider. The options include public services, key population-led organizations, NGOs—including faith-based, national and international NGOs—or other entities (such as private for-profit organizations). The purpose of this disaggregation is to track the proportion of prevention services provided by key population-led organizations, including for the following: (a) individual HIV prevention interventions designed for each key population; (b) distribution of condoms and lubricants; (c) distribution of needles and syringes; and (d) opioid substitution therapy.

This exercise to report on community-leadership in service provision should be conducted in close consultation with communities of male, female and transgender sex workers, gay men and other men who have sex with men, people who use drugs and transgender people at the national, subnational and local levels. Regional and global key population-led networks may also be consulted about best practice approaches for meaningfully engaging with communities at the country level.

Key population-led organizations and networks are often targets of violence and vandalism due to criminalization and/or the stigma and discrimination they face. Every effort should be made to protect their safety and security. This includes protecting information about their leadership and employees, the physical location of their offices and the areas where they conduct peer outreach. Such information should be treated with the same level of confidentiality that is extended to individuals receiving services.

Definitions

Key populations share experiences of stigma and discrimination, criminalization and violence, and they shoulder a disproportionate HIV burden in all parts of the world. Key population-led organizations and networks are entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives and voices of their constituencies.

For reporting on these indicators, the focus is on key population-led organizations and networks that are defined as being led by the following groups: female, male and transgender sex workers; gay men and other men who have sex with men; people who use drugs, including women who use drugs; and transgender people. Although the specific focus is on obtaining better information about the proportion of prevention services being delivered by organizations that are led by members of key populations,

UNAIDS acknowledges that people may belong to more than one group. Furthermore, people living with HIV, prisoners, people with a history of incarceration, migrants, women and young people also may be included within each of the key populations named here.

The reporting on Indicators 1.6, 1.9 and 1.10, as well as a number of questions in the NCPI, focuses on these four key populations—sex workers, gay men and other men who have sex with men, people who use drugs and transgender people—and their involvement in the delivery of the selected HIV prevention services, as well as the societal barriers and enablers that prevent or enable access to services and affect risk of acquisition. UNAIDS recognizes that the disaggregated data reported here are a subset of the full picture of all service delivery led by communities, but they do provide valuable preliminary information for monitoring the commitment in the 2021 Political Declaration on AIDS.

How to select the appropriate response category or categories

Key population-led organizations

When determining which of the organizations or networks providing the services described in 1.6, 1.9 and 1.10 are key population-led, countries should consider the following criteria (which build from the above definitions):

- The majority of the organization's governance structure is comprised of individuals who identify as belonging to the key population referred to in the indicator.
- The majority of the leadership, staff, spokespeople and volunteers of the organization or network are themselves members of key populations.
- The majority of the clients, members or constituents of the organization or network are from one or more key population.
- The organization or network has one or more mechanisms for holding itself accountable to the key population communities it serves.

Nongovernmental organizations

All NGOs (also referred to as "civil society organizations" or "CSOs") that do not meet all the above criteria for being key population-led fall under the category of NGOs. This includes international, national and local NGOs—including faith-based organizations—that provide prevention services for key populations. This category includes key population-friendly NGOs that are not key population-led.

Other

It is recommended to choose the option Other if a service provider is not a public or a nongovernmental entity (for example, if it is a private for-profit provider).

Additional text field: name of the organizations

If you indicated that services are provided by key population-led organizations, NGOs or other entities, please indicate the name and URL/website of the organization(s) providing these services (if available).

Indicators for GAM

1.1 HIV incidence

Number of people newly infected with HIV in the reporting period per 1000 uninfected population

What it measures
Progress towards ending the AIDS epidemic

Rationale
The overarching goal of the global AIDS response is to reduce the number of people newly infected to less than 200 000 in 2030. Monitoring the rate of people newly infected over time measures the progress towards achieving this goal. This indicator is one of the priority indicators in the WHO 2022 Consolidated guidelines on person-centered HIV strategic information.

Numerator
Number of people newly infected during the reporting period

Denominator
Total number of uninfected population (or person-years exposed)

Calculation
Rate: (Numerator x 1000)/denominator

Method of measurement
Methods for monitoring incidence can vary depending on the epidemic setting and are typically categorized either as direct or indirect measures. Direct measurement at a population level is preferred but can often be difficult to obtain. As a result, most if not all countries rely on indirect measures or triangulate direct and indirect methods.

Strategies for directly measuring HIV incidence include longitudinal follow-up and repeat testing among individuals who do not have HIV infection and estimation using a laboratory test for recent HIV infection and clinical data in the population. Longitudinal monitoring is often costly and difficult to perform at a population level. Laboratory testing of individuals to determine the recency of infection also raises cost and complexity challenges since a nationally representative population-based survey is typically required to obtain estimates.

Indirect methods most frequently rely on estimates constructed from mathematical modelling tools, such as Spectrum or the AIDS Epidemic Model. These models may incorporate geographical and population-specific HIV surveys, surveillance, case reporting, mortality, programme and clinical data and, in some instances, assumptions about risk behaviour and HIV transmission. In some instances, countries may wish to triangulate these data with other sources of estimates of the number of people newly infected, including from serial population-based HIV prevalence estimates or estimates of HIV prevalence in young, recently exposed populations.

Note that case-based surveillance systems capturing newly reported people acquiring HIV infection should not be used as a direct source of estimating the number of people newly infected with HIV in the reporting year. Because of reporting delays and underdiagnosis, newly reported cases may not reflect the actual rate of people becoming newly infected. This information may be useful, however, for triangulation or validation purposes, especially when combined with tests for the recency of HIV infection.

Disaggregated data reported for the numerator should be used to monitor progress towards eliminating new child infections and reducing the number of new HIV infections among adolescent girls and young women to below 100 000 per year.

Measurement frequency
Annually

Disaggregation

- Sex (male and female)
- Age (0–14, 15–24, 15–49 and 50+ years)

Additional information requested

The source of the estimate is requested. For countries providing estimates of incidence derived from a source other than Spectrum, please provide any accompanying estimates of uncertainty around the rate and upload an electronic copy of the report describing the calculation if available.

Countries preferably should report a modelled estimate rather than one calculated only from a population-based survey or the number of newly reported cases of HIV infection reported through case-based surveillance. Users now have the option to use their Spectrum estimate or to enter nationally representative population-level data. If Spectrum estimates are chosen, the values will be pulled directly from the software once the national file is finalized.

Strengths and weaknesses

Estimates of the rate of new infections and changes over time in this rate are considered the gold standard for monitoring programme impact. However, even in high-risk populations, people becoming newly infected with HIV is a relatively rare event. The accuracy of estimates of incidence and changes in this rate over time can therefore be uncertain. Such uncertainty should be reported when using HIV incidence rates to monitor programme impact, especially when disaggregated by sex and age and for key populations or in specific geographical areas. Countries should use caution when applying incidence rates from small studies to a population more generally.

Further information

Consolidated guidelines on person-centered HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Spectrum software. Glastonbury (CT): Avenir Health; 2024 (http://www.avenirhealth.org/software-spectrum.php).

1.2 Estimates of the size of key populations (A–E)

What it measures
Number of people engaging in the specific behaviour that put the given population at risk for HIV transmission or a proxy for those types of behaviour:

A. Sex workers.

B. Gay men and other men who have sex with men.

C. People who inject drugs.

D. Transgender people.

E. People in prisons and other closed settings.

Rationale
Programme planning for key populations can be more efficient if the size of these populations can be accurately estimated. The figures enable national AIDS programmes, health ministries, donors and not-for-profit and multilateral organizations to efficiently allocate resources to adequately meet the prevention needs of specific populations at higher risk. Size estimates are also important for modelling the HIV epidemic.

Numerator
Not applicable

Denominator
Not applicable

Calculation
Not applicable

Method of measurement
Several methods for estimation are available, including capture-recapture, service multipliers and network scale-up. See the Further Information section below for specific details.

Measurement frequency
Population size should be estimated every five years. However, any time an integrated biobehavioural survey is implemented, size estimates should be incorporated, if only to add to the database to confirm or refine estimates.

Disaggregation
- Estimating population sizes by age or sex is generally impractical. However, if a survey measures women who inject drugs or male sex workers, for example, a size estimate should be included.

Additional information requested
To better understand the size estimates submitted, we request that the following additional information be included in the comment box:

- Definition used for the population, and inclusion criteria used in the study/survey, as applicable.
- Method to derive the size estimate.
- Site-specific estimates for all available estimates.

In keeping with efforts 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.

If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. You may also upload an Excel spreadsheet of these data instead of entering them in the online tool. Submit the digital version of any available size estimation reports using the upload tool.

Strengths and weaknesses

The quality of population size estimates varies according to the methods used and the fidelity with which the methods are implemented. Every effort to assess bias and adjust the estimates accordingly should be attempted and explained. Size estimates for small areas should not be presented as national estimates: either a rational approach to extrapolation should be used and explained or the small area estimates should explicitly be submitted for the relevant areas. Please indicate in the comment field whether a multi-stakeholder consensus has been reached for the reported size estimates.

Please note that guidance from the World Health Organization and UNAIDS suggests that size estimates for gay men and other men who have sex with men should not represent less than 1% of the adult male population (aged 15-49 years). If the size estimate is calculated as less than 1%, then the results should be reviewed, as per the guidance.

Technical brief: reasonable population size estimates for men who have sex with men. Geneva: World Health Organization and UNAIDS; 2020. (https://www.unaids.org/sites/default/files/media_asset/2020-recommended-population-size-estimates-of-men-who-have-sex-with-men_en.pdf).

Further information

UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. Guidelines on estimating the size of populations most at risk to HIV. Geneva: World Health Organization, and UNAIDS; 2010 (https://data.unaids.org/pub/manual/2010/guidelines_popnestimationsize_en.pdf).

1.3 HIV prevalence among key populations (A-E)

Percentage of specific key populations living with HIV

This indicator is divided into five sub-indicators:

A. HIV prevalence among sex workers.

B. HIV prevalence among gay men and other men who have sex with men.

C. HIV prevalence among people who inject drugs.

D. HIV prevalence among transgender people.

E. HIV prevalence among people in prisons and other closed settings.

What it measures
Progress on reducing HIV prevalence among key populations

Rationale
Sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people and people in prisons and other closed settings typically have higher HIV prevalence than the general population in all epidemic contexts. Addressing HIV among these populations is an important component of the national response.

Numerator
Number of people in a specific key population who test positive for HIV

Denominator
Number of people in a specific key population tested for HIV

Calculation
Numerator/denominator

Method of measurement
A–D. This indicator is calculated using data from HIV tests conducted among respondents in the sentinel site(s) or participants in biobehavioural surveys. The sentinel surveillance sites used for calculating this indicator should remain constant to allow for tracking changes over time.

E. This indicator is calculated using data from HIV tests conducted by prisons and other closed settings. HIV testing programme data are acceptable. Conducting surveys can be challenging and should therefore not be relied on. Testing should be conducted only with the consent of the people in prisons and other closed settings.

Measurement frequency
Annual (programme data) or every two years (biobehavioural survey).

Disaggregation
- **A, C and E:** Gender (female, male and transgender)
- **D:** gender (transman, transwoman, other).
- **A–E:** Age (<25 and 25+ years)

Additional information requested
A–E: If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. You may also upload an Excel spreadsheet of these data instead of entering them in the online tool. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses

In theory, progress in reducing the number of people newly infected with HIV is best assessed by monitoring the changes in incidence over time. In practice, however, prevalence data rather than incidence data are available. In analysing the prevalence data from key populations for assessing the impact of prevention programmes, it is desirable not to restrict analysis to young people but to report on the people newly initiating behaviour that puts them at higher risk of infection, such as by restricting the analysis to people participating in sex work for less than one year, to men who first had sex with another man within the past year or to people initiating injecting drug use within the past year. This type of analysis also has the advantage of not being affected by antiretroviral therapy increasing survival and thereby increasing prevalence.

Because of the difficulties in accessing key populations, biases in serosurveillance data are likely to be more significant than in data collected from a less stigmatized population, such as women attending antenatal clinics. If there are concerns about the data, the interpretation should reflect these concerns.

Understanding how the sampled populations relate to any larger populations sharing similar high-risk behaviour is critical to interpreting this indicator.

Trends in HIV prevalence among key populations in the capital city provide a useful indication of the performance of HIV prevention programmes in that city. However, they are not representative of the situation in the country as a whole.

The addition of new sentinel sites will increase the sample's representativeness and therefore provide a more robust point estimate of HIV prevalence. However, adding new sentinel sites reduces the comparability of values over time. As such, using consistent sites when undertaking trend analysis is important.

Surveys exclusively covering transgender people are rare. Most data for transgender communities are drawn from surveys of men who have sex with men or sex workers. The risk environment reported in most transgender communities is great, placing transgender women at especially high risk of becoming HIV- positive and transmitting the infection. Examples from several Latin American countries demonstrate that successful surveys can be conducted in transgender communities. If transgender women are respondents in surveys of sex workers, include the data with sex workers as a disaggregation. If transgender people are respondents in surveys of gay men and other men who have sex with men, include the data under the transgender tab.

People in prisons and other closed settings are easily reached with services, while released individuals can be efficiently linked to appropriate care and prevention services. The HIV prevalence can be readily estimated and quickly provide information that can be acted on.

In settings where high-risk behaviours for HIV transmission are criminalized, there is potential for high HIV prevalence and over-interpreting the results. Full understanding of the prison population is helpful during the analysis, especially the reasons for detention.

Further information

UNAIDS epidemiology publications (http://www.unaids.org/en/dataanalysis/knowyourepidemic/epidemiologypublications).

WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. Guidelines on surveillance among populations most at risk for HIV. Geneva: World Health Organization; 2011 (http://www.unaids.org/sites/default/files/sub_landing/files/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. Chapel Hill (NC): MEASURE Evaluation; 2012 (https://www.measureevaluation.org/resources/publications/ms-11-49a.html).

Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240052390).

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. In: MEASURE Evaluation [Internet]. Chapel Hill (NC): MEASURE Evaluation; c2019 (https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs.html).

1.4 HIV testing and status awareness among key populations (A–D)

Percentage of people from key populations who report having tested negative for HIV in the past 12 months, or who know that they are living with HIV

This indicator is divided into four sub-indicators:

A. HIV testing and status awareness among sex workers.

B. HIV testing and status awareness among gay men and other men who have sex with men.

C. HIV testing and status awareness among people who inject drugs.

D. HIV testing and status awareness among transgender people.

What it measures
Progress providing HIV testing services to members of key populations.

Rationale
Ensuring that people living with HIV receive the care and treatment required to live healthy, productive lives and reduce the chance of transmitting HIV, requires that they know their HIV status. In many countries, targeting testing and counselling for locations and populations with the highest HIV burden is the most efficient way to reach people living with HIV and ensure that they know their HIV status. This indicator captures the effectiveness of HIV testing interventions in reaching populations at higher risk of HIV infection.

Numerator
Respondent knows they are living with HIV (answer to Question 3 is "positive")

plus

Respondent reports having tested for HIV in last 12 months and result was negative

(answer to Question 2 is "a" or "b"; answer to Question 3 is "negative").

		Result of last HIV test	
		Positive	Negative
When was your last HIV test?	<6 months		
	6–12 months		
	>12 months		

The number of respondents in the green boxes is the numerator.

If still using the old indicator—HIV test in last 12 months—please note this in the comment field.

Denominator
Number of people in key populations who answered Question 1 (below). The denominator should include all respondents who answered Question 1 regardless of their answers being "Yes" or "No".

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys

Respondents are asked the following questions:

1. Do you know your HIV status from an HIV test?
   a. No, I have never been tested
   b. Yes, I have been tested
2. If yes, when were you last tested?
   a. In the last 6 months
   b. In the last 6–12 months
   c. More than 12 months ago
3. Was the result of your last test:
   a. Positive
   b. Negative

Measurement frequency
Every two years.

Disaggregation
A, C: Gender (female, male and transgender) **D:** gender (transman, transwoman, other).

A—D: Age (<25 and 25+ years).

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
HIV testing and counselling is the necessary first step to addressing a person's HIV infection. People living with HIV need to be aware of their HIV status able to make use of prevention and treatment services for their own health and to prevent transmission of the virus. National programmes aim to have 95% of people who are living with HIV know their HIV status.

HIV-positive respondents may be less willing to accurately report their HIV status than HIV-negative respondents, leading to under-reporting of testing coverage among people living with HIV.

Further information
Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

1.5A Condom use among sex workers

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

What 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, by consistently and correctly using condoms.

Note: Countries with generalized epidemics may also have a concentrated subepidemic among sex workers. If so, calculating and reporting on this indicator for this population would be valuable.

Numerator
Number of sex workers who reported using a condom with their last client

Denominator
Number of sex workers who reported having commercial sex in the past 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 with whom you had sexual intercourse?

Whenever possible, data for sex workers should be collected through or with civil society organizations that have worked closely with this population in the field. Access to sex workers and the data collected from them must remain confidential and secure.

Measurement frequency
Every two years

Disaggregation
- Gender (female, male and transgender)
- Age (<25 and 25+ years)

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
Condoms are most effective when they are used consistently rather than occasionally. The current indicator will overestimate the level of consistent condom use. However, the alternative method of asking whether condoms are always, sometimes or never used in sexual encounters with clients in a specified period is subject to recall bias. Further, the trend in condom use in the most recent sexual act will generally reflect the trend in recent consistent condom use.

This indicator asks about commercial sex in the past 12 months. If data are available on another time period, such as the past three or six months, please include the alternate indicator definition in the metadata in the comments section of the reporting tool.

Surveying sex workers can be challenging. Consequently, the 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, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

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

Further information

World Health Organization, United Nations Population Fund, UNAIDS, Global Network of Sex Work Projects, The World Bank, United Nations Development Programme. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva: World Health Organization; 2013 (https://www.nswp.org/sites/nswp.org/files/SWIT_en_UNDP%20logo.pdf).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

1.5B Condom use among gay men and other men who have sex with men

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

What 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 sexually transmitting HIV. Consistently and correctly using condoms is therefore 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 the most recent male partner is considered a reliable indicator of longer term behaviour.

Note: countries with generalized epidemics may also have a concentrated subepidemic among gay men and other men who have sex with men. If so, calculating and reporting on this indicator for this population would be valuable.

Numerator
Number of men who have sex with men who reported using a condom the last time they had anal sex with a male partner

Denominator
Number of men who have sex with men who reported having had anal sex with a male partner in the past six months

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys

In a behavioural survey of a sample of gay men and other men who have sex with men, respondents are asked about sexual partnerships in the past six months, about anal sex within these partnerships and about condom use when they last had anal sex. Condom use applies whether the respondent is the receptive and insertive partner.

Whenever possible, data for gay men and other men who have sex with men should be collected with civil society organizations that have worked closely with this population in the field.

Access to gay men and other men who have sex with men and the data collected from them must remain confidential and secure.

Measurement frequency
Every two years

Disaggregation
- Age (<25 and 25+ years).

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
For gay men and other men who have sex with men, condom use at last anal sex with any partner indicates well the overall levels and trends in 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 in which men in the subpopulation surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for the female and male partners.

This indicator asks about sex between men in the past six months. If data are available for a different time period, such as the past three or 12 months, please include this information in the metadata in the comments section of the reporting tool.

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

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

Further information

United Nations Population Fund, Global Forum on MSM & HIV, United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York (NY): United Nations Population Fund; 2015 (https://mpactglobal.org/wp-content/uploads/2015/11/MSMIT-for-Web.pdf).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

1.5C Condom use among people who inject drugs

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

What 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 in which other modes of HIV transmission predominate, because the risk of HIV transmission from contaminated injecting equipment is extremely high, and people who inject drugs can spread HIV (such as through sexual transmission) to the wider population.

Note: countries with generalized epidemics may also have a concentrated subepidemic among people who inject drugs. If so, calculating and reporting on this indicator for this population would be valuable.

Numerator
Number of people who inject drugs who reported using a condom 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 past 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 past month?

2. If yes, have you had sexual intercourse in the past month?

If they answer yes to both 1 and 2:

3. Did you use a condom when you last had sexual intercourse?

Whenever possible, data for people who inject drugs should be collected with civil society organizations that have worked closely with this population in the field.

Access to survey respondents and the data collected from them must remain confidential and secure.

Measurement frequency
Every two years

Disaggregation
- Gender (female, male and transgender).
- Age (<25 and 25+ years).

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
Surveying people who inject drugs can be challenging. Consequently, 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, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

The extent of HIV transmission associated with injecting drug use within a country depends on four factors: (1) the size, stage and pattern of dissemination of the national AIDS epidemic; (2) the extent of injecting drug use; (3) the degree to which people who inject drugs use contaminated injecting equipment; and (4) 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 fourth factor. To maximize the utility of these data, it is recommended that the same sample used for calculating this indicator be used for the calculating the other indicators related to these populations.

Further information

United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, UNAIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017 (https://www.unodc.org/documents/hiv-aids/publications/Implementing_Comprehensive_HIV_and_HCV_Programmes_with_People_Who_Inject_Drugs_PRACTICAL_GUIDANCE_FOR_COLLABORATIVE_INTERVENTIONS.pdf).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

1.5D Condom use among transgender people

Percentage of transgender people reporting using a condom during their most recent sexual intercourse or anal sex

What it measures
Progress in preventing exposure to HIV among transgender people through unprotected sex with partners

Rationale
Condoms can substantially reduce the risk of sexually transmitting HIV. Consistently and correctly using condoms is therefore important for transgender people, particularly transwomen, because of the high risk of HIV transmission during unprotected anal sex. Condom use with the most recent penetrative sex partner is considered a reliable indicator of longer-term behaviour.

Note: Countries with generalized epidemics may also have a concentrated subepidemic among transgender people. If so, calculating and reporting on this indicator for this population would be valuable.

Numerator
Number of transgender people who reported using a condom at last sexual intercourse or anal sex

Denominator
Number of transgender people surveyed who reported having sexual intercourse or anal sex in the past six months

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys

Respondents are asked the following question:

Did you use a condom during your most recent sexual intercourse or anal sex?

Whenever possible, data for transgender people should be collected with civil society organizations that have worked closely with this population in the field. Access to transgender people and the data collected from them must remain confidential and secure.

Measurement frequency
Every two years

Disaggregation
- Gender (transman, transwoman, other).
- Age (<25 and 25+ years).

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
For transgender people, condom use at last sexual intercourse or anal sex with any partner indicates well the overall levels of and trends in protected and unprotected sex in this population. In countries in which transgender people in the subpopulation surveyed are likely to have cis- and trans-gendered partners, condom use with female, male and transgender partners should be investigated. In these cases, data on condom use should always be presented separately for female, male and transgender partners.

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

Surveying transgender people can be challenging. Consequently, the 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, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

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

Further information

United Nations Development Programme, IRGT: A Global Network of Transgender Women and HIV, United Nations Population Fund, UCSF Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health, World Health Organization et al. Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions. New York (NY): United Nations Development Programme; 2016 (https://www.unfpa.org/sites/default/files/pub-pdf/TRANSIT_report_UNFPA.pdf).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

1.6 Coverage of HIV prevention programmes among key populations (A–D)

Coverage of HIV prevention programmes: percentage of people in a key population reporting having received a combined set of HIV prevention interventions

This indicator is divided into four sub-indicators:

A. Coverage of HIV prevention programmes among sex workers.

B. Coverage of HIV prevention programmes among gay men and other men who have sex with men.

C. Coverage of HIV prevention programmes among people who inject drugs.

D. Coverage of HIV prevention programmes among transgender people.

Each sub-indicator is divided in two parts. Please report both parts. Surveys and programme data are considered complementary.

PART I. Behavioural surveillance or other special survey

What it measures
People in key populations who received at least two HIV prevention interventions in the past three months

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Rationale
Successfully confronting the HIV epidemic requires combining preventive behaviour and antiretroviral therapy. Coverage with evidence-informed prevention programming is a critical component of the response, the importance of which is reflected in the UNAIDS Strategy.

Numerator
Number of people in a key population who report receiving two or more of the prevention interventions listed in the past three months

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Denominator
Number of people in a key population responding to the survey

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Calculation
Numerator/denominator

Method of measurement
Percentage of respondents who report receiving at least two of the following HIV prevention services from an nongovernmental organization, health-care provider or other sources.

- In the past three months, have you been given condoms and lubricant (for example, through an outreach service, drop-in centre or sexual health clinic)?
- In the past three months, have you received counselling on condom use and safe sex (for example, through an outreach service, drop-in centre or sexual health clinic)?
- Have you been tested for sexually transmitted infections in the past three months? (sex workers, transgender people and gay men and other men who have sex with men)
- Have you received new, clean needles and syringes in the past three months? (people who inject drugs)

Measurement frequency
Every two years.

Disaggregation
- Age (<25 and 25+ years).
- **A, C:** gender (male, female and transgender).
- **D:** gender (transman, transwoman, other).

Strengths and weaknesses
Survey data provide the opportunity to measure the uptake of multiple intervention services by individuals. Weaknesses associated with survey data relate to any sampling or response bias and the limited geographical coverage of the information.

Further information
Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations. Supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/177992/9789241508995_eng.pdf?sequence=1).

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. In: MEASURE Evaluation [Internet]. Chapel Hill (NC): MEASURE Evaluation; c2019 (https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs).

What it measures
People in key populations who are reached with HIV prevention interventions designed for the intended population

Rationale
Successfully confronting the HIV epidemic requires combining preventive behaviour and antiretroviral therapy. Coverage with evidence-informed prevention programming is a critical component of the response, the importance of which is reflected in the UNAIDS Strategy.

Numerator
Number of people in a key population reached with HIV prevention interventions designed for the intended population

Denominator
Number of people in a key population

Calculation
Numerator/denominator

Method of measurement
For the numerator: Number of people in a key population reached with individual HIV prevention interventions designed for the intended population and the following:

- For sex workers, gay men and other men who have sex with men and transgender people: number of condoms and lubricants distributed.
- For people who inject drugs: number of needles and syringes distributed.

Plus: [1.6.1] Number of service provision sites dedicated to key populations per administrative area.

For the denominator: Validated population size estimate

Measurement frequency
Annual

Disaggregation
- Type of provider (public services, key population-led organization, NGOs, or other entities).
- Name of the organisation/s. Please indicate the name and URL/website (if available) of the key population-led organization, NGOs, or other entities that are providing these services

Strengths and weaknesses
Programme data provide a national picture to the extent that programmes offer services nationally. While programme data reflect a national commitment to deliver services to specified key population communities, they do not accurately reflect the individuals served and data cannot typically be deduplicated. Furthermore, analysis of two separate programme data sets can only be considered ecologically: that is, we can see the number of people contacted by programmes and we can see the number of condoms provided by programmes, but we cannot know who among the people contacted received condoms.

Additional information requested
Service provision sites designed specifically for one or more key populations demonstrate commitment to deliver context-sensitive services to communities that are often stigmatized. Please provide the total number of such sites and the total number of first-level (e.g., state/province/oblast) or second-level (e.g., county/district) administrative areas that have at least one service and the total number in the country. For example, Country A reports 10 needle–syringe programmes across five provinces, and it has seven total provinces.

If known, please report if the site is operated by the national programme (government) or the community (civil society or nongovernmental organization).

Please provide the number of peer outreach workers active at the time of reporting for each key population.

Further information
Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/177992/9789241508995_eng.pdf?sequence=1).

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. In: MEASURE Evaluation [Internet]. Chapel Hill (NC): MEASURE Evaluation; c2019 (https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs).

1.7 HIV prevention programmes in prisons

HIV prevention and treatment programmes offered to people in prisons and other closed settings while detained

What it measures
The number of people in prisons and other closed settings who receive HIV preventive or treatment services while detained.

Rationale
People in prisons and other closed settings are often at risk for acquiring HIV when they are released and living in the community. This is especially true for people involved with illicit drug use or where selling sex is illegal. Offering HIV prevention and treatment services in prisons can reduce HIV transmission risk both within the prison and in the community on release. A strong national HIV response will include such services to people in prisons and other closed settings.

Numerator
Number of sterile needles distributed to people in prisons and other closed settings

Number of people in prisons and other closed settings receiving opioid agonist maintenance therapy

Number of condoms distributed to people in prisons and other closed settings

Number of people in prisons and other closed settings receiving antiretroviral therapy

Number of people in prisons and other closed settings tested for HIV

Number or percentage of people living with HIV among people in prisons and other closed settings

Number or percentage of people in prisons and other closed settings with hepatitis C

Number of people in prisons and other closed settings co-infected with HIV and hepatitis C virus

Number or percentage of people in prisons and other closed settings with TB or co-infected with HIV and TB

Denominator
Not applicable

Calculation
Not applicable

Method of measurement
Routine programme data

Measurement frequency
Annual

Disaggregation
None

Additional information requested
Number of prisons offering any HIV prevention or treatment services

Strengths and weaknesses
Programme data provide a strong picture of services and the burden of HIV among inmates. The indicator informs whether a national programme is taking advantage of serving a readily accessible population at higher risk.

Given the turnover in most prison systems, any programme data provide a snapshot of a given time period. Concerns for confidentiality and the welfare of inmates mitigates against surveys, although they can be useful if they can be conducted safely.

Further information
UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions.Technical brief update. Vienna: UNODC; 2020 (https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/20-06330_HIV_update_eBook.pdf).

1.8 Safe injecting practices among people who inject drugs

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

What it measures
Progress in preventing HIV transmission associated with injecting drug use

Rationale
Safer injecting and sexual practices among people who inject drugs are essential, even in countries in which other modes of HIV transmission predominate, because the risk of HIV transmission from contaminated injecting equipment is extremely high, and people who inject drugs can spread HIV (such as through sexual transmission) to the wider population.

Note: countries with generalized epidemics may also have a concentrated subepidemic among people who inject drugs. If so, calculating and reporting on this indicator for this population would be valuable.

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 past 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 past month?

If yes:

2. 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 with civil society organizations that have worked closely with this population in the field.

Access to people who inject drugs and the data collected from them must remain confidential and secure.

Measurement frequency
Every two years

Disaggregation
- Gender (female, male and transgender)
- Age (<25 and 25+ years)

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
Surveying people who inject drugs can be challenging. The data obtained may therefore 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, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

The extent of HIV transmission associated with injecting drug use within a country depends on four factors: (1) the size, stage and pattern of dissemination of the national AIDS epidemic; (2) the extent of injecting drug use; (3) the degree to which people who inject drugs use contaminated injecting equipment; and (4) 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 calculating this indicator be used for calculating the other indicators related to these populations.

Further information

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/177992/9789241508995_eng.pdf?sequence=1).

A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. Geneva: UNAIDS; 2007 (http://www.unaids.org/sites/default/files/sub_landing/files/17_Framework_ME_Prevention_Prog_MARP_E.pdf).

Practical guidelines for intensifying HIV prevention: towards universal access. Geneva: UNAIDS; 2007 (http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf).

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. In: MEASURE Evaluation [Internet]. Chapel Hill (NC): MEASURE Evaluation; c2019 (https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs.html).

1.9 Needles and syringes distributed per person who injects drugs

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

What it measures
Progress in improving the coverage of needles and syringes provided, an essential HIV prevention service for people who inject drugs

Rationale
Injecting drug use is one of the main routes through which people acquire HIV globally. Preventing HIV transmission caused by injecting drug use is one of the key challenges in reducing the burden of HIV.

Needle–syringe programmes are included as an essential health sector intervention in the World Health Organization (WHO) comprehensive package of interventions for HIV and hepatitis C virus prevention and treatment among key populations (see further information below) described in the Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (2022).

Needle–syringe programmes greatly enhance HIV prevention for people who inject drugs, and a wealth of scientific evidence supports their efficacy in preventing the spread of HIV.

Numerator
Number of needles and syringes distributed in the past 12 months by needle–syringe programmes

Denominator
Number of people who inject drugs in the country

Calculation
Numerator/denominator

Method of measurement
For the numerator: Programme data used to count the number of needles and syringes distributed

For the denominator: Estimation of the number of people who inject drugs in the country

Measurement frequency
Annual.

Disaggregation
- Type of provider (public services, key population-led organization, NGOs, or other entities).
- Name of the organisation/s. Please indicate the name and URL/website (if available) of the key population-led organization, NGOs, or other entities that are providing these services.

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. You may also upload an Excel spreadsheet of these data instead of entering them in the online tool. Submit the digital version of any available size estimation reports using the upload tool.

Strengths and weaknesses
Some difficulties in counting needles and syringes are reported. Some commonly used syringes are 1 ml or 2 ml needle and syringe units; others are syringes to which needles need to be fitted. In most cases, only data on the number of syringes distributed by needle–syringe programmes but not pharmacy sales are available.

Estimating the number of people who inject drugs at the country level presents challenges. People who inject drugs are defined in many ways, and the estimates have ranges. The UNODC publishes estimates of the number 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 the rationale in the comment field.

Countries that have legalized sales of needles and syringes without a prescription may appear to have artificially low coverage with this indicator. Countries can monitor this indicator against the following coverage levels:

- Low: <100 syringes per person who injects drugs per year.
- Medium: 100–200 syringes per person who injects drugs per year.
- High: >200 syringes per person who injects drugs per year.

These levels are based on studies in low- and middle-income countries investigating the levels of syringe distribution and how these affect HIV transmission. The levels required for preventing hepatitis C are likely to be much higher than those presented here.

Further information

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/177992/9789241508995_eng.pdf?sequence=1).

Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among IDUs. Geneva: World Health Organization; 2004 (https://iris.who.int/handle/10665/43107)

WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. Guidelines on estimating the size of populations most at risk to HIV. Geneva: World Health Organization and UNAIDS; 2010 (https://data.unaids.org/pub/manual/2010/guidelines_popnestimationsize_en.pdf).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

1.10 Coverage of opioid agonist maintenance therapy

Percentage of people who inject drugs receiving opioid agonist maintenance therapy

What it measures
A programme's ability to deliver opioid agonist maintenance therapy among people who inject drugs as a method of directly reducing injecting frequency.

Rationale
Opioid agonist maintenance therapy represents a commitment to treat opioid dependence and reduce the frequency of injecting, preferably to zero. It is the most effective, evidence-based public health tool for reducing use among the people who inject opioids. Opioid agonist maintenance therapy provides crucial support for treating other health conditions, including HIV, tuberculosis and viral hepatitis.

Numerator
Number of people who inject drugs and are receiving opioid agonist maintenance therapy at a specified date

Denominator
Number of opioid-dependent people who inject drugs in the country

Calculation
Numerator/denominator

Method of measurement
For the numerator: Programme records: for example, opioid agonist maintenance therapy registries.

For the denominator: Size estimation of opioid dependent people: users or injectors.

Measurement frequency
Annual

Disaggregation
- Gender (male, female and transgender).
- Age (<25 and 25+ years).
- Type of provider (public services, key population-led organization, NGOs, or other entities).
- Name of the organisation/s. Please indicate the name and URL/website (if available) of the key population-led organization, NGOs, or other entities that are providing these services

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city or site using the space provided. You may also upload an Excel spreadsheet of these data instead of entering them in the online tool. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
The population size estimate used as the denominator should be appropriate for the numerator: not all opioid agonist maintenance therapy recipients have a history of injecting and not all people who inject drugs use or are dependent on opioids.

Biobehavioural surveys can collect this information but are often biased by an inclusion criterion of being a current injector. This would exclude those people receiving opioid agonist maintenance therapy who may not be injecting anymore or who may deny current injecting in order to access the OAMT programme

Further information
Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/177992/9789241508995_eng.pdf?sequence=1).

United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, UNAIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017. (https://www.unodc.org/documents/hiv-aids/publications/Implementing_Comprehensive_HIV_and_HCV_Programmes_with_People_Who_Inject_Drugs_PRACTICAL_GUIDANCE_FOR_COLLABORATIVE_INTERVENTIONS.pdf#:~:text=Implementing%20comprehensive%20HIV%20and%20HCV%20programmes%20with%20people%20who%20inject).

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. In: MEASURE Evaluation [Internet]. Chapel Hill (NC): MEASURE Evaluation; c2019 (https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs.html).

1.11 People who received pre-exposure prophylaxis

Number of people who received pre-exposure prophylaxis (PrEP) at least once during the reporting period

What it measures
Progress towards scaling up PrEP globally

Rationale
This indicator is key to assessing the availability and uptake of pre-exposure prophylaxis (PrEP), especially among people at substantial risk of HIV infection. Through data disaggregation, this indicator will also attempt to monitor the availability and use by population (based on age, gender and key population). The use of antiretroviral medicines by people who are HIV-negative before they are exposed to HIV can prevent HIV infection. In 2015, the World Health Organization (WHO) recommended that oral PrEP containing tenofovir (TDF) be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches. In 2021, WHO recommended the dapivirine vaginal ring (DVR) as an additional PrEP option to be offered to cisgender women at substantial risk of HIV. In 2022, WHO recommended that long-acting injectable cabotegravir (CAB-LA) may be offered as an additional PrEP option to people at substantial risk of HIV.

In 2024, WHO updated the guidance on oral PrEP dosing regimens, which are determined by a combination of factors based on a person's characteristics, circumstances and route of exposure. The guidance no longer uses the term "event-driven PrEP" (ED-PrEP), given the variation possible within oral PrEP dosing.

Implementation of PrEP should be informed by several contextual factors. These include national and subnational epidemiological trends; programmatic feasibility and demand; and consideration of the social environment for people living with HIV and people from key populations and their access to services. PrEP implementation criteria may vary by country.

Numerator
Number of people who received any PrEP product at least once during the reporting period

Denominator
Not applicable

Calculation
Not applicable

Method of measurement
The numerator is generated by counting the number of people who received PrEP at least once during the reporting period (the previous calendar year), in accordance with national guidelines or WHO/UNAIDS standards. This can include oral PrEP, DVR or CAB-LA. The numerator should count individuals only once—that is, the first time they received any PrEP product during the reporting period. People who received oral PrEP through national programmes or pilots, implementation studies, research or private means should be included.

For disaggregation by PrEP product (oral PrEP, DVR or CAB-LA), individuals can be counted for each product (if they received multiple products). The sum of the data disaggregated by PrEP product and dosing schedule can therefore be greater than the total.

Age is defined as the person's age when they received PrEP for the first time during the reporting period.

If a person identifies as belonging to more than one key population, all key populations that are relevant should be recorded. The sum of the data disaggregated by key populations can therefore be greater than the total. As with all types of record-keeping used to disaggregate indicators by key population, efforts must be made to avoid disclosing the identities of people who use PrEP in the client records and registers of facilities that offer PrEP.

Measurement frequency
Data should be collected continuously at the facility level and aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting.

Disaggregation
- People who received PrEP for the first time in their lives.
- Gender (male, female or transgender).
- Age (<15, 15+, 15–19, 20–24, 25–49 and 50+ years).
- PrEP product (oral PrEP, DVR, CAB-LA).
- Key population (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people and people in prisons and other closed settings).

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses

This indicator will not capture the number of person-years at risk, since it will not account for how long PrEP is used. It will also not measure the treatment cost, quality, effectiveness or adherence, which vary within and among countries and are likely to change over time.

The availability and use of PrEP will depend on such factors as cost, service delivery infrastructure and quality, legal and policy environment, perceptions of effectiveness and possible side-effects.

Countries with strong monitoring systems that use unique identifiers will likely be able to more accurately estimate the number of people receiving PrEP for the first time during the calendar year than those with aggregate data systems. In countries with weaker monitoring systems, avoiding double-counting of the people receiving PrEP may be difficult, including of people who may transfer to another facility to receive medication during the reporting period. In these cases, the number of people receiving PrEP for the first time during the calendar year may be overstated.

Further information

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240031593).

WHO implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection. Geneva: World Health Organization; 2017 (http://www.who.int/hiv/pub/prep/prep-implementation-tool/en/).

What's the 2+1+1? Event-driven oral pre-exposure prophylaxis to prevent HIV for men who have sex with men: update to WHO's recommendation on oral PrEP. Technical brief. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/325955/WHO-CDS-HIV-19.8-eng.pdf?ua=1).

Differentiated and simplified pre-exposure prophylaxis for HIV prevention: update to WHO implementation guidance. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240053694).

Guidelines on long-acting injectable cabotegravir for HIV prevention. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240054097).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Male circumcision indicators

Indicators 1.12 and 1.13 are required only from 15 countries with high HIV prevalence, low levels of male circumcision and generalized heterosexual epidemics: Botswana, Ethiopia, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

1.12 Prevalence of male circumcision

Percentage of men 15–49 that are circumcised

What it measures
Progress towards increased coverage of male circumcision

Rationale
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 acquiring HIV. Other benefits of medical male circumcision include the reduced risk of some other STIs, including human papillomavirus, the cause of cervical cancer. The World Health Organization (WHO) and UNAIDS recommendations emphasize that voluntary medical male circumcision should continue to be provided as an additional efficacious HIV prevention option within combination prevention for adolescents 15 years and older and adult men in settings with generalized epidemics to reduce the risk of heterosexually acquired HIV infection. Voluntary medical male circumcision services should be provided as part of a package of prevention interventions including safer sex education, condom education and provision, HIV testing and linkages to care and treatment, and management of sexually transmitted infections

Numerator
Number of male respondents aged 15–49 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, 25–29 and 25–49 years)
- Source or practitioner of circumcision procedure: formal health-care system or traditional

Additional information requested
None.

Strengths and weaknesses
A programme may or may not change the rate of male circumcision. For example, changing societal norms not caused by a programme may lead to changing rates of male circumcision. This indicator measures the total change in the population, regardless of the reasons.

Existing population-based surveys (such as Demographic and Health Surveys) may not accurately measure true male circumcision status because people may lack knowledge of what male circumcision is, be confused about their circumcision status or perceive the social desirability of circumcision status. Other approaches to determining circumcision status might be used: for example, using photographs or drawings (drawings may be more culturally appropriate), prompts or even direct examination. Modelling how changing rates of male circumcision can potential affect HIV incidence requires accurate knowledge of male circumcision status over time.

Further information

Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/rest/bitstreams/1296029/retrieve).

A guide to indicators for male circumcision programmes in the formal health-care system. Geneva: World Health Organization and UNAIDS; 2009 (http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf).

1.13 Annual number of males voluntarily circumcised

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

What it measures
Progress in scaling up male circumcision services

Rationale
Three randomized controlled trials—plus post-trial studies—have shown that male circumcision provided by well-trained health professionals in properly equipped settings is safe and can reduce the risk of acquiring HIV. Other benefits of medical male circumcision include the reduced risk of some other STIs, including human papillomavirus, the cause of cervical cancer. The World Health Organization (WHO) and UNAIDS recommendations emphasize that voluntary medical male circumcision should be provided as part of a package of prevention interventions including safer sex education, condom education and provision, HIV testing and linkages to care and treatment, and management of sexually transmitted infections

Numerator
Number of males circumcised during the past 12 months according to national standards

Denominator
Not applicable

Calculation
Not applicable

Method of measurement
Health facility recording and reporting forms, programme data, health information system. It is important to ensure that voluntary male medical circumcision is provided with an ethics and human rights approach. The procedure should be voluntary and include procedures for informed consent and assent.

Measurement frequency
Annual

Disaggregation
- Age (<1, 1–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–49 and 50+ years).

WHO recommends that voluntary medical male circumcision should continue to be provided as an additional efficacious HIV prevention option within combination prevention for adolescents 15 years and older and adult men in settings with generalized epidemics. Decisions on offering voluntary medical male circumcision to younger adolescents 10–14 years must consider several factors based on new evidence, human rights and national and local context.

Additional information requested
Optional to estimate coverage: Estimated number of uncircumcised, HIV-negative males.

Strengths and weaknesses

The total number of men and boys circumcised 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.

As countries successfully scale up voluntary medical male circumcision (VMMC), the number of uncircumcised adolescent boys and men eligible for the procedure will decrease and the number of procedures performed becomes more difficult to interpret. It can be helpful to estimate the coverage of circumcisions performed relative to need; in this instance, need can be understood as the number of uncircumcised, HIV-negative adolescent boys and men who would be eligible for the procedure. These estimates can be derived from models such as those used for the purposes of monitoring progress against HIV Fast-Track Targets and the VMMC Decision Makers' Program Planning Toolkit (DMPPT) 2.

Further disaggregation is recommended at the country level:

- HIV-positive by test(s) on site, HIV-negative by test(s) on site, HIV-indeterminate results by test(s) on site, or unknown/refused HIV test(s).
- Groups identified as being at increased risk of HIV infection (for example, men seeking services for STI management, male clients of sex workers or occupational groups).
- Type and location of health facility.
- Cadre of the provider.
- Surgical versus device-based procedure.

Disaggregating the number of male circumcisions by HIV status and age will enable the impact of male circumcision programmes on HIV incidence to be determined using models. If a country has given priority to specific age groups, this disaggregation will help to determine whether age-specific communication strategies are creating demand. If the data are available by the type and location of health-care facility where the circumcision was performed, resource allocation needs can be assessed. Disaggregating these data by the cadre of health-care provider will determine whether task-shifting efforts are succeeding and help to determine resource allocation.

Some programmes will work closely with voluntary HIV testing services to provide HIV testing. A man desiring circumcision may have been recently tested, and an on-site HIV test may be unnecessary. In these cases, the facility may request a written verified result 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 HIV-positive, but to provide HIV testing to men seeking health care and to identify men living with HIV who, if they choose to be circumcised, are likely to be at higher risk of surgical complications (men with chronic infections and low CD4 counts).

Further information

Preventing HIV through safe voluntary medical male circumcision for adolescent boys and men in generalized HIV epidemics: recommendations and key considerations. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/rest/bitstreams/1296029/retrieve).

A guide to indicators for male circumcision programmes in the formal health care system. Geneva: World Health Organization and UNAIDS; 2009 (http://whqlibdoc.who.int/publications/2009/9789241598262_eng.pdf).

1.14 Condom use at last high-risk sex

The percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months

What it measures
Progress towards preventing exposure to HIV through unprotected sexual intercourse among people with non-marital non-cohabiting partners.

Rationale
Condom use is an important way of protecting against HIV, especially among people with non-regular sexual partners.

Numerator
The number of respondents who report using a condom the last time they had sex with a non-marital, non-cohabiting partner.

Denominator
Total number of respondents who report that they had sex with a non-marital, non-cohabiting 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 had sex with a non-marital, non-cohabiting partner in the past 12 months and, if so, whether the respondent used a condom the last time the respondent had sexual intercourse with such a partner.

Measurement frequency
3–5 years

Disaggregation
- Gender (male, female)
- Age (15–19, 20–24 and 25–49 years)

Strengths and weaknesses
A rise in this indicator is an extremely powerful indication that condom promotion campaigns are having the desired effect among their principle target market.

Since condom promotion campaigns aim for consistent use of condoms with non-regular partners rather than simply occasional use, some surveys have tried to ask directly about consistent use, often using an always/sometimes/never question. While this may be useful in sub-population surveys, it is subject to recall bias and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act of non-cohabiting sex minimises recall bias and gives a good cross-sectional picture of levels of condom use. It is recognised that consistent use of condoms is an important goal. But inevitably, if consistent use rises, this indicator will also rise.

Further information
Demographic and Health Survey or AIDS Indicator Survey methods and survey instruments (http://dhsprogram.com/What-We-Do/Survey-Types/AIS.cfm); (http://hivdata.dhsprogram.com/ind_tbl.cfm).

1.15 Annual number of condoms distributed

Number of condoms distributed during the past 12 months

This indicator is divided into two sub-indicators:

A. Number of male condoms distributed in the past 12 months.

B. Number of female condoms distributed in the past 12 months.

What it measures
Progress in scaling up distribution of male and female condoms.

Rationale
Condoms have been shown to be one of the most effective methods in preventing the sexual transmission of HIV, other sexually transmitted infections (STIs) and unintended pregnancy, with effectiveness that increases with consistent and correct use. The World Health Organization (WHO) and UNAIDS recommendations emphasize that condom distribution and promotion is an efficacious intervention and a critical component of combination HIV prevention.

Numerator
A. Number of male condoms distributed in the past 12 months.

B. Number of female condoms distributed in the past 12 months.

Denominator
A. Not applicable.

B. Not applicable.

Calculation
A. Not applicable.

B. Not applicable.

Method of measurement
Count of the number of male and female condoms that left the central or regional warehouses for onward distribution in the previous calendar year. Data should include condoms distributed for free (public providers), condoms sold at subsidized rates through social marketing (nongovernmental organizations as providers) and condoms sold through the commercial sector (private sector providers). There should be no double-counting of condoms in case of overlap. If condoms from public sector warehouses are given to nongovernmental organizations or community workers for distribution, condoms should be accounted for in the public sector.

Measurement frequency
Annual

Disaggregation
- Provider (public, private and nongovernmental organizations).

Additional information requested
None.

Strengths and weaknesses

A count of the number of condoms that have left the central or regional warehouses can provide useful information on the supply of condoms. Since condom use is only tracked through surveys every three to five years, it is important to monitor distribution closely to be able to track uptake of condoms in real time. Analyzing these data jointly with condom needs estimates can provide information on supply gaps. Countries can also use this indicator for comparing subnational distribution per male aged 15–64 years in order to understand inequities in supply and uptake. The indicator requires countries to aggregate and analyze data from different distribution channels, including the public or private sectors and social marketing, making this indicator critical for building a total market approach and exploring complementarity between different market segments.

Distribution from central or regional warehouses will not capture whether condoms are reaching facilities, are being distributed before expiry and are being used. To obtain more accurate information on uptake of condoms, countries should ideally track condom consumption, which is the number of condoms that left distribution points like health facilities, shops or community outreach teams. This is usually done through stock counts at each distribution point at the time of replacing supply. However, since such consumption data are not available in aggregated form in most countries, distribution from central and regional warehouses is recommended as a proxy indicator.

Further information

United Nations Population Fund, World Health Organization, UNAIDS. Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy. 2015 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/01/Condom-position-statement-WHO-UNFPA-UNAIDS-final-logo-clearance-26-June-2015-1.pdf).

Condoms: the prevention of HIV, other sexually transmitted infections and unintended pregnancies. Geneva: UNAIDS; 2016 (https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/01/JC2825-7-1.pdf).

1.16 Young people: knowledge about HIV prevention

Percentage of women and men 15–24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission

What it measures
Progress towards universal knowledge of the essential facts about HIV transmission

Rationale
HIV epidemics are perpetuated primarily through the sexual transmission of infection to successive generations of young people. Sound knowledge about HIV and AIDS is necessary (although often insufficient) for adopting behaviour that reduces the risk of HIV transmission.

Numerator
Number of respondents 15–24 years old who correctly answered all five questions

Denominator
Number of all respondents 15–24 years old

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
3–5 years

Disaggregation
- Age (15–19 and 20–24 years)
- Sex (male, female)

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

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

Further information
Demographic and Health Survey and AIDS Indicator Survey methods and survey instruments (http://dhsprogram.com).

2.1 People living with HIV who know their HIV status

Percentage of people living with HIV who know their HIV status at the end of the reporting period

What it measures

Progress towards increasing the proportion of people living with HIV who know their HIV status and the efficacy of HIV testing interventions

Rationale

People living with HIV who know their HIV status will be able to access the HIV care and treatment services required to live healthy, productive lives and to reduce the potential of transmitting HIV to other people. The most effective way to ensure that people living with HIV are aware of their HIV status is to offer HIV testing services at locations and among populations with the highest HIV burden.

This measure is the first 95 of the UNAIDS 95–95–95 target: that 95% of the people living with HIV know their HIV status by 2025.

Numerator

Number of people living with HIV who know their HIV status

Denominator

Number of people living with HIV

Calculation

Numerator/denominator

Note: Countries with a population of more than 250 000 will report on this indicator by broad and detailed age and sex groups within their national Spectrum estimation file. Those indicator results will be obtained directly from the final national Spectrum file, along with all other Spectrum-based indicators. Reporting on sub-national data for the indicator will be done in the Global AIDS Monitoring reporting tool. If a country has sub-national estimates developed using Naomi, these data will be obtained directly from the final Naomi file.

Method of measurement

There are two recommended methods for estimating the proportion of people living with HIV who know their status. The method used depends on the availability of data in the country.

1. **Direct estimates from HIV case surveillance systems**

   For the numerator. In countries with well-functioning HIV case surveillance systems, the number of people living with HIV who know their status is the same as the number of people diagnosed with HIV and reported to the surveillance system who are still alive.

   For the denominator. Estimation models such as Spectrum are the preferred source for the number of people living with HIV. If models other than Spectrum are used, documentation of the estimation method and uncertainty bounds should be provided.

   On case surveillance methods. An HIV case surveillance system is considered to be functioning well if reporting from all facilities providing confirmatory HIV testing, care and treatment services has been in place since at least 2015, and if people who have died, been lost to follow-up or emigrated are removed from the numerator. Only confirmed HIV diagnoses should be counted, although countries should be sure to adjust for reporting delays by including an estimate of the number of people diagnosed but not yet reported during the latest calendar year (if necessary). Mechanisms should be in place to deduplicate individuals diagnosed and reported multiple times or from multiple facilities.

2. **Modelled estimates**

   For the numerator: The approach to modelling the estimate of the number of people who know their HIV status among those living with HIV will depend on the availability of data in the country.

   For countries with robust case surveillance and vital registration systems, the number of people who know their HIV status can be derived using the Case Surveillance and Vital Registration (CSAVR) HIV prevalence estimation tool in Spectrum. A similar estimation method is available through the European Centres for Disease Control (ECDC) HIV Modelling Tool (https://ecdc.europa.eu/en/publications-data/hiv-modelling-tool). Estimates from other country-specific approaches to modelling this count that are based on case surveillance and clinical data may also be reported where these methods have been peer-reviewed and published.

   For countries with household population survey data that either directly capture the number of HIV-positive respondents who report that they know their status or the number of HIV-positive people who report ever having been tested, UNAIDS recommends (as of 2018) that knowledge of HIV-positive status be modelled using the Shiny90 model. More information about the tool, including the required inputs, can be found at https://shiny90.unaids.org/.

   Estimates of knowledge of HIV-positive status that are based only on self-reported knowledge of status or on historical household population survey data about testing history should not be reported.

   For the denominator. Estimation models such as Spectrum are the preferred source for the number of people living with HIV. UNAIDS will work with countries to develop a Spectrum model that matches the estimates of people living with HIV if estimates other than those produced through Spectrum are used.

   On estimating the number of children who know their status in countries with modelled estimates based on household survey data. Since household surveys are often restricted to respondents of reproductive age, a separate estimate of knowledge of HIV status among children (0–14 years old) may need to be constructed using programme data in order to produce an overall (i.e., all ages) estimate. In this case, UNAIDS recommends that countries use the number of children on treatment, as reported in Indicator 2.2, as a proxy measure. This approach represents the most conservative measure of knowledge of status in the population.

Measurement frequency
Annually

Disaggregation
- 0–14 years for children and 15 years and older by sex (men and women) for adults.
- As available: Disaggregation by detailed age and sex: <1 year, 1–4 years, 5–9 years and 10–14 years for children and 15–19 years, 20–24 years, 25–49 years and 50+ years by sex (men and women) for adults; by gender (men, women, other gender) for adults.

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided.

Strengths and weaknesses
Case-based reporting method
Case-based surveillance provides reasonable measures of knowledge of HIV status in the following instances:

- The system has been in place for long enough that all people diagnosed and still alive have been reported.
- There are timely and complete mechanisms for reporting newly diagnosed cases to the system from all facilities that offer HIV diagnostic testing.
- Mechanisms are in place to de-duplicate repeat diagnoses among individuals reported multiple times and/or from multiple facilities.
- There is sufficient continuous or periodic follow-up of individuals to identify that they are still alive, as opposed to having died or moved out of the country.

Countries relying on weak systems may overestimate or underestimate knowledge of HIV status in the following cases:

- De-duplication of case reports has not occurred (leading to overestimation).
- Deaths or out-migration among people diagnosed and reported to the system have not been removed (overestimation).
- Case reporting is not routine from all HIV testing facilities with confirmatory capacity (underestimation).

Modelled estimates
The accuracy of modelled estimates of knowledge of HIV-positive status will depend on the quality of the data inputs in each country and the accuracy of the assumptions underpinning each model. Countries should review the quality of the data inputs with UNAIDS and the selected modelling approach to determine the extent to which modelled estimates might overstate or understate knowledge of status among people living with HIV in the country.

Further information
Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Spectrum. In: Avenir Health [Internet]. Glastonbury (CT): Avenir health; 2024 (http://www.avenirhealth.org/software-spectrum.php).

The DHS Program: Demographic and Health Surveys [webpage]. Rockville (MD): ICF; c2024 (http://dhsprogram.com).

2.2 People living with HIV on antiretroviral therapy

Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period

What it measures
Progress towards providing antiretroviral therapy to all people living with HIV

Rationale
Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among people living with HIV, and to halt onward transmission of the virus. Studies also show that early initiation, regardless of a person's CD4 cell count, can enhance treatment benefits and save lives. The World Health Organization (WHO) currently recommends treatment for all people living with HIV.

The percentage of people on antiretroviral therapy among all people living with HIV provides a benchmark for monitoring global targets over time and comparing progress across countries. When considered as a proportion of Indicator 2.1, this indicator monitors progress toward the second 95 of the UNAIDS 95–95–95 targets: that 95% of people who know their HIV-positive status are accessing treatment by 2025.

Numerator
Number of people on antiretroviral therapy at the end of the reporting period

Denominator
Estimated number of people living with HIV (to determine treatment coverage)

OR

Number of people among all people living with HIV who know their HIV-positive status (to determine the second 95)

Calculation
Numerator/denominator

Note: Starting in 2018, countries with a population of more than 250 000 report on this indicator by broad and detailed age groups within Spectrum. Results will be obtained directly from the final national Spectrum file. Reporting on sub-national data for the indicator will be done in the Global AIDS Monitoring reporting tool. If a country has sub-national estimates developed using Naomi, these data will be obtained directly from the final Naomi file.

Method of measurement
For the numerator. The numerator is generated by counting the number of adults and children who are on antiretroviral therapy at the end of the reporting period. The numerator should include people on antiretroviral therapy in the private sector (if these data are available). The count should include pregnant women living with HIV who are receiving lifelong antiretroviral therapy.

Protocols should be in place to avoid duplicate counting of individuals across facilities or over time, and to ensure that all facility-level data are reported in a timely manner. The count should not include people who have stopped treatment, died or emigrated to another country, or those who were otherwise lost to follow-up at the facility during this period. People are considered lost to follow-up if they have not been seen within 28 days of the last expected clinical contact (for either an appointment or drug pick-up). Some people pick up several months of antiretroviral medicines at one visit; if the duration of the medicine picked up covers the last month of the reporting period, these people should still be counted as receiving antiretroviral therapy (as opposed to having stopped treatment or having been lost to follow-up).

Important: Countries should routinely conduct data quality reviews to determine the accuracy of the count data. This should include triangulation of the programme data with national procurement and drug monitoring systems and other pharmacy or drug distribution data. Estimates of coverage of antiretroviral therapy from surveys can also be used to inform or validate the numerator based on programme data, although survey results should be based on drug testing and not self-reported data since self-reported data has been shown to be of limited quality.

Countries that have undertaken data quality assessments or reviews should adjust current and historical reported data to account for these inconsistencies. UNAIDS will work with countries to agree on a set of best practices for adjusting reported programme data specific to the country.

For the denominator. Models such as Spectrum are the preferred source for estimating the number of people living with HIV. UNAIDS will work with countries to develop a Spectrum model that matches the estimate of people living with HIV if estimates other than those produced through Spectrum are used. For numbers of people living with HIV who know their status, please see Indicator 2.1 for more information about the denominator.

Measurement frequency
Data should be collected continually at the facility level and aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data with the count of the number of people currently on treatment should be used for annual reporting.

Disaggregation

- 0–14 years for children, and 15 years and older by sex (men and women) for adults. Data reported for unknown age or sex should be allocated to the age- and sex-disaggregated data cells using the same distribution of the data with known age and sex.
- Disaggregation by detailed age groups for children : <1 year, 1–4 years, 5–9 years and 10–14 years for children; and by detailed age sex groups for adults: 15–19 years, 20–24 years, 25–49 years and 50+ years.
- Numbers of people newly initiating antiretroviral therapy during the current reporting year. This disaggregation should only count people who were previously treatment naïve (had not previously been on antiretroviral therapy). These data should be available from the same sources as the total number of people receiving antiretroviral therapy.
- Numbers of people reinitiating antiretroviral therapy during the current reporting year after previously having stopped treatment or being classified as lost to follow-up. These data should be available from the same sources as the total number of people receiving antiretroviral therapy.

Additional information requested

More detailed age-specific data are requested for: (a) children; and (b) separately, by sex, for adults. The subset of people newly initiating antiretroviral therapy and reinitiating treatment during the last reporting year is requested.

If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided.

Strengths and weaknesses

This indicator monitors trends in antiretroviral therapy coverage in a comparable way across countries and over time. It does not, however, measure treatment cost, quality, effectiveness or adherence, which vary within and between countries and are likely to change over time.

The accuracy of the number of people on antiretroviral therapy will depend on the quality of the underlying reporting system. Numbers of people on antiretroviral therapy may be under-reported due to missing or delayed reporting of facility data to the national level. Numbers of people on antiretroviral therapy also may be over-reported as a result of not removing from registries people who stopped treatment, died, transferred facilities or were lost to follow-up. Other errors—such as incorrectly abstracting data from facility-based registries or completing reporting forms—can lead to over- and under-reporting to varying degrees of magnitude.

Further information

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach: Geneva: World Health Organization 2021. https://www.who.int/publications/i/item/9789240031593

2.3 People living with HIV who have suppressed viral loads

Percentage and number of adults and children living with HIV who have suppressed viral loads at the end of the reporting period

What it measures

Individual-level viral load is the recommended measure of antiretroviral therapy efficacy and indicates treatment adherence and the risk of transmitting HIV. A viral load threshold of <1000 copies/mL defines treatment success according to the 2016 World Health Organization (WHO) *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. People with viral load test results below the threshold should be considered as having suppressed viral loads.

Rationale

Viral suppression among people living with HIV provides a benchmark for monitoring global targets over time and a standardized indicator of HIV treatment and prevention success, critical to ending the AIDS epidemic. When considered as a proportion of the number of people on treatment (the numerator of Indicator 2.2), this indicator monitors the third 95 of the UNAIDS 95–95–95 targets: that 95% of the people receiving antiretroviral therapy will have suppressed viral loads by 2025.

Numerator

Number of people living with HIV in the reporting period with suppressed viral loads (<1000 copies/mL)

Denominator

Estimated number of people living with HIV (to estimate viral load suppression coverage);

OR

Estimated number of people living with HIV who are on treatment (to determine progress towards the third 95).

Calculation

Numerator/denominator

Note: Countries with a population of more than 250 000 will report on this indicator by broad age groups, in the Spectrum HIV estimates file. Results will be obtained directly from the final national Spectrum file, alongside all other Spectrum-estimated indicators. Reporting on sub-national data for the indicator will be done in the Global AIDS Monitoring reporting tool.

Method of measurement

Viral suppression is defined as <1000 copies/mL. Some countries use other thresholds (such as undetectable, <50 copies/mL or <400 copies/mL), and require adjustment for comparability with other countries and for monitoring the global 95-95-95 targets. UNAIDS recommends that countries adjust for lower threshold detection. This is done using the formula:

$$y^{\left(\frac{6-log\,(1000)}{6-log\,(t_1)}\right)^{\phi}}$$

In this instance, $\boldsymbol{y}$ is the standard (1000 copies/mL) viral suppression level, $\boldsymbol{t}_1$ is the country's alternative threshold that was used, and ϕ is the region-specific adjustment factor. This adjustment will be done automatically in Spectrum, where required.

Viral load suppression may be reported from three different data sources: (1) clinical and programme data; (2) nationally representative surveys (such as the Population-based HIV Impact Assessment [PHIA] and HIV drug resistance surveys); or (3) early warning indicators of HIV drug resistance surveys. Countries should report data from whichever source is most recent and nationally representative.

1. **Routine viral load suppression tests from people on antiretroviral treatment collected through clinical or laboratory registers or case surveillance.**
   For the numerator. Countries should report the estimated number of people nationally who have suppressed viral loads during the reporting period if viral load testing coverage (i.e., the number of people routinely tested during the reporting period, as per WHO guidance, among all people on treatment) is 50% or greater.

   Countries that report viral load testing coverage of less than 50% should, in contrast, only report the number of routine viral load tests – but not the number where the viral load is below the threshold, because this then is not a good, representative estimate for the overall population on treatment. Countries still wishing to use viral load result data despite viral load testing coverage below 50% should discuss with UNAIDS, to determine whether the percentage of people suppressed in the tested population can be considered representative for the population on ART with no access to testing.

   Countries should only include testing data that result from routine testing among those on treatment, and not targeted testing to a select subgroup of patients on treatment. For example, a person's results should not be included if testing was done prior to treatment initiation or for the reason of a suspected treatment failure. If viral load is tested repeatedly for a person within the year, only the last routine test result should be used.

   For countries where annual viral load testing coverage is 50% or over, an estimated number of people with suppressed viral loads should be reported. This is calculated from the number suppressed among those tested, multiplied by the total number of people on treatment. This assumes that levels of suppression in the untested population are the same as those in the tested population. This assumption is supported by evidence from South Africa, which shows that although viral load information was frequently missing, estimates of viral suppression did not change substantially after adjusting for missing data.

Example: A country with an estimate of 100 000 people living with HIV has routine viral load tests for 12 000 of the 24 000 people receiving antiretroviral therapy. The viral load testing coverage is 50%, and the country deems the level of viral load suppression in the untested population to be like that among the tested population of people on treatment. Of the 12 000 people tested, 10 000 people have suppressed viral loads. The estimated national number of people living with HIV who have suppressed viral loads is 20 000 [(10 000/12 000) x 24 000].

Where viral load suppression in the untested population on treatment is likely to not equal that in the tested population, please contact UNAIDS for further discussion about approaches for estimating this count.

For the denominator. Estimation models such as Spectrum are the preferred source for the number of people living with HIV. UNAIDS will work with countries to develop a Spectrum model that matches the estimate of people living with HIV if national estimates other than those produced through Spectrum are used.

For more information on estimating the number of people living with HIV who are on treatment, as part of calculating the third 95, please see Indicator 2.2.

2. **Recent nationally representative population surveys (including household, acquired HIV drug resistance surveys or early warning indicators (EWI) surveys of HIV drug resistance)**
For the numerator. The proportion reported to have suppressed viral loads among people testing positive in the survey should be multiplied by the total number of people estimated to be living with HIV nationally to obtain the total number of people who have a suppressed viral load. This value may slightly overstate the number of people who are virally suppressed among those on treatment, since it will include some people who are not on treatment but naturally suppress the virus. If using data from an acquired HIV drug resistance survey, either the 12- or 48-month cohort data may be used. Data from early warning indicators should only be used to generate national aggregate statistics if:

   a) all clinics in a country—or a random sampling of clinics—reported early warning indicators data that includes at least 70% of all people on ART from the sampled clinics.

   OR

   b) if convenience sampling of clinics was used, a national aggregate statistic can be reported if the data from the sampled clinics includes at least 70% of the eligible population on ART in the country (see page 8 of the Early Warning Indicators (EWI) annex – sampling guidance – see References below).

   Note: Countries using survey data should still report on the number of people on treatment with ***routine*** viral load tests during the reporting period. Survey data should only be used if conducted in both children and adults.

   For the denominator. Estimation models such as Spectrum are the preferred source for the number of people living with HIV. UNAIDS will work with countries to develop a Spectrum model that matches the estimate of people living with HIV if estimates other than those produced through Spectrum are used. For more information on estimating the number of people living with HIV who are on treatment as part of calculating the third 95 target, please see Indicator 2.2

Measurement frequency
Annually

Disaggregation
- 0–14 years for children and 15 years and older by sex (men and women) for adults; data reported for unknown age or sex should be allocated to the age and sex disaggregated data cells using the same distribution of the data with known age and sex. These adjustments should be noted in the box providing additional information.
- As available. Disaggregation by detailed age and sex: <1 year, 1–4 years, 5–9 years and 10–14 years for children and 15–19 years, 20–24 years, 25–49 years and 50+ years by sex (men and women) for adults; by gender (men, women, other gender) for adults.

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided.

Strengths and weaknesses
When viral load suppression testing data are collected from all people receiving antiretroviral therapy or a nationally representative sample, this measurement provides important information on adherence, treatment efficacy and transmission risk at the individual and programme levels. Despite the indicator's importance, several challenges may arise in accurately monitoring it using currently available programme data. First, because viral load monitoring capacity is being scaled up but remains limited in low-income settings, estimates of viral load suppression in the tested population may not be representative of the untested population when measured through programme data. This is especially the case if scale-up of testing is biased to higher or lower performing sites. By assuming that the levels of viral load suppression are the same in the tested and untested population when testing coverage is not complete, progress toward the 95–95–95 targets may be under- or overstated.

A second challenge arising from the currently available programme data is that viral load testing may be performed selectively to confirm suspected treatment failures. The data reported from the viral load testing of people suspected of treatment failure will underestimate population-level viral load suppression. UNAIDS recommends that countries closely review reported data to exclude targeted, non-routine testing.

A third challenge when using routine programme data is that viral load testing data are only reported for the subset of people who are on antiretroviral treatment. This may underestimate overall population-level suppression, since people not on treatment who naturally suppress the virus will not be included in the numerator. UNAIDS is examining available evidence from cohorts and population surveys to better quantify and adjust for this effect, when reporting on global and regional progress towards the third 95.

Further information

UNAIDS, WHO. Guidelines on monitoring the impact of the HIV epidemic using population-based surveys. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/si-guidelines-population-survey/en).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach Geneva: World Health Organization 2021. https://www.who.int/publications/i/item/9789240031593

Consolidated guidelines on person-centred HIV patient monitoring and case surveillance. Annex 2.4.6: HIVDR EWI sampling, abstraction and reporting guidance. Geneva: World Health Organization; 2017 (https://www.who.int/hiv/pub/guidelines/WHO_Consolidated_Guidelines_Annexes_2.4.6.pdf).

Pillay T, Cornell M, Fox MP, Euvrard J, Fatti G, Technau KG et al. Recording of HIV viral loads and viral suppression in South African patients receiving antiretroviral treatment: a multicentre cohort study. Antivir Ther. 2020;25(5): 257–266 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7982353/

2.4 Advanced HIV disease and late HIV diagnosis

Percentage and number of adults and children with CD4 cell count <200 cells/mm^3 (or <15%) at initial diagnosis or initiation/reinitiation of antiretroviral therapy during the reporting period

What it measures
People living with HIV identified to have a CD4 cell count <200 cells/mm^3, a criterion for advanced HIV disease.

Rationale
As countries scale up HIV services, it is important to monitor whether people living with HIV have advanced HIV disease. Advanced HIV disease is associated with substantially higher mortality and morbidity from HIV, opportunistic infections and comorbidities. It also identifies people who should receive the WHO recommended package of care for advanced HIV disease to help reduce the risk of poor outcomes.

Numerator
At initial HIV diagnosis or at initiation/re-initiation of antiretroviral therapy, the number of:
- Adults (aged ≥15 years) living with HIV with CD4 cell count <200 cells/mm^3 recorded at that time; and,
- Children aged 5–14 years living with HIV with CD4 cell count <200 cells/mm^3 or CD4 <15% recorded at that time; and,
- Children 0–59 months living with HIV.

Denominator
Number of people diagnosed with HIV for the first time or initiating/re-initiating antiretroviral therapy during the reporting period with:
- Adults (aged ≥15 years): a CD4 cell count recorded within one month of initial diagnosis or initiation/re-initiation of ART; and,
- Children aged 5–14 years: a CD4 cell count (or percentage) recorded within one month of initial diagnosis or initiation/re-initiation of ART;
- Children 0–59 months: all living with HIV.

Calculation
Numerator/denominator.

Method of measurement
Based on data from laboratory information systems and from the clinical records of people in treatment. Data can be compiled from health services registries, case report forms or laboratory information systems. People with CD4 count results should be included only if the CD4 test was conducted within 1 month of the time of initial diagnosis, initiation of antiretroviral therapy or reinitiation of antiretroviral therapy.

Measurement frequency
Annually.

Disaggregation
- Aged 0–14 years (disaggregated by ages 0–59 months and 5–14 years) for children, and aged ≥15 years by sex (men and women) for adults.
- First time diagnosis, versus initiation or reinitiation of antiretroviral therapy.

Explanation of the numerator
Adults living with HIV whose CD4 lymphocyte count was <200 cells/mm^3 at initial diagnosis, or at initiation/reinitiation of antiretroviral therapy in the reporting period.

All children aged under 5 years are considered to have advanced HIV disease at the time of initial diagnosis or upon reinitiation of antiretroviral therapy following a period of disengagement, and so disaggregation by CD4 cell count or percentage category is not requested.

Explanation of the denominator
Number of people living with HIV who had a CD4 lymphocyte count within 1 month of the time of diagnosis or initiation/ reinitiation of antiretroviral therapy in the reporting period.

Additional information requested
The total number of people who received a CD4 test at initial diagnosis or at initiation/reinitiation of antiretroviral therapy in four mutually exclusive CD4 cell count categories (<200 cells/mm^3, 200 to <350 cells/mm^3, 350 to <500 cells/mm^3, ≥500 cells/mm^3), and the total number of people newly diagnosed with HIV, and initiating and reinitiating ART during the reporting period are requested.

Data quality review for this indicator should consider the full CD4 distribution across all four CD4 categories, assessing completeness and mutual consistency, and as the coverage and representativeness of the CD4 measurements to represent all new diagnoses and all antiretroviral therapy (re-)enrolments.

Strengths and weaknesses
This indicator may not include all people diagnosed, initiated on antiretroviral therapy or reinitiated on antiretroviral therapy if there are substantial reporting delays in the diagnosis data or CD4 count test result (which may indicate a delay in linkage from diagnosis to care) or if CD4 count measurement is not routine and universal.

If the coverage of CD4 count measurement (of all new diagnoses, or of antiretroviral therapy enrolments and re-enrolments) is far below 100%, the results may not be representative for the full population of clients. If the country is not able to report CD4 results separately for people newly diagnosed, versus initiated on antiretroviral therapy and re-initiated on antiretroviral therapy, the CD4 results will be difficult to interpret.

2.5 HIV testing volume and positivity

The number of HIV tests conducted (testing volume) and the percentage of HIV-positive results returned to people (positivity) in the calendar year

What it measures
Trends in the uptake of HIV testing services, including through different modalities, and their effectiveness at identifying people living with HIV.

Rationale
Testing volume and data on positivity are useful for programme monitoring. Knowing the numbers of people tested annually and the modality of testing or uptake of self-tests is critical to commodity forecasting and staff resource planning. Positivity data among those tested who have received a result can help to validate the number of people reported as newly diagnosed through routine reporting systems and estimates of HIV prevalence from survey data. Finally, when disaggregated by age, sex, testing modality and HIV status, these data are useful in assessing the effectiveness of delivering HIV testing services and addressing gaps in various settings, contexts and populations.

In addition to programme monitoring activities, annual testing volumes and positivity rates are inputs into the UNAIDS model that estimates progress towards the first 95 (95% of people living with HIV know their HIV status). This model is used primarily in countries that have national surveys to measure the population's historic testing coverage by HIV serostatus, but weak HIV case reporting systems (see Indicator 2.1).

Numerator
Number of tests conducted where an HIV-positive result was returned to the person (positivity)

Denominator
Number of tests performed where results were received by the person (testing volume)

Calculation
Numerator/denominator

Method of measurement
The numerator and denominator should be collected from HIV testing services programme registers, log books and reporting forms on a quarterly or annual basis. Reported data should be a count of the number of tests conducted where results were returned to a person and not the number of unique persons who tested at least once during the calendar year. For example, if a person who is HIV-positive tests once at a mobile testing van and then again at a clinic during the same calendar year, they should be counted twice in the numerator and twice in the denominator. In an alternative scenario, if a person tests negative at a voluntary counselling and testing (VCT) centre and then positive through provider-initiated testing, she should be reported once in the numerator and twice in the denominator.

Please note that only tests conducted where the results are returned to the person should be counted. Also, a person should only be counted as testing once in the numerator and the denominator, even if up to three different assays are performed to confirm an HIV-positive diagnosis according to the national testing algorithm.

Please separately report numbers of self-test kits procured and distributed in the calendar year (where available). Procured self-test kits refers to the total number of self-test kits purchased (not distributed or used) in a year by the national government, including (but not limited to) donors. Test kits procured via other channels, such as the private sector, should not be counted; rather, they should be detailed in the comments. Self-test kits distributed refers to the total number of individual self-test kits that were distributed in a year; it is not the total number of people self-tested, nor is it the total number of people who received a self-test (as individuals may obtain more than one kit in a year). No sex- or age-disaggregation or information on positivity is required for self-test procurement or distribution data.

Measurement frequency
Annually

Disaggregation

- 0–14 years for children and 15 years and older by sex (men and women) for adults.
- Testing modality (for all populations including key population services).
  - Community-level HIV testing services reporting:
    - Mobile testing (e.g., through vans or temporary testing facilities).
    - Voluntary counselling and testing centres (not within a health-facility setting).
    - Other community-based testing.
  - Facility-level testing:
    - Provider-initiated testing in clinics or emergency facilities.
    - Antenatal care clinics (including labour and delivery).
    - Voluntary counselling and testing (within a health-facility setting).
    - TB clinic (if available)
    - Family planning clinic.
    - Other facility-level testing.

Note: If testing volume and positivity cannot be disaggregated by modality, please report overall numbers.

Additional information requested

Please provide information in the comments box about any national testing campaigns or shifts in testing strategies or practices that might explain changes to testing volumes when compared to previous years. People who test positive may seek additional confirmatory testing and people who are HIV-negative may test repeatedly during the year. If data on retesting among HIV-positive or HIV-negative individuals (volumes or rates/proportions) are available, please also provide this in the comments box.

Strengths and weaknesses

Not all countries have unique identifiers or underlying systems to deduplicate first and repeat testing among individuals nor to differentiate by HIV status of the person re-testing. As a result, this indicator is not directly comparable to knowledge of status (as measured in Indicator 2.1).

As HIV information systems evolve, it will be important to be able to disaggregate tests by previous testing history (e.g., people who have never been tested, people who were HIV-negative at their last test, and people who already know their HIV-positive status and are seeking or otherwise requiring confirmatory testing) as well as by the year of previous testing. In future years, this indicator could be extended to request this information so as to better understand testing patterns and capture the valid numbers of new diagnoses to better assess the effectiveness of HIV testing services.

Further information

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

2.6 Antiretroviral therapy coverage among people living with HIV in key populations (A–E)

Percentage of the people living with HIV in a key population receiving antiretroviral therapy in the past 12 months

This indicator is divided into five sub-indicators:

A. Antiretroviral therapy coverage among sex workers living with HIV

B. Antiretroviral therapy coverage among gay men and other men who have sex with men living with HIV

C. Antiretroviral therapy coverage among people who inject drugs living with HIV

D. Antiretroviral therapy coverage among transgender people living with HIV

E. Antiretroviral therapy coverage among people in prisons and other closed settings living with HIV

What it measures
Progress towards providing antiretroviral therapy to people living with HIV in key populations

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Rationale
Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among people living with HIV and to reduce the transmission of HIV. People living with HIV in key populations should be able to access mainstream services that provide antiretroviral therapy without fear of facing stigma or discrimination and to be able to receive care from health-care workers who have the clinical knowledge to meet their specific needs. Ideally, all of these mainstream services should meet the standards for becoming sensitized to the needs of key populations. Accordingly, antiretroviral therapy coverage is a crucial way of assessing access to mainstream services.

Numerator
Number of respondents living with HIV who report receiving antiretroviral therapy in the past 12 months

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Denominator
Number of respondents living with HIV

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys.

Measurement frequency
Every two years for behavioural surveys

Annual if special programme data are available

Disaggregation
A, C and E: Gender (female, male and transgender) **D:** gender (transman, transwoman, other)

A-E: Age (<25 and 25+ years)

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
This is an indicator that recognizes the importance of antiretroviral therapy and the need to achieve equity in access to ART. This has not been a standard question in biobehavioural surveys. It is, however, increasingly asked in surveys, including household surveys. Treatment programmes do not collect data on risk behaviour and therefore do not comprise a routine source for this information. Data on treatment distribution permit measurement of the second 95 of the 95–95–95 target and provide information to advocate for equity for treatment access for all key population communities.

It remains unclear how many people will respond accurately to this question in a survey. Additional analysis and research is required to assess the validity of the responses and to improve the elicitation of valid responses in the future.

Further information
WHO, CDC, UNAIDS, FHI 360. Biobehavioral survey guidelines for Populations at Risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/177992/9789241508995_eng.pdf?sequence=1).

2.7 AIDS mortality

Total number of people who have died from AIDS-related causes per 100 000 population

What it measures
Impact of HIV prevention, care and treatment programmes

Rationale
Efforts to scale up access to life-saving antiretroviral therapy, including the 2016 WHO guidelines that recommend treatment for all, should significantly reduce the number of people dying from AIDS-related causes, if these services are accessible and delivered effectively. The impact of the HIV response should be assessed by monitoring changes in AIDS-related mortality over time. This indicator, modified as the total number of people who have died from AIDS-related causes in the reporting period divided by the population (per 100 000), is also included in the WHO consolidated strategic information guidelines for HIV in the health sector.

Numerator
Number of people dying from AIDS-related causes during the calendar year

Denominator
Total population regardless of HIV status

Calculation
Numerator/denominator times 100 000

Method of measurement
The number of people dying from AIDS-related causes can be obtained using a variety of measures, including through a vital registration system adjusted for misreporting, as part of a facility- or population-based survey that may include verbal autopsy and through mathematical modelling using such tools as Spectrum. Modelling tools typically use demographic data, HIV prevalence from survey and surveillance, the number of people receiving antiretroviral therapy, HIV incidence and assumptions around survival patterns to estimate the number of people dying. In some instances, data from vital reporting systems and estimates of underreporting and misclassification also may be incorporated into these models to derive estimates of the number of AIDS-related deaths.

Measurement frequency
Annual

Disaggregation
- Sex.
- Age (<5, 5–14 and 15+ years).

Additional information requested
The source of the estimate is requested. Countries providing the number of people dying from AIDS-related causes derived from a source other than Spectrum should provide any accompanying estimates of uncertainty around this number and upload an electronic copy of the report describing how the number was calculated.

Countries should preferably report a modelled estimate rather than one derived from their vital registration system unless this system has been recently evaluated as one of high quality. Users can now opt to use their Spectrum estimate or enter nationally representative population-level data. If Spectrum estimates are chosen, the values will be obtained directly from the final national file.

Strengths and weaknesses
For countries with strong vital registration systems, changes in AIDS-related mortality estimates provide an accurate measure of the impact of prevention, care and treatment programmes. Even in these systems, periodic evaluation is useful to measure delays or underreporting and misclassification of the cause of death.

For countries that do not have strong systems in place, estimates of AIDS-related deaths are an important programme monitoring tool but subject to more uncertainty. In particular, information about survival patterns for those receiving or not receiving antiretroviral therapy is important. Estimates of AIDS-related deaths should be reported along with the ranges of uncertainty. The estimate will only be as reliable as the data entered into the models and the assumptions made in the model.

Further information
Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Spectrum software. Glastonbury (CT): Avenir Health; 2024 (https://www.avenirhealth.org/software-spectrum.php).

2.8 Management of cryptococcal infection

Percentage of people living with HIV with a CD4 count below 200 cells/mm^3 who were screened for, diagnosed with and treated for cryptococcal infection.

What it measures

This indicator measures the screening and treatment cascade for cryptococcal infection among people with advanced HIV disease: the proportion of people with CD4 count below 200 cells/mm^3 screened for cryptococcal infection; the proportion of people who screened positive for cryptococcal infection; and the proportion of people who were treated for cryptococcal infection among those who screened positive.

Rationale

To reduce AIDS-related deaths, HIV programmes must emphasize identification of people with advanced HIV disease, prevention of opportunistic infections, and treatment of opportunistic infections. Cryptococcal infections are responsible for substantial mortality and morbidity among people living with HIV, particularly in people with a CD4 cell count below 200 cells/mm^3 (advanced HIV disease). This indicator supports the surveillance of screening, diagnosis and treatment of cryptococcal infection, one of the most common opportunistic infections among people with advanced HIV disease.

Numerator

A. Number of people living with HIV with CD4 count below 200 cells/mm^3 with cryptococcal infection who received treatment.

B. Number of people living with HIV and CD4 count below 200 cells/mm^3 who tested positive for cryptococcal infection.

C. Number of people living with HIV and CD4 count below 200 cells/mm^3 who were tested for cryptococcal infection.

Denominator

A. Number of people living with HIV and CD4 count below 200 cells/mm^3 who tested positive for cryptococcal infection.

B. Number of people living with HIV and CD4 count below 200 cells/mm^3 who were tested for cryptococcal infection.

C. Number of people living with HIV with CD4 count below 200 cells/mm^3.

Calculation

Numerator A/Denominator A

Numerator B/Denominator B

Numerator C/Denominator C

Method of measurement

Based on data from laboratory information systems and from the records of people in treatment. Data can be compiled from health services registries, case report forms and laboratory information systems.

Data can include people with a CD4 test at or within 1 month of initial diagnosis, and also people with a repeat CD4 test at re-enrolment in care or at any time during antiretroviral therapy.

Measurement frequency

Annually.

Disaggregation

None.

Additional information requested

None.

Strengths and weaknesses

This indicator will improve surveillance of a key opportunistic infection, improve identification of people with advanced HIV disease, and contribute to understanding the causes of death among people living with HIV.

A weakness of this indicator is that only cryptococcal infection is monitored. Other common opportunistic infections, such as tuberculosis, histoplasmosis and *Pneumocystis jirovecii* infections, are not included.

Further information

Izco S, Garcia-Basteiro AL, Denning DW, Boulware DR, Penn-Nicholson A, Letang E. Management of advanced HIV disease in Africa. Lancet HIV. 2023;10(6):e358–e360.

Rajasingham R, Govender NP, Jordan A, Loyse A, Shroufi A, Denning DW, et al. The global burden of HIV-associated cryptococcal infection in adults in 2020: a modelling analysis. Lancet Infect Dis. 2022;22(12):1748–1755.

Guidelines for diagnosing, preventing and managing cryptococcal disease among adults, adolescents and children living with HIV. Geneva: World Health Organization; 2022 (https://www.who.int/publications-detail-redirect/9789240052178, accessed 15 October 2023).

Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241550062, accessed 12 October 2023).

3.1 HIV testing in pregnant women

Percentage of pregnant women with known HIV status

What it measures

Coverage of the first step in the prevention of vertical transmission cascade.[1] High coverage enables early initiation of care and treatment for HIV-positive mothers. The total number of identified HIV-positive women provides the facility-specific number of pregnant women with HIV to start a facility-based prevention of vertical transmission cascade.

Rationale

The risk of vertical transmission can be reduced significantly by: (a) providing antiretroviral medicines for the mother during pregnancy and delivery; (b) supplying antiretroviral prophylaxis for the infant and antiretroviral medicines for the mother or child during breastfeeding (if applicable); (c) instigating safe delivery practices and safer infant feeding.

Data will be used in the following ways: (a) to track progress towards global and national goals of eliminating vertical transmission; (b) to inform policy and strategic planning; (c) to contribute to advocacy efforts; and (d) to leverage resources for accelerated scale-up. It will help measure trends in coverage of antiretroviral prophylaxis and treatment, and when disaggregated by regimen type, will assess progress in implementing more effective regimens and antiretroviral therapy.

Numerator

Number of pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labour and/or delivery, or those who already knew they were HIV-positive at the first antenatal care visit.

Denominator

Population-based denominator: Number of pregnant women giving birth in the past 12 months.

Programme-based denominator: Number of pregnant women who attended an antenatal clinic or gave birth at a facility in the past 12 months.

Calculation

Numerator/denominator

Note: Countries with a population of more than 250 000 will report on this indicator within Spectrum. Global AIDS Monitoring users have the option to use their Spectrum estimate or to enter nationally representative population-level data. If Spectrum estimates are chosen, the values will be obtained directly from the final Spectrum file.

Method of measurement

Numerator: programme records, such as antenatal care registers or labour and delivery registers.

Population-based denominator: estimates from central statistics office, UN Population Division or vital statistics.

Facility-based denominator: programme records, such as antenatal care registers or labour and delivery registers.

Measurement frequency

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

Disaggregation

HIV status/test results:

- Known (positive) HIV infection at antenatal clinic entry.
- Tested HIV-positive at first antenatal care during current pregnancy, labour and/or delivery. This excludes women who already knew their HIV-positive status prior to current pregnancy.
- Tested HIV-negative at first antenatal care during current pregnancy, labour and/or delivery. This should be based on the latest test result in the case of repeat testing.

The sum of the above three counts should equal the number of women tested for HIV. The total identified HIV-positive women should equal the sum of known HIV-positive women at their first antenatal clinic entry plus those who tested HIV-positive at antenatal care during pregnancy, labour and/or delivery.

- Pregnant women who inject drugs.

Additional information requested

Look at trends over time: if disaggregated data are available by region, see whether any lower performing areas can be identified. Review if data are available on the percentage of antenatal care attendees who know their status, including those with previously confirmed HIV status and those tested and the percentage of labour and delivery attendees who know their status.

[1] In this document, vertical transmission includes transmission to the child that occurs during pregnancy, delivery or breastfeeding. "Vertical transmission" in this document is used as a neutral, non-stigmatising alternative to "mother-to-child" transmission.

Strengths and weaknesses

This indicator enables a country to monitor trends in HIV testing among pregnant women. The points at which dropouts 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.

Further information

Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis. Second edition. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/259517/9789241513272-eng.pdf;jsessionid=015C03A78EC01FA22E13641A3DE9B3E3?sequence=1).

3.2 Early infant diagnosis

Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth

What it measures
Progress in the extent to which infants born to women living with HIV are tested within the first two months of life to determine their HIV status and eligibility for antiretroviral therapy disaggregated by test results

Rationale
Infants acquiring HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. The World Health Organization (WHO) recommends that national programmes establish the capacity to provide early virological testing of infants for HIV at six weeks or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progresses rapidly among children; they need to start 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 virological test within two months of birth during the reporting period. Infants tested should only be counted once. The numerator should not include infants tested after two months.

Denominator
Number of pregnant women living with HIV giving birth in the past 12 months

Calculation
Numerator/denominator

Method of measurement
For the numerator. Early infant diagnosis testing from laboratories.

For the denominator. Estimation models such as Spectrum or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to the coverage of antenatal clinic surveys.

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

Global AIDS Monitoring users have the option to use their Spectrum estimate or to enter data for the denominator. If Spectrum estimates are chosen, the values will be obtained directly from the software once the national file is finalized.

Disaggregation
The numerator should be disaggregated by the result: positive, negative, indeterminate or rejected for testing.

Explanation of the numerator
To be collected from the databases held at early infant diagnosis testing laboratories. The numerator should represent the number of infants who received virological 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 databases. Where possible, double counting should be minimized when the data are aggregated to produce national-level data.

The number of infants receiving more than one virological test in the first two months of life is expected to be low. Efforts should be made to include all health facilities operated by public, private and nongovernmental organizations that are providing HIV testing for children with perinatal HIV exposure. Where antenatal care coverage, health facility deliveries and HIV screening in antenatal care and delivery are high and reporting is complete, program data can be used to triangulate with data from either source.

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

Explanation of the denominator
This is a proxy measure for the number of infants born to women living with HIV. Two methods can be used to estimate the denominator:

1. An estimation model, such as Spectrum software, using the output, the number of pregnant women needing services to prevent vertical transmission[1] as a proxy.
2. If Spectrum projections are unavailable, multiplying the total number of women giving birth in the past 12 months (which can be obtained from central statistics office estimates of births or United Nations Population Division estimates) by the most recent national estimate of HIV prevalence for pregnant women (which can be derived from HIV sentinel surveillance in antenatal clinics after appropriate adjustments related to the coverage of antenatal clinic surveys).

To ensure comparability, the Spectrum output will be used for the denominator for global analysis.

[1] In this document, vertical transmission includes transmission to the child that occurs during pregnancy, delivery or breastfeeding. "Vertical transmission" in this document is used as a neutral, non-stigmatising alternative to "mother-to-child" transmission.

Strengths and weaknesses

This indicator allows countries to monitor progress in providing early HIV virological testing to HIV-exposed infants two months or younger, which is critical for appropriate follow-up care and treatment. Limiting the age to two months or younger also eliminates the potential for repeat tests for the same infant, which can lead to double counting. The only three fields needed for this indicator—date of sample collection, age at collection (actual or calculated based on the date of birth) and results—are systematically entered into central early infant diagnosis testing databases at testing laboratories.

Because of the small number of testing laboratories and the electronic format of testing databases, this indicator should not have a heavy collection burden. The data quality of the laboratories is generally high, resulting in a robust indicator. The indicator does not capture the number of children with a definitive diagnosis of HIV infection or measure whether appropriate follow-up services were provided to the child based on interpretation of the test results. It also does not measure the quality of testing or 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 virological test kits, poor data collection, poor follow-up and mismanagement of testing samples.

Disaggregation by test results should not be used as a proxy for early vertical transmission rates. If early infant diagnosis testing coverage in the first two months of life is low, low positivity rates among the infants tested will not necessarily mean programme success, since this sample does not include infants who were not tested and who likely have higher transmission rates.

Although early virological testing is a critical intervention for identifying infants living with HIV, countries should also strengthen the quality of follow-up of HIV-exposed infants and train health providers to recognize the signs and symptoms of early HIV infection among exposed infants, especially if 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 the infants born to women living with HIV. Countries should ensure that appropriate systems and tools, especially tools for logistics management information systems, are in place to procure, distribute and manage supplies at the facility, district and central levels.

Additional information

The numerator for this indicator is a subset of the United States Government MER indicator on PMTCT Early Infant Diagnosis (PMTCT_EID). The MER indicator is disaggregated to include the number of children with an HIV outcome between 0 and two months and two and 12 months. The Global AIDS Monitoring indicator described here includes only those diagnosed by two months of age, and it uses a denominator of births to women living with HIV, including those women who were not in the prevention of vertical transmission programme.

Further information

MER indicator reference guide, version 2.7 [Internet]. Washington (DC): United States President's Emergency Plan for AIDS Relief (PEPFAR); 2023 (https://help.datim.org/hc/article_attachments/19439675645076).

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 (http://apps.who.int/iris/bitstream/10665/75478/1/9789241504362_eng.pdf).

3.3 Vertical transmission of HIV

Estimated percentage of children newly infected with HIV in the past 12 months due to vertical transmission[1]

What it measures

When compared with values from previous years, this indicator shows the impact of providing women with antiretroviral medicines and retaining them in care to reduce vertical transmission of HIV.

Rationale

Efforts have been made to increase access to interventions that can significantly reduce vertical transmission of HIV, including treatment regimens and strengthening counselling on infant feeding. The impact of interventions for preventing vertical transmission in reducing the number of children newly infected with HIV through vertical transmission needs to be assessed.

The percentage of children who are living with HIV should decrease as the coverage of interventions for preventing vertical transmission and the use of more effective regimens increase.

Numerator

Estimated number of children newly infected with HIV in the previous 12 months from vertical transmission (although the denominator is limited to births in the past 12 months, the numerator can include children infected by HIV during the breastfeeding period and thus the birth might have occurred more than 12 months earlier. The indicator is thus actually a ratio and not a true percentage.)

Denominator

Estimated number of births to women living with HIV in the previous 12 months

Calculation

Numerator/denominator

Method of measurement

Ideally, this indicator would be measured through programmes identifying HIV infection in young children. However, these programmes often are not able to identify infections among children of 1) women who seroconvert while they are pregnant or breastfeeding 2) women who do not continue in care during either antenatal or post natal services or 3) those women who never received services. Modelled estimates are used for global reporting in settings where final outcomes of vertical transmission at the population level are not available.

The probability of vertical transmission differs depending on the timing of initiating antiretroviral therapy, the antiretroviral drug regimen received and infant feeding practices. The transmission can be calculated using Spectrum. The Spectrum computer programme uses information on the following:

- The distribution of pregnant women living with HIV who are receiving antiretroviral medicines by the timing of treatment initiation (before conception, early in the pregnancy or late in the pregnancy).
- The proportion of pregnant women retained on antiretroviral medicines at the time of delivery.
- Estimated HIV incidence among pregnant women and breastfeeding women.
- The distribution of women receiving antiretroviral medicines after delivery (postpartum).
- Among women receiving antiretroviral medicines, the percentage whose infants have stopped breastfeeding by age of the child in months (from 0–35 months)
- Among women *not* receiving antiretroviral medicines, the percentage whose infants have stopped breastfeeding by age of the child in months (from 0–35 months)
- Among breastfeeding women receiving antiretroviral medicine, the percentage who drop out each month.
- Estimated incidence among breastfeeding women.
- Probabilities of vertical transmission of HIV based on various categories of antiretroviral medicine regimen and infant feeding practices.
- The estimated number of women living with HIV giving birth by age group.

The summary display for preventing vertical transmission in Spectrum reports the estimated national population-level transmission rate. This variable can also be calculated in Spectrum by dividing the number of children newly infected with HIV through vertical transmission by the number of women who need services for preventing vertical transmission.

Not enough information is available about other HIV transmission routes for children to include such infections in Spectrum. In addition, other modes of transmission are believed to cause a small fraction of the overall number of children acquiring HIV. The Spectrum output variable "new HIV infections for children 0–1 years" is not used because some children older than one year will acquire HIV from breastfeeding.

Global AIDS Monitoring users have the option to use their Spectrum estimate or to enter nationally representative population-level data. If Spectrum estimates are chosen, the values will be obtained directly from the software once the national file is finalized. If programme data are included, report the data based on equal birth cohorts for the numerator and denominator and not by the year of diagnosis.

Measurement frequency

Annually

[1] In this document, vertical transmission includes transmission to the child that occurs during pregnancy, delivery or breastfeeding. "Vertical transmission" in this document is used as a neutral, non-stigmatising alternative to "mother-to-child" transmission.

Disaggregation
None.

Additional information requested
This indicator is different from the United States Government MER indicator on PMTCT Final Outcome (PMTCT_FO), as the MER indicator is a cohort measure that does not capture child infections among women who seroconvert during breastfeeding or those who did not participate in (or who dropped out of) prevention of vertical transmission programmes. The denominator is also different: the MER indicator attempts to estimate the number of women who will seroconvert during breastfeeding.

Strengths and weaknesses
Strengths. Over time, this indicator assesses the ability of programmes to prevent vertical transmission. The modelled estimate is preferred as directly measuring this indicator is very difficult. The modelled estimate overcomes multiple challenges:

1. Following up mother–child pairs is difficult, especially at the 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 services for preventing vertical transmission and child care interventions delivered over a time span.
2. Children (especially those living with HIV) may die before they are tested to determine whether transmission has occurred.
3. A directly measured indicator will not capture women and their children who do not attend programmes, possibly because of high levels of stigma.
4. Most directly measured values will not include women who seroconvert while breastfeeding.

Weaknesses. This indicator is generated from a model that provides estimates of HIV infection among children. The estimated indicator is only as good as the assumptions and data used in the model. In countries where caesarean section is widely practised, the indicator will overestimate vertical transmission. It also relies on programme data that often capture the antiretroviral medicine regimens provided rather than those consumed and could therefore underestimate vertical transmission.

This indicator does not capture efforts to reduce the risk of vertical transmission by reducing the number of reproductive-age women acquiring HIV or by reducing unintended pregnancies among women living with HIV.

In countries in which data are available, facility attendance is high and confirmatory tests are conducted systematically, efforts should be made to monitor the impact by directly assessing the percentage of children living with HIV among those born to mothers living with HIV. All countries should make efforts to monitor the HIV status and survival of children born to women living with HIV, gathered during follow-up health-care visits.

Further information
Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

3.4 Preventing vertical transmission of HIV

Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of vertical transmission[1] of HIV

What it measures
Progress in preventing vertical transmission of HIV during pregnancy and delivery by providing antiretroviral medicine.

This indicator allows countries to monitor the coverage of initiation of antiretroviral medicines among pregnant women living with HIV to reduce the risk of transmitting HIV to infants during pregnancy and delivery and breastfeeding. Since the indicator usually measures the antiretroviral medicines dispensed and not those consumed, adherence to the regimen cannot be determined in most cases.

Rationale
Providing antiretroviral medicines to a woman living with HIV—either before conception or during pregnancy and during breastfeeding—can significantly reduce the risk of vertical transmission. This intervention is most effective if antiretroviral medicine is provided before conception and carefully adhered to throughout breastfeeding. This indicator can be used to: (a) track progress towards global and national goals of eliminating vertical transmission; (b) inform policy and strategic planning; (c) contribute to advocacy efforts; and (d) leverage resources for accelerating scale-up.

Numerator
Number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of vertical transmission of HIV. Global reports summarizing the coverage of antiretroviral medicine for preventing vertical transmission will exclude women who received single-dose nevirapine, since it is considered a suboptimal regimen. However, the country should report the number of women who only received single-dose nevirapine.

This count should include all women who delivered in the past 12 months, regardless of which year they started on antiretroviral medicines.

Denominator
Estimated number of women living with HIV 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 registries and summary reporting forms.

For the denominator. Estimation models such as Spectrum or antenatal clinic surveillance surveys combined with demographic data and appropriate adjustments related to the coverage of antenatal clinic surveys.

Measurement frequency
Annually or more frequently, depending on a country's monitoring needs.

Global AIDS Monitoring users have the option to use their Spectrum estimate or to enter data for the denominator. If Spectrum estimates are chosen, the values will be obtained directly from the software once the national file is finalized.

Disaggregation
The numerator should be disaggregated across the regimens described below.

Additional information requested
None.

Explanation of the numerator
The numerator should be disaggregated by the categories below. Each woman should only be counted once in one of the cells:

1. Newly initiated on antiretroviral therapy during the current pregnancy.
2. Already receiving antiretroviral therapy before the current pregnancy.
3. Other (please specify regimen).

[1] In this document, vertical transmission includes transmission to the child that occurs during pregnancy, delivery or breastfeeding. "Vertical transmission" in this document is used as a neutral, non-stigmatising alternative to "mother-to-child" transmission.

Disaggregation of regimen definitions

Categories	Further clarification	Common examples
The first two options include women receiving lifelong antiretroviral therapy (including Option B+): 1. Newly initiating treatment during the current pregnancy. 2. Already receiving treatment before the pregnancy.	A three-drug regimen intended to provide antiretroviral therapy for life: 1. Number of pregnant women living with HIV identified in the reporting period newly initiating lifelong antiretroviral therapy. 2. Number of pregnant women living with HIV who were already receiving antiretroviral therapy at their first antenatal clinic visit. If a woman initiates lifelong antiretroviral therapy during labour, she would be counted in Category 1. If the number of women receiving antiretroviral therapy is not available by the timing of when they started, the number can be included in the cell entitled "total number of pregnant women receiving lifelong antiretroviral therapy."	Standard national treatment regimen, for example: ▪ TDF + 3TC + EFV.

3. If another regimen that does not include lifelong therapy was provided, please enter the other regimen (using one of the options below) and the number of women receiving that alternative regimen.

Maternal triple antiretroviral medicine prophylaxis (prophylaxis component of World Health Organization (WHO) Option B during pregnancy and delivery)	A three-drug regimen provided for prophylaxis of vertical transmission 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 antiretroviral medicines 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.
Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	A prophylactic regimen that uses AZT (or another nucleoside reverse-transcriptase inhibitor (NRTI)) started as early as 14 weeks—or as late as during labour or delivery—to prevent HIV transmission. If a woman is receiving antiretroviral medicines 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 + intrapartum NVP. ▪ AZT at any point before labour + intrapartum NVP + 7-day postpartum tail of AZT + 3TC.
Single-dose nevirapine to the mother during pregnancy or delivery	▪ Count this if nevirapine is the only regimen provided to a pregnant woman living with HIV during pregnancy, labour or delivery. Do not count as single-dose nevirapine if: ▪ Nevirapine is provided as part of Option A during pregnancy. ▪ A pregnant woman living with HIV initiates Option A, B or B+ at labour and delivery.	▪ Single-dose nevirapine for mother only at onset of labour. ▪ Single-dose nevirapine + 7-day AZT + 3TC tail only. ▪ Single-dose nevirapine for mother at onset of labour and single-dose nevirapine for baby only.

Explanation of the denominator

Two methods can be used to estimate the denominator: an estimation model, such as Spectrum, using the output: the number of pregnant women needing services for preventing vertical transmission. This indicator is calculated as births to women living with HIV

Or, if Spectrum estimates are not available, by multiplying the number of women giving birth in the past 12 months (which can be obtained from estimates of the central statistics office, United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence among pregnant women (which can be derived from HIV sentinel surveillance in antenatal clinic and appropriate adjustments related to coverage of antenatal clinic surveys).

To ensure comparability, the Spectrum output will be used for the denominator for global analysis.

Strengths and weaknesses

Countries are encouraged to track and report the number of women receiving treatment by the timing of ART initiation so that the impact of antiretroviral medicines on vertical transmission of HIV can be modelled (see indicator 3.3 on vertical transmission rate). The numerator should be deduplicated to remove women attending multiple clinics over the course of the pregnancy.

Further information

The prevention of vertical transmission is a rapidly evolving programme area, and methods for monitoring coverage of this service are likewise evolving. To access information, please consult the following:

Publications on vertical transmission of HIV. Geneva: World Health Organization; c2024
https://www.who.int/initiatives/triple-elimination-initiative-of-mother-to-child-transmission-of-hiv-syphilis-and-hepatitis-b/validation

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

3.5 Syphilis among pregnant women

Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and were treated

What it measures

A. Percentage of women attending antenatal care services who received syphilis testing.

B. Percentage of women attending antenatal care services who received syphilis testing and who had a positive syphilis serology.

C. Percentage of women attending antenatal care services who had a positive syphilis serology and who were treated adequately.

Rationale

Testing (screening) coverage, the prevalence of syphilis in women attending antenatal care services, and treatment coverage are all key indicators for assessing a country's progress towards eliminating vertical transmission[1] of syphilis. At the country level, these data can be used to identify areas with the greatest need for comprehensive congenital syphilis prevention interventions. At the global level, these data are also used to estimate the perinatal mortality and morbidity caused by syphilis that could be averted with effective programmes to eliminate vertical transmission of syphilis.

A. Testing all pregnant women for syphilis early in pregnancy is important for the pregnant woman's health and that of the foetus. This indicator also contributes to monitoring the quality of antenatal care and services to prevent sexually transmitted infections (including HIV) among pregnant women.

B. The prevalence of syphilis in antenatal care attendees can be used to highlight areas within a country that require additional support, and it may provide early warning of potential changes in HIV and sexually transmitted infection transmission in the general population. The data are also an important source of information for generating national, regional and global incidence and prevalence estimates for syphilis and congenital syphilis.

C. Treating antenatal care attendees who test positive for syphilis is essential for reducing vertical transmission of syphilis.

Numerator

A. Number of women attending antenatal care services who were tested for syphilis.

B. Number of women attending antenatal care services who tested positive for syphilis.

C. Number of women attending antenatal care services with a positive syphilis test who received at least one dose of benzathine penicillin 2.4 million units intramuscularly.

Denominator

A. Number of women attending antenatal care services.

B. Number of women attending antenatal care services who were tested for syphilis.

C. Number of women attending antenatal care services who tested positive for syphilis.

Calculation

Numerator/denominator (for A, B and C, respectively)

Method of measurement

A. All pregnant women should be tested for syphilis at their first antenatal care visit. Ideally, countries will report on testing at every visit (including the first one). Countries unable to distinguish the first visit from testing at any visit should still report data on this indicator, but they should ensure that it is clearly reported as data for any visit. This indicator should be measured annually.

   Testing (screening) may be done using either a nontreponemal test (e.g., venereal disease research laboratory [VDRL] or rapid plasma reagin [RPR]) or a treponemal test (e.g., Treponema pallidum haemagglutination assay [TPHA], Treponema pallidum particle agglutination assay [TPPA], enzyme immunoassay or rapid treponemal test). For this indicator, having either type of test (treponemal or nontreponemal) is sufficient, although being tested with both is preferred.

   Ideally, national programme records aggregated from health-facility data should be used. However, if such data are not available, data from sentinel surveillance or special studies can be reported. Specify the source and coverage of your data (e.g., national programme data from all 12 provinces) in the comments section.

B. Syphilis positivity can either be a positive treponemal test, a reactive nontreponemal test or a combination of both. It is important to report the testing (screening) algorithm generally used in the country. The type of test is factored into data analysis. For this indicator (intended to measure seropositivity), reporting positivity based on a single test result is acceptable. If both treponemal and nontreponemal test results on an individual person are available, then syphilis positivity should be defined as having positive results in both tests.

   The following sources of data may be used: national programme records aggregated from health-facility data, sentinel surveillance or special surveys. In the comments section, specify the source and coverage of your data: for example, sentinel surveillance of all antenatal care attendees in two of 10 provinces.

   Countries are encouraged to use unique identifiers or registries that separate first and subsequent tests to avoid double counting and that reflect the true prevalence or incidence of syphilis rather than test positivity. Please specify the source and coverage of your data in the comments section.

C. Pregnant women with positive syphilis serology should be treated with benzathine penicillin, ideally on the same day as they are tested in order to prevent vertical transmission. For the purposes of this indicator, documentation of a single dose of penicillin is sufficient. Treatment of syphilis in pregnant women should be based on national treatment guidelines. Knowledge of treatment policies and practices should be used to interpret trends in treatment.

Please specify the source and coverage of your data in the comments section.

[1] In this document, vertical transmission includes transmission to the child that occurs during pregnancy, delivery or breastfeeding. "Vertical transmission" in this document is used as a neutral, non-stigmatising alternative to "mother-to-child" transmission.

Measurement frequency
Annual

Disaggregation
- Tested at any visit, tested at first visit.
- Age (15–24 and 25+ years).

Additional information requested
Please provide information on the type of test used most frequently at the first testing visit and whether a confirmatory test is done. If a confirmatory test is done, please state the proportion of women who receive a confirmatory test. Please also comment on whether the data you provide are deemed to be representative of the entire country and whether data from private providers of antenatal care are included in the data reported. Submit the digital version of any available survey reports using the upload tool.

If available, please provide data on the stage of pregnancy when a woman receives testing, and on the time between testing and treatment.

Strengths and weaknesses
Programmes that test pregnant women separately for syphilis and HIV should collaborate to align and enhance the effectiveness of their work. Preventing congenital syphilis requires testing early in pregnancy, since stillbirth may occur in the second trimester. Knowing that women are being tested late in pregnancy indicates that women are not accessing antenatal care early or that testing is not occurring early in pregnancy.

Knowledge of testing practices within the country (such as the proportion of treponemal versus nontreponemal testing used) and any changes over time are key to interpreting disease trends.

Further information
WHO guidelines on syphilis screening and treatment of pregnant women. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241550093).

Dual HIV/syphilis rapid diagnostic tests can be used as the first test in antenatal test. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/WHO-CDS-HIV-19.38).

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus. Geneva: World Health Organization; 2021 (https://iris.who.int/bitstream/handle/10665/349550/9789240039360-eng.pdf?sequence=1).

Framework for monitoring sexually transmitted infections and strengthening surveillance. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378238/9789240097674-eng.pdf?sequence=1).

Analysis and use of health facility data: guidance for maternal, newborn, child and adolescent health programme managers. Geneva: World Health Organization; 2023 (https://iris.who.int/bitstream/handle/10665/373826/9789240080331-eng.pdf?sequence=1).

Unemo M, Cole M, Lewis D, Ndowa F, Van Der Pol B, Wi T, editors. Laboratory and point-of-care diagnostic testing for sexually transmitted infections, including HIV. Geneva: World Health Organization; 2023 (https://iris.who.int/bitstream/handle/10665/374252/9789240077089-eng.pdf?sequence=1).

Updated recommendations for the treatment of Neisseria gonorrhoeae, Chlamydia trachomatis and Treponema pallidum (syphilis), and new recommendations on syphilis testing and partner services. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378213/9789240090767-eng.pdf?sequence=1).

3.6 Congenital syphilis rate (live births and stillbirth)

Reported congenital syphilis cases per 100 000 live births in the 12-month reporting period

What it measures
Progress in eliminating vertical transmission5 of syphilis

Rationale
Untreated syphilis infection in pregnancy can result in stillbirth, neonatal death and congenital disease (collectively defined as "congenital syphilis"). Untreated syphilis infection in pregnancy also increases the risk of vertical transmission of HIV. Given the high efficacy, appropriate simplicity and low cost of syphilis testing and treatment, global and regional initiatives to eliminate the vertical transmission of syphilis are well established. The rate of congenital syphilis is a measure of national surveillance and the impact of programmatic interventions to eliminate vertical transmission of syphilis.

Numerator
Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months

Denominator
Number of live births in the past 12 months

Calculation
Numerator/denominator

Method of measurement
Routine health information systems.

Measurement frequency
Annual

Disaggregation
None

Additional information requested
It is important to indicate in the comments section the case definition of congenital syphilis used in your country for reported cases. In particular, countries should note whether the reported data include stillbirths. Please comment on the extent to which the data are deemed representative of the national population. If a country is unable to report on the denominator, WHO will use the denominator from the United Nations Population Division.

Strengths and weaknesses
Diagnosing congenital syphilis is most reliable when specific diagnostic tests are used, but unfortunately these are seldom available. In most countries, therefore, diagnosis relies on clinical history of maternal testing and treatment and clinical examination of the infant, which makes surveillance challenging.

Given the difficulties in diagnosing congenital syphilis—and depending on the case definition used—underreporting and overreporting can be a problem. The likely magnitude of such reporting errors should always be considered when looking at rates of congenital syphilis over time.

Further information
Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus. Geneva: World Health Organization; 2021 (https://iris.who.int/bitstream/handle/10665/349550/9789240039360-eng.pdf?sequence=1).

3.7 Hepatitis B virus among pregnant women attending antenatal care services

Proportion of women attending antenatal care services who were tested for hepatitis B virus (HBV), found to be living with HBV, assessed for treatment eligibility and treated for HBV

What it measures

A. Percentage of women attending antenatal care services who were tested for HBV surface antigen (HBsAg).

B. Percentage of women attending antenatal care services who were tested for HBsAg and had a positive HBsAg test.

C. Percentage of women attending antenatal care services with a positive HBsAg test who receive additional testing for HBV DNA or, where this is not available, HBV envelope antigen (HBeAg).

D. Percentage of eligible women attending antenatal care services who were treated according to national policy, in line with World Health Organization (WHO) guidelines.

Rationale

A. Testing pregnant women for HBV in pregnancy is important for their own health, and it is also the first step in the prevention of mother-to-child transmission of HBV. Knowing the testing coverage contributes to quality assessment across the full scope of antenatal care services. This indicator also monitors programmatic targets used for validation in countries with a targeted HBV vaccination birth dose policy.

B. HBsAg positivity rate in antenatal care attendees can be used to monitor the prevalence of HBV in the population and give an indication of the HBV burden in pregnant women.

C. Additional testing for different HBV markers can identify women who are eligible for treatment where there is an increased risk of mother-to-child transmission of HBV that necessitates extra interventions.

D. Not all pregnant women who test positive for HBsAg are eligible for treatment to reduce the risk for mother-to-child transmission of HBV. Treatment coverage is a further measure of sustained service quality throughout antenatal care. This indicator also monitors programmatic targets used for validation in countries with a targeted HBV vaccination birth dose policy.

Numerator

A. Number of pregnant women attending antenatal care services who were tested for HBsAg.

B. Number of pregnant women attending antenatal care services who tested positive for HBsAg.

C. Number of pregnant women attending antenatal care services with a positive HBsAg who then received HBV DNA testing and/or HBeAg.

D. Number of pregnant women attending antenatal care services who met eligibility criteria and received antiviral treatment.

Denominator

A. Number of pregnant women attending antenatal care services.

B. Number of pregnant women attending antenatal care services who were tested for HBsAg.

C. Number of pregnant women attending antenatal care services who tested positive for HBsAg.

D. Number of pregnant women attending antenatal care services who were eligible for antiviral treatment.

Calculation

Numerator/denominator

Method of measurement

A. Ideally, national programme records aggregated from health-facility data should be used. However, if such data are not available, data from sentinel surveillance or special studies can be reported. In this case, please give the source and coverage of your data, and provide a comment on how far they are thought to be representative of the national situation.

B. The following sources of data may be used: national programme records aggregated from health-facility data, sentinel surveillance or special surveys that use serological tests. In the comments section, specify the source and coverage of your data: for example, sentinel surveillance of all antenatal care attendees in two of 10 provinces.

C. Ideally, national programme records aggregated from health-facility data should be used. However, if such data are not available, data from sentinel surveillance or special studies can be reported. In this case, please give the source and coverage of your data, and make a comment on how far they are thought to be representative of the national situation.

D. Not all pregnant women who are positive for HBsAg are eligible for treatment. Treatment eligibility is based on available supplementary tests (see the resources under "Further information"). Thus, treatment coverage is based on the number of pregnant women eligible for this treatment.

Measurement frequency

Data should be recorded daily, and reported quarterly to the national or subnational level. They should also be consolidated annually and reported to WHO.

Disaggregation
Age (15–24 and 25+ years)

Strengths and weaknesses
High indicator values indicate well-integrated services for antenatal care and the prevention of mother-to-child transmission of HBV.

Low indicator values suggest low uptake, availability or integration of testing and follow-up, but they do not provide an indication of where the problem lies.

Programme data will not provide information on key population access to services.

Specific points for the sub-indicators

A. Programmes should align antenatal testing for HBV, syphilis and HIV to enhance the effectiveness of their work.

B. Data on HBsAg positivity among pregnant women are not readily available in many of the most affected countries through routine health-system reporting. Knowledge of testing practices within the country should be used to interpret and compare disease trends.

C. Tests to identify eligibility for treatment and risk of mother-to-child transmission of HBV among antenatal care attendees are not always available or routinely monitored in health facilities.

D. Evaluating treatment coverage depends on the appropriate use of eligibility criteria.

Additional information requested
As per "Method of measurement" (above), please comment on whether the data you are providing are routine programme data deemed to be representative of the entire country.

Further information
Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: World Health Organization; 2015 (https://www.who.int/publications/i/item/policy-brief-prevention-care-treatment-persons-chronic-hep-b-WHO-HIV-2015-5).

Prevention of mother-to-child transmission of hepatitis B virus: guidelines on antiviral prophylaxis in pregnancy. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/333391/9789240002708-eng.pdf?sequence=1&isAllowed=y).

4.1 Physical and/or sexual violence experienced by key populations (A–D)

Percentage of people in a key population who report having experienced physical and/or sexual violence in the last 12 months

This indicator is divided into four sub-indicators:

A. Experience of physical and/or sexual violence among sex workers.

B. Experience of physical and/or sexual violence among gay men and other men who have sex with men.

C. Experience of physical and/or sexual violence among people who inject drugs.

D. Experience of physical and/or sexual violence among transgender people.

What it measures
Progress towards reducing physical and sexual violence among key populations

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Rationale
Globally, high rates of HIV infection among key populations—including sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people—have brought into sharp focus the problem of gender-based violence. There is growing recognition that deep-rooted, pervasive gender inequalities, reflected in gender-based violence, shape their risk of and vulnerability to HIV infection.

Violence and HIV have been linked through direct and indirect pathways, and studies in a range of countries indicate that many sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people have experienced violence in some form or another at some point in their lives. Violence has also been demonstrated to impede HIV prevention, care and treatment services among key populations.

Numerator
Number of people in a key population group (sex workers, gay men and other men who have sex with men, people who inject drugs or transgender people) who reported that either of the incidents happened to them at least once in the last 12 months

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Denominator
Total number of respondents from a key population group

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys. Indicators A–D are constructed from responses to the following questions among respondents who report belonging to a key population group (i.e., sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people).

- In the last 12 months, how many times has anyone physically hurt you, such as hit or choked you or threatened you with a knife or other weapon? (this has not happened in the last 12 months, once, 2–5 times, 6–10 times, 10 or more times, don't know, refuse to answer)

and/or

- In the last 12 months, how many times has someone tricked you, lied to you or threatened you in order to make you have sex when you didn't want to? (this has not happened in the last 12 months, once, 2–5 times, 6–10 times, 10 or more times, don't know, refuse to answer)

Measurement frequency
Every two years

Disaggregation
- **A, B, C, D:** age (<25 years, 25+years).
- **A and C:** gender (male, female, transgender)
- **D:** gender: transman, transwoman, other.

Additional information requested
Submit the digital version of any available survey reports using the upload tool. The report submitted with this indicator should include information on the sample size, quality and reliability of the data, and any related issues.

If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided.

Strengths and weaknesses

These indicators directly measure the experience of physical and/or sexual violence among key populations (i.e., sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people). The indicators are calculated from responses to two questions. The questions were developed by technical experts based on previously validated measures of violence among key populations. Changes in the indicator should be interpreted as follows: an increase in the prevalence indicates a rise in physical and/or sexual violence among key populations, signaling the need for mitigating actions, whereas a decrease in the prevalence indicates progress towards reducing violence against key populations.

Respondent-driven sampling (RDS) is used to implement integrated biobehavioural surveys. This sampling methodology allows researchers to access, in a systematic way, members of typically hard-to-reach populations who may not otherwise be accessible. Because RDS is a probability sampling method, researchers are able to provide unbiased population estimates and measure the precision of those estimates. RDS can be especially successful at rapid recruitment in dense urban environments, but in contexts where the hard-to-reach populations are not well-networked—or in contexts where the stigma associated with some key populations is severe—recruitment rates using RDS may be unpredictable.

Other disadvantages to using RDS relate to the difficulties that may arise when analyzing collected data. For instance, since RDS must take into account weighting for network size and recruitment patterns, the statistical strength of the sample as it applies to the target population decreases if participants only recruit people who share the same characteristics as themselves.

Further information

Buller AM, Devries KM, Howard LM, Bacchus LJ. Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. PLoS Med. 2014 (Mar);11(3):e1001609.

Bhattacharjee P, Morales G, Kilonzo T, Dayton R, Musundi R, Mbole J et al. Can a national government implement a violence prevention and response strategy for key populations in a criminalized setting? A case study from Kenya. J Intl AIDS Soc. 2018. 21(S5):e25122.

Deering KN, Amin A, Shoveller J, Nesbitt A, Garcia-Moreno C, Duff P et al. A systematic review of the correlates of violence against sex workers. Am J Public Health. 2014 (May);104(5):e42-e54.

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

4.2 Attitudes towards violence against women

The percentage of women and men aged 15 to 49 years who agree that a husband is justified in hitting or beating his wife for specific reasons

What it measures
Progress towards achieving gender equality

Rationale
Gender inequality continues to stand in the way of global goals to end AIDS by 2030. Inequitable gender norms that confine women and men to specific roles in society—together with gender disparities in education and employment—greatly limit HIV prevention strategies among women, girls, and gender and sexual minorities. Fear, experiences of violence and power imbalances in relationships also increase vulnerability to HIV among these groups, limiting their access to HIV services and reducing their adherence to HIV prevention or treatment technologies. This leaves them disproportionately affected by HIV. Scaling up programmes to increase gender equity and intensifying efforts to achieve gender equality is therefore critical for ending AIDS as a global public health threat by 2030.

Numerator
Number of respondents who agree with at least one of the statements

Denominator
Total number of respondents

Calculation
Numerator/denominator

Method of measurement
Population-based surveys. The indicator is constructed from responses to the following question among respondents:

In your opinion, is a husband justified in hitting or beating his wife in the following situations?

a. If she goes out without telling him? (yes, no, don't know)

b. If she neglects the children? (yes, no, don't know)

c. If she argues with him? (yes, no, don't know)

d. If she refuses to have sex with him? (yes, no, don't know)

e. If she burns the food? (yes, no, don't know)

The numerator included respondents who expressed agreement with one or more of the situations.

Measurement frequency
Every 3-5 years

Disaggregation
- Age (15–19, 20–24, 25–49 years).
- Gender (male, female).

Additional information requested
None

Strengths and weaknesses
This indicator indirectly assesses inequitable gender norms, which have been associated with a higher risk of HIV infection and violence. The indicator is calculated from responses to a validated question that has been asked for many years in population-based surveys. This indicator will be generalizable to adults within a given country, as it is based on data from a random sample of the general population. Changes in the indicator should be interpreted as follows: an increase in the prevalence indicates a rise in harmful gender norms that may indicate a widening of gender inequalities in a country, signaling the need for mitigating actions, whereas a decrease in the prevalence indicates progress towards achieving gender equality.

The indicator only examines one aspect of inequitable norms: attitudes about the appropriateness of physical abuse in marital relationships. It does not capture other inequitable gender norms among men and women (e.g., power in the relationship, control of financial resources and so on), nor does it capture inequitable norms towards sexual and gender minorities.

The list of reasons and/or wording of the reasons that justify hitting a wife may vary slightly between specific country surveys in order to better reflect the country context. In some countries, the questions are only asked of married women or married men.

Further information

Asaolu I, Alaofè H, Gunn JKL, Adu A, Monroy A, Ehiri J et al. Measuring women's empowerment in sub-Saharan Africa: exploratory and confirmatory factor analyses of the Demographic and Health Surveys. Front Psychol. 2018;9:994.

Das M, Ghosh S, Miller E, O'Connor B, Verma R. Engaging coaches and athletes in fostering gender equity: findings from the Parivartan program in Mumbai, India. New Dehli; 2012.

Hanmer L, Klugman J. Exploring women's agency and empowerment in developing countries: where do we stand? Feminist Economics. 2016;22(1):237-63.

Jennings L, Na M, Cherewick M, Hindin M, Mullany B, Ahmed S. Women's empowerment and male involvement in antenatal care: analyses of Demographic and Health Surveys (DHS) in selected African countries. BMC Pregnancy Childbirth. 2014;14(1):297.

Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Puren A et al. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ. 2008;337.

Kishor S, Subaiya L. Understanding women's empowerment: a comparative analysis of Demographic and Health Surveys (DHS) data. DHS Comparative Reports. No. 20. Calverton (MD): Macro International Inc; 2008 (https://dhsprogram.com/publications/publication-cr20-comparative-reports.cfm).

Pulerwitz J, Gottert A, Kahn K, Haberland N, Julien A, Selin A et al. Gender norms and HIV testing/treatment uptake: evidence from a large population-based sample in South Africa. AIDS Behav. 2019;23(Suppl 2):162-71.

For more on the methods and survey instruments for the Demographic and Health Survey and AIDS Indicator Survey, see: http://dhsprogram.com

4.3 Gender-responsiveness of HIV services

Percentage of health facilities providing gender-responsive HIV services

What it measures
Progress towards ensuring HIV services acknowledge and take specific actions to respond to the gender norms, roles and inequalities that impede HIV services.

Rationale
Gender-responsive approaches acknowledge and take specific actions to respond to the gender norms, roles and inequalities that impede HIV services.

In the context of HIV, gender-responsive approaches take into account gender-related drivers of HIV risk (e.g. harmful gender norms, unequal power dynamics, fear and risk of violence) and gender-related barriers to HIV services (e.g. decision-making power, differing service and support needs, gender-related discrimination) in their design, implementation and evaluation to ensure HIV services reach people of all genders.

Gender-responsive approaches do not seek to transform the social contexts (e.g. societal norms around gender) and structural contexts (e.g. discriminatory legal frameworks, inequitable hiring practices within institutions) that fuel gender inequalities.

Gender-responsive HIV services have been demonstrated to increase HIV testing, male engagement in HIV prevention services such as prevention of mother-to-child transmission, youth engagement in HIV services, and adherence to treatment. This indicator will provide feedback to the country and facilities surveyed on where improvements are needed.

Numerator
Number of health facilities providing gender-responsive HIV services.

Denominator
Total number of health facilities providing HIV services surveyed.

Calculation
Numerator/denominator.

Method of measurement
Checklist to assess the gender-responsiveness of HIV services completed by health facilities providing HIV prevention, treatment or care services. See the technical brief for this survey for additional information on survey implementation, including sampling.

Health facilities are considered to be providing gender-responsive HIV services if they reach a score of 75–100 on the checklist using the following scale:

0–25: limited gender-responsiveness.

26–50: working towards gender-responsiveness.

51–74: mostly gender-responsive.

75–100: gender-responsive.

Measurement frequency
Every 2 years.

Disaggregation
None

Additional information requested
None

Strengths and weaknesses
This indicator directly assesses the gender-responsiveness of HIV services from the perspective of health facilities. Gender-responsive approaches can support more equitable access to services. The checklist used to construct this indicator was developed based on literature review, with input from technical experts. The questions to construct the indicator assess agreement with various statements on services provided rather than measuring specific events. Social desirability bias may occur, leading to overreporting of gender-responsiveness of HIV services.

This indicator provides general information on the gender-responsiveness of HIV services, but it does not reflect how this may vary for different groups of clients, such as people from key populations. It is recommended that this indicator is analysed in conjunction with data on user perspectives or client feedback collected through other tools, which can be complementary and provide information to better understand how experiences may differ for people of different genders and gender identities, including people from key populations.

Analysis of data disaggregated by various facility characteristics, such as geographical location, type of facility (public/private), services (e.g. prevention, treatment, care and support, sexual and reproductive health), may provide further insights to inform programmes and policies.

Further information

Dovel K, Dworkin SL, Cornell M, Coates TJ, Yeatman S. Gendered health institutions: examining the organization of health services and men's use of HIV testing in Malawi. J Int AIDS Soc. 2020;23(Suppl 2):e25517.

Gupta GR, Oomman N, Grown C, Conn K, Hawkes S, Shawar YR, et al. Gender equality and gender norms: framing the opportunities for health. Lancet. 2019;393(10190):2550–2562.

Pettifor A, Lippman SA, Gottert A, Suchindran CM, Selin A, Peacock D, et al. Community mobilization to modify harmful gender norms and reduce HIV risk: results from a community cluster randomized trial in South Africa. J Int AIDS Soc. 2018;21(7):e25134.

Remme M, Siapka M, Vassall A, Heise L, Jacobi J, Ahumada C, et al. The cost and cost-effectiveness of gender-responsive interventions for HIV: a systematic review. J Int AIDS Soc. 2014;17(1):19228.

Basic steps in gender-responsive programming: integrating gender into HIV/AIDS programmes in the health sector. Geneva: World Health Organization; 2009 (https://www.ncbi.nlm.nih.gov/books/NBK143050/, accessed 7 November).

6.1 Discriminatory attitudes towards people living with HIV

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

What it measures
Progress towards reducing discriminatory attitudes and support for discriminatory policies

Rationale
Discrimination is a human rights violation 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, fueling the HIV epidemic. This indicator does not directly measure discrimination but rather measures discriminatory attitudes that may result in discriminatory acts (or omissions). One item in the indicator measures the potential support by respondents for discrimination that takes place at an institution and 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 HIV discrimination by: showing change over time in the percentage of people with discriminatory attitudes; allowing comparisons between national, provincial, state and more local administrations; and indicating priority areas for action.

Numerator
Number of respondents (15–49 years old) who respond no to either of the two questions

Denominator
Number of all respondents (15–49 years old) 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 to the following questions in a general population survey from respondents who have heard of HIV.

- 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 that 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 and 25–49 years)
- Gender (male, female)
- Responses for each question (based on the same denominator) are required as well as the consolidated response for the composite indicator

Explanation of the numerator
The respondents 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.

Yes and no responses to each question may not add up to 100% if any participants respond "don't know" or values are missing. Calculating the percentage of people responding "no" to this question by subtracting the percentage of yes responses from 100% would therefore be inaccurate.

Strengths and weaknesses

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

The question about buying vegetables is virtually identical to one used in a Demographic and Health Survey for monitoring "accepting attitudes" towards people living with HIV, enabling continued monitoring of trends. This question, however, focuses on "no" (discriminatory attitudes) rather than "yes" (accepting attitudes) responses, improving the previous measures for the "accepting attitudes" indicator, since it is applicable in settings with both high and low HIV prevalence and in high-, middle- and low-income countries and is 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 are rare and difficult to characterize and quantify in many contexts. Rather, the individual measures and the composite indicator assess an individual's attitudes, which may more directly influence behaviour.

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

Ideally, in addition to conducting surveys that measure the prevalence of discriminatory attitudes in a community, qualitative data should be collected to inform about the origins of discrimination. It would also be advisable to routinely collect data from people living with HIV on their experiences of stigma and discrimination via the People Living with HIV Stigma Index process (www.stigmaindex.org) and to compare the findings with the data derived from the discriminatory attitudes indicator.

Further information

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

Stangl A, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? J Int AIDS Soc. 2013;16(3 Suppl. 2) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833106/).

Thematic segment: non-discrimination. Background note. In: Thirty-first meeting of the UNAIDS Programme Coordinating Board, Geneva, 11–13 December 2012. Geneva: UNAIDS; 2012 (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121111_PCB%2031_Non%20Discrimination_final_newcoverpage_en.pdf).

For more on the methods and survey instruments for the Demographic and Health Survey and AIDS Indicator Survey: http://dhsprogram.com.

This indicator provides an important measure of prevalence of discriminatory attitudes towards people living with HIV. More completely assessing progress towards eliminating HIV-related stigma and discrimination and the success or failure of efforts to reduce stigma requires measuring other domains of stigma and discrimination.

6.2 Internalized stigma reported by people living with HIV

Percentage of people living with HIV who report internalized stigma

What it measures

Progress towards reducing internalized, also known as selfstigma among people living with HIV

Rationale

Internalized stigma, where people living with HIV cognitively or emotionally absorb negative messages or stereotypes about HIV and then apply these negative feelings to themselves, has been linked with the refusal to accept antiretroviral therapy among newly diagnosed people living with HIV. Internalized stigma also impedes antiretroviral therapy adherence among people living with HIV by compromising social support and adaptive coping, and it has been linked to lower viral suppression among people living with HIV who are taking antiretroviral therapy.

This indicator can be monitored as a measure of a key manifestation of HIV-related stigma among people living with HIV.

Numerator

Source: Population-based survey

Number of people living with HIV who report receiving a positive HIV test result and agreed with the statement

Or

Source: People Living with HIV Stigma Index

Number of respondents who agreed with the statement

Denominator

Source: Population-based survey

Number of respondents who report receiving a positive HIV test result

Or

Source: People Living with HIV Stigma Index

Number of all respondents

Calculation

Numerator/denominator

Method of measurement

Population-based surveys. This indicator is constructed from responses to the following question among respondents who report receiving a positive HIV test result.

- I have felt ashamed because of my HIV status (agree/disagree).

People Living with HIV Stigma Index study. This indicator is constructed from responses to the following question among respondents.

- I am ashamed that I am HIV-positive (agree/disagree/prefer not to answer).

Measurement frequency

Population-based surveys: every 3-5 years.

People Living with HIV Stigma Index study: every 2-3 years.

Disaggregation

- Age (15–19, 20–24, 25–49, and 50+). Data from People Living with HIV Stigma Index are from respondents aged 18 years and older.
- Gender (male, female, transgender, other, prefer not to say). The last three options are only available for data from People Living with HIV Stigma Index Version 2.0.
- Key population (gay men and other men who have sex with men, sex workers, transgender people, people who use drugs).

Additional information requested

None

Strengths and weaknesses

This indicator directly measures internalized stigma, an important manifestation of stigma that has been demonstrated to impede HIV care and treatment among people living with HIV. It is calculated from responses to a single question, which assesses internalized stigma among respondents living with HIV. The question is drawn from a validated measure of internalized stigma.

Changes in the indicator should be interpreted as follows: an increase in the prevalence indicates an increase in internalized stigma and a need for mitigating actions, whereas a decrease in the prevalence indicates progress towards and a reduction in internalized stigma.

Using population-based survey data to construct this indicator will enhance comparison across countries and contexts, as the indicator will be based on data from people who self-report living with HIV drawn from a random sample of the general public. This reduces potential response and selection biases that are possible when using a snowball sampling approach, as is done with the People Living with HIV Stigma Index. However, in countries where HIV prevalence is low, or where HIV stigma is very high, population-based surveys may not achieve large sample sizes of self-reported people living with HIV. In these instances, targeted studies like the People Living with HIV Stigma Index may be more appropriate.

Typically, internalized stigma is captured with a composite indicator composed of agreement with one of at least three items. As this indicator is based on responses to only one question, it is possible that internalized stigma may be underestimated, but the single item recommended to construct this indicator had the highest level of agreement of the three items previously validated together.

Further information

Hargreaves J, Pliakas T, Hoddinott G, Mainga T, Mubekapi-Musadaidzwa C, Donnell D et al. HIV stigma and viral suppression among people living with HIV in the context of universal test and treat: analysis of data from the HPTN 071 (PopART) trial in Zambia and South Africa. J Acquir Immune Defic Syndr. 2020;85(5):561-570 (https://pubmed.ncbi.nlm.nih.gov/32991336/).

Stangl AL, Lilleston P, Mathema H, Pliakas T, Krishnaratne S, Sievwright K et al. Development of parallel measures to assess HIV stigma and discrimination among people living with HIV, community members and health workers in the HPTN 071 (PopART) trial in Zambia and South Africa. J Int AIDS Soc. 2019;22(12):e25421 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6912047/).

For more on the methods and survey instruments for the Demographic and Health Survey and the AIDS Indicator Survey, see: http://dhsprogram.com

For more on the methods and survey instrument for the People Living with HIV Stigma Index, see: https://www.stigmaindex.org/

6.3 Stigma and discrimination experienced by people living with HIV in community settings

Percentage of people living with HIV who report experienced stigma and discrimination in the general community in the last 12 months

What it measures

Progress towards reducing experiences of stigma and discrimination among people living with HIV in community settings

Rationale

Stigma is a negative stereotype based on distinguishing characteristics, such as behaviour, gender or health status. It is a well-documented barrier to the HIV care continuum, creating gaps across the prevention and treatment cascades. HIV stigma results from a range of drivers and facilitators, including negative and judgmental attitudes towards people living with HIV, shame of an HIV-positive status, and social, cultural and gender norms. These manifest in a range of stigmatizing practices and experiences, including discrimination, that deny people living with HIV full social acceptance. This consequently deters them from accessing essential services and fueling social inequalities. Reducing HIV stigma and discrimination experienced by people living with HIV is critical for increasing uptake of and adherence to antiretroviral therapy and increasing viral suppression, all of which will improve health outcomes for people living with HIV.

Previous research suggests that it is import to measure community stigma separately from stigma experienced in health-care settings. This is due to the differing impacts of stigma experienced in these settings and the different programmatic responses needed to address them.

Numerator

Source: Population-based survey

- Number of people living with HIV who report receiving a positive HIV test result and who agreed that one or more of the three experiences happened to them because of their HIV status in the last 12 months.

Or

Source: People Living with HIV Stigma Index

- Number of respondents living with HIV who agreed that one or more of the eight experiences happened to them because of their HIV status in the last 12 months.

Denominator

Source: Population-based survey

- Number of respondents who report receiving a positive HIV test result.

Or

Source: People Living with HIV Stigma Index

- Number of all respondents.

Calculation

Numerator/denominator

Method of measurement

From population-based surveys: this indicator is constructed from responses to the following questions among respondents who report receiving a positive HIV test result.

- Please tell me if the following things have happened to you, or if you think they have happened to you, because of your HIV status in the last 12 months:
  - People have talked badly about me because of my HIV status (yes/no).
  - Someone else disclosed my HIV status without my permission (yes/no).
  - I have been verbally insulted, harassed, or threatened because of my HIV status (yes/no).

Or

From the People Living with HIV Stigma Index: this indicator can also be constructed from responses to the following questions among all respondents.

- Thinking about the last 12 months:
  - Have you felt excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Have you felt excluded from religious activities or places of worship because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Have you felt excluded from family activities because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Have you felt that family members have made discriminatory remarks or gossiped about you because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Has someone verbally harassed you (e.g., yelled, scolded or was otherwise verbally abusive) because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Has someone physically harassed you (e.g., pushed, hit or was otherwise physically abusive) because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Have you been refused employment or a work opportunity because of your HIV status? (yes, no, don't know, prefer not to answer)
  - Have you lost a source of income or job because of your HIV status? (yes, no, don't know, prefer not to answer)

Measurement frequency
Population-based surveys: every 3-5 years.

People Living with HIV Stigma Index study: every 2-3 years.

Disaggregation
- Age (15–19, 20–24, 25–49 and 50+ years). Data from People Living with HIV Stigma Index are from respondents aged 18 years and older.
- Gender (male, female, transgender, other, prefer not to say). The last three options are only available for data from People Living with HIV Stigma Index Version 2.0.
- Key population (gay men and other men who have sex with men, sex workers, transgender people, people who use drugs).

Additional information requested
None

Strengths and weaknesses
This indicator directly measures experienced stigma and discrimination in the community setting, an important manifestation of stigma that has been demonstrated to impede HIV care and treatment among people living with HIV.

This indicator is calculated from responses to three questions collected in population-based surveys. The questions are drawn from a validated measure of experienced stigma and discrimination. The indicator can also be constructed from eight questions included in the People Living with HIV Stigma Index 2.0. The alternative questions capture a broader range of stigmatizing experiences, use slightly different phrasing and have different response categories. However, they were recommended for inclusion in the People Living with HIV Stigma Index 2.0 by technical experts and should provide a good indication of the level of experienced stigma and discrimination in the absence of population-level data.

Changes in the indicator should be interpreted as follows: an increase in the percentage indicates an increase in experienced stigma and discrimination among people living with HIV in a community setting and the need for mitigating action, whereas a decrease in the percentage indicates progress and a reduction in experienced stigma and discrimination among people living with HIV.

Using population-based data to construct this indicator will enhance comparison across countries and contexts, as the indicator will be based on data from people who self-report living with HIV drawn from a random sample of the general public. This reduces potential response and selection biases that are possible when using a snowball sampling approach, as is done with the People Living with HIV Stigma Index 2.0. Selection bias is still a possibility, though, as the experiences of people living with HIV who are willing to self-report their HIV status in population-based surveys may be significantly different from those who choose not to self-report. In countries where HIV prevalence is low, or where HIV stigma is very high, population-based surveys may not achieve large sample sizes of self-reported people living with HIV. In these instances, targeted studies like the People Living with HIV Stigma Index 2.0 may be more appropriate.

The questions about experiences of stigma in the population-based survey focus mainly on verbal abuse and unwanted disclosure. Typically, measures of experienced stigma and discrimination include several items that capture different types of stigma in each of these settings, so it is possible that estimates of experienced stigma and discrimination may be underestimates. The questions about experiences of stigma from the People Living with HIV Stigma Index cover a wider range of experienced stigmas, including social exclusion, verbal abuse, physical harassment, refusal of employment and job loss. As such, constructing this indicator using data from the People Living with HIV Stigma Index 2.0 may provide a more robust indication of the level and types of experienced stigma and discrimination. However, the data are not generalizable beyond the people living with HIV sampled, as respondents are selected using snowball sampling versus random sampling methods.

Further information
Stangl AL, Lilleston P, Mathema H, Pliakas T, Krishnaratne S, Sievwright K et al. Development of parallel measures to assess HIV stigma and discrimination among people living with HIV, community members and health workers in the HPTN 071 (PopART) trial in Zambia and South Africa. J Int AIDS Soc. 2019;22(12):e25421 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6912047/).

For more on the methods and survey instruments for the Demographic and Health Survey and AIDS Indicator Survey, see: http://dhsprogram.com

For more on the methods and survey instrument for the People Living with HIV Stigma Index, see: https://www.stigmaindex.org/

6.4 Experience of HIV-related discrimination in health-care settings

Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings

What it measures
Progress in reducing HIV-related discrimination experienced by people living with HIV when seeking health-care services.

Rationale
Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. In the context of HIV, discrimination refers to unfair or unjust treatment of an individual (either through actions or by failure to act) based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, thus fueling the HIV epidemic.

Stigma is the attribution of undesirable characteristics to an individual or group that reduces their status in the eyes of society. It frequently drives experiences of discrimination. The indicator measures HIV-related discrimination experienced in health-care settings. HIV is often associated with a range of behaviours that are viewed as socially deviant or immoral, such as injecting drug use and sexual promiscuity. Because of these underlying societal beliefs, people living with HIV often are viewed as shameful and are thought to be responsible for having contracted HIV. This shaming process has repercussions beyond the individual because it greatly reduces incentives to be tested for HIV or, in the event the test result is positive, to disclose HIV status to sexual partners or family members.

The health sector is one of the main settings where people living with HIV—and those perceived to be living with HIV—experience discrimination. This indicator directly measures discrimination experienced by people living with HIV when seeking services in health-care settings.

The composite indicator can be monitored as a measure of the prevalence of HIV-related discrimination experienced in the health sector by people living with HIV. This indicator could provide further understanding of HIV-related health outcomes and improve interventions to reduce and mitigate HIV-related stigma and discrimination experienced along the treatment and care cascade by (a) showing change over time in the percentage of people living with HIV who experience discrimination in health-care settings and (b) indicating priority areas for action.

Numerator
Number of respondents who respond in the affirmative ("Yes") to at least one of the seven items per question.

Denominator
Number of all respondents

Calculation
Numerator/denominator

Method of measurement
People Living with HIV Stigma Index

Respondents of the study are asked if they experienced any of the following forms of HIV-related discrimination when seeking HIV and non-HIV-specific health services in the last 12 months:

- Denial of care due to HIV status.
- Advised not to have sex because of HIV status.
- Being the subject of gossip or negative talk because of HIV status.
- Verbal abuse because of HIV status.
- Physical abuse because of HIV status.
- Avoidance of physical contact because of HIV status.
- Sharing of HIV status without consent.

Measurement frequency
Every 2–3 years

Disaggregation
Responses for each question are required, as is the consolidated response for the composite indicator. The composite indicator can be disaggregated by the following:

- Type of health service (HIV, non-HIV).
- Gender (male, female, transgender, other, prefer not to say).
- Key population (gay men or other men who have sex with men, sex workers, transgender people, people who use drugs).
- Age group (18–19 years, 20–24 years, 25–49 years, 50+ years).
- Length of time knowing HIV-positive status (0–<1 years, 1–4 years, 5–9 years, 10–14 years, or 15+ years).

Explanation of the numerator

The proposed indicator combines 14 items that capture discrimination experienced by people living with HIV when seeking HIV care (seven items) and non-HIV care (seven items). During the 2016 consultation process to update the People Living with HIV Stigma Index survey, people living with HIV highlighted the importance of separately measuring discrimination experienced when seeking HIV and non-HIV care. In response, the new version of the survey asks about experiences of discrimination when seeking both HIV care and non-HIV care (whereas the original survey only asked about stigma experienced when seeking health services in general).

Strengths and weaknesses

This indicator directly measures experiences of discrimination among people living with HIV who sought health services.

The recommended questions assess whether specific forms of discrimination have been experienced in a health-care setting. The experience of discrimination may be dependent on whether the health-care provider is aware of the person's HIV status. Given this, disclosure of HIV status to the health-care provider should be collected whenever possible in order to help interpret the indicator.

In addition, people seeking HIV services at specialty HIV clinics may report fewer experiences of discrimination than people seeking HIV services that are integrated within general health-care services. Thus, capturing the type of clinic is recommended where possible. It also would be advisable to compare the findings from this indicator with Indicators 6.1 (Discriminatory attitudes towards people living with HIV) and 6.6 (Avoidance of health care among key populations) for a broader understanding of the stigma environment and the discrimination that can result in a given context.

Findings from this indicator should also be analysed in conjunction with the NCPI responses on programmes to address stigma and discrimination in health care and their scale, as well as programs to train health-care providers on human rights and medical ethics.

Further information

Mahajan AP, Sayles JN, Patel VA, Remien RH, Sawires SR, Ortiz DJ et al. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS. 2008;22(Suppl 2):S67–79.

Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? J Int AIDS Soc. 2009;12(1):15.

Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond. Geneva: UNAIDS; 2017 (http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf).

For more on the methods and survey instrument for the People Living with HIV Stigma Index, see: https://www.stigmaindex.org/

6.5 Stigma and discrimination experienced by key populations (A–D)

Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months

This indicator is divided into four sub-indicators:

A. Experience of stigma and discrimination among sex workers

B. Experience of stigma and discrimination among gay men and other men who have sex with men

C. Experience of stigma and discrimination among people who inject drugs

D. Experience of stigma and discrimination among transgender people

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What it measures
Progress towards reducing experiences of stigma and discrimination among key populations.

Rationale
Key population stigma is a negative stereotype based on an individual belonging to a key population group. Stigma is a well-documented barrier to the HIV care continuum, creating gaps across the prevention and treatment cascades, particularly for key populations including sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people. Key population stigma results from a range of drivers and facilitators, including: negative and judgmental attitudes towards key populations; shame related to an individual's occupation, drug use, or sexual and gender identity; and social, cultural and gender norms. These manifest in a range of stigmatizing practices and experiences, including discrimination, that deny key populations full social acceptance, consequently reducing their life chances, deterring access to essential services, and fuelling social inequalities.

Reducing HIV stigma and discrimination experienced by sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people is critical for increasing HIV testing, uptake of and adherence to antiretroviral therapy, and viral suppression, all of which will improve health outcomes for key populations.

Numerator
Number of people in the key population group (sex workers, gay men and other men who have sex with men, people who inject drugs or transgender people) who report that one or more of the three experiences has happened to them in the last 6 months because of their key population status.

Denominator
Total number of respondents from the key population group

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys. This indicator is constructed from responses to the following questions among respondents who report belonging to a key population group (i.e. sex workers, gay men and other men who have sex with men, people who inject drugs, and transgender people).

- Have you ever felt excluded from family activities because you [sell sex; have sex with men; inject drugs; are transgender]? (No, Yes, in the last 6 months, yes, but not in the last 6 months, don't know)
- Has someone ever scolded you because you [sell sex; have sex with men; inject drugs; are transgender]? (No, Yes, in the last 6 months, yes, but not in the last 6 months, don't know)
- Has someone ever blackmailed you because you [sell sex; have sex with men; inject drugs; are transgender]? (No, Yes, in the last 6 months, yes, but not in the last 6 months, don't know)

Measurement frequency
Every two years

Disaggregation
- **A, B, C, D:** age (<25 years, 25+years).
- **A and C:** gender (male, female, transgender).
- **D:** gender (transman, transwoman, other).

Additional information requested
Submit the digital version of any available survey reports using the upload tool. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided.

Strengths and Weaknesses

These indicators directly measure experienced stigma and discrimination among sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people, important manifestations of stigma that have been demonstrated to impede HIV prevention, care and treatment services among key populations. The indicators are calculated from responses to three questions. The questions were developed by technical experts based on previously validated measures of key population stigma and discrimination used in primary research studies. Changes in the indicator should be interpreted as follows: an increase in the percentage indicates an increase in experienced stigma and discrimimantion among key populations and a need for mitigating action, whereas a decrease in the percentage indicates progress and a reduction in experienced stigma and discrimination among key populations.

Respondent-driven sampling (RDS) is used to implement integrated bio-behavioral surveys. This sampling methodology allows researchers to access, in a systematic way, members of typically hard-to-reach populations who may not otherwise be accessible. Because RDS is a probability sampling method, researchers are able to provide unbiased population estimates as well as measure the precision of those estimates. RDS can be especially successful at rapid recruitment in dense urban environments. However, in contexts where the hard-to-reach populations are not well-networked, or in contexts where the stigma associated with some key populations is severe, recruitment rates using RDS may be unpredictable. Other disadvantages to using RDS relate to the difficulties that may arise when analyzing collected data. For instance, since RDS must take into account weighting for network size and recruitment patterns, the statistical strength of the sample as it applies to the target population decreases if participants only recruit people who share the same characteristics as themselves.

Further information

Friedland, B, Sprague, L, Nyblade, L, Baral, S, Pulerwitz, J, Gottert, A, et al. Measuring intersecting stigma among key populations living with HIV: implementing the people living with HIV Stigma Index 2.0. J Int AIDS Soc. 2018;21(S5):e2513.1 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055043/).

Stahlman, S, Hargreaves, J, Sprague, L, Stangl, A, Baral, S. Measuring sexual behavior stigma to inform effective HIV prevention and treatment programmes for key populations. JMIR Public Health Surveill. 2017;3(2):e23. (https://publichealth.jmir.org/2017/2/e23/).

Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

6.6 Avoidance of health care among key populations because of stigma and discrimination (A–D)

Avoidance of health care among key populations because of stigma and discrimination

This indicator is divided into four sub-indicators:

A. Avoidance of health care by sex workers because of stigma and discrimination.

B. Avoidance of health care by gay men and other men who have sex with men because of stigma and discrimination.

C. Avoidance of health care by people who inject drugs because of stigma and discrimination.

D. Avoidance of health care by transgender people because of stigma and discrimination.

What it measures
Progress towards reducing discriminatory attitudes and support for discriminatory policies in health-care settings.

Rationale
Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. In the context of HIV, discrimination refers to unfair or unjust treatment of an individual (either through actions or by failure to act) based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, thus fueling the HIV epidemic. HIV-related stigma refers to negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g., the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, gay men and other men who have sex with men and transgender people. In addition to HIV-related stigma, people from key populations experience further discrimination because of the stigma relating to same-sex attraction and sexual behaviour, engagement in sex work, drug use and non-conforming or diverse gender expression.

This indicator is important for providing a measure of the proportion of members of key populations who have avoided accessing general health-care services, due to fear of stigma and discrimination. Related reasons for avoiding such services may include (but are not limited to) the following: a lack (or perceived lack of) confidentiality within health-care settings; negative attitudes and behaviours among health-care providers; and fears of disclosing or hinting at individual behaviours and sexual preference/orientation.

Data related to the avoidance of health-care services are important in measuring the proportion of key populations who are not fulfilling their basic health-care needs (such as routine medical check-ups) and thus may be less likely to attend health-care settings for more specialized services and care (such as HIV testing, treatment and medical care).

This indicator is important for understanding and addressing the barriers to achieving the 95–95–95 targets among members of key populations. Data from this indicator directly measure fear of stigma or discrimination. This indicator could provide further understanding and improve interventions in reducing HIV stigma and discrimination by (1) showing change over time in the percentage of people who fear experiencing stigma, (2) enabling comparisons between national, provincial, state and more local administrations, and (3) indicating priority areas for action.

Numerator
Number of respondents who reported having avoided seeking healthcare in the last 12 months.

Avoidance of services due to fear of stigma and discrimination may be asked in different ways across countries/surveys.

Denominator
Number of respondents

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys

Measurement frequency
Every two years

Disaggregation
- **A–D:** Age (<25 and 25+ years).
- **A and C:** Gender (female, male and transgender).
- **D:** gender (transman, transwoman, other)

Additional information requested
Please provide the questions included in the survey instruments.

If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. Submit the digital version of any available survey reports using the upload tool.

Strengths and weaknesses
As a measure of stigma and discrimination, this indicator focuses on the outcomes of such behaviour. If perceived or experienced stigma and discrimination is sufficiently severe enough to dissuade people from seeking necessary health services, not only can it readily be identified as a problem, but it also affects critical service uptake. Some respondents, however, may experience and perceive important stigmatizing and discriminatory behaviour in their communities but, because of their own resilience or discrete or specialized services, may still seek out services. The indicator is not going to measure achieving zero discrimination but can inform on whether discrimination is reducing service uptake.

Further information
Global HIV Strategic Information Working Group. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

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. Geneva UNAIDS; 2012 (https://files.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121111_PCB%2031_Non%20Discrimination_final_newcoverpage_en.pdf#:~:text=the%20broad%20theme%20of%20%E2%80%9Cnon-discrimination%E2%80%9D:%20populations%20at%20higher%20risk%20with).

Confronting discrimination: Overcoming HIV-related stigma and discrimination in health-care settings and beyond. Geneva: UNAIDS; 2017 (http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf, accessed 21 November 2017).

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 (https://www.icrw.org/wp-content/uploads/2017/07/STRIVE_stigma-brief-A4.pdf).

Stangl A, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? J Int AIDS Soc. 2013;16(3 Suppl. 2). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833106/pdf/JIAS-16-18734.pdf

6.7 People living with HIV seeking redress for violation of their rights

Proportion of people living with HIV who have experienced rights abuses in the last 12 months and have sought redress

What it measures
Progress towards upholding the rights of people living with HIV

Rationale
The existence of formal and informal redress mechanisms, and mechanisms for accessing affordable legal support services, are critical to ensuring that people living with HIV and key populations are able to access justice in the event that their rights are not upheld. However, availability does not necessarily equal use. It is important to capture the percentage of people living with HIV and key populations who are availing themselves of such services in order to identify potential challenges to access or acceptability of these mechanisms, including geographical location, sociodemographics or key population status.

Numerator
Number of respondents who experienced one or more rights abuses in the last 12 months and reported seeking redress

Denominator
Total number of respondents who reported having experienced one or more rights abuses in the last 12 months

Calculation
Numerator/denominator

Method of measurement
People Living with HIV Stigma Index. The indicator is calculated based on responses to a series of questions that first assess whether rights abuses have occurred in the last 12 months. Those who reported that rights abuses did occur in the past 12 months are asked if they tried to do anything about the matter, with those who answer "yes" asked specifically about what they did.

The indicator is constructed based on the response to the following question:

- If yes, what did you try to do about the matter?
  - Filed a complaint (yes/no).
  - Contacted a lawyer (yes/no).
  - Contacted a government official or politician (yes/no).
  - Spoke out publicly (yes/no).
  - Contacted a community organization/network of persons living with HIV for support (yes/no).
  - Other (please specify).

Agreement with any of these response options would constitute seeking formal or informal redress.

Measurement frequency
Every 2-3 years

Disaggregation
- Age group (18–19 years, 20–24 years, 25–49 years, 50+ years).
- Key population (gay men or other men who have sex with men, sex workers, transgender people, people who use drugs).
- Gender (male, female, transgender, other, prefer not to say).
- Type of redress sought (**formal** = filed a complaint and/or contacted a lawyer; **informal** = contacted a politician, spoke out publicly and/or contacted a community organization/network of persons living with HIV for support; or **other** = other).

Additional information requested
None

Strengths and weaknesses

This indicator directly captures whether people living with HIV have sought redress following rights abuses experienced in the last 12 months.

Changes in the indicator should be interpreted as follows: an increase in the percentage indicates progress towards ensuring that redress mechanisms are available and utilized in response to rights abuses, whereas a decrease in the percentage indicates a reduction in redress sought after rights abuses and suggests the need for interventions to ensure availability, access to, use and effectiveness of redress mechanisms.

Such data will provide important information on whether people living with HIV are accessing available legal support services, and if they are using formal or informal redressal mechanisms that are in place in country. The indicator does not capture whether a resolution to the rights abuse was achieved. While they are indicative of redress sought by people living with HIV in a given country or context, the data used to calculate the indicator are not generalizable beyond the people living with HIV sampled, as respondents to the People Living with HIV Stigma Index are selected using snowball sampling (versus random sampling methods).

Further information

Evidence for eliminating HIV-related stigma and discrimination: guidance for countries to implement effective programmes to eliminate HIV-related stigma and discrimination in six settings. Geneva: UNAIDS; 2020 (https://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-guidance_en.pdf).

For more on the methods and study instrument for the People Living with HIV Stigma Index, see: https://www.stigmaindex.org/

6.8 Discriminatory attitudes towards people living with HIV among health facility staff

Percentage of health facility staff who report discriminatory attitudes towards people living with HIV

What it measures
Progress towards reducing negative attitudes towards people living with HIV among health facility staff.

Rationale
An individual driver of HIV stigma and discrimination in health-care settings is attitudes and opinions of health facility staff towards people living with HIV. Measuring stereotypes and prejudices among health facility staff towards people living with HIV is important. Values and attitudes may affect whether a provider treats clients with dignity; may affect the health-care options offered to people, for example which people are offered testing, and when and how people are offered testing; and may lead to inaccurate risk assessment.

Numerator
Number of health facility staff who agree with any of the first three statements and/or disagree with the fourth statement.

Denominator
Number of all health facility staff who answered at least one statement.

Calculation
Numerator/denominator.

Method of measurement
Any type of facility-based survey, such as the Service Provision Assessment, quality assurance surveys, or the Health Policy Project Measuring HIV Stigma and Discrimination among Workers in Health Facilities Questionnaire. The indicator is constructed from responses to the following question:

Do you strongly agree, agree, disagree or strongly disagree with the following statements?

A. Most people living with HIV do not care if they infect other people.

B. People living with HIV should feel ashamed of themselves.

C. People get infected with HIV because they engage in irresponsible behaviours.

D. Women living with HIV should be allowed to have babies if they wish.

The numerator includes respondents who agree or strongly agree with any of statements A–C and/or disagree or strongly disagree with statement D.

The questions recommended for the construction of this indicator were selected from a longer, 25-item tool that has been validated in health-care settings in several countries.[1]

Measurement frequency
Every 3–5 years.

Disaggregation
None.

Additional information requested
None.

[1] Measuring HIV stigma and discrimination among health facility staff. Washington, DC: Futures Group, Health Policy Project; 2013 (http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=49).

Strengths and weaknesses

This indicator directly assesses discriminatory attitudes towards people living with HIV among health facility staff, which has been linked with poorer engagement in care and poorer adherence to treatment among people living with HIV. Each item included in this indicator captures an important aspect of stigma that can be shifted or improved through intervention:

"Most people living with HIV do not care if they infect other people" aims to capture the level of blame from staff associated with "spreading" HIV in the community.

"People get infected with HIV because they engage in irresponsible behaviours" is related to the perception of a person's responsibility for their infection. It captures the assumption that people are to blame for contracting HIV or contracted HIV because they were irresponsible with their health. Identifying this perception among providers is important. Based on assumptions about a person's responsibility or ability to adhere to treatment, this perception can influence clinical decisions, and lead providers to not offer the preferred course of treatment.

"People living with HIV should feel ashamed of themselves" taps into an emotional component of stigma.

"Women living with HIV should be allowed to have babies" is aimed at assessing views on the reproductive rights of women living with HIV.

This indicator can be subject to social desirability bias, which occurs when respondents provide what they perceive to be the "correct" or "acceptable" response rather than what they actually believe, leading to underreporting of stigma. Even with the potential for this type of response bias, field-testing showed high levels of stigmatizing attitudes across these four statements and across countries. This suggests the observed stigma levels would be even higher in the absence of response bias. The use of self-administered rather than interviewer-administered questionnaires may reduce social desirability bias by providing a greater sense of anonymity.

Research has shown that respondents who skip these types of question, including due to discomfort with the question, will answer at least one question if several questions measuring the same stigma domain are provided. By offering four questions, if a respondent has a stigmatizing response to at least one of the items, the respondent is included in the numerator and denominator. Using a range of questions helps to reduce missing data and social desirability on this indicator.

Further information

Carr D, Kidd R, Fitzgerald M, Nyblade L. Achieving a stigma-free health facility and HIV services: resources for administrators. Washington, DC: Futures Group, Health Policy Project; 2015 (https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf, accessed 7 November 2023).

Measuring HIV stigma and discrimination among health facility staff. Washington, DC: Futures Group, Health Policy Project; 2013 (http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=49, accessed 16 November 2013).

Krishnaratne S, Bond V, Stangl A, Pliakas T, Mathema H, Lilleston P, et al. Stigma and judgment towards people living with HIV and key population groups among three cadres of health workers in South Africa and Zambia: analysis of data from the HPTN 071 (PopART) Trial. AIDS Patient Care STDs. 2020;34(1):38–50.

Sampling manual for facility surveys for population, maternal health, child health and STD programs in developing countries. Chapel Hill, NC: MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill; 2001 (https://www.measureevaluation.org/resources/publications/ms-01-03.html, accessed 7 November 2023).

Nyblade L, Addo NA, Atuahene K, Alsoufi N, Gyamera E, Jacinthe S, et al. Results from a difference-in-differences evaluation of health facility HIV and key population stigma-reduction interventions in Ghana. J Int AIDS Soc. 2020;23(4):e25483.

Nyblade L, Stockton M, Giger K, Bond V, Ekstrand ML, Lean RM, et al. Stigma in health facilities: why it matters and how we can change it. BMC Med. 2020;17(25):25.

Nyblade L, Jain A, Benkirane M, Li L, Lohiniva AL, McLean R, et al. A brief, standardized tool for measuring HIV-related stigma among health facility staff: results of field testing in China, Dominica, Egypt, Kenya, Puerto Rico and St. Christopher & Nevis. J Int AIDS Soc. 2013;16(Suppl 2):18718.

Siraprapasiri T, Srithanaviboonchai K, Chantcharas P, Suwanphatthana N, Ongwandee S, Khemngern P, et al. Integration and scale-up of efforts to measure and reduce HIV-related stigma: the experience of Thailand. AIDS. 2020;34(Suppl 1):S103–S114.

Srithanaviboonchai K, Stockton M, Pudpong N, Chariyalertsak S, Prakongsai P, Chariyalertsak C, et al. Building the evidence base for stigma and discrimination-reduction programming in Thailand: development of tools to measure healthcare stigma and discrimination. BMC Public Health. 2017;17(1):245.

Stangl A, Lilleston P, Mathema H, Pliakas T, Krishnaratne S, Sievwright K, et al. Development of parallel measures among people living with HIV, community members and health workers in the HPTN 071 (PopART) trial in Zambia and South Africa. J Int AIDS Soc. 2019;22(12):e25421.

6.9 Discriminatory attitudes towards people from key populations among health facility staff (A–D)

Percentage of health facility staff who report discriminatory attitudes towards people from key populations

This indicator is divided into four subindicators:

A. Discriminatory attitudes towards sex workers.

B. Discriminatory attitudes towards gay men and other men who have sex with men.

C. Discriminatory attitudes towards people who inject drugs.

D. Discriminatory attitudes towards transgender people.

What it measures
Progress towards reducing negative attitudes towards people from key populations among health facility staff.

Rationale
Attitudes and opinions of health-care staff towards people from key populations are a driver of HIV stigma and discrimination in health-care settings. Globally, many people from key populations, including gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs, experience negative attitudes and harmful actions in health-care settings, which undermines their health and ability to lead a productive life.

Administrators and health facility staff worldwide have shown that stigma and discrimination can be addressed successfully. Stigma-reduction efforts in Brazil, China, Ghana, India, Thailand, the United Republic of Tanzania and Viet Nam have resulted in significant changes in attitudes and practices of health facility staff, and improved care for people from key populations. Asking about provider preferences related to service provision can help to understand discriminatory attitudes towards people from key populations.

Numerator
Number of respondents who agreed with the stigmatizing statement.

Denominator
Total number of respondents.

Calculation
Numerator/denominator.

Method of measurement
Any type of facility-based survey, such as the Service Provision Assessment, quality assurance surveys, or the Health Policy Project Measuring HIV Stigma and Discrimination Among Workers in Health. Facilities Questionnaire. The indicator is constructed from responses to the following question:

Please tell us if you strongly agree, agree, disagree or strongly disagree with the following statement:

A. If I had a choice, I would prefer not to provide services to sex workers.

B. If I had a choice, I would prefer not to provide services to men who have sex with men.

C. If I had a choice, I would prefer not to provide services to people who inject drugs.

D. If I had a choice, I would prefer not to provide services to transgender people.

The numerator includes respondents who agree or strongly agree with the statement.

The questions recommended for the construction of this indicator were selected from a 25-item tool validated in health facility settings in several countries.[1]

Measurement frequency
Every 3–5 years.

Disaggregation
None

Additional information requested
None.

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[1] Measuring HIV stigma and discrimination among health facility staff. Washington, DC: Futures Group, Health Policy Project; 2013 (http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=49).

Strengths and weaknesses

This indicator directly assesses discriminatory attitudes towards people from key populations among health facility staff, which has been linked with poorer engagement in care and reduced adherence to treatment. The questions used to construct these indicators are included in the Health Policy Project Measuring HIV Stigma and Discrimination Among Workers in Health. Facilities Questionnaire, which is typically implemented as part of an intervention to achieve stigma-free health facilities and HIV services. The tool has been validated in six countries.

This indicator may be subject to social desirability bias if respondents provide what they perceive to be the "correct" or "acceptable" response rather than what they actually believe, leading to underreporting of stigma. This suggests the observed stigma levels would be higher in the absence of response bias. The use of self-administered rather than interviewer-administered questionnaires may reduce social desirability bias by providing a greater sense of anonymity.

Further information

Carr D, Kidd R, Fitzgerald M, Nyblade L. Achieving a stigma-free health facility and HIV services: resources for administrators. Washington, DC: Futures Group, Health Policy Project; 2015 (https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf, accessed 7 November 2023).

Krishnaratne S, Bond V, Stangl A, Pliakas T, Mathema H, Lilleston P, et al. Stigma and judgment towards people living with HIV and key population groups among three cadres of health workers in South Africa and Zambia: analysis of data from the HPTN 071 (PopART) Trial. AIDS Patient Care STDs. 2020;34(1):38–50.

Sampling manual for facility surveys for population, maternal health, child health and STD programs in developing countries. Chapel Hill, NC: MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill; 2001 (https://www.measureevaluation.org/resources/publications/ms-01-03.html, accessed 7 November 2023).

Nyblade L, Stockton M, Giger K, Bond V, Ekstrand ML, Lean RM, et al. Stigma in health facilities: why it matters and how we can change it. BMC Med. 2020;17(25):25.

Nyblade L, Jain A, Benkirane M, Li L, Lohiniva AL, McLean R, et al. A brief, standardized tool for measuring HIV-related stigma among health facility staff: results of field testing in China, Dominica, Egypt, Kenya, Puerto Rico and St. Christopher & Nevis. J Int AIDS Soc. 2013;16(Suppl 2):18718.

Stangl A, Lilleston P, Mathema H, Pliakas T, Krishnaratne S, Sievwright K, et al. Development of parallel measures among people living with HIV, community members and health workers in the HPTN 071 (PopART) trial in Zambia and South Africa. J Int AIDS Soc. 2019;22(12):e25421.

6.10 Discriminatory attitudes towards people from key populations among police (A–D)

Percentage of police who report discriminatory attitudes towards people from key populations

This indicator is divided into four subindicators:

A. Discriminatory attitudes towards sex workers.

B. Discriminatory attitudes towards gay men and other men who have sex with men.

C. Discriminatory attitudes towards people who inject drugs.

D. Discriminatory attitudes towards transgender people.

What it measures

Progress towards reducing negative attitudes towards people from key populations among police.

Rationale

People from key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people, often face stigma and discrimination from the police, which heightens their risk of HIV infection. Physical and sexual abuse, harassment, blackmail from police and prison guards, and wrongful arrest and imprisonment have been reported by people from key populations in various settings.

Several research projects and case studies have shown that we cannot end AIDS as a public health threat when the people most affected are excluded from equal access to services. To reduce and mitigate the stigma and discrimination experienced by people from key populations in justice settings, there is a need to routinely measure the attitudes and practices of police officers towards people from key populations to inform interventions.

Duty-bearers such as politicians, lawmakers, police officers and lawyers can be positive agents of change with regard to stigma and discrimination and access to justice, and can be trained and supported to fulfil this critical role.

Numerator

A. Number of respondents who report discriminatory attitudes by responding "yes" to at least one of items 1–4 and/or "no" to at least one of items 5–7

1. It is OK to physically assault people who sell sex.
2. Sex workers are less deserving of police assistance and protection than other people.
3. It is appropriate to scold or verbally insult sex workers.
4. Confiscating the condoms of sex workers is acceptable.
5. Sex workers have the same right to access public spaces as everyone else.
6. Sex workers deserve to be treated with respect.
7. I should investigate the crimes reported by sex workers.

B. Number of respondents who report discriminatory attitudes by responding "yes" to at least one of items 1–4 and/or "no" to at least one of items 5–7

1. It is OK to physically assault gay men and other men who have sex with men.
2. Gay men and other men who have sex with men are criminals.
3. I do not trust the word of a gay men and other men who have sex with men reporting crimes.
4. It is appropriate to scold or verbally insult gay men and other men who have sex with men.
5. Gay men and other men who have sex with men have the same right to access public spaces as everyone else.
6. Gay men and other men who have sex with men deserve to be treated with respect.
7. I should investigate the crimes reported by gay men and other men who have sex with men.

C. Number of respondents who report discriminatory attitudes by responding "yes" to at least one of items 1–4 and/or "no" to at least one of items 5–7

1. It is OK to physically assault people who inject drugs.
2. People who inject drugs are less deserving of police assistance and protection than other people.
3. It is appropriate to scold or verbally insult people who inject drugs.
4. People who report or assist a person who is overdosing should be arrested or detained.
5. People who inject drugs have the same right to access public spaces as everyone else.
6. People who inject drugs deserve to be treated with respect.
7. I should investigate the crimes reported by someone who inject drugs.

D. Number of respondents who report discriminatory attitudes by responding "yes" to at least one of items 1–5 and/or "no" to at least one of items 6–7

1. It is OK to physically assault transgender people.
2. Transgender people are less deserving of police assistance and protection than other people.
3. I do not trust the words of transgender people reporting crimes.
4. It is appropriate to scold or verbally insult transgender people.
5. It is acceptable to force transgender people to dress as their original sex if they are arrested.
6. Transgender people have the same right to access public spaces as everyone else.
7. Transgender people deserve to be treated with respect.

Denominator
Total number of respondents.

Calculation
Numerator/denominator.

Method of measurement
Police attitudes towards key populations survey. The indicators are constructed from responses to seven items. Some items are similar across the four key populations, and others are population-specific. See the technical brief for this survey for additional information on survey implementation, including sampling.

Measurement frequency
Every 3–5 years.

Disaggregation
- Gender (male, female, other).

Additional information requested
None.

Strengths and weaknesses
This indicator directly assesses discriminatory attitudes towards people from key populations among police, which has been linked with heightened risk of HIV, poorer access to services, and reduced adherence to HIV treatment. The questions were developed with input from technical experts on key population stigma and discrimination, pretested with police officers reflecting a range of ranks, and piloted and validated with police officers in South Africa.

The recommended questions assess agreement with hypothetical situations rather than measuring events of discrimination witnessed. Social desirability bias may therefore occur, leading to underreporting of discriminatory attitudes.

Ideally, in addition to conducting surveys that measure the prevalence of discriminatory attitudes among police, qualitative data should be collected to inform about the origins of discrimination. It is also advisable to routinely collect data from people from key populations on their experiences of stigma and discrimination (e.g. via biobehavioural surveys), and to compare the findings with the data derived from the discriminatory attitudes indicator.

Analysis of data disaggregated by various characteristics of police officers surveyed, including gender, age and rank, may provide further insights to inform programmes.

Further information
Amon JJ, Sun N, Iovita A, Jurgens R, Csete J. Addressing stigma is not enough. Health Hum Rights. 2022;24(2):111–114.

Carr D, Kidd R, Fitzgerald M, Nyblade L. Achieving a stigma-free health facility and HIV services: resources for administrators. Washington, DC: Futures Group, Health Policy Project; 2015 (https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf, accessed 6 November 2023).

Decker MR, Lyons C, Guan K, Mosenge V, Fouda G, Levitt D, et al. A systematic review of gender-based violence prevention and response interventions for HIV key populations: female sex workers, men who have sex with men, and people who inject drugs. Trauma Violence Abuse. 2022;23(2):676–694.

Footer K, Silberzahn B, Tormohlen K, Sherman S. Policing practices as a structural determinant for HIV among sex workers: a systematic review of empirical findings. J Int AIDS Soc. 2016;19(4 Suppl 3):20883.

Nick GA, Williams S, Lekas HM, Pahl K, Blau C, Kamin D, et al. Crisis Intervention Team (CIT) training and impact on mental illness and substance use-related stigma among law enforcement. Drug Alcohol Depend Rep. 2022;5:100099.

Polonsky M, Azbel L, Wegman M, Izenberg JM, Bachireddy C, Wickersham JA, et al. Pre-incarceration police harassment, drug addiction and HIV risk behaviours among prisoners in Kyrgyzstan and Azerbaijan: results from a nationally representative cross-sectional study. J Int AIDS Soc. 2016;19(4 Suppl 3):20880.

Schneiders M, Weissman A. Determining barriers to creating an enabling environment in Cambodia: results from a baseline study with key populations and police. J Int AIDS Soc. 2016;19(4 Suppl 3):20878.

Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/978-92-4-151301-2, accessed 7 November 2023).

7.1 Viral hepatitis among key populations

Prevalence of hepatitis and coinfection with HIV among key populations

What it measures
Comorbidity with HIV and potential need for appropriate treatment

Rationale
Appreciation of hepatitis and HIV coinfection has improved recently. Many people living with HIV receiving antiretroviral therapy are dying from liver disease resulting from untreated viral hepatitis. HIV treatment regimens can be adjusted to treat chronic hepatitis B infection as well. New, highly effective hepatitis C treatment is available and has a high rate of virus clearance regardless of hepatitis C virus subtype. Measuring the hepatitis burden among key populations living with HIV can help national planners determine the resources needed to address the syndemic.

Numerator
Number of people in a key population who test positive for antibody to hepatitis C virus

or

Number of people in a key population who test positive for hepatitis B surface antigen

and

Number of people in a key population who also test positive for HIV together with one of the above

Denominator
Number of respondents tested for both HIV and one or both of hepatitis B and C

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys

Measurement frequency
Every two years

Disaggregation
- For people who inject drugs: Age (<25 and 25+ years).
- For people who inject drugs: Gender (male, female and transgender).
- Key population (sex workers, gay men and other men who have sex with men and transgender people).

Additional information requested
If the testing algorithm is available for hepatitis C screening, please include this information, especially if complementary or PCR testing is conducted.

Strengths and weaknesses
Probability-based estimates of coinfection with HIV and hepatitis C virus or HIV and hepatitis B virus among key populations are generally unavailable, although several biobehavioural surveys have conducted hepatitis antibody testing. Improving knowledge about coinfection will help to improve treatment programmes and help to maximize the survival of the affected populations. The numbers of people coinfected are likely to be small, with the possible exception of people who inject drugs, so the confidence intervals will be large.

Further information
Global HIV Strategic Information Working Group. 2017. Biobehavioural survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, UNAIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization et al. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017 (https://www.unodc.org/documents/hiv-aids/publications/Implementing_Comprehensive_HIV_and_HCV_Programmes_with_People_Who_Inject_Drugs_PRACTICAL_GUIDANCE_FOR_COLLABORATIVE_INTERVENTIONS.pdf#:~:text=Implementing%20comprehensive%20HIV%20and%20HCV%20programmes%20with%20people%20who%20inject).

7.2 Management of viral hepatitis C

Percentage of people living with HIV on antiretroviral therapy who were tested for, diagnosed with and treated for chronic hepatitis C virus (HCV) infection

What it measures

This indicator measures the testing and treatment cascade for chronic HCV infection among people living with HIV on antiretroviral therapy: the proportion of people tested for chronic HCV infection; the proportion of people diagnosed with chronic HCV infection; and the proportion of people initiated on HCV treatment among those diagnosed with chronic HCV infection.

The indicator monitors trends in HCV testing, a critical intervention for assessing needs related to managing chronic HCV infection. HCV testing provides information on the prevalence of HIV and HCV coinfection, informing clinicians on the need for further clinical and laboratory evaluation and treatment.

Rationale

Measuring the hepatitis burden among people living with HIV and in populations at risk can help national planners determine the resources needed to address both HIV and HCV. Testing for HCV coinfection among people living with HIV can inform clinicians on the need for further clinical and laboratory evaluation and the need to adapt treatment. The prevalence of HCV coinfection is especially high among people living with HIV who inject drugs.

Many people living with HIV and receiving antiretroviral therapy die from liver disease resulting from untreated chronic HCV. Testing people living with HIV for HCV identifies HIV and HCV coinfection and allows for adaptation of treatment. Highly effective HCV treatment with a high rate of virus clearance, regardless of subtype, is available.

WHO currently recommends treatment for all people with chronic HCV to achieve HCV cure. This indicator measures progress towards providing treatment to all people living with HIV coinfected with chronic HCV.

Numerator

A. Number of people living with HIV on antiretroviral therapy who were tested for HCV using the recommended testing sequency (anti-HCV followed by HCV RNA or HCV antigen) during the reporting period.

B. Number of people living with HIV on antiretroviral therapy who have been diagnosed with chronic HCV infection[1] (positive HCV RNA (PCR) or HCV core antigen) by the end of the reporting period.

C. Number of people living with HIV on antiretroviral therapy diagnosed with chronic HCV infection who have initiated HCV treatment by the end of the reporting period.

Denominator

A. Number of people living with HIV on antiretroviral therapy during the reporting period.

B. Number of people living with HIV on antiretroviral therapy who were tested for HCV using the recommended testing sequency (anti-HCV followed by HCV RNA or HCV antigen) during the reporting period.

C. Number of people living with HIV on antiretroviral therapy and coinfected with chronic HCV who have been diagnosed with a positive HCV RNA (PCR) or HCV core antigen by the end of the reporting period.[2]

Calculation

Numerator A/Denominator A

Numerator B/Denominator B

Numerator C/Denominator C

Method of measurement

The numerator and denominator are calculated from clinical records of health-care facilities providing HIV treatment and care.

Measurement frequency

Annual.

Disaggregation

- People who inject drugs.
- People newly enrolled on antiretroviral therapy.

Additional information requested

None.

[1] Chronic HCV infection is defined as the presence of viraemia (HCV RNA or HCV core antigen) in association with positive serology for HCV antibodies.

[2] All people already diagnosed with HCV infection but who have been treated and cured or who have spontaneously cleared the infection would be excluded.

Strengths and weaknesses

People who are anti-HCV positive have serological evidence of past or present infection. People who are anti-HCV positive must be tested for HCV RNA (which detects HCV circulating in the blood) to differentiate resolved infections from current infections that require treatment.

This indicator monitors progress in HCV testing and treatment activities on a regular basis. It does not reflect the overall proportion of people coinfected with HIV and HCV on antiretroviral therapy who are aware of their HCV coinfection.

This indicator also monitors access to HCV treatment for people living with HIV on antiretroviral therapy coinfected with HCV. The weakness is that it reflects only one year of activity. Describing the cumulative effect of people coinfected with HIV and HCV starting treatment requires compiling cumulative data on the number of people starting treatment and accounting for people newly infected with HCV and reinfected with HCV in the denominator.

Collecting information on past or current injecting drug use allows reporting of disaggregated data for people who inject drugs. Recording information on stigmatized and commonly criminalized behaviours such as drug use poses a risk where an individual can be identified. Efforts must be made to ensure patient records and registers avoid disclosing information that would permit identification of individuals engaged in stigmatized or criminalized behaviours.

Further information

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Updated recommendations on treatment of adolescents and children with chronic HCV infection, and HCV simplified service delivery and diagnostics. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240052734).

Consolidated guidelines on person-centred viral hepatitis strategic information: using data to support country scale-up of hepatitis prevention, diagnosis and treatment services. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240091313).

7.3 Syphilis prevalence among key populations (A, B, D)

Prevalence of syphilis in specific key populations

This indicator is divided into three sub-indicators:

A. Syphilis prevalence among sex workers.

B. Syphilis prevalence among gay men and other men who have sex with men.

D. Syphilis prevalence among transgender people.

What it measures
Progress towards reducing syphilis prevalence among key populations

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Rationale
The prevalence of syphilis is typically much higher in key populations than in the general population. Reducing the prevalence of syphilis among key populations is important for the health of the populations and also a critical measure of the national-level response to syphilis.

The increasing use of rapid tests for testing (screening) individuals for syphilis has increased access to syphilis testing in settings that were previously without capacity. As a result, this indicator has been expanded to syphilis prevalence rather than focusing solely on active syphilis.

Testing for syphilis in key populations is a component of second-generation HIV surveillance.

Numerator
Number of people in a key population who test positive for syphilis

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Denominator
Number of people in a key population tested for syphilis

Calculation
Numerator/denominator

Method of measurement
This indicator is calculated using data from syphilis tests conducted among respondents in sentinel site(s) or participants in biobehavioural surveys or regular sexually transmitted infection screening services. The sentinel surveillance sites used for calculating this indicator should remain constant to allow for tracking changes over time.

Screening may be done with either a nontreponemal test (e.g., venereal disease research laboratory [VDRL] or rapid plasma reagin [RPR]) or a treponemal test (e.g., Treponema pallidum haemagglutination assay [TPHA], Treponema pallidum particle agglutination assay [TPPA], enzyme immunoassay or rapid treponemal test). While nontreponemal serologic tests are sensitive, they lack specificity and can result in false positive cases. Treponemal tests are more specific, but cannot differentiate between current and past infection or treated and untreated infection. For the purpose of this indicator (intended to measure seropositivity), reporting positivity based on a single test result is acceptable. However, if both treponemal and nontreponemal test results for an individual person are available, then syphilis positivity should be defined as having positive results on both tests. Countries are required to report the testing algorithm used to determine positivity so prevalence estimates can be adjusted to look at trends over time and generate regional and global estimates.

Frequency of measurement
Annual (programme data) or every two years (biobehavioural survey).

Disaggregation
A,B,D: age (<25 and 25+ years).

A: gender (male, female and transgender).

D: gender (transman, transwoman and other).

Additional information requested
Please document in the comments section if the testing algorithm has changed since the last Global AIDS Monitoring report.

Please comment on the extent to which the data are deemed representative of the national population.

Strengths and weaknesses

Understanding how the sampled populations relate to any larger populations sharing similar high-risk behaviour is critical to interpreting this indicator. Trends in syphilis prevalence among key populations in the capital city provide a useful indication of the performance of HIV and sexually transmitted infection prevention programmes in that city, but they may not be representative of the situation in the country as a whole. The addition of new sentinel sites increases the sample's representativeness and therefore provides a more robust point estimate of syphilis prevalence. However, adding new sentinel sites reduces the comparability of values over time. As such, any changes in number of sites providing data needs to be documented in the comments section.

Surveys exclusively covering transgender people are rare. Most data for transgender communities are drawn from surveys of gay men and other men who have sex with men or sex workers. The risk environment reported for most transgender communities is high, placing transgender women at especially high risk of acquiring a sexually transmitted infection and of transmitting that infection. If transgender women are respondents in surveys of sex workers, include the data with sex workers as a disaggregation. If transgender people are respondents in surveys of gay men and other men who have sex with men, include the data under the transgender tab.

Testing using both nontreponemal and treponemal tests enhances the likelihood that the reported numbers of positive tests represent active infection. Some countries, however, only have information for one test type. Please note in the comment fields if syphilis testing practices have changed, as this will need to be considered when interpreting the disease trends.

Further information

Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2022. (https://www.who.int/publications/i/item/9789240052390)

7.4 Men with urethral discharge

Number of men reporting urethral discharge in the past 12 months

What it measures
Burden of sexually transmitted infections in men.

Rationale
Urethral discharge among men is commonly caused by Neisseria gonorrhoeae or Chlamydia trachomatis. Characteristically, men with urethritis (inflammation of the urethra) present with urethral discharge with or without dysuria (pain on urination). Untreated urethral discharge can result in infertility and facilitate HIV transmission and acquisition.

Data on urethral discharge provide information on burden of sexually transmitted infections in men and provide a marker of unprotected sex. Monitoring urethral discharge is critical as a proxy for the burden of gonorrhoea. N. gonorrhoeae has shown increasing resistance to recommended treatment options and may render this infection untreatable.

Numerator
Number of men reported with urethral discharge during the reporting period

Denominator
Number of men aged ≥15 years

Calculation
Numerator/denominator

Method of measurement
Routine health information systems

Measurement frequency
Annually.

Disaggregation
None

Additional information requested
Countries are requested to communicate the extent to which the data reported are representative of the national population and advise on how this would impact on interpretation of the data. Countries are also asked to indicate whether data reported in GAM include data from private providers.

Strengths and weaknesses
Although WHO has provided a global case definition, the actual case definition may vary between and within countries. Data on the number of men with urethral discharge and trends over time provide a proxy measure for incident cases of sexually transmitted infections in a population.

Data on vaginal discharge among women, although useful for monitoring purposes at the local and national levels, are not requested at the global level because, in many settings, sexually transmitted infections do not cause most cases of vaginal discharge. In many countries, this indicator is not routinely collected from all health facilities.

Countries should periodically assess the causes of urethral discharge syndrome to understand the aetiology and patterns of antimicrobial resistance to inform appropriate treatment guidelines.

Further information
Guidelines for the management of symptomatic sexually transmitted infections. Geneva: World Health Organization. 2021 (https://iris.who.int/bitstream/handle/10665/342523/9789240024168-eng.pdf?sequence=1).

Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012. Geneva: World Health Organization; 2012 (https://www.who.int/publications/i/item/9789241504478, accessed 6 November 2023).

Updated recommendations for the treatment of Neisseria gonorrhoeae, Chlamydia trachomatis and Treponema pallidum (syphilis), and new recommendations on syphilis testing and partner services. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378213/9789240090767-eng.pdf?sequence=1).

Framework for monitoring sexually transmitted infections and strengthening surveillance. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378238/9789240097674-eng.pdf?sequence=1).

Unemo M, Cole M, Lewis D, Ndowa F, Van Der Pol B, Wi T, editors. Laboratory and point-of-care diagnostic testing for sexually transmitted infections, including HIV. Geneva: World Health Organization; 2023 (https://iris.who.int/bitstream/handle/10665/374252/9789240077089-eng.pdf?sequence=1).

7.5 Gonorrhoea among men

Rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis

What it measures
Burden of sexually transmitted infections in men.

Rationale
Untreated gonococcal infection in men can result in urethral discharge and infertility and facilitate HIV transmission. Data on the number of men who test positive for N. gonorrhoeae provide information on the prevalence of infection and burden of sexually transmitted infections in men, and provide a marker of unprotected sex or sex without a condom. Data on gonorrhoea test positivity are important for understanding the challenges imposed by increasing resistance to currently recommended treatment options.

Numerator
Number of men reported with laboratory-diagnosed gonorrhoea in the past 12 months

Denominator
Number of men aged ≥15 years

Calculation
Numerator/denominator

Method of measurement
Routine health information systems

Measurement frequency
Annually.

Disaggregation
None

Additional information requested
Countries are requested to communicate the extent to which the data reported are representative of the national population and advise on how this would impact on interpretation of the data. Countries are also asked to indicate whether data reported in GAM include data from private providers.

Strengths and weaknesses
The capacity to test for N. gonorrhoeae varies between and within countries. In many countries, people with symptoms related to sexually transmitted infections are treated based on their symptoms and not on any test results.

Data on gonorrhoea among women, although useful for monitoring purposes at the local and national levels, are not requested at the global level because most women infected with N. gonorrhoeae are asymptomatic, and sensitive diagnostic tests for gonorrhoea among women are not widely available in low- and middle-income countries.

Further information
Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012. Geneva: World Health Organization; 2012 (https://www.who.int/publications/i/item/9789241504478, accessed 6 November 2023).

Updated recommendations for the treatment of Neisseria gonorrhoeae, Chlamydia trachomatis and Treponema pallidum (syphilis), and new recommendations on syphilis testing and partner services. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378213/9789240090767-eng.pdf?sequence=1),

Framework for monitoring sexually transmitted infections and strengthening surveillance. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378238/9789240097674-eng.pdf?sequence=1).

Unemo M, Cole M, Lewis D, Ndowa F, Van Der Pol B, Wi T, editors. Laboratory and point-of-care diagnostic testing for sexually transmitted infections, including HIV. Geneva: World Health Organization; 2023 (https://iris.who.int/bitstream/handle/10665/374252/9789240077089-eng.pdf?sequence=1).

Enhanced Gonococcal Antimicrobial Surveillance Programme (EGASP): general protocol. Geneva: World Health Organization; 2021 (https://iris.who.int/bitstream/handle/10665/341333/9789240021341-eng.pdf?sequence=1).

7.6 Co-management of tuberculosis and HIV treatment

Percentage of people living with HIV estimated to have incident tuberculosis (TB) that received treatment for both TB and HIV

What it measures
Progress in detecting and treating TB and HIV among people with HIV-associated TB

Rationale
TB is a leading cause of morbidity and mortality among people living with HIV, including those receiving antiretroviral therapy. Prompt TB treatment and early antiretroviral therapy are critical for reducing the mortality due to HIV-associated TB and must be the highest-priority activity for both the AIDS Programme and National TB Programme. A measure of the percentage of HIV-positive TB patients that access appropriate treatment for their TB and HIV is therefore very important.

Numerator
Number of people living with HIV with new or relapse TB started on TB treatment during the reporting period who were already on antiretroviral therapy or started on antiretroviral therapy during TB treatment within the reporting year

Denominator
Estimated number of people living with HIV with incident TB cases

Calculation
Numerator/denominator

Method of measurement
For the numerator.: Facility antiretroviral therapy registers and reports; programme monitoring tools. Count the total number of HIV-positive new and relapse TB patients who were started on TB treatment (as recorded in the TB register) and antiretroviral therapy, or those already on antiretroviral therapy (as recorded in the antiretroviral therapy register). The information should be reconciled quarterly and annually with the TB registers in the relevant basic management units before consolidation and reporting.

For the denominator: Programme data and estimates of the number of people living with HIV with incident TB. WHO calculates annual estimates of the number of people living with HIV with incident TB. The denominator become available only in August of the reporting year and do not need to be provided at the time of reporting. The estimates for 2023 are available at https://www.who.int/teams/global-tuberculosis-programme/data.

See Annex 5 for further understanding of the indicator.

Measurement frequency
Data should be collected continuously at the facility level, reconciled with the TB registers and aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here.

Disaggregation
None.

Additional information requested
None.

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 people living with HIV newly infected with TB should start TB treatment and antiretroviral therapy within eight weeks of starting TB treatment, regardless of CD4 count. The people with both HIV and TB with profound immunosuppression (such as CD4 counts less than 50 cells/mm^3) should receive antiretroviral therapy within the first two weeks of initiating TB treatment. TB treatment should be started in accordance with national TB programme guidelines.

This indicator measures the extent to which collaboration between national TB and HIV programmes ensures that people living with HIV and TB are able to access appropriate treatment for both diseases. However, this indicator will be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral therapy and poor access to TB diagnosis and treatment. Separate indicators for each of these factors 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, since this information has implications for antiretroviral therapy eligibility and choice of antiretroviral regimen. It is therefore recommended that the date TB treatment starts be recorded in the antiretroviral register.

Further information

WHO policy on collaborative TB/HIV activities. Geneva: World Health Organization; 2012). (http://apps.who.int/iris/bitstream/handle/10665/44789/9789241503006_eng.pdf?sequence=1).

Global tuberculosis report 2024. Geneva: World Health Organization; 2024 (https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2024).

A guide to monitoring and evaluation for collaborative TB/HIV activities: 2015 revision. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/150627/9789241508278_eng.pdf?sequence=1).

7.7 People living with HIV newly enrolled on HIV treatment with tuberculosis disease

Percentage of people living with HIV newly enrolled on HIV treatment diagnosed with tuberculosis (TB) disease during the reporting period

What it measures
The burden of TB disease among people living with HIV who are newly enrolled in HIV treatment. It also indirectly measures efforts to detect HIV-associated TB early.

Rationale
The primary aims of TB screening in HIV care settings and provider-initiated HIV testing and counselling for people diagnosed with TB are early detection of HIV-associated TB and prompt provision of antiretroviral therapy and TB treatment. Although intensified TB case-finding should be implemented among all people living with HIV at each visit to HIV care and treatment facilities, it is particularly important at the time of enrolment, since the risk of undetected TB is higher among newly enrolled patients than among those already receiving antiretroviral therapy. Furthermore, newly enrolled people living with HIV may be less aware of TB symptoms and the importance of early detection and treatment, and they may not seek care for general or specific TB symptoms. Intensified TB case-finding offers an opportunity to educate people living with HIV and to detect TB early. All people living with HIV among which TB disease is detected should start anti-TB treatment immediately and antiretroviral therapy within eight weeks (if they are not already receiving antiretroviral medicine).

Numerator
Total number of people living with HIV newly enrolled in HIV treatment who have been diagnosed with TB disease during the reporting period

Denominator
Total number of people newly enrolled in HIV treatment (i.e., those who registered for antiretroviral therapy during the reporting period)

Calculation
Numerator/denominator

Method of measurement
The outcome of TB investigations among people living with HIV presumed to have TB should be recorded on the HIV antiretroviral therapy card (in the "Investigations" column in the Encounters section) and in the antiretroviral therapy registers (the monthly and quarterly follow-up sections, respectively). Similarly, people diagnosed with TB who are found to be HIV-positive should be enrolled into HIV treatment promptly and their TB status recorded on the antiretroviral therapy card and registers.

For the numerator. At the end of the reporting period, count the total number of people living with HIV newly enrolled in HIV treatment who were diagnosed with TB disease. Data should be drawn from TB- and HIV-sided services and data sources.

For the denominator. Count the total number of people living with HIV who are newly enrolled in HIV treatment (i.e., those who started antiretroviral therapy during the reporting period).

The information on TB status in the antiretroviral therapy registers should be updated and reconciled with the TB registers in relevant basic management units before consolidation and reporting to higher levels.

See Annex 5 for further understanding of the indicator.

Measurement frequency
Data should be recorded daily and reported to the national or subnational level as part of routine quarterly reporting. Data should also be submitted annually to UNAIDS.

Disaggregation
None.

Additional information requested
None.

Strengths and weaknesses
Reviewing the trends in TB among people living with HIV who are newly enrolled in treatment over a period of time may provide useful information on: (a) the TB burden among them; and (b) the effectiveness of efforts to detect and treat HIV-associated TB early.

This indicator may underestimate the actual burden of HIV-associated TB, since it may exclude: (a) people among whom TB was detected through provider-initiated HIV testing and counselling, but who were not enrolled in HIV treatment; or (b) those who have disseminated forms of TB, remain asymptomatic and were missed during routine TB screening. A high indicator value may mean high TB rates or effective TB screening and HIV testing programmes, whereas a low value may reflect poor TB screening and HIV testing or successful TB control efforts. The indicator value, therefore, needs to be interpreted carefully.

Further information
A guide to monitoring and evaluation for collaborative TB/HIV activities. 2015 revision. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/150627/9789241508278_eng.pdf?sequence=1).

7.8 People living with HIV on antiretroviral therapy who started tuberculosis preventive treatment

Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment during the reporting period

What it measures
The extent to which people who are on antiretroviral therapy started TB preventive treatment

Rationale
TB preventive treatment reduces the risk of developing active TB and improves survival among all people living with HIV. People living with HIV should be screened for TB at every clinic visit using a clinical algorithm recommended by the World Health Organization (WHO). Adults and adolescents living with HIV who do not report any of the symptoms of TB —current cough, fever, weight loss or night sweats—are unlikely to have active TB and should be offered TB preventive treatment. WHO recommends a number of screening tools that can be used to rule out active TB (eg. chest x-ray, c-reactive protein).

Children living with HIV who do not have poor weight gain, fever or current cough should be offered TB preventive treatment regardless of whether or not they are receiving antiretroviral therapy.

Numerator
1. Total number of people newly enrolled on antiretroviral therapy during the reporting period who also started TB preventive treatment during the reporting period.
2. Total number of people currently on antiretroviral therapy who started TB preventive treatment during the reporting period.

Denominator
1. Total number of people newly enrolled on antiretroviral therapy during the reporting period.
2. Total number of people currently on antiretroviral therapy during the reporting period.

Calculation
Numerator/denominator

Method of measurement
TB preventive treatment should be started for all eligible people living with HIV, and the start date should be recorded on the HIV care/antiretroviral therapy card (in the Encounter section). Those who accept treatment and receive at least the first dose should then be recorded in the antiretroviral therapy registers (under the TB preventive treatment start month and year column).

1. *Numerator.* Count the total number of people living with HIV newly enrolled on antiretroviral therapy during the reporting period who also started TB preventive treatment during the same reporting period (i.e., those who received at least one dose of the regimen)

   Denominator. Count the total number of people living with HIV newly enrolled on antiretroviral therapy during the reporting period.

2. *Numerator.* Count the total number of people currently on antiretroviral therapy (regardless of when they started antiretroviral therapy) who also started TB preventive treatment during the current reporting period (i.e., those who received at least one dose of the regimen).

   Denominator. Count the total number of people living with HIV currently on antiretroviral therapy (regardless of when they started antiretroviral therapy).

Countries are asked to report on 1 and/or 2, as available.

If available, also provide the number of people living with HIV currently on antiretroviral therapy who have ever received TB preventive treatment (excluding those who received it during the current reporting period).

Measurement frequency
Data on people who started antiretroviral therapy and TB preventive treatment should be recorded daily and reported quarterly to the national or subnational level. They should be consolidated annually and reported to UNAIDS.

Disaggregation
- Age (<5 years, 5–15 years, 15+ years).

Additional information requested
None.

Strengths and weaknesses

This indicator provides insight on progress towards provision of TB preventive treatment among all people living with HIV. Unless further data are collected, this indicator provides no information on the number of individuals who adhere to or complete the course of treatment.

For accurate planning and drug management, more detailed information needs to be collected in addition to this indicator. A pharmacy-based register may be used to record client attendance and drug collection. Alternatively, the HIV treatment facility may maintain a TB preventive treatment register in parallel with the antiretroviral therapy register. Such a record may provide valuable information on the number of new and continuing patients on TB preventive treatment, as well as treatment completion rates and adverse events.

Further information

WHO guidelines on tuberculosis infection prevention and control. 2019 update. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/311259/9789241550512-eng.pdf).

WHO consolidated guidelines on tuberculosis. Module 1: prevention. Tuberculosis preventive treatment. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/who-consolidated-guidelines-on-tuberculosis-module-1-prevention-tuberculosis-preventive-treatment).

7.9 Percentage of people living with HIV on antiretroviral therapy who completed a course of tuberculosis preventive treatment among those who initiated tuberculosis preventive treatment

Percentage of people living with HIV currently on antiretroviral therapy initiating tuberculosis (TB) preventive treatment and who completed a course of TB preventive treatment

What it measures

This indicator measures the effectiveness of scaled-up TB preventive treatment programmes by assessing the proportion of people living with HIV on antiretroviral therapy who completed a recommended course of TB preventive treatment during the reporting period.

Rationale

TB preventive treatment reduces the risk of developing TB disease and improves survival of all people living with HIV. Completing TB preventive treatment as prescribed optimizes its efficacy. All people on antiretroviral therapy should be screened for TB at every visit, using a clinical algorithm recommended by the World Health Organization (WHO). Adults and adolescents living with HIV who do not report any of the symptoms of TB — current cough, fever, weight loss or night sweats—are unlikely to have TB disease and should be offered TB preventive treatment. Similarly, children living with HIV who do not have poor weight gain, fever or current cough should be offered TB preventive treatment; extra care is needed to exclude TB disease in children who are also malnourished before starting TB preventive treatment.

While many countries have made progress in initiating TB preventive treatment among eligible people living with HIV, completion rates remain poor or unknown. Assessing completion of TB preventive treatment is a critical element of the TB/HIV cascade of services and essential to ensuring impact.

Numerator

Among people living with HIV who initiated any course of TB preventive treatment in 2023, the number of people on antiretroviral therapy who completed TB preventive treatment (Figures 1 and 2).

Denominator

Number of people on antiretroviral therapy who initiated any course of TB preventive treatment during 2023.

Calculation

Numerator/denominator.

Method of measurement

Numerator: Programme records (for example, antiretroviral therapy registers or electronic medical records (EMRs)). Count the total number of people living with HIV on antiretroviral therapy initiating TB preventive treatment during the cohort reporting year who completed the course of TB preventive treatment. The cohort reporting year would usually be the last calendar year during which all people who initiate TB preventive treatment can be assessed for treatment completion. As mentioned above, for the 2025 reporting cycle, the cohort would comprise those initiating TB preventive treatment during 2023.

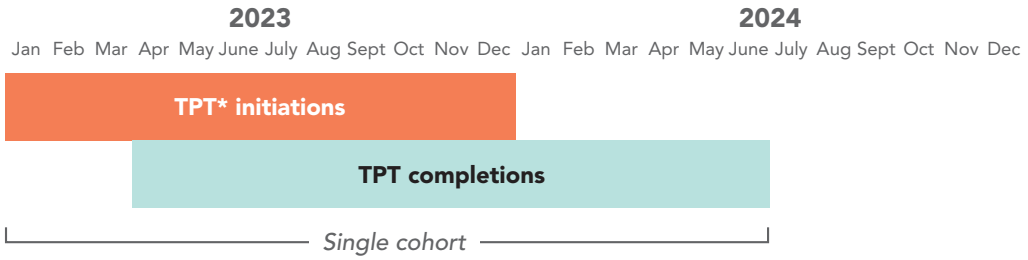
This includes all those eligible for TB preventive treatment who started TB preventive treatment (including those newly on antiretroviral therapy and currently on treatment) and who completed TB preventive treatment during the same year or the following year. Completion of TB preventive treatment should be determined on the basis of national clinical guidelines using criteria that relate to the specific regimen duration and composition (see the WHO operational handbook on tuberculosis—module 1: prevention).

Denominator: Programme records (for example, antiretroviral therapy registers or EMRs). Count the total number of people living with HIV who were on antiretroviral therapy and initiated a course of TB preventive treatment during the cohort (2023 for 2025 reporting). If a person who is initiated on TB preventive treatment dies before TB preventive treatment completion, they should be recorded in the denominator, but not in the numerator.

This reflects an annual cohort approach where 2025 reporting is based on those who initiated TB preventive treatment in 2023, regardless of whether they completed in 2023 or 2024.

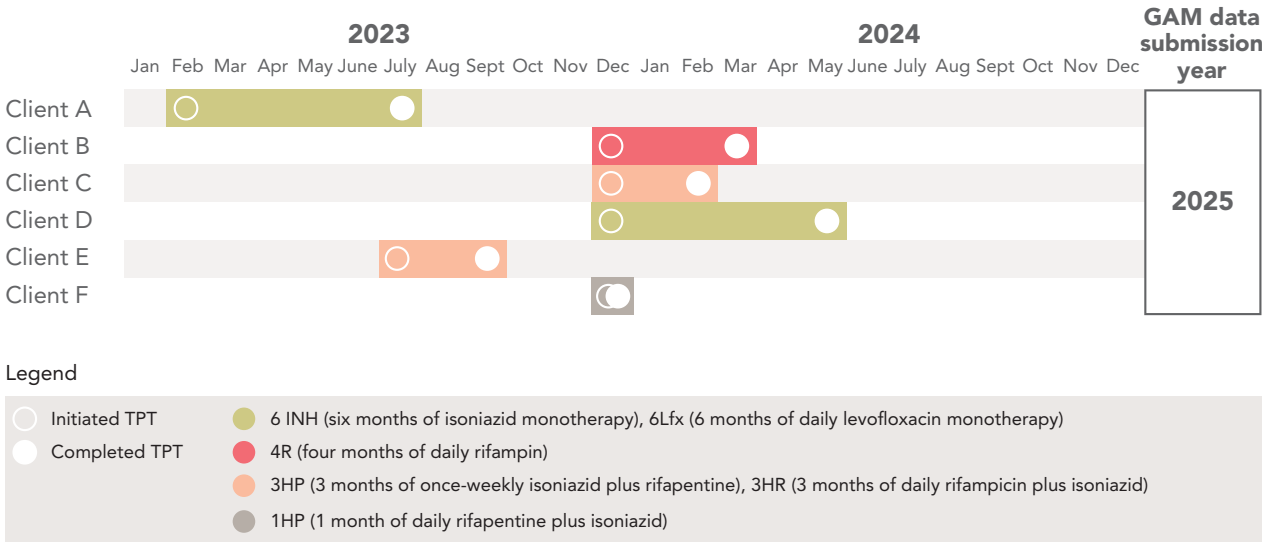
Illustration of completion cohort

Figure 1. Cohort TPT initiation and TPT completion for reporting to GAM in 2025



*TPT = TB preventive treatment

Figure 2. Examples of cohort TPT initiations and completions for reporting to GAM in 2025:



Measurement frequency

Annually. A periodicity more frequent than annual may be expedient (e.g., quarterly reporting for more timely reporting of patients on a new TB preventive treatment regimen)

Disaggregation

- Gender (female, male, transgender).
- Age (<5 years, 5–14 years, 15+ years).
- Type of TB preventive treatment regimen (if the country is able to report on disaggregation).

Strengths and weaknesses

This indicator would more accurately provide information on people living with HIV who have received this intervention to reduce TB incidence and mortality among people living with HIV. It has already been field tested by United States President's Emergency Plan for AIDS Relief (PEPFAR) programmes for a number of years and reported through the monitoring, evaluation and reporting (MER) system.

Challenges include incomplete recording and reporting, information systems that may not capture TB preventive treatment completion, use of different criteria to determine completion and account for TB preventive treatment interruptions, and suboptimal programme implementation.

Further information

WHO operational handbook on tuberculosis. Module 1: prevention – tuberculosis preventive treatment, second edition. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378535/9789240097773-eng.pdf?sequence=1).

7.10 Number of women living with HIV who were screened for cervical cancer using any screening test

The number of women living with HIV who were screened for cervical cancer in the last 12 months using any screening test

What it measures
Progress towards scaling up population-based screening for the prevention of cervical cancer among women living with HIV

Rationale
The purpose of this indicator is to assess the availability and uptake of screening to prevent cervical cancer among women living with HIV. To prevent invasive cervical cancer, women can be screened using various tests to identify those who have or are at risk of cervical precancer. Low cost and appropriate technology screening methods are available that make most precancerous lesions identifiable at stages when they can easily be treated and cured. Achieving high coverage of screening of women—with treatment of precancerous lesions detected by screening—can lead to a low incidence of invasive cervical cancer.

The traditional method to screen women for cervical cancer has been cytology (the Papanicolaou test, also known as the Pap or smear test). Newer screening tests include visual inspection with acetic acid (VIA) and molecular tests, mainly high-risk HPV DNA-based tests, which are suitable for use in all settings. Other molecular tests—as well as more advanced visual inspection tests based on artificial intelligence/machine learning platforms—have also been developed. Cervical cancer screening can be done using different primary screening and triage tests, and there are numerous combinations or algorithms in use in different settings.

Numerator
Number of women living with HIV who had a screening test for cervical cancer using any screening test

Denominator
N/A

Calculation
N/A

Method of measurement
The number is generated by counting the number of women living with HIV among all women who were screened for cervical cancer in the last 12 months, using cervical cancer programme screening and/or HIV programme data as the source.

Each individual should only be counted once within the reporting period. If a second triage test or a follow-up test was performed as part of the screening strategy, that individual should only be counted once.

Measurement frequency
Annual

Disaggregation
- Age (15–19, 20–24, 25–29, 30–49, 50+ years).
- People who were screened for the first time in their lives.

Additional information requested
None.

Strengths and weaknesses
Since the screening interval between tests depends on the test used, the number of women screened may vary from year to year.

Coverage levels of screening for all women living with HIV is not possible without an estimate of the population size.

Changes in this indicator as measures of progress over time should be interpreted in light of related data, including the number of women known to be living with HIV.

Further information

Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA Cancer J Clin. 2021;71:209-249.

Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240014107).

Comprehensive cervical cancer control: a guide to essential practice. 2nd ed. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf).

Guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240030824).

Introducing and scaling up testing for human papillomavirus as part of a comprehensive programme for prevention and control of cervical cancer. A step-by-step guide. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240015166).

WHO technical guidance and specifications of medical devices for screening and treatment of precancerous lesions in the prevention of cervical cancer. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240002630).

7.11 Cervical precancer treatment in women living with HIV

Percentage of women living with HIV, who screened positive for cervical precancer who received treatment for precancerous lesions in the last 12 months

What it measures
Progress towards the treatment coverage target of 90% of women with a positive screening test, receiving treatment.

Rationale
The purpose of this indicator is to assess availability, access and coverage of precancer treatment among women living with HIV who were diagnosed with precancerous lesions upon screening and were deemed eligible for precancer treatment in line with the World Health Organization (WHO) *Recommendations for screening and treatment to prevent cervical cancer.*

The WHO Global Strategy targets to eliminate cervical cancer are to vaccinate 90% of eligible girls against human papillomavirus (HPV), to screen 70% of eligible women at least twice in their lifetimes and to effectively treat 90% of those with a positive screening test or a cervical lesion, including palliative care when needed, all by 2030.

Numerator
Number of women living with HIV who received treatment for precancerous lesions after screening positive for cervical precancer.

Denominator
Number of women living with HIV who screened positive for cervical precancer

Calculation
Numerator/denominator

Method of measurement
The numerator and denominator are generated from programmatic data from HIV or cervical cancer screening programmes. Women who screened positive, but were ineligible for treatment of precancerous lesions, for example because they were referred for evaluation of potential invasive cervical cancer, should not be counted.

Measurement frequency
Annual

Disaggregation
- Age (15–19, 20–24, 25–29, 30–49, 50+ years).
- Cervical precancer treatment episode (1st in lifetime, 2nd, 3rd, 4th, etc.).
- Treatment method (cryotherapy, thermal ablation, large-loop excision of the transformation zone [LLETZ], other).

Additional information requested
None.

Strengths and weaknesses
Variation in the denominator over time may reflect the changing skill of healthcare workers to evaluate eligibility for precancerous treatment, the screening test used and its accuracy, and whether a triage test is used

Further information
Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA Cancer J Clin. 2021;71:209-249.

Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240014107).

Comprehensive cervical cancer control: a guide to essential practice. 2nd ed. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf).

Guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240030824).

WHO technical guidance and specifications of medical devices for screening and treatment of precancerous lesions in the prevention of cervical cancer. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240002630).

7.12 Treatment of invasive cervical cancer in women living with HIV

The percentage of women living with HIV with suspected invasive cervical cancer who were treated within the last 12 months

What it measures
Progress towards increasing access to treatment for invasive cervical cancer for women living with HIV

Rationale
The purpose of this indicator is to assess availability and access to treatment services for invasive cervical cancer for women living with HIV over time. In the longer run, it is expected that the number of women living with HIV who received treatment for invasive cervical cancer will plateau and slowly decrease, as screening programmes will expand detection and treatment of precancerous lesions, and coverage of human papillomavirus (HPV) vaccination will increase in line with the World Health Organization (WHO) 90–70–90 elimination targets.

Numerator
Number of women living with HIV with suspected invasive cervical cancer who received treatment

Denominator
Number of women living with HIV who were screened for cervical cancer and had suspected invasive cancer

Calculation
Numerator/denominator

Method of measurement
The number is generated from programmatic data from HIV or cervical cancer programmes, or from a national cancer registry, if HIV status is recorded there

Measurement frequency
Annual

Disaggregation
- Age (15–19, 20–24, 25–29, 30–49, 50+ years).
- Invasive cervical cancer treatment episode (1st in lifetime, 2nd, 3rd, 4th etc.).
- Treatment type: medical, surgical.

Additional information requested
None.

Strengths and weaknesses
Changes in this indicator over time should be interpreted in light of related interventions, such as the generalization of the precancer screening and treatment programme.

Variation may also represent changes in health care workers' ability to identify invasive cancer.

Further information
Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA Cancer J Clin. 2021;71:209-249.

Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240014107).

Comprehensive cervical cancer control: a guide to essential practice. 2nd ed. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf).

WHO framework for strengthening and scaling-up services for the management of invasive cervical cancer. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240003231).

Guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240030824).

7.13 People living with HIV receiving multimonth dispensing of antiretroviral medicine

Proportion of people living with HIV and currently on antiretroviral therapy who are receiving multimonth dispensing of antiretroviral medicine

What it measures
The proportion of all people living with HIV and currently on antiretroviral therapy, who received a multimonth (as specified below) supply of antiretroviral medicine at their most recent antiretroviral medicine pick-up.

Rationale
The option for people living with HIV who are established on antiretroviral therapy to receive multiple months of antiretroviral medicines is a key component of care that responds to the needs and preferences of people living with HIV (known as differentiated service delivery – see "Definitions," below). For people living with HIV who are established on antiretroviral therapy, multimonth dispensing has the potential to improve health outcomes and support long term treatment adherence, while also reducing unnecessary clinic attendance, thus contributing to system efficiency. Broadly, multimonth dispensing can contribute to efforts to achieve the 95–95–95 targets.

Adoption and roll-out of multimonth dispensing as part of national government strategies and plans are increasing. Since 2016, differentiated service delivery—including the option of multimonth dispensing—has been recommended in World Health Organization (WHO) HIV treatment and public health guidelines. The COVID-19 pandemic has particularly exposed the fragility of health systems and, in response, finding ways to maintain service delivery and reduce unnecessary clinic attendance has been prioritised.

The extent to which these models of care have been scaled up in many countries is uncertain and reporting on this indicator will support efforts to expand the offer of multimonth dispensing.

Numerator
Number of people living with HIV and currently on antiretroviral therapy who received 3 – <6 or 6+ months of antiretroviral medicine at their most recent antiretroviral medicine pick-up.

(The number receiving <3 months of antiretroviral supply is also collected for validation purposes)

If countries cannot report on the number of months of antiretroviral medicine dispensed by the disaggregation described above, they could, as an alternative, report the total number of people currently on antiretroviral therapy and receiving ≥3 months of antiretroviral medicine at their last medicine pick-up.

Denominator
Number of people living with HIV and currently on antiretroviral therapy.

Calculation
Numerator / Denominator

Method of measurement
The data for this indicator are collected at the end of the reporting period from facility antiretroviral therapy registers (including antiretroviral medicine dispensed outside the facility), programme monitoring tools or other databases. (If data are available from the private sector these should be included).

All people currently on antiretroviral therapy should be identified. People who have not received antiretroviral medicine within 28 days of their scheduled medicine pick-up are considered lost to follow-up and should not be counted in the denominator or the numerator. For example, if antiretroviral medicine was provided for three months (12 weeks), the time since the last medicine pick-up should be no longer than 16 weeks (12 weeks plus 28 days).

For the numerator: registers should capture the duration of antiretroviral medicine dispensed for each patient currently on antiretroviral therapy at their most recent medicine pick-up visit. If possible, this should be categorized as <3 months, 3- <6 months, or 6+ months and summarized for each age/sex group.

The denominator should match the total number of people currently on antiretroviral therapy at the end of the year, and be aligned with the national values submitted through the Global AIDS Monitoring tool.

If this indicator result is only available for a proportion of people currently on treatment, please enter the number of people that the percentage is based on, as well as the national denominator value, so that it is clear what proportion of the population currently on treatment is represented in the calculation.

Please note: multimonth dispensing should not be confused with multimonth prescriptions. Someone who receives a six-month antiretroviral medicine prescription but needs to attend clinic every one or two months for refills would not be counted as receiving multimonth dispensing.

Measurement frequency
Annual

Disaggregation
- Age 0–14
- Age 15+ by sex (male, female and transgender).

Additional information requested
None.

Strengths and weaknesses

An indicator focused on the scale of multimonth dispensing is a pragmatic way of capturing one important aspect of differentiated service delivery. The indicator gives an overall sense of how widely a differentiated service delivery approach to HIV treatment is being adopted and the extent of possible individual benefit. It also suggests the potential for further improvements in system efficiency through increased spacing of antiretroviral medicine dispensing.

The presence of this indicator does not imply that all individuals living with HIV should be provided multimonth supplies of antiretroviral medicines. In addition to considering the clinical needs of people living with HIV – multimonth dispensing is proposed only for people who are established on antiretroviral therapy – dispensing frequency should also be guided by the needs and preferences of affected individuals and populations. Other factors that influence the capacity to provide multimonth supplies of antiretroviral medicines include supply chain issues, policy considerations and health care staff readiness. The fact that 100% coverage should not be seen as the target for multimonth dispensing highlights the importance of having some contextual information to guide the interpretation of results.

Focusing only on the duration of antiretroviral medicine dispensed provides an incomplete picture of differentiated service delivery. Monitoring of outcomes such as viral load suppression, patient satisfaction and retention in care would add to this picture, as would information on the quality and extent of social and other support being provided as part of differentiated service delivery. Ideally, the proportion of people living with HIV who were offered a choice of a differentiated treatment model would be captured, but this may not be feasible.

Definitions

Differentiated service delivery for HIV is defined by the WHO as a person-centred approach that simplifies and adapts HIV services to better serve the needs of people living with HIV and to optimize the available resources in health systems.

Multi-month dispensing refers to the provision of multiple months' supply of antiretroviral medicine and/or other medicines at single time point. Multimonth dispensing is frequently offered as a component of differentiated service delivery. WHO recommends that people who are established on antiretroviral therapy should be offered antiretroviral medicine refills lasting three to six months, preferably six months where feasible.

Established on antiretroviral therapy. The criteria for determining that a person is successfully established on antiretroviral therapy are a) receiving antiretroviral therapy for at least six months; b) no current illness, [which does not include well-controlled chronic health conditions]; c) good understanding of lifelong adherence: adequate adherence counselling provided; and d) evidence of treatment success: at least one suppressed viral load result within the past six months (if viral load is not available: CD4 count >200 cells/mm^3 (CD4 count >350 cells/mm^3 for children 3-5 years old) or weight gain, absence of symptoms and concurrent infections).

The definition of being established on antiretroviral therapy should be applied to all populations, including those receiving second- and third-line regimens, those with controlled comorbidities, children, adolescents, pregnant and breastfeeding women and key populations.

Further information

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240031593).

7.14 Coverage of differentiated service delivery antiretroviral therapy models among people living with HIV currently on antiretroviral therapy

Percentage of people enrolled in differentiated service delivery (DSD) antiretroviral therapy models among all people living with HIV on antiretroviral therapy at the end of the reporting period

What it measures

This indicator measures the rollout and implementation of DSD models of antiretroviral therapy during the reporting period.

Rationale

WHO recommends DSD models of care for eligible people, including those established on antiretroviral therapy, to ensure care meets the diversity of needs of people living with HIV. This indicator measures the proportion of people on treatment receiving DSD antiretroviral therapy models of care—and, if feasible, whether people eligible for DSD antiretroviral therapy are receiving such services.

DSD for HIV treatment aims to improve retention in care and viral suppression by optimizing models of treatment and care delivery to improve client experience and health outcomes and leverage resources towards improving programmatic efficiency.

DSD models for HIV treatment can be broadly classified into four categories: group models managed by health-care workers; group models managed by clients; individual models based at facilities; and individual models not based at facilities:

Group models managed by health-care workers, such as adherence clubs, teen clubs, and advance HIV disease care packages.

- **Group models managed by clients**, such as community antiretroviral therapy adherence groups and client-led antiretroviral therapy delivery.
- **Individual models based at facilities**, such as multimonth antiretroviral medicine refills and fast-track antiretroviral medicine pick-up.
- **Individual models not based at facilities**, such as community antiretroviral therapy distribution points, antiretroviral medicine lockers, home antiretroviral medicine delivery, and mobile clinics.

Within these four categories, many adaptations can

be made to provide person-centred services to meet the distinct and evolving needs of people from specific populations, such as people receiving second- or third-line regimens, people with controlled comorbidities, people from key populations, pregnant women, children and adolescents.

This indicator measures all individuals enrolled in DSD antiretroviral therapy models, including but not limited to multimonth dispensing of antiretroviral medicines. Both less intensive and more intensive models should be reported under this indicator.

For more guidance, see Chapter 7.3 of the WHO 2021 consolidated guidelines for HIV prevention, testing, treatment and service delivery(https://www.who.int/publications/i/item/9789240031593).

A wide range of DSD antiretroviral therapy models have been developed by countries adapted to different contexts and populations within this evolving programme area and therefore will be defined by countries. Regardless of which DSD antiretroviral therapy models are adopted, it is important to assess coverage to scale up services and strengthen implementation.

Numerator

Number of people living with HIV enrolled in DSD antiretroviral therapy models during the reporting period.

Denominator

A. Number of people living with HIV receiving antiretroviral therapy at the end of the reporting period.

B. Number of people living with HIV on antiretroviral therapy eligible for DSD antiretroviral therapy models (for countries that are able to report).[1]

Countries should preferably report denominator B: the number of people living with HIV on antiretroviral therapy who are eligible for DSD antiretroviral therapy models (for countries that are able to report). If this information is not available, countries should report denominator A: the number of people living with HIV receiving antiretroviral therapy at the end of the reporting period.

Calculation

Numerator / denominator A

Numerator / denominator B (for countries that are able to report)

[1] Eligibility for DSD of antiretroviral therapy as defined in national guidelines.

Method of measurement
Patient monitoring tools (electronic or paper), such as antiretroviral therapy registers or electronic medical records.

Coverage measures all people living with HIV currently enrolled in DSD antiretroviral therapy models, including those newly enrolled and those enrolled in previous reporting periods.

DSD is a person-centred approach that simplifies and adapts HIV services across the cascade in ways that serve the needs of people living with or vulnerable to HIV and optimize available resources in the health system. DSD for HIV treatment should consider clinical needs and adapt services for people with advanced HIV disease and high viral load, for specific populations and for contextual settings.

DSD for HIV treatment is based on four building blocks: when (frequency), where (location), what (type/package) and who (provider). In any given DSD model for HIV treatment, the building blocks should be defined separately for clinical consultations, antiretroviral therapy refills and psychosocial support.

Multimonth dispensing of antiretroviral medicines refers to the provision of multiple months' supply of antiretroviral medicines or other medicines at a single time point. Multimonth dispensing is frequently offered as a component of differentiated service delivery. WHO recommends that people who are established on antiretroviral therapy should be offered antiretroviral medicine refills lasting 3–6 months (preferably 6 months).

The criteria for determining that a person is successfully established on antiretroviral therapy are:

- Receiving antiretroviral therapy for at least 6 months.
- No current illness (not including well-controlled chronic health conditions).
- Good understanding of lifelong adherence, with adequate adherence counselling provided.
- Evidence of treatment success, with at least one suppressed viral load result within the past 6 months (if viral load is not available,

CD4 count >200 cells/mm^3 for adults or >350 cells/mm^3 for children aged 3–5 years, weight gain, and absence of symptoms and concurrent infections).

The definition of being established on antiretroviral therapy should be applied to people from all populations, including people receiving second- and third-line regimens, people with controlled comorbidities, children, adolescents, pregnant or breastfeeding women, and people from key populations.

Measurement frequency
Annually.

Disaggregation
- Gender (female, male, other[2]).
- Age (0–14 years, ≥15 years).

Additional information requested
Please include any information on sustained changes in national guidance on dispensing frequency that is related to COVID-19 in the narrative report.

Strengths and weaknesses
This indicator monitors trends in the coverage of DSD of HIV treatment in a standardized and comparable way across countries and over time. It does not measure the quality of services, impact on treatment outcomes such as retention or viral suppression, or programmatic efficiencies such as reduced clinic visits or staff time.

The accuracy of the number of people enrolled in DSD antiretroviral therapy models will depend on the quality of the underlying reporting system and its ability to identify clients enrolled in DSD antiretroviral therapy models. Data quality challenges may lead to underreporting due to missing data or delays in reporting of facility data to the national level, or overreporting if clients are reported by both facilities and community or private settings.

Issues with linkages and flow of data between health facilities and community-delivered services may lead to delays in data transmission and underreporting. Countries should adapt monitoring tools such as antiretroviral therapy registers or electronic medical records to track and monitor clients enrolled in DSD antiretroviral therapy models at the service delivery and national levels.

Further information
Consolidated guidelines on person centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315, accessed 7 November 2023).

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240031593, accessed 7 November 2023).

[2] "Other" includes transgender and gender-diverse people who choose an identity other than male or female.

7.15 Viral suppression among people living with HIV engaged in differentiated service delivery antiretroviral therapy models

Percentage of people living with HIV engaged in differentiated service delivery (DSD) antiretroviral therapy models who have virological suppression during the reporting period.

What it measures
Viral suppression among people enrolled in DSD antiretroviral therapy models. This is a measure of antiretroviral therapy efficacy and indicates treatment adherence and risk of transmitting HIV.

Rationale
This indicator enables monitoring of viral load suppression among people living with HIV enrolled in DSD models for antiretroviral therapy. Since viral suppression is a key treatment outcome, it is important to monitor and assess whether people enrolled in DSD antiretroviral therapy models have better or similar viral suppression to people receiving standard of care to ensure quality of services. Viral load suppression is also the best available measure of adherence to antiretroviral therapy.

Numerator
Number of people living with HIV enrolled in a DSD antiretroviral therapy model with at least one routine viral load test during the reporting period who have virological suppression (<1000 copies/mL).

Denominator
Number of people living with HIV enrolled in a DSD antiretroviral therapy model with at least one routine viral load result in a medical or laboratory record during the reporting period.

Calculation
Numerator / denominator

Method of measurement
Patient monitoring tools (electronic or paper), such as antiretroviral therapy registers or electronic medical records.

DSD is a person-centred approach that simplifies and adapts HIV services across the cascade in ways that serve the needs of people living with or vulnerable to HIV and optimize available resources in the health system. DSD for HIV treatment should consider clinical needs and adapt services for people with advanced HIV disease and high viral load, for people from specific populations, and in different contextual settings.

DSD for HIV treatment is based on four building blocks: when (frequency), where (location), what (type/package) and who (provider). In any given DSD model for HIV treatment, the building blocks must be defined separately for clinical consultations, antiretroviral therapy refills and psychosocial support. Both less intensive and more intensive models should be reported under this indicator. Broadly speaking, these models can be described within four categories:

- **Group models managed by health-care workers**, such as adherence clubs, teen clubs, and advance HIV disease care packages.
- **Group models managed by clients**, such as community antiretroviral therapy adherence groups and client-led antiretroviral therapy delivery.
- **Individual models based at facilities**, such as multimonth antiretroviral medicine refills and fast-track antiretroviral therapy pick-up.
- **Individual models not based at facilities**, such as community antiretroviral therapy distribution points, antiretroviral medicine lockers, home antiretroviral medicine delivery, and mobile clinics.

Measurement frequency
Annually.

Disaggregation
- Gender (female, male, other[1]).
- Age (0–14 years, ≥15 years).

[1] "Other" includes transgender and gender-diverse people who choose an identity other than male or female.

Strengths and weaknesses

Several challenges may arise in accurately monitoring viral suppression among people engaged in DSD antiretroviral therapy models. There may be limited viral load monitoring capacity in low-income settings despite efforts invested in scale-up. In some settings, viral load testing may be performed selectively to confirm suspected treatment failure, or it may be prioritized for people from specific populations—as a result, it may underestimate levels of viral suppression among all people enrolled in DSD antiretroviral therapy models.

There may be challenges in the ability of the reporting system to identify clients enrolled in DSD antiretroviral therapy models. Data quality challenges may lead to underreporting due to missing data or delays in reporting of facility data to the national level, or overreporting if clients are reported by both facilities and community or private settings. Challenges in linkages and flow of data between health facilities and community-delivered services may lead to delays in data transmission and underreporting.

Countries should adapt monitoring tools such as antiretroviral therapy registers or electronic medical records to track and monitor clients enrolled in DSD antiretroviral therapy models and their treatment outcomes at the service delivery and national levels.

Further information

Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315, accessed 6 November 2023).

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240031593, accessed 6 November 2023).

8.1 Domestic public budget for HIV

Budget for HIV and AIDS programmes from domestic public sources

What it measures

The allocated and executed government budget earmarked for HIV programmes, along with perceived near-term trends in budget (i.e., next year's budget).

The total domestic public resources allocated and executed for HIV from central and subnational levels are to be reported.

Rationale

Domestic resources have contributed significantly to the HIV funding landscape over the last decade. In recent years, domestic resources have accounted for more than half of the total financial resources for HIV in low- and middle-income countries.

The monitoring of domestic public budgets and their short-term forecasts aims to foster global efforts to mobilize resources to achieve the targets to end AIDS by 2030.

Numerator

Not applicable

Denominator

Not applicable

Data type

Currency and monetary values (nominal currency), and categorical variables indicating the magnitude of change to represent short-term forecasts of the domestic funding landscape.

Calculation

Planned and executed budgets by each fiscal year.

The relevant department of government financial statistics maintains the budgets allocated to various sectors. Many countries may have earmarked budgets for HIV and AIDS programmes, while some may have budgets for those activities under different sectors.

The indicator aims to capture the budget for HIV and AIDS activities allocated through the government's own sources of funding. Budgeted activities funded through external aid transfers from foreign entities must be excluded.

Virtually all countries have an earmarked public budget for HIV, even while not all HIV expenditures are derived from budgets. The scope of budgets may differ occasionally across countries, but trends are useful for in-country analysis.

Method of measurement

Budget analysis

Note: The short-term forecast for the approaching fiscal year must be reported based on the information obtained through the government finance statistics, the Ministry of Health or the National AIDS Commission.

Measurement frequency

Annually for fiscal year

Disaggregation

- Budgets by level of government (i.e., national/federal, provincial/state/district or municipal/city/local) as appropriate in each country.
- If segmented budgetary units exist (e.g., social security institutions or national AIDS bodies), they should be reported separately.

Strengths and weaknesses

The data quality may be robust in countries that have earmarked budgets for HIV. When there are no earmarked budgets for HIV reporting on this indicator may need coordination between government departments concerned with health and social welfare. When service provision is integrated within facilities, such expenditures will not be identified easily in earmarked budgets.

Further information

Annex 2

8.2 Antiretrovirals and other HIV-related regimens: unit prices and volume

What it measures
The average unit prices of antiretroviral regimens and other HIV-related regimens for a country's HIV programme and the associated procurement volume

Rationale
The average unit prices and procurement volume of HIV commodities help monitor the market dynamics of antiretrovirals and other HIV-related regimens and support the process of triangulating with people reported to be on antiretroviral therapy.

Numerator
Not applicable

Denominator
Not applicable

Data type
The average unit price per pack of regimen in current US$ or the local currency units for the reporting year, and the absolute number of packs procured within a given period.

Calculation
Not applicable

Method of measurement
Procurement and supply chain management systems

Data collection tools
Logistics Management Information Systems (LMIS)

Measurement frequency
Annually

Disaggregation
- By funding source (domestic, international)

Strengths and weaknesses
The procurement supply chain management systems (PSM) in countries maintain information on health commodity procurement at the central level. In some countries, there are LMIS that monitor commodities data at the level of the health facility. These information systems may be able to provide the data for reporting on this indicator.

Further information
Annex 3

8.3 HIV expenditure by origin of resources

Domestic and international HIV expenditure by programme category and financing source

What it measures

In-country expenditures of HIV programmes and services by source in a standardized and comparable manner according to mutually exclusive categories. The HIV expenditures by programme or service reported here would need to be consistent with the number of people who have received the services (as reported elsewhere in Global AIDS Monitoring).

Rationale

The indicator to be reported is total and subtotal HIV expenditures by services or programme categories and by financing sources. Countries are requested to report the spending for eight core sub-indicators (services or programme categories). These are outlined under Annex 3.

By the end of 2021, the international and domestic resource availability for the HIV response reached an estimated US$ 20.8 billion (in constant 2019 dollars) in low- and middle-income countries. Achieving country and global targets requires increased focus, resources, programme effectiveness and efficiency to provide the HIV care, treatment and prevention to reduce HIV incidence and extend life.

It is critical to identify long-term, sustainable financing sources, including domestic resource mobilization, to maintain and build upon the success achieved. However, filling the financing gap and pursuing efficient resource allocation can only be achieved by assessing and managing the resources available and their use.

The quantification of financing flows and expenditures helps to examine the questions of who benefits from HIV programmes and to determine the current state of allocations for HIV programmes and services that focus on key or other specific populations.

The vast majority of the AIDS Spending Categories (or ASCs, per National AIDS Spending Assessment [NASA] classifications) or the sub-indicators are drawn from existing frameworks and are now structured around the 2021 Political Declaration on Ending AIDS. The resource needs for low- and middle-income countries resulted in a target to mobilize at least US$ 29 billion (in constant 2019 US dollars) by 2025.

Numerator

Not applicable

Denominator

Not applicable

Data type

Currency and monetary values (nominal currency)

Calculation

Social accounting and costing principles need to be applied for producing expenditure data. Rules, frameworks and principles are described in the specific manuals and guidelines (links provided below).

The calculation of each service/programme or sub-indicator may have individual characteristics to ensure proper accounting of all components (e.g., direct and shared costs of service provision) and to avoid double-counting; these calculations may be different by each financing source and service delivery modality (or even by service provider). Further guidance is available in the respective guidelines and manuals listed at the end of this section.

The quantification is limited to in-country expenditures, using international development assistance funds and the expenditures incurred using public or private funds reported in the current US$ or local currency units for the chosen reporting year.

There are certain requirements for data collection and quality to ensure the reliability and validity of the indicators to assure credibility.

The conciliation of top-down expenditures (from the financing sources) and bottom-up (from the costing of service delivery) provides the best assessment of the total HIV in-country spending.

Financial and programme records from providers or service delivery organizations are the basis for data collection.

There may be significant documented discrepancies between budgetary allocations and actual expenditures. Budget analysis is not recommended as the sole basis for reporting total in-country HIV expenditure.

It is good practice to validate expenditures funded by international sources, national financing sources and financing agents, as well as with all relevant stakeholders.

Method of measurement

Primary:

- National AIDS Spending Assessment (NASA).

Alternative:

- Budget analysis.
- System of Health Accounts 2011 (SHA-2011) with HIV module.

Note:

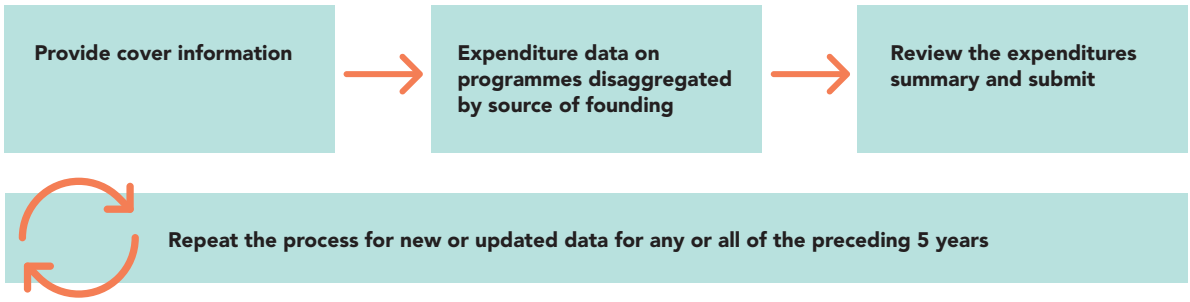
- When a NASA is not available, countries may use centrally produced results from the PEPFAR expenditure reporting system and request expenditure data from the Global Fund, that can be made available to reporting countries as a part of global coordination and resource alignment across UNAIDS, PEPFAR and the Global Fund. The reporting of expenditures for programmes funded by the Global Fund must conform to the reporting guidelines on Progress Update and Disbursement Request.[1]
- Health accounts using the SHA-2011 framework with full disease distribution attempt to capture top-level aggregated programme categories with cost item. However, depending on the objectives of a given resource-tracking exercise, SHA-2011 may or may not inform on the totality of HIV granular expenditure (disaggregated by programme) as required, and applied distribution keys must be examined and updated if necessary. The countries' health account report and data may have to be supplemented by robust costing principles to disaggregate the HIV portion of the joint costs incurred by the system.

[1] Please see Progress Update and Disbursement Request Form Instructions (https://www.theglobalfund.org/media/11754/fundingmodel_pudr_instructions_en.pdf).

Data collection tools

Countries develop their reports on HIV expenditures by core programme/service categories and financing sources using the national funding matrix template. A full range of HIV programme categories is provided in Annex 2. If countries have developed a full and proper NASA, the filling of the funding matrix constitutes only an output template from the exercise. If countries have developed a health account using the SHA-2011 framework, the cells of the funding matrix can be filled, particularly for the international sources, and in some cases, for the domestic private and public sources of financing.

Process flow for reporting on this indicator



The amended data for previous years can be submitted if the data submitted in previous years were preliminary or were not submitted previously.

Measurement frequency

Annually for calendar or fiscal year. Since the results of any accounting exercise may take time longer than the deadline for annual reporting, countries may submit preliminary results, which will be substituted when final results are available. In this reporting cycle, we suggest that countries submit any number of annual final reports available from the last five years, indicating their status as preliminary or final and whether they substitute for previous reports. It is not required to resubmit the data that have previously been reported and that remained unchanged. The UNAIDS team can be contacted for assistance if countries would like to submit recently amended or final reports on expenditures prior to 2016.

Disaggregation

- Financing source.
- HIV and AIDS programme categories.
- For selected sub-indicators, countries are encouraged to report expenditures on the most salient commodities under each of the relevant programmes representing sub-indicators, as data allow. Reporting of total expenditures by programme is acceptable if the disaggregation is not known but there is certainty that both commodities and service delivery costs are included.

Strengths and weaknesses

Countries that have appropriately implemented a full NASA are able to fill the template with an output table from the NASA exercise. Final country estimates need to be validated with all stakeholders and triangulated to increase reliability and validity.

Countries that have implemented an SHA-2011 annual exercise may need to ensure that the allocation keys used to estimate HIV expenditures from the utilization of the health system are updated and allow the granular data for domestic sources. This process may not use certified data as some accounting principles might require. Countries that have just started the process of full distributional health accounts need to validate the results with other existing sources and all stakeholders to increase reliability and validity of the estimates, particularly the overall level, potential duplication and significant unaccounted expenditures. Countries using health accounts should add non-health-related expenditures and ensure that consistent HIV expenditure is reported, particularly for shared costs in the health system. The implementation of health accounts needs medium- to long-term planning, and it is resource-intensive and depends on coordination between health accountants and programme managers.

Countries using budget analysis need to ensure that allocated budgets were spent as planned; the estimates for any additional expenditures that are not incurred using an earmarked budget should be added to each subtotal, as appropriate.

Countries have the choice of reporting on: (a) separate costs (commodities and service delivery) if they have the data; (b) on only one cost (if that is what is available); or (c) a disaggregated total that includes both commodities and service delivery.

List of core sub-indicators and associated statistical metadata

Total HIV expenditure	Funding source or service/programme category	Not applicable	Total expenditure from all sources spent on HIV and AIDS at the national level, including health and non-health
Sub-indicators	**Disaggregation**	**Target population**	**What it measures**
A. Expenditure on HIV testing and counselling (non-targeted; specific commodities separately)	Funding source	General population under specific indications	HIV testing and counselling is used to refer to all services involving HIV testing provided alongside counselling, including: ▪ Client-initiated HIV testing and counselling. ▪ Provider-initiated testing and counselling. ▪ HIV testing and counselling (HTC) as part of a campaign, through outreach services or through home-based/self-testing. Direct expenditures in the purchase of reagents for laboratory and rapid tests to be reported separately from other costs (as available).
B. Expenditure on antiretroviral therapy (adults and paediatric; specific commodities separately)	Funding source, adults and children (younger than 15 years old)	Persons living with HIV	Antiretroviral therapy. Direct expenditures in the purchase of antiretrovirals separately from other from other costs (as available).
C. Expenditure on HIV-specific laboratory monitoring (specific commodities separately)	Funding source	Persons living with HIV on antiretroviral therapy	Diagnostic services related to HIV clinical monitoring. Direct expenditures in the purchase of laboratory reagents for use in determining CD4+ cell counts and viral load quantification, separately from costs associated with other commodities and service delivery (as available).
D. Expenditure on tuberculosis (TB) and HIV (specific commodities separately)	Funding source	People living with HIV and people living with TB	Examinations, clinical monitoring, related laboratory services, treatment and prevention of TB (including isoniazid and drugs for treating active TB), and screening and referring clients of TB clinics for HIV testing and clinical care. Direct expenditures in the purchase of drugs for the treatment and prevention of TB (including isoniazid and drugs for treating active TB) separately from other commodities and service delivery costs (as available).
E. Expenditure on the five pillars of combination prevention (specific commodities separately)	Funding source, five pillars of combination prevention: ▪ Prevention for young women and adolescent girls (age 10–24 years, exclusively high-prevalence countries). ▪ Voluntary medical male circumcision (exclusively high-prevalence countries). ▪ Pre-exposure prophylaxis (PrEP) stratified by key population (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people, people in prisons and other closed settings, young women and adolescent girls, and serodiscordant couples). ▪ Condoms (non-targeted). ▪ Prevention among key populations (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people and people in prisons and other closed settings).	General population, key populations	This subset of prevention services is labelled and defined as combination prevention. The rest of the HIV prevention services are to be specified within the categories of the national funding matrix as part of broader prevention services. This subset includes prevention services specifically designed and delivered for each of the key populations, including prevention services for: ▪ Young women and adolescent girls (age 10–24 years) in high-prevalence countries. ▪ Gay men and other men who have sex with men. ▪ Sex workers and their clients. ▪ People who inject drugs. ▪ Voluntary medical male circumcision. ▪ PrEP, stratified by key populations. ▪ Condom promotion and provision for the general population. Direct expenditures in the purchase of condoms, needles and syringes, and drugs for substitution therapy separately from other costs (as available).

F. Expenditure on prevention of vertical transmission of HIV (specific commodities separately)	Funding source	Pregnant women and newborns	Activities aimed at elimination of new HIV infections in children, including: ▪ HIV testing for pregnant women. ▪ Antiretroviral therapy for pregnant women living with HIV. ▪ Antiretroviral medicine for newborns. ▪ Safe childbirth practices. ▪ Counselling and support for maternal nutrition and for exclusive breastfeeding. **Note:** When a woman living with HIV receives antiretroviral therapy as a part of her treatment before she knows she is pregnant, the treatment should be included under antiretroviral therapy for adults rather than for the prevention of mother-to-child transmission.
G. Expenditure on social enablers	Funding source	Not Applicable	Activities to support the implementation of basic programmes as defined in the UNAIDS Investment Framework, including: ▪ Political commitment and advocacy. ▪ Mass media. ▪ Laws, legal policies and practices. ▪ Community mobilization. ▪ Stigma reduction. ▪ Human rights programmes
H. Expenditure on cash transfers for young women and girls (age 10–24 years, high-prevalence countries)	Funding source	Young women and girls (age 10–24 years)	Total expenditure on cash transfers for young women and girls (age 10–24 years). This is defined as a development synergy with implications for HIV prevention.

Further information

To access guidelines, framework tools and classifications for NASAs, please contact AIDSspending@unaids.org

Health Accounts reports are available at the World Health Organization (WHO) Global Health Expenditure Database: http://apps.who.int/nha/database/DocumentationCentre/Index/en

Eurostat. HEDIC – Health expenditures by diseases and conditions. 2016 edition [Internet]. Luxembourg: Publications Office of the European Union; 2016 (http://ec.europa.eu/eurostat/web/products-statistical-working-papers/-/KS-TC-16-008).

Guidelines for completing the 2025 interim National Commitments and Policy Instrument

Introduction

Policy monitoring has been a component of global AIDS reporting since 2003, and it has been implemented every two years, most recently in 2024. The National Commitments and Policy Instrument (NCPI) is an integral component of Global AIDS Monitoring (GAM) that aims to measure progress in developing and implementing policies, strategies and laws related to the HIV response. It achieves this by doing the following:

- Promoting consultation and dialogue between key stakeholders at the national level, especially government and civil society and communities, in order to capture their perspectives on the AIDS response.
- Supporting countries in assessing the status of their HIV epidemic and response, and in identifying barriers, gaps and facilitators to strengthen the response.
- Collecting data on the policy and legal environment related to the AIDS response.

The responses directly monitor several targets and provide context on progress towards achieving global targets.

The NCPI is to be completed and submitted as part of GAM reports every two years. This interval reflects the expectation that changes to laws, policies and regulations occur slowly, and that the need for more frequent monitoring may be limited.

During interim years, an interim NCPI is to be completed and submitted as part of GAM reports. The interim NCPI includes a subset of questions from the NCPI Part A that relate to policy elements that may change more frequently.

Based on extensive consultations, the NCPI questionnaire was restructured and the questions revisited in 2021 to reflect the global commitments in the 2021 United Nations (UN) Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. The wording of some of the questions has since been further refined based on experiences in previous reporting rounds and to reflect developments in policy recommendations and available technologies.

Structure of the National Commitments and Policy Instrument

The NCPI has two parts: Part A is to be completed by national authorities, and Part B is to be completed by civil society, communities and other nongovernmental partners involved in the national AIDS response. For interim reporting years, only a subset of questions from Part A are included in the interim NCPI.

The questions are structured around the commitments in the 2021 Political Declaration on AIDS.

Proposed steps for gathering and validating data

The process described below for completing the NCPI should be integrated within each country's plan and time frame for the overall GAM process. This suggested process aims to integrate consistency checks for NCPI data collected throughout the process and to promote analysis of the information that is as objective as possible.

While questions from the NCPI Part B—which are to be completed by civil society, communities and other nongovernmental partners engaged in the response—are not included in the interim NCPI, countries are encouraged to engage civil society and communities in the overall GAM process.

1. Establish a working group to accompany NCPI reporting. This could be an existing multisectoral monitoring and evaluation technical working group.
2. Identify a focal point to coordinate the completion of the questionnaire.
3. An NCPI working group conducts a stakeholder mapping exercise to select contributors systematically.

   A mapping exercise can ensure that the most up-to-date and accurate data can be collected through the NCPI by involving relevant experts and avoiding the influence of potential biases in the reporting process. It can ensure that the reporting reflects a broad range of perspectives. Involving a broad range of stakeholders can also help with interpreting qualitative or potentially ambiguous data.

   The list of all of the people or entities who could provide information or insight on the questions included in the NCPI can be drawn from the knowledge of working group members, through contacts with other people knowledgeable about the national HIV response and by reviewing relevant documentation. Stakeholders can be identified from the following sectors and groups (among others):

   - Health ministry or the equivalent.
   - Education ministry or the equivalent.
   - Gender ministry or the equivalent.
   - Justice ministry or the equivalent.
   - Trade ministry or the equivalent.
   - Representatives of people living with HIV, including women and young people living with HIV.
   - Representatives of the various key population groups.
   - Bilateral and multilateral organizations engaged in the HIV response.
   - Other nongovernmental organizations or foundations engaged in the HIV response.
   - The private sector.

Geographical diversity should be considered in identifying stakeholders to ensure representativeness.

The following information should be recorded for all stakeholders contacted throughout the NCPI reporting process:

- Name.
- Contact details.
- Organization affiliation.
- Role in the organization.
- Stakeholder type (e.g., health ministry, other ministry, private sector, civil society, community, international nongovernmental organization, bilateral organization, UNAIDS or other UN organization).

This information could be helpful for documenting the multisectoral nature of the process and supporting preparations for future rounds of NCPI reporting.

4. Collect responses to NCPI questions. To ensure accuracy and avoid respondent fatigue, it is suggested that specific questions be directed to specific respondents who are knowledgeable in that area. Focal points for the questionnaire or consultant(s) recruited to support the process should coordinate contact with identified stakeholders—such as through in-person interviews, or by phone or email—in order to share the NCPI questions in their area of expertise and gather their responses.

   If possible, it is recommended that the same question be sent to more than one stakeholder knowledgeable in the area. If there are discrepant answers, the coordinator for the NCPI could share a summary of the information received for that question with the various stakeholders who have provided it in order to clarify the source of the different responses and to reach a consensus (if possible). To avoid potential sources of bias, the anonymity of respondents should be maintained as much as possible during this process of data verification and follow-up.

   A PDF version of the questionnaire can also be downloaded through the NCPI header in the indicator list in the GAM online reporting tool (https://AIDSreportingtool.unaids.org).

   Please refer to the glossary of key terms (below) and to additional guidance on responding to laws-related questions in the NCPI (found in Annex 6).

5. The national GAM focal point enters responses in the online reporting tool.

6. Stakeholders view and provide comments on the draft responses. The draft of the completed NCPI can be shared with stakeholders by giving them viewing rights to the GAM online reporting tool or by sharing the NCPI questionnaire with draft responses in PDF. The PDF can be extracted from the online reporting tool by clicking **Print all NCPI to PDF** in the indicator list page.

7. Conduct a validation consultation:
    - To review NCPI responses for selected questions.
    - To analyse NCPI data jointly with indicator data, identifying progress, gaps, barriers and facilitators to the AIDS response.
    - To identify key points for narrative summaries for each commitment area.

    Because of the length of the questionnaire, it is suggested that instead of reviewing responses to all questions during the national validation workshop, the workshop should instead focus on: (a) specific questions identified as being key for discussion during the data collection and review process before the workshop; and (b) on discussing progress and gaps for each commitment area more broadly.
8. Update the NCPI responses entered in the GAM online reporting tool based on comments received in preparation for and during the consultation, and complete the narrative summaries for each commitment area.
9. Submit the NCPI responses with other GAM components on or before 31 March 2025.
10. Respond to queries posted through the online reporting tool during the data validation process.

Operationalizing and using the National Commitments and Policy Instrument data

Data collected through the NCPI will complement indicator and expenditure data that are also collected and reported through the GAM process. Countries are encouraged to use the NCPI data in analysing the status of the national epidemic and response, and in their national strategic planning efforts.

NCPI data will also be used: (a) to directly monitor progress globally towards several of the 10–10–10 targets and as proxy measures for the 30-80-60 targets; (b) to provide context to quantitative data collected through GAM indicators during the analysis of progress towards other global commitments in the 2021 Political Declaration on AIDS; and (c) to inform global strategies and reports. The responses to the NCPI questions from each country will be aggregated in order to generate regional and global values. The NCPI data by country will be available through AIDSInfo (http://aidsinfo.unaids.org/) and Laws and Policies Analytics (http://lawsandpolicies.unaids.org/).

For important guidance on interpreting and responding to questions within the NCPI on the existence of certain laws, please refer to Annex 6 in these guidelines.

Loading policy data previously reported through Global AIDS Monitoring

Countries that submitted responses to questions through a previous NCPI that have remained the same from the previous reporting round can choose to load those responses into the GAM online reporting tool. Responses can then be updated or resubmitted where there has been no change.

Definitions

The following are definitions of key terms included in the NCPI questionnaire, as indicated by an asterisk (*).

These definitions should be followed to complete the questionnaire. Consistent use of these definitions over time and across countries strengthens comparability and trend analyses.

Cash transfers. Programmes that give money to poor and vulnerable people. Cash transfers may be conditional, giving money in return for fulfilling specific behavioural conditions (such as school attendance among children) or unconditional (not attached to specific behavioural requirements).

Established on antiretroviral therapy. The World Health Organization (WHO) defines people established on antiretroviral therapy as having met all of the following criteria: (a) they have been receiving antiretroviral therapy for at least six months; (b) they have no current illness, which does not include well-controlled chronic health conditions; (c) they have a good understanding of lifelong adherence: (d) they are provided with adequate adherence counselling; and (e) there is evidence of treatment success (at least one suppressed viral load result within the past six months; if viral load is not available, at least one of the following can be considered: CD4 count >200 cells/mm^3 [CD4 count >350 cells/mm^3 for children aged 3 to 5 years] or weight gain, absence of symptoms and concurrent infections).[1]

Gender-based violence. Any intentional act or failure to act—whether threatened or actual—against a person on the basis of their gender that results, or is likely to result, in physical, sexual or psychological harm.[2]

HIV case surveillance. HIV case surveillance refers to the reporting of an initial diagnosis of HIV infection and defined sentinel events from every person diagnosed with HIV to a public health agency responsible for monitoring and controlling the epidemic. Case surveillance entails individual-level, longitudinal data obtained from multiple sources that are linked by unique identifiers and maintained in a dedicated data repository at the national level.[3]

Life skills-based HIV and sexuality education. An age-appropriate, culturally sensitive approach to teaching sex and relationships by providing scientifically accurate, realistic and non-judgemental information.[4]

Non-nucleoside/nucleotide transcriptase inhibitors (NNRTI). Antiviral drug class non-analogue to nucleosides that blocks/interferes with HIV reverse transcriptase and prevents HIV replication.

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1 See: Consolidated guidelines on HIV prevention, testing, treatment, service delivery, and monitoring. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240031593).

2 UNAIDS terminology guidelines. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf).

3 See: Consolidated guidelines on person-centred HIV patient monitoring and case surveillance. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/978-92-4-151263-3).

4 UNESCO, UNAIDS, UNFPA, UNICEF, WHO. International technical guidance on sexuality education. Volume I. Paris: UNESCO; 2009.

Participation. Active and informed participation in formulating, implementing and monitoring and evaluating all decisions, policies and interventions that affect one's health in order to ensure respect for human rights. It also means ensuring that health systems and interventions are responsive, effective, appropriate and sustainable. Participation is informed when people can access the information required to participate in a meaningful and effective way. If necessary, capacity-building activities should be carried out to ensure this.[5]

Routine viral load testing. Routine viral load monitoring can be carried out at six months and 12 months, and then every 12 months thereafter, if the patient is stable on antiretroviral therapy.[6]

Social protection. Defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups."[7] Social protection is HIV-sensitive when it is inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV.[8]

Stock-out. Unplanned interruption in the stock of a health product.

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5 See: Sander G. HIV, HCV, TB and harm reduction in prisons: human rights, minimum standards and monitoring at the European and international levels. London: Harm Reduction International; 2016 (https://www.hri.global/files/2016/02/10/HRI_PrisonProjectReport_FINAL.pdf).

6 See: Consolidated guidelines on HIV prevention, testing, treatment, service delivery, and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240031593).

7 See: Devereux S, Sabates-Wheeler R. Transformative social protection. IDS Working Paper 232. Brighton: Institute of Development Studies; 2004 (https://www.ids.ac.uk/download.php?file=files/dmfile/Wp232.pdf).

8 See: HIV and social protection guidance note. Geneva: UNAIDS; 2014 (http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_HIVandsocialprotection_en.pdf).

Interim NCPI

Abbreviations

1HP	1 month of daily rifapentine plus isoniazid
3HP	3 months of weekly rifapentine plus isoniazid
3HR	3 months of daily rifampicin plus isoniazid
3TC	lamivudine
4R	4 months of daily rifampicin
6H	6 months of daily isoniazid monotherapy
6Lfx	6 months of daily levofloxacin monotherapy
9H	9 months of daily isoniazid monotherapy
ABC	abacavir
ATV/r	atazanavir/ritonavir
AZT	zidovudine
CAB-LA	long-acting injectable cabotegravir
CPR	C-reactive protein
CrAg	cryptococcal antigen
DPV-VR	dapivirine vaginal ring
DRV/r	darunavir/ritonavir
DTG	dolutegravir
DVR	dapivirine vaginal ring
EFV	efavirenz
EWI	early warning indicator
FDC	fixed-dose combination
FTC	emtricitabine
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B virus
HIVDR	HIV drug resistance
IGRA	interferon-gamma release assay
LF-LAM	lateral flow urine lipoarabinomannan assay
LPV/r	lopinavir with a ritonavir boost
MNCH	maternal, newborn and child health
NCD	noncommunicable diseases
NCPI	National Commitments and Policy Instrument
NNRTI	non-nucleoside/nucleotide transcriptase inhibitors
NRTI	nucleoside reverse transcriptase inhibitor
PDR	pre-treatment drug resistance
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
RPR	rapid plasma reagin
TAF	tenofovir
TB	tuberculosis
TDF	tenofovir disoproxil fumarate
TPHA	*Treponema pallidum* hemagglutination assay
TPPA	*Treponema pallidum* particle agglutination assay
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VDRL	venereal disease research laboratory
WHO	World Health Organization

Interim National Commitments and Policy Instrument

* The guidelines for the NCPI define the terms marked with an asterisk (*).

1. Combination prevention for all

- Reduce new HIV infections to under 370 000 by 2025.
- Ensure that 95% of people at risk of HIV infection—within all epidemiologically relevant groups, age groups and geographic settings—have access to and use appropriate, prioritized, person-centred and effective combination prevention options.
- Reduce the number of new HIV infections among adolescent girls and young women to below 50 000 by 2025.
- Ensure availability of pre-exposure prophylaxis (PrEP) for 10 million people at substantial risk of HIV and post-exposure prophylaxis (PEP) for people recently exposed to HIV by 2025.
- 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options.

Pre-exposure prophylaxis

1. Do your country's national guidelines recommend any of the following pre-exposure prophylaxis (PrEP) modalities or products (select all that apply)?

☐ Oral PrEP containing tenofovir (TDF)
☐ Dapivirine vaginal ring (DPV-VR or DVR)
☐ Long-acting Injectable cabotegravir (CAB-LA)
☐ No PrEP modalities/products are recommended in the national guidelines

1.1 To which populations is PrEP provided under the national guidelines (select all that apply)?

☐ Gay men and other men who have sex with men
☐ Sex workers
☐ People who inject drugs
☐ Transgender people
☐ Serodiscordant couples
☐ Young women (aged 18–24 years)
☐ Adolescents (aged <17 years)
☐ People in prisons and other closed settings
☐ Pregnant and breastfeeding women
☐ People who request PrEP
☐ Other (please specify): _____
☐ No national PrEP guidelines have been developed

1.2 Who has the authority to provide PrEP in your country (select all that apply)?

☐ Doctors
☐ Clinical officers
☐ Nursing cadre (e.g. midwives, nurse practitioners, registered nurses)
☐ Pharmacists
☐ Community health workers
☐ Other (please specify): _____
☐ No provider has authority to provide PrEP in the country

1.3 Is PrEP available through any of the following in your country (select all that apply)?

☐ Public health-care facilities
☐ Community-based distribution (including mobile services)
☐ Pharmacies (stand-alone, including online)
☐ Private health-care providers
☐ The internet
☐ Research sites
☐ Other (please specify): _____

Post-exposure prophylaxis

2. Do your country's national guidelines recommend post-exposure prophylaxis (PEP) for the following groups (select all that apply)

- ☐ Exposure related to health care (occupational exposure)
- ☐ Exposure related to sexual or gender-based violence
- ☐ Any other exposure

2.1 Who has the authority to provide PEP in your country (select all that apply)?

- ☐ Doctors
- ☐ Clinical officers
- ☐ Nursing cadre (e.g. midwives, nurse practitioners, registered nurses)
- ☐ Pharmacists
- ☐ Community health workers
- ☐ Other (please specify): _____

2.2 Is PEP available through any of the following in your country (select all that apply)?

- ☐ Public health-care facilities
- ☐ Community-based distribution (including mobile services)
- ☐ Pharmacies (stand-alone, including online)
- ☐ Private health-care providers
- ☐ The internet
- ☐ Research sites

Voluntary medical male circumcision

Please note that these questions are only asked of 15 countries with high HIV prevalence, low levels of male circumcision and generalized heterosexual epidemics: Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

3. What medical male circumcision methods are recommended/approved by the national programme (select all that apply)?

- ☐ Conventional surgical methods (dorsal slit, forceps guided, sleeve resection)
- ☐ World Health Organization (WHO) prequalified device method approved for use

Condoms

4. Has the national need for condoms been estimated?

- ☐ Yes
- ☐ No

4.1 If yes, what is the estimated number of condoms needed? _____

4.2 If yes, for what year is the condom needs estimate? _____

4.3 If yes, what method was used to estimate the number of condoms needed (select all that apply)?

- ☐ General population (condoms per sexually active man/year)
- ☐ Historical (same as last year + population growth)
- ☐ Budget-driven (based on what can be bought)
- ☐ Demand-based (based on past condom usage rates, such as using the GOALS model)
- ☐ Capacity-based (how many can be supplied and distributed with current capacity)
- ☐ Part of family planning commodity needs estimates
- ☐ "Total universe of need" approach
- ☐ UNFPA/UNAIDS Condom Needs and Resource Requirement Estimation Tool
- ☐ Other (please specify): _____

5. **Have there been condom stock-outs* in the past 12 months?**

5.a **National stock-outs**

☐ Yes

☐ No

5.b **Local stock-outs**

☐ Yes

☐ No

2. 95–95–95 for HIV testing and treatment

- Reduce annual AIDS-related deaths to under 250 000 by 2025.
- Ensure that 34 million people are on HIV treatment by 2025.
- Achieve the 95–95–95 testing, treatment and viral suppression targets within all demographics, groups and geographic settings, including children and adolescents living with HIV:
  - 95% of people living with HIV know their HIV status.
  - 95% of people who know their HIV-positive status are accessing treatment.
  - 95% of people on treatment have suppressed viral loads.
- Ensure that 90% of people living with HIV receive preventive treatment for tuberculosis (TB) by 2025.
- Reduce TB-related deaths among people living with HIV by 80% by 2025 (compared to a 2010 baseline).

HIV testing

6. **Which of the following HIV testing approaches are used in your country (select all that apply)?**

☐ Client-initiated testing and counselling

☐ Provider-initiated testing and counselling

☐ Indicator condition testing

☐ Routine antenatal testing

☐ Dual HIV/syphilis rapid diagnostic testing (such as for pregnant women, partners or any population)

☐ Community-based testing

☐ Lay provider testing

☐ Self-testing

☐ Network-based testing (including partner services, social network testing, or family testing)

☐ Other (please specify): _____

7. **Has your country adapted the recommendations from the 2024 World Health Organization (WHO) *Consolidated guidelines on differentiated HIV testing services* in a national process on testing guidelines?**

☐ Yes, fully

☐ Yes, partially

☐ No

☐ Don't know

8. **Has your country included self-testing as a national policy (either within the national testing policy/plan or as a stand-alone self-testing policy)?**

8.a **HIV self-testing**

☐ Yes
☐ No

8.a.i **If yes, is the HIV self-testing policy routinely implemented in your country?**

☐ HIV self-testing policy is routinely implemented on a national scale
☐ HIV self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

8.a.ii **If yes to Q8.a, has your country included HIV self-testing to support PrEP initiation or continuation (either within the national HIV testing policy or plan or as a standalone HIV self-testing policy)?**

☐ Yes
☐ No

8.a.iii **If yes to Q8.a.ii, is HIV self-testing to support PrEP routinely implemented in your country?**

☐ Yes, routinely implemented on a national scale
☐ Yes, routinely implemented on a subnational scale or in selected districts
☐ No, only in pilot projects
☐ No, not implemented anywhere

8.a.iv **If yes to Q8.a, has your country included HIV self-testing to support PEP initiation or continuation (either within the national HIV testing policy or plan or as a standalone HIV self-testing policy)?**

☐ Yes
☐ No

8.a.v **If yes to Q8.a.iv, is HIV self-testing to support PEP routinely implemented in your country?**

☐ Yes, routinely implemented on a national scale
☐ Yes, routinely implemented on a subnational scale or in selected districts
☐ No, only in pilot projects
☐ No, not implemented anywhere

8.b **Syphilis self-testing**

☐ Yes
☐ No

8.b.i **If yes, is the syphilis self-testing policy routinely implemented in your country?**

☐ Syphilis self-testing policy is routinely implemented on a national scale
☐ Syphilis self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

8.c **Hepatitis C self-testing**

☐ Yes
☐ No

8.c.i **If yes, is hepatitis C self-testing policy routinely implemented in your country?**

☐ Hepatitis C self-testing policy is routinely implemented on a national scale
☐ Hepatitis C self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

8.d **Other self-testing (please specify)**

☐ Yes
☐ No

8.d.i **If yes, is the other self-testing policy routinely implemented in your country?**

☐ Other self-testing policy is routinely implemented on a national scale
☐ Other self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

9. Has your country included any form of network-based testing (partner services, social network testing, family testing) in a national policy (select all that apply)?

- ☐ Yes, partner services
- ☐ Yes, social network testing
- ☐ Yes, family testing
- ☐ No, none of the above

9.1 If yes, which of the following network-based testing approaches are being used (select all that apply)?

- ☐ Provider-assisted partner services
- ☐ Passive partner services
- ☐ Social network testing in key populations
- ☐ Social network testing in the general population
- ☐ Secondary distribution of HIV self-test kits to partners or network contacts
- ☐ Testing of biological children of people living with HIV

10. Has your country adopted or included dual HIV/syphilis rapid diagnostic tests for pregnant women and/or key populations as a national policy or plan?

- ☐ Yes, for pregnant women only
- ☐ Yes, for key populations only
- ☐ Yes, for both pregnant women and key populations
- ☐ No

10.1 If yes, is dual HIV/syphilis rapid diagnostic testing routinely implemented in your country?

10.1.a For pregnant women:

- ☐ Yes, routinely implemented on a national scale
- ☐ Yes, routinely implemented on a subnational scale or in select districts
- ☐ No, only in pilot projects
- ☐ No, not implemented anywhere

10.1.b For people from key populations:

- ☐ Yes, routinely implemented on a national scale, including subnational
- ☐ Yes, routinely implemented on a subnational scale or in selected districts
- ☐ No, only in pilot projects
- ☐ No, not implemented anywhere

11. Does your country use three consecutive reactive tests (3-test strategy/algorithm) for an HIV-positive diagnosis?

- ☐ Yes
- ☐ No

11.1 If yes to Q11, is the 3-test strategy routinely implemented in your country?

- ☐ Yes
- ☐ No

11.2 If no to Q11, does your country have a plan to adopt a 3-test strategy/algorithm for an HIV-positive diagnosis?

- ☐ Yes
- ☐ No

11.3 If yes to Q11.2, please indicate the year in which a national policy on 3-test strategy for an HIV-positive diagnosis is planned to be adopted.

- ☐ No planned year
- ☐ 2025
- ☐ 2026
- ☐ 2027
- ☐ 2028

11.4 Does your country use the following assays in the standard/routine national testing strategy/algorithm (select all that apply)?

- ☐ Rapid diagnostic (antibody test)
- ☐ Rapid diagnostic (antibody/antigen test)
- ☐ Immunoassay
- ☐ Western blotting
- ☐ Nucleic acid test
- ☐ Recency test

Antiretroviral therapy

12. **Has your country adopted the recommendations on rapid Initiation of antiretroviral therapy in the 2021 World Health Organization (WHO) *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach?***

- ☐ Yes, rapid initiation within 7 days of HIV diagnosis
- ☐ No
- ☐ Other (please specify): _____

12.1 **If your country has adopted a policy on rapid initiation of antiretroviral therapy, what is the status of implementation?**

- ☐ Implemented in few (<50%) treatment sites
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

13. **Does your country have a policy to offer starting antiretroviral therapy on the same day as an HIV diagnosis, as part of the policy on rapid initiation of antiretroviral therapy?**

- ☐ Yes
- ☐ No

13.1 **If yes, what is the status of implementation?**

- ☐ Implemented in few (<50%) treatment sites
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

14. **Is CD4 testing for diagnosing advanced HIV disease available?**

- ☐ Yes
- ☐ No

14.1 **Is yes, where is it available (select all that apply)?**

- ☐ Point-of-care
- ☐ Facility laboratory
- ☐ Centralized laboratory
- ☐ Other (please specify): _____

14.2 **If yes, in what percentage of sites (estimated) do clients have access to CD4 testing and return of results?**

- ☐ In few (<50%) sites
- ☐ In many (50–95%) sites
- ☐ Countrywide (>95% of sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

14.3 **If yes, what is the median time (in number of days) for the person to receive the CD4 result?**

- ☐ Please specify:_____
- ☐ Not available

15. **Is nurse-initiated antiretroviral therapy allowed in your country for any of the following populations (select all that apply)?**

- ☐ Adults, except pregnant women
- ☐ Pregnant women
- ☐ Adolescents (aged 10–19 years)
- ☐ Children younger than 10 years
- ☐ None of the above

16. Does your country have a national policy promoting community delivery of antiretroviral therapy (such as outside of health facilities)?

☐ Yes
☐ No

16.1 If yes, where is delivery in a community setting implemented?

☐ Nationally
☐ Regionally
☐ At pilot sites
☐ Other (please specify): _____

16.2 If yes, to which populations is antiretroviral therapy provided in community settings in your country (such as outside of health facilities)?

☐ For all people on antiretroviral therapy, including pregnant and breastfeeding women and children
☐ For all people on antiretroviral therapy, excluding pregnant and breastfeeding women and children
☐ For all people on antiretroviral therapy, including pregnant and breastfeeding women, but excluding children
☐ For all people on antiretroviral therapy, including children, but excluding pregnant and breastfeeding women
☐ For all people who are stable on antiretroviral therapy, according to the national guidelines
☐ Other (please specify):_____

16.3 If yes, which differentiated service delivery models is your country using for the pick-up of antiretroviral medicine (select all that apply)?

☐ Group models managed by health-care workers (such as adherence clubs, teen clubs)
☐ Group models managed by clients (such as community adherence groups, client-led ART delivery)
☐ Individual models based at facilities (such as multi-month ARV refills, fast track ARV pick-up)
☐ Individual models not based at facilities (such as community drug distribution points, ARV lockers, home ARV delivery, mobile clinics)
☐ Other (please specify):_____

17. Does your country have a national policy on the frequency of clinic visits for adults who are established* on antiretroviral therapy?

☐ Yes
☐ No

17.1 If yes, please specify the frequency of clinic visits in the national policy.

☐ Once a month
☐ Every 2 months
☐ Every 3 months
☐ Every 6 months
☐ Every 12 months

17.2 If yes, what is the status of implementation?

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

18. **Does your country have a national policy on how frequently adults who are established* on antiretroviral therapy should pick-up antiretroviral medicine?**

☐ Yes
☐ No

18.1 **If yes, please specify the frequency of antiretroviral medicine pick-up included in the national policy.**

☐ Once a month
☐ Every 2 months
☐ Every 3 months
☐ Every 6 months
☐ Every 12 months
☐ Other (please specify): _____

18.2 **If yes, what is the status of implementation?**

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

19. **Do the country's national criteria for (or definition of) people established* on antiretroviral therapy include the following elements defined in the 2021 World Health Organization (WHO) *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (select all that apply)?**

☐ Receiving antiretroviral therapy for at least 6 months
☐ No current Illness (does not Include well-controlled chronic health conditions)
☐ Good understanding of lifelong adherence
☐ Evidence of treatment success (i.e. at least one suppressed viral load result within the past six months)
☐ Other (please specify): _____

20. **Does the country provide psychological support for adolescents living with HIV?**

☐ Yes
☐ No

21. **Does your country implement interventions to trace people who have disengaged from care and provide support for reengagement?**

☐ Yes
☐ No

22. **Please provide the country's national criteria for (or definition of) lost to follow-up. For guidance, the World Health Organization (WHO) defines "lost to follow-up" as a patient who has not received antiretroviral medicines within 28 days of their last missed drug collection appointment.**[1]

_____

23. **Has your country adopted the recommendations in the 2021 World Health Organization (WHO) *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* to offer a package of interventions to all patients presenting with advanced HIV disease (defined by WHO as CD4<200)?**

☐ Yes, fully adopted
☐ Yes, partially adopted (only for specific interventions and/or populations, such as children, adolescents or adults) (please specify): _____
☐ No

23.1 **If yes, how widely is it implemented?**

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

[1] Source: Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022, page 127)

24. Which of the following components of the package of advanced HIV disease interventions for tuberculosis (TB), severe bacterial infections and cryptococcal meningitis recommended in the 2021 WHO *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* are included in the national policy on antiretroviral therapy for adults, adolescents and children (select all that apply)?

- ☐ Baseline CD4 count test to diagnose advanced HIV disease
- ☐ Molecular diagnostic tests for TB diagnosis
- ☐ Urine LF-LAM for TB diagnosis
- ☐ Cryptococcal antigen (CrAg) screening
- ☐ Co-trimoxazole prophylaxis
- ☐ TB preventive treatment
- ☐ Fluconazole empirical prophylaxis
- ☐ Fluconazole pre-emptive therapy
- ☐ Rapid antiretroviral therapy initiation
- ☐ Adapted adherence support
- ☐ Other (please specify): _____

25. Which of the following service provision modalities are included in the national policy on antiretroviral therapy for adults, adolescents and children (select all that apply)?

- ☐ Tuberculosis (TB) service providers provide antiretroviral therapy in TB clinics for the duration of TB treatment
- ☐ Antiretroviral therapy providers provide TB treatment in antiretroviral therapy settings for the duration of TB treatment
- ☐ Maternal, newborn and child health (MNCH) service providers provide antiretroviral therapy in MNCH clinics
- ☐ Antiretroviral therapy providers deliver antiretroviral therapy for pregnant women
- ☐ Antiretroviral therapy providers deliver antiretroviral therapy for newborns, infants and children
- ☐ Nutrition assessment, counselling and support provided to malnourished people living with HIV
- ☐ Antiretroviral therapy delivered in settings providing opioid agonist maintenance therapy
- ☐ Primary health-care providers deliver antiretroviral therapy in primary health care for adults and adolescents
- ☐ Primary health-care providers deliver antiretroviral therapy in primary health-care settings for children
- ☐ Psychosocial support strategies for patient-centered care (e.g. support groups, enhanced adherence counselling, support for disclosure or referral for psychological/socioeconomic services) linked to facilities
- ☐ Patient-centered support (e.g. counselling, enhanced adherence counselling, support for disclosure or referral for psychological/socioeconomic services) separated from facilities
- ☐ Key population-friendly services
- ☐ Adolescent-friendly health services
- ☐ Antiretroviral therapy delivered in the community as part of a differentiated care model
- ☐ Antiretroviral therapy providers carry out cardiovascular disease screening and management
- ☐ Antiretroviral therapy providers carry out mental health screening and treatment
- ☐ Other (please specify): _____

26. **Do patients pay any routine user fees or charges for services when visiting a public sector health facility?**

☐ Yes

☐ No

26.1 **If yes, is there a specific formal fee or an informal/variable fee for the following?**

26.1.a. **HIV testing**

☐ Formal

☐ Informal

26.1.b. **Dispensing of pre-exposure prophylaxis (PrEP)**

☐ Formal

☐ Informal

26.1.c. **Primary care appointment**

☐ Formal

☐ Informal

26.1.d. **Patient cards**

☐ Formal

☐ Informal

26.1.e. **Diagnostic services (including viral load test)**

☐ Formal

☐ Informal

26.1.f. **Dispensing of HIV treatment**

☐ Formal

☐ Informal

26.1.g **Dispensing of prevention and treatment of co-infections**

☐ Formal

☐ Informal

26.1.h **Dispensing of other co-therapies (eg: medicines for NCDs, sexual & reproductive health, immunizations)**

☐ Formal

☐ Informal

Antiretroviral therapy regimens

Adults and adolescents

27. **Based on the recommendations in the 2021 WHO *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach*, is TDF + 3TC (or FTC) + DTG the preferred first-line antiretroviral combination for treatment initiation in national guidelines for the following:**

27.a **Adults and adolescents?**

☐ Yes
☐ No, TDF + 3TC (or FTC) + DTG is included as alternative first-line regimen
☐ No

27.a.i. **If yes, what is the status of implementation?**

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

27.a.ii **If no, what is (are) the preferred option(s):**

☐ TDF + 3TC (or FTC) + EFV 600 mg
☐ TDF + 3TC + EFV 400 mg
☐ ABC + 3TC + DTG
☐ TAF + 3TC (or FTC) + DTG
☐ Other regimens (please specify): _____

27.a.iii **If no, is there a plan to adopt TDF + 3TC (or FTC) + DTG as the preferred first-line antiretroviral combination for treatment initiation in 2025?**

☐ Yes
☐ No

27.b **Women of childbearing age?**

☐ Yes
☐ No

27.b.i **If no, what is (are) the preferred option(s):**

☐ TDF + 3TC (or FTC) + EFV 600 mg
☐ TDF + 3TC + EFV 400 mg
☐ TAF + 3TC (or FTC) + DTG
☐ Other regimens (please specify): _____

27.b.ii **If no, is there a plan to adopt TDF + 3TC or (FTC) + DTG as the preferred first-line antiretroviral medicine combination for treatment initiation in 2025?**

☐ Yes
☐ No

27.c. **Pregnant and/or breastfeeding women?**

☐ Yes
☐ No

27.c.i **If no, what is (are) the preferred option(s):**

☐ TDF + 3TC (or FTC) + EFV 600 mg
☐ TDF + 3TC + EFV 400 mg
☐ TAF + 3TC (or FTC) + DTG
☐ Other regimens (please specify): _____

27.c.ii. **If no, is there a plan to adopt TDF + 3TC or (FTC) + DTG as the preferred first-line antiretroviral medicine combination for treatment initiation in 2025?**

☐ Yes
☐ No

28. Does your country use fixed-dose combination (FDC) antiretroviral therapy as the preferred first-line therapy (select all that apply)?

- ☐ Yes, 3-drug fixed-dose combination, taken once a day
- ☐ Yes, 2-drug fixed-dose combination plus 1 other drug, taken once a day
- ☐ No
- ☐ Other (please specify): _____

29. Is a DTG-based regimen included in the national guidelines as an option for second-line antiretroviral combination for adults and adolescents with HIV?

- ☐ Yes, as preferred option
- ☐ Yes, as alternative option
- ☐ No
- ☐ Other (please specify): _____

30. Is atazanavir/ritonavir (ATV/r) included in national guidelines as a protease inhibitor option for second-line antiretroviral combination for adults and adolescents with HIV?

- ☐ Yes, as preferred option
- ☐ Yes, as alternative option
- ☐ Yes, as third-line option
- ☐ No
- ☐ Other (please specify): _____

31. Is lopinavir/ritonavir (LPV/r) included in national guidelines as a protease inhibitor option for second-line antiretroviral combination for adults and adolescents with HIV?

- ☐ Yes, as preferred option
- ☐ Yes, as alternative option
- ☐ Yes, as third-line option
- ☐ No
- ☐ Other (please specify): _____

32. Is darunavir/ritonavir (DRV/r) included in national guidelines as a protease inhibitor option for second-line antiretroviral combination for adults and adolescents with HIV?

- ☐ Yes, as preferred option
- ☐ Yes, as alternative option
- ☐ Yes, as third-line option
- ☐ No
- ☐ Other (please specify): _____

Children

33. **Are DTG regimens the preferred treatment initiation option in the national guidelines for all infants and children with HIV?**

- ☐ Yes, for all children older than 4 weeks and weighing more than 3kg
- ☐ Yes, but only for children weighing more than 20kg
- ☐ No
- ☐ Other (please specify): _____

33.1 **If DTG is not the preferred treatment option for infants and children older than 4 weeks and weighing more than 3kg, are LPV/r-based regimens the preferred treatment option?**

- ☐ Yes, for all
- ☐ No, but only for children weighing less than 20kg
- ☐ No

---

34. **What is the recommended NRTI backbone in the national guidelines for treatment initiation in children?**

- ☐ TDF + 3TC (or FTC)
- ☐ AZT + 3TC (or FTC)
- ☐ ABC + 3TC (or FTC)
- ☐ Other (please specify): _____

---

35. **Is DTG recommended as the preferred second-line option for children failing NNRTI*-based regimens?**

- ☐ Yes, for all children older than 4 weeks
- ☐ Yes, for children weighing more than 20 kg
- ☐ No
- ☐ Other (please specify): _____

---

36. **Is DTG recommended as the preferred second-line option for children failing protease inhibiting-based regimens?**

- ☐ Yes, for all children older than 4 weeks and weighing more than 3kg
- ☐ Yes, but only for children weighing more than 20kg
- ☐ No
- ☐ Other (please specify): _____

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37. **What is the recommended second-line option for children failing DTG-based regimens?**

- ☐ LPV/r
- ☐ ATV/r
- ☐ Other (please specify): _____

---

38. **Is a darunavir/ritonavir (DRV/r)-based regimen included in the national guidelines as an option for antiretroviral therapy of children with HIV?**

- ☐ Yes, as preferred second-line option
- ☐ Yes, as alternative second-line option
- ☐ Yes, only as third-line option
- ☐ Not recommended
- ☐ Other (please specify): _____

---

39. **Are any of the following early childhood development activities integrated into HIV programmes (select all that apply)?**

- ☐ Responsive caregiving
- ☐ Promote early learning
- ☐ Integrate caregiving and nutrition interventions
- ☐ Support maternal mental health
- ☐ None of the above

Viral load

40. **Please identify the measured threshold in national treatment guidelines at which viral load suppression[2] in an individual is defined as suppressed:**

- ☐ ≤1000 copies/ml
- ☐ ≤400 copies/ml
- ☐ ≤200 copies/ml
- ☐ ≤50 copies/ml
- ☐ Not detected by assay or sample type used
- ☐ Other (please specify): _____

41. **Does your country have a current national policy on routine viral load testing* for monitoring antiretroviral therapy?**

41.a **Adults and adolescents**

- ☐ Yes
- ☐ No

41.a.i **If yes, what is the status of implementation?**

- ☐ Implemented in few (<50%) treatment sites
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

41.b. **For children**

- ☐ Yes
- ☐ No

41.b.i **If yes, what is the status of implementation?**

- ☐ Implemented in few (<50%) treatment sites
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

42. **Does your country have a current national policy on point-of-care viral load testing?**

- ☐ Yes
- ☐ No

42.1 **If yes, what is the status of implementation?**

- ☐ Implemented in few (<50%) treatment sites
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

43. **Are dried blood spot specimens recommended in the national policy for viral load testing?**

- ☐ Yes
- ☐ No
- ☐ Other (please specify): _____

43.1 **If yes, what is the level of implementation?**

- ☐ Fully
- ☐ Partially
- ☐ Not implemented

[2] The viral suppression threshold for may differ from the threshold to determine treatment failure.

HIV drug resistance and toxicity monitoring

44. **Does your country have a national plan to monitor HIV drug resistance?**

☐ Yes

☐ No

44.1 **If yes, please specify the years covered by the plan:** _____

45. **In the past three years, has your country carried out HIV drug resistance (HIVDR) surveillance according to any of the following World Health Organization (WHO) protocols?**

45.a **Pre-treatment drug resistance (PDR) surveys**[3]

☐ Yes

☐ No, but there is a plan to implement the PDR survey this year

☐ No, and there is no plan to implement the PDR survey this year

45.a.i. **If yes, please specify the year the last PDR survey started:** _____

45.b **HIV drug resistance survey among individuals exposed to pre-exposure prophylaxis (PrEP) diagnosed with HIV infection**

☐ Yes

☐ No, but there is a plan to implement the survey this year

☐ No, and there is no plan to implement the survey this year

45.b.i **If yes, please specify the year the last survey started:** _____

45.c **Acquired drug resistance surveys among adults**[4]

☐ Yes

☐ No, but there is a plan to implement the survey this year

☐ No, and there is no plan to implement the survey this year

45.c.i. **If yes, please specify the year the last survey started:** _____

45.d **Acquired drug resistance surveys among children**

☐ Yes

☐ No, but there is a plan to implement the survey this year

☐ No, and there is no plan to implement the survey this year

45.d.i. **If yes, please specify the year the last survey started:** _____

45.e **HIV drug resistance among infants (<18 months) using early infant diagnosis**[5]

☐ Yes

☐ No, but there is a plan to implement the infant survey this year

☐ No, and there is no plan to implement the infant survey this year

45.e.i. **If yes, please specify the year the last infant survey started:** _____

45.f **Survey or routine monitoring of clinic performance using early warning indicators (EWI) for HIV drug resistance**

☐ Yes

☐ No

45.f.i. **If yes, please specify:**

☐ Year it was last monitored: _____

☐ Number of clinics monitored: _____

45.g **The early warning indicators (EWI) for HIV drug resistance were collected through:**

☐ EWI survey in a sample of clinics

☐ Routine patient monitoring systems

[3] For more details, please see: Surveillance of HIV drug resistance in adults initiating antiretroviral therapy. Geneva: WHO; 2014 (https://www.who.int/publications/i/item/9789241507196).

[4] For more details, please see: Surveillance of HIV drug resistance in adults receiving ART. Geneva: WHO; 2014 (https://www.who.int/publications/i/item/9789241507073).

[5] For more details, please see: HIV drug resistance. In: World Health Organization: Global HIV Programme: Treatment & Care [website]. Geneva; WHO; c2018 (https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/treatment/hiv-drug-resistance).

46. **Does your country have a national policy for HIV drug resistance testing for individual patients who fail antiretroviral therapy for clinical management?**

☐ Yes
☐ No

46.1 **If yes, which of the following groups are considered in the policy (select all that apply)?**

☐ Adults failing DTG-based first-line antiretroviral therapy
☐ Children failing DTG-based first-line antiretroviral therapy
☐ Adults failing DTG-based second-line antiretroviral therapy
☐ Children failing DTG-based second-line antiretroviral therapy
☐ Adults failing protease inhibitor-based second-line antiretroviral therapy
☐ Children failing protease inhibitor-based second-line antiretroviral therapy
☐ Patients failing third-line antiretroviral therapy
☐ Other (please specify): _____

47. **Does your country have a national policy for HIV drug resistance testing for individual patients who initiate antiretroviral therapy?**

☐ Yes
☐ No

47.1 **If yes, which of the following groups are considered in the policy (select all that apply)?**

☐ All adults initiating first-line DTG-based first-line antiretroviral therapy
☐ People with a history of tenofovir-based PrEP for the prevention of HIV
☐ People with a prior history of cabotegravir-based PrEP for the prevention of HIV
☐ Infants and children initiating first-line antiretroviral therapy
☐ Pregnant women initiating first-line antiretroviral therapy
☐ Other (please specify): _____

48. **Excluding passive pharmacovigilance approaches, does your country make an ongoing systematic effort to monitor the toxicity of antiretroviral medicines in the country?**

☐ Yes
☐ No

48.1 **If yes, what approaches are used (select all that apply)?**

☐ Routine toxicity monitoring as part of the national monitoring and evaluation system
☐ Active toxicity monitoring/surveillance within cohorts in adults
☐ Active toxicity monitoring/surveillance within cohorts in adolescents and children
☐ Pregnancy registry and surveillance of birth defects

49. **Have toxicity monitoring approaches been introduced to monitor adverse drug reactions to DTG use?**

☐ Yes
☐ No

49.1 **If yes, what approaches are used (select all that apply)?**

☐ Routine toxicity monitoring as part of the national monitoring and evaluation system
☐ Active toxicity monitoring/surveillance within cohorts in adults
☐ Active toxicity monitoring/surveillance within cohorts in adolescents and children
☐ Pregnancy registry and surveillance of birth defects

49.2 **If yes, has training of health-care workers on the management, capture and reporting of adverse drug reactions related to DTG been implemented?**

☐ Yes
☐ No

Adherence and retention

50. Does your country have national policies and/or strategies on adherence support (community and facility-based)?

☐ Yes
☐ No

51. Are any of the following adherence support services being implemented in your country (select all that apply)?

☐ Peer counsellors
☐ Text messages
☐ Use of reminder devices
☐ Patient reintegration follow-up calls/home visits
☐ Enhanced adherence counselling
☐ Referral to psychological/socioeconomic support
☐ Cognitive behavioural therapy
☐ Behavioural skills training/medication adherence training
☐ Fixed-dose combinations and once-daily regimens
☐ Case management
☐ Peer navigation
☐ Other (please specify): _____

52. Does your country have national policies and/or strategies on retention in antiretroviral therapy?

☐ Yes
☐ No

53. Are any of the following retention support services being implemented in your country (select all that apply)?

☐ Community-based interventions
☐ Adherence clubs and peer support
☐ Other (please specify): _____

54. Are treatment literacy programmes available in your country to people living with HIV, including information on side effects, drug resistance, etc.?

☐ Yes
☐ No

Tuberculosis/HIV

55. Are the following screening tools recommended for people living with HIV in national guidelines related to tuberculosis (TB) and/or HIV (select all that apply)?

- ☐ World Health Organization-recommended four symptom screen for adults and adolescents (>10 years)
- ☐ C-reactive protein (CRP) for adults and adolescents (>10 years)
- ☐ Chest X-ray for adults and adolescents (>10 years)
- ☐ Molecular World Health Organization-approved rapid diagnostic tests for TB (mWRD) for adults and adolescents (>10 years)
- ☐ Symptom screen, including cough, fever, poor weight gain or close contact with a TB patient for children <10 years
- ☐ None of the above

56. Has your country adopted the 2019 WHO policy update on the use of lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis and screening of active tuberculosis in people living with HIV (select all age groups that apply)?

- ☐ Yes, for adults and adolescents (>10 years)
- ☐ Yes, for children (<10 years)
- ☐ No

57. Which of the following regimens are recommended for tuberculosis (TB) preventive treatment in national guidelines?

57.a Adults and adolescents living with HIV (select all that apply)

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3HR)
- ☐ 1 month of daily rifapentine plus isoniazid (1HP)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____
- ☐ None of the World Health Organization recommended TB preventive treatment regimens are recommended in national guidelines for adults and adolescents

57.a.i If more than one regimen is recommended, which is the preferred regimen?

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3HR)
- ☐ 1 month of daily rifapentine plus isoniazid (1HP)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____

57.b Children living with HIV (select all that apply)

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3HR)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____
- ☐ TB preventive treatment not recommended in national guidelines for children

57.b.i. If more than one regimen is recommended, which is the preferred regimen?

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3HR)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____

58. **Are the following required in national guidelines prior to initiating tuberculosis (TB) preventive treatment in people with HIV?**

58.a **Skin tests or interferon-gamma release assay (IGRA)**

☐ Yes, for all
☐ No
☐ Only if available

58.b **X-ray**

☐ Yes, for all
☐ No
☐ Only if available

59. **In the last reporting period, has there been a stock-out* of any of the following?**

59.a **Isoniazid**

☐ Yes, at the national level
☐ Yes, at the local level
☐ No

59.b **Vitamin B6**

☐ Yes, at the national level
☐ Yes, at the local level
☐ No

59.c **Rifapentine (including fixed-dose combinations with isoniazid)**

☐ Yes, at the national level
☐ Yes, at the local level
☐ No

60. **What is the status of integration of the following HIV and tuberculosis (TB) services?**

60.a **World Health Organization-recommended rapid molecular diagnostics (e.g. Xpert MTB/RIF) are co-located:**

☐ In few (<50%) health facilities providing HIV testing and care
☐ In many (50–95%) health facilities providing HIV testing and care
☐ Countrywide (>95% of health facilities providing HIV testing and care)
☐ Not integrated in practice
☐ Other (please specify): _____

60.b **People living with HIV who have tuberculosis (TB) received antiretroviral medicines at the same place as they receive their TB treatment:**

☐ In few (<50%) health facilities
☐ In many (50–95%) health facilities
☐ Countrywide (>95% of health facilities)
☐ Not integrated in practice
☐ Other (please specify): _____

60.c **Antiretroviral therapy is initiated by the same health-care worker providing tuberculosis (TB) treatment for people living with HIV who have TB:**

☐ In few (<50%) health facilities
☐ In many (50–95%) health facilities
☐ countrywide (>95% of health facilities)
☐ Not integrated in practice
☐ Other (please specify): _____

60.d **Antiretroviral therapy and tuberculosis (TB) treatment for people living with HIV who have TB are monitored by one health-care worker:**

☐ In few (<50%) health facilities
☐ In many (50–95%) health facilities
☐ Countrywide (>95%) of health facilities
☐ Not integrated in practice
☐ Other (please specify): _____

3. End paediatric AIDS and eliminate vertical transmission

- Ensure that 75% of all children living with HIV have suppressed viral loads by 2023 and 86% by 2025, in line with the 95–95–95 HIV treatment targets.
- Ensure that 95% of pregnant women have access to testing for HIV, syphilis, hepatitis B and other sexually transmitted infections by 2025.
- Ensure that 95% of pregnant and breastfeeding women in high HIV burden settings have access to retesting during late pregnancy and in the post-partum period by 2025.
- Ensure that all pregnant and breastfeeding women living with HIV are receiving life-long antiretroviral therapy, with 95% achieving and sustaining viral suppression before delivery and during breastfeeding by 2025.
- Ensure that all HIV-negative pregnant and breastfeeding women in high HIV burden settings—or those who have male partners at high risk of HIV in all settings—have access to combination prevention, including pre-exposure prophylaxis (PREP), and that 90% of their male partners who are living with HIV are continuously receiving antiretroviral therapy.
- Ensure that 95% of children with perinatal HIV exposureare tested by two months of age and after the cessation of breastfeeding.

Prevention of vertical transmission of HIV

61. **Does your country have a policy on retesting HIV-negative women during pregnancy, delivery and/or the post-partum/breastfeeding period?**

☐ Yes
☐ No

61.1 **If yes, when is retesting done?**

61.1.a **During pregnancy**

☐ Yes
☐ No

61.1.a.i **If yes, which month of pregnancy:** _____

61.1.b **At delivery**

☐ Yes
☐ No

61.1.c **Post-partum/breastfeeding**

☐ Yes
☐ No

61.1.c.i **If yes, how long after delivery (in months):** _____

62. **Does your country have a national plan for the elimination of vertical transmission of HIV:**

☐ Yes
☐ No

62.1 **If yes, please specify:**

62.1.a Target(s) for the vertical transmission rate (%): _____

62.1.b Year: _____

62.1.c Elimination target(s) (such as the number of cases/100 000 population): _____

62.1.d Year: _____

63. **Is your country implementing a treat all policy for pregnant and breastfeeding women living with HIV?**

☐ Yes
☐ No

64. **What is the current nationally recommended regimen for infants with perinatal HIV exposure for preventing vertical transmission of HIV?**

☐ Please specify the infant prophylaxis regimen: _____

☐ Recommended duration of the regimen: _____

64.a **Are different regimens recommended for high-risk infants?**

☐ Yes

☐ No

64.a.i **If yes, please specify the regimens:** _____

64.a.ii **What is the definition of "high-risk infant" in the national policy (select all that apply)?**

☐ Born to women with established HIV infection who have received less than 4 weeks of antiretroviral therapy at the time of delivery

☐ Born to women with established HIV infection with viral load >1000 copies/mL in the 4 weeks before delivery (if viral load is available)

☐ Born to women with incident HIV infection during pregnancy or breastfeeding

☐ Born to women identified for the first time during the postpartum period, with or without a negative HIV test prenatally

☐ Other (please specify): _____

65. **Does your country have a national recommendation on infant and young child feeding for infants with perinatal HIV exposure?**

☐ Yes, breastfeeding

☐ Yes, replacement feeding

☐ Yes, both are recommended, left to individual choice or different settings

☐ No

65.1 **If breastfeeding is recommended for HIV-positive women and infants with perinatal HIV exposure, is the recommended duration specified?**

☐ Yes (please specify the duration in months): _____

☐ No

66. **Is food and nutrition support in your country integrated within prevention of vertical transmission programmes?**

☐ Implemented in few (<50%) maternal and child health sites

☐ Implemented in many (50–95%) maternal and child health sites

☐ Implemented countrywide (>95% of maternal and child health sites)

☐ Not implemented in practice

☐ Other (please specify): _____

67. **Does your country have a national strategy on interventions at delivery for women living with HIV who have not previously been tested for HIV?**

☐ Yes, fully implemented

☐ Yes, partially implemented

☐ Yes, but not implemented

☐ No

68. **Does your country have a policy on viral load testing for women during pregnancy, delivery and/or the post-partum/ breastfeeding period?**

☐ Yes

☐ No

68.1 **If yes, when is viral load testing done?**

68.1.a **During pregnancy**

☐ Yes

☐ No

68.1.a.i **If yes, which month of pregnancy:** _____

68.1.b **At delivery**

☐ Yes

☐ No

68.1.c **Post-partum/breastfeeding**

☐ Yes
☐ No

68.1.c.i **If yes, how long after delivery (in months): _____**

Elimination of vertical transmission of syphilis

69. **Does your country have a national plan for the elimination of vertical transmission of syphilis?**

☐ Yes, integrated with HIV or other elimination initiative(s)
☐ Yes, stand-alone (not integrated with HIV or other elimination initiatives)
☐ No national plan

69.1 **If yes, when was the national plan last updated?**

☐ 2020 or before
☐ 2021
☐ 2022
☐ 2023
☐ 2024

70. **Does your country have a national policy for routinely screening pregnant women for syphilis?**

☐ Yes
☐ No

70.1 **If yes, what is the national testing algorithm for the routine screening of pregnant women for syphilis?**

☐ Rapid treponemal test only (either syphilis only or dual HIV/syphilis test)
☐ Laboratory-based treponemal test only (e.g. Treponema pallidum haemagglutination assay [TPHA], T. pallidum particle agglutination assay [TPPA], or enzyme immunoassay)
☐ Non-treponemal test only (e.g. venereal disease research laboratory [VDRL] or rapid plasma reagin [RPR])
☐ Rapid treponemal test followed by non-treponemal test
☐ Laboratory-based treponemal test followed by non-treponemal test
☐ Non-treponemal test followed by treponemal test
☐ Other (please specify):_____

71. **Does your country have national guidelines to treat pregnant women with syphilis?**

☐ Yes
☐ No

72. **Does your country have a national policy on the clinical follow-up of infants born to syphilis-positive mothers?**

☐ Yes
☐ No

73 **Is congenital syphilis a notifiable condition?**

☐ Yes
☐ No

74. **Does the national definition for congenital syphilis include stillbirths?**

☐ Yes
☐ No

Prevention of vertical transmission of hepatitis B virus

75. **Does your country have a national plan for the elimination of vertical transmission of hepatitis B virus (HBV)?**

☐ Yes
☐ No

76. **Does your country have a policy on testing women for HBV during pregnancy?**

☐ Yes
☐ No

76.1 **If yes, what Is the status of implementation?**

☐ Implemented in few (<50%) antenatal care clinics
☐ Implemented in many (50–95%) antenatal care clinics
☐ Implemented countrywide (>95% of antenatal care clinics)
☐ Not implemented in practice
☐ Other (please specify) _____:

76.2 **If yes, do all HBsAg positive pregnant women have access to HBeAg or HBV DNA testing?**

☐ Yes
☐ No

77. **Does your country have a national recommendation on hepatitis B testing among infants exposed to HBV ?**

☐ Yes
☐ No

77.1 **If yes, please specify the age (in months) at which infants exposed to HBV are tested for HBV: _____**

78. **Does your country have a policy on universal timely hepatitis B birth dose vaccination to all newborns (provided within 24 hours of birth)?**

☐ Yes
☐ No

78.1 **If no, does your country have a policy on targeted timely hepatitis B birth dose vaccination to all newborns exposed to HBV (provided within 24 hours of birth)?**

☐ Yes
☐ No

Infant diagnosis

79. **Do your national guidelines recommend that infants with perinatal HIV exposure be tested for HIV as follows (select all that apply)?**

☐ Nucleic acid testing at birth
☐ Nucleic acid testing at 6 weeks
☐ Nucleic acid testing at 9 months
☐ Antibody test at 18 months
☐ Antibody test after 3 months from cessation of breastfeeding
☐ Other (please specify):_____

80. **In addition to prevention of vertical transmission settings, do any of the following sites in your country carry out HIV testing of children (select all that apply)?**

☐ Paediatric inpatient wards
☐ Nutrition centres
☐ Immunization clinics
☐ Outpatient clinics
☐ Tuberculosis (TB) clinics
☐ Other (please specify): _____

81. **Does your country have a policy or recommendation for point-of-care infant diagnosis testing?**

☐ Yes
☐ No

81.1 **If yes, where is it implemented?**

☐ Implemented in few (<50%) sites
☐ Implemented in many (50–95%) sites
☐ Implemented countrywide (>95% of sites)
☐ Not implemented in practice
☐ Other (please specify): _____

Child antiretroviral therapy

82. **Does your country have a national policy on the frequency of clinic visits for children who are established* on antiretroviral therapy?**

☐ Yes
☐ No

82.1 **If yes, please specify the frequency of clinic visits in the national policy:**

☐ Once a month
☐ Every 2 months
☐ Every 3 months
☐ Every 6 months
☐ Every 12 months
☐ Other (please specify): _____

82.2 **If yes, what is the status of implementation?**

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

83. **Does your country have a national policy on how frequently children who are established* on antiretroviral therapy should pick up antiretroviral medicine?**

☐ Yes
☐ No

83.1 **If yes, please specify the frequency of antiretroviral medicine pick-up included in the national policy:**

☐ Once a month
☐ Every 2 months
☐ Every 3 months
☐ Every 6 months
☐ Every 12 months
☐ Other (please specify): _____

83.2 **If yes, what is the status of implementation?**

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

84. **Are cohorts of children receiving antiretroviral therapy monitored (i.e., ensuring that these children are alive and receiving antiretroviral therapy) in national registers at six-month and 12-month intervals?**

☐ Yes
☐ No

85. When is a child who initiated antiretroviral therapy considered lost to follow-up in your country?

☐ Has not been seen for HIV care or pharmacy pick-up in 1 month
☐ Has not been seen for HIV care or pharmacy pick-up in 2 months
☐ Has not been seen for HIV care or pharmacy pick-up in 3 months
☐ Has not been seen for HIV care or pharmacy pick-up in 6 months

86. Does your country have a strategy or plan to ensure that adolescents born with HIV are not lost to follow-up as they transition into adult HIV care?

☐ Yes
☐ No

87. Are growth monitoring and nutrition programmes for children integrated with HIV testing and treatment in your country?

☐ Implemented in few (<50%) treatment sites
☐ Implemented in many (50–95%) treatment sites
☐ Implemented countrywide (>95% of treatment sites)
☐ Not implemented in practice
☐ Other (please specify): _____

4. Gender equality and empowerment of women and girls

- Reduce to no more than 10% the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence.
- Ensure that 95% of women and girls of reproductive age have their HIV and sexual and reproductive health-care service needs met, including antenatal and maternal care, information and counselling

Violence

88. **Does your country have at least one service delivery point that provides elements of comprehensive post-rape care as per World Health Organization (WHO) guidelines? The elements are: (1) first-line support, psychological first aid and psychosocial support; (2) emergency contraception; (3) sexually transmitted infection prophylaxis or treatment; (4) HIV post-exposure prophylaxis (PEP); and (5) safe abortion to the full extent of the law.**

☐ Yes, provides all 5 elements
☐ Yes, provides 4 out of 5 elements
☐ Yes, provides 1 to 3 elements
☐ No services delivery point provides any of these elements

88.1 **If yes, what proportion of health facilities provides each of the following elements of comprehensive post-rape care as per World Health Organization (WHO) guidelines:**

88.1.a **First-line support, psychological first aid and psychosocial support**

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

88.1.b **Emergency contraception**

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

88.1.c **Sexually transmitted infection treatment or prophylaxis**

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

88.1.d **HIV post-exposure prophylaxis (PEP)**

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

88.1.e **Safe abortion to the full extent of the law**

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

5. Community leadership

- Ensure that community-led organizations deliver 30% of testing and treatment services by 2025, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy.
- Ensure that community-led organizations deliver 80% of HIV prevention services for populations at high risk of HIV infection by 2025, including for women within those populations.
- Ensure that community-led organizations deliver 60% of programmes to support the achievement of societal enablers by 2025.

89. Does your country differentiate between community-led organizations and other types of civil society organizations in the national HIV strategic plan, community health strategies or other documents guiding the HIV response?

☐ Yes
☐ No

89.1 If yes, are the specific roles of community-led organizations articulated in the(se) document(s)?

☐ Yes
☐ No

90. Are there any laws, regulations or policies that provide for the registration of community-led organizations in your country (select all that apply)?

☐ Registration of organizations led by people living with HIV is possible
☐ Registration of organizations led by sex workers is possible
☐ Registration of organizations led by gay men and other men who have sex with men is possible
☐ Registration of organizations led by transgender people is possible
☐ Registration of organizations led by people who inject drugs is possible
☐ There are no laws, regulations or policies that provide for the registration of community-led organizations in the country
☐ Other (please specify): _____

91. Are there laws, policies or regulations that enable access to funding for community-led organizations (select all that apply)?

☐ Social contracting allowing for funding of service delivery by communities from domestic funding
☐ From international donors
☐ Require a certain percentage of government funding for community-led organizations to be allowed to operate
☐ No laws enabling access to funding, but community-led organizations are able to access funding under general laws, policies or regulations
☐ There are no laws, policies or regulations enabling access to funding for community-led organizations
☐ Other (please specify): _____

92. Are representatives of community-led organizations included in the national HIV coordinating mechanism or equivalent?

☐ There is no national HIV coordinating mechanism or equivalent
☐ There is a national HIV coordinating mechanism or equivalent, but it does not include any representatives of community-led organizations
☐ There is a national HIV coordinating mechanism or equivalent, and it includes representatives of community-led organizations

92.1 If yes, please specify from which of the following community-led organizations (including youth-led and women-led) are representatives included (select all that apply):

☐ Representatives of organizations led by people living with HIV
☐ Representatives of sex worker-led organizations
☐ Representatives of organizations led by gay men and other men who have sex with men
☐ Representatives of transgender-led organizations
☐ Representatives of organizations led by people who inject drugs

93. Can community-led organizations legally provide any of the following services (select all that apply)?

☐ Linkage to HIV treatment
☐ Adherence and retention support
☐ Treatment literacy
☐ Distribution of antiretroviral medicines
☐ Distribution of condoms and lubricants
☐ HIV testing
☐ Needle–syringe distribution
☐ Naloxone distribution
☐ Legal literacy
☐ Legal services
☐ Information on life skills-based HIV and sexuality education*
☐ Sexual and gender-based violence prevention, psychosocial and medical support and referrals
☐ Information on sexual and reproductive health
☐ Trainings for healthcare workers

Participation

94. **Do people living with HIV participate* in developing national policies, guidelines and/or strategies relating to their health in your country?**

☐ Yes
☐ No

95. **Do women living with HIV participate* in developing national policies, guidelines and strategies relating to prevention of vertical transmission?**

☐ Yes
☐ No

96. **Do gay men and other men who have sex with men participate* in developing national policies, guidelines and/or strategies relating to their health in your country?**

☐ Yes
☐ No

97. **Do sex workers participate* in developing national policies, guidelines and strategies relating to their health in your country?**

☐ Yes
☐ No

98. **Do people who inject drugs participate* in developing national policies, guidelines and strategies relating to their health in your country?**

☐ Yes
☐ No

99. **Do transgender people participate* in developing national policies, guidelines and strategies relating to their health in your country?**

☐ Yes
☐ No

100. **Do former or current people in prisons and other closed settings participate* in developing national policies, guidelines and strategies relating to their health in your country?**

☐ Yes
☐ No

101. **Do young people (aged 15–24 years) participate* in developing national policies, guidelines and strategies relating to their health in your country?**

☐ Yes
☐ No

101.1 **If yes, do young people participate* in any of the following decision-making spaces in the national HIV response (where they exist)?**

Decision-making space	Does it exist?	Do young people participate in this space?
Technical teams for the development, review and update of national AIDS strategies and plans	Yes/No	Yes/No
Technical teams for the development or review of programmes that relate to young people's access to HIV testing, treatment, care and support services	Yes/No	Yes/No
National AIDS Coordinating Authority or equivalent, with a broad-based multisector mandate	Yes/No	Yes/No
Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) Country Coordinating Mechanism	Yes/No	Yes/No
Community advisory body for hospitals, clinics and/or research projects	Yes/No	Yes/No
Other (please specify): _____	Yes/No	Yes/No

6. Realize human rights and eliminate stigma and discrimination

- Ensure that less than 10% of countries have restrictive legal and policy frameworks that unfairly target people living with, at risk of and affected by HIV by 2025. Examples include age of consent laws and laws related to HIV nondisclosure, exposure and transmission, laws that impose HIV-related travel restrictions and mandatory testing, and laws that lead to the denial or limitation of access to services by 2025.
- Invest US$ 3.1 billion in societal enablers—including protection of human rights, reduction of stigma and discrimination and law reform, where appropriate—in low- and middle-income countries by 2025.
- Ensure that less than 10% of people living with, at risk of and affected by HIV experience stigma and discrimination by 2025.

Punitive laws

102. **If HIV non-disclosure, exposure or transmission are criminalized, have any legal actions to decriminalize HIV non-disclosure, exposure or transmission either started or been in process in the last two years? Please select all that apply.**

☐ Strategic litigation
☐ Proposal put before parliament
☐ Other (please specify):_____
☐ There are no laws at the national or subnational level criminalizing HIV non-disclosure, exposure or transmission

103. **If transgender people are criminalized, have any legal actions to decriminalize transgender people either started or been in process in the last two years? Please select all that apply.**

☐ Strategic litigation
☐ Proposal put before parliament
☐ Other (please specify):_____
☐ There are no laws at the national or subnational level that criminalize transgender people

104. **If sex work is criminalized, have any legal actions to decriminalize sex work either started or been in process in the last two years? Please select all that apply.**

☐ Strategic litigation
☐ Proposal put before parliament
☐ Other (please specify):_____
☐ There are no laws at the national or subnational level criminalizing sex work

105. **If same-sex sexual acts are criminalized, have any legal actions to decriminalize same-sex sexual acts either started or been in process in the last two years? Please select all that apply.**

☐ Strategic litigation
☐ Proposal put before parliament
☐ Other (please specify):_____
☐ There are no laws at the national or subnational level criminalizing same-sex sexual acts in private

106. **If drug use and/or possession for personal use are criminal offences, have any legal actions to decriminalize drug use or possession for personal use either started or been in process in the last two years? Please select all that apply.**

☐ Strategic litigation
☐ Proposal put before parliament
☐ Other (please specify):_____
☐ There are no laws at the national or subnational level criminalizing drug use and/or possession for personal use

7. Universal health coverage and integration

- Invest in robust, resilient, equitable and publicly funded systems for health and social protection systems that provide 90% of people living with, at risk of and affected by HIV with people-centred and context-specific integrated services for: HIV and other communicable diseases; noncommunicable diseases; sexual and reproductive health care; gender-based violence; mental health; palliative care; treatment of alcohol dependence; drug use legal services; and other services they need for their overall health and well-being Ensure that by 2025, 45% of people living with, at risk of and affected by HIV and AIDS have access to social protection benefits.
- Ensure that 90% of people in humanitarian settings have access to integrated HIV services.
- Ensure the systematic engagement of HIV responses in pandemic response infrastructure and arrangements, leveraging national HIV strategic plans to guide key elements of pandemic preparedness planning and ensuring that 95% of people living with, at risk of and affected by HIV are protected against pandemics, including COVID-19.

Cervical cancer

107. Have the recommendations in the 2021 World Health Organization (WHO) guidelines for screening of cervical pre-cancer lesions for cervical cancer prevention among women living with HIV been adopted in your country's national guidelines?

☐ Yes
☐ No

107.1 If yes, please indicate the WHO recommendations for women living with HIV that have been adopted (select all that apply):

☐ Age to start regular cervical cancer screening is 25 years
☐ HPV-DNA Is used as the primary screening test as part of a screen and treat approach
☐ VIA is used as a primary screening test as part of a screen, triage and treat approach
☐ Cytology Is used as a primary screening test as part of a screen and treat approach
☐ Cytology Is used as a primary screening test as part of a screen, triage and treat approach
☐ Screening interval recommended for cytology/VIA is every 3 years
☐ Screening interval recommended for HPV-DNA is every 3–5 years
☐ Other (please specify): _____

108. Has re-testing of women living with HIV who underwent treatment for cervical precancerous lesions been adopted in national guidelines (select all that apply):

☐ Yes, at 12 months
☐ Yes, at 24 months
☐ Yes, using HPV-DNA
☐ Yes, using VIA
☐ Yes, using cytology

Sexually transmitted infections

109. Does your country have a national strategy or action plan for the prevention and control of sexually transmitted infections?

☐ Yes
☐ No

109.1 If yes, in what year were they last updated?

☐ Before 2021
☐ 2021
☐ 2022
☐ 2023
☐ 2024

110. Does your country have national case management guidelines for sexually transmitted infections?

☐ Yes
☐ No

110.1 If yes, in what year were they last updated?

☐ Before 2021
☐ 2021
☐ 2022
☐ 2023
☐ 2024

111. **What are the recommended first line treatment for uncomplicated anogenital infection with *Neisseria gonorrhoeae* in adults in the most recent national treatment guideline (select all that apply)?**

- ☐ Cefixime 400 mg orally
- ☐ Cefixime 400 mg orally PLUS azithromycin 1 g orally
- ☐ Cefixime 800 mg orally PLUS azithromycin 1 g orally
- ☐ Cefixime 800 mg orally PLUS azithromycin 2 g orally
- ☐ Ceftriaxone 250 mg intramuscularly
- ☐ Ceftriaxone 1 g intramuscularly
- ☐ Ceftriaxone 250 mg intramuscularly PLUS azithromycin 1 g orally
- ☐ Other (please specify): _____

111.1 **When were the treatment guidelines for *N. gonorrhoeae* last updated?**

- ☐ Before 2022
- ☐ 2022
- ☐ 2023
- ☐ 2024
- ☐ Currently being updated
- ☐ No treatment guidelines

112. **Is gonococcal antimicrobial resistance testing available in country?**

- ☐ Yes, for clinical cases (i.e. to test in case of clinical treatment failure)
- ☐ Yes, for annual surveillance of resistance
- ☐ Yes, for clinical cases and annual surveillance of resistance
- ☐ No

Social protection

113. **Does the country have an approved social protection* strategy, policy or framework?**

- ☐ Yes, and it is being implemented
- ☐ Yes, but it is not being implemented
- ☐ No

113.1 **If yes:**

113.1.a **Does it refer to HIV?**

- ☐ Yes
- ☐ No

113.1.b **Does it recognize people living with HIV as key beneficiaries?**

- ☐ Yes
- ☐ No

113.1.b.i. **If no, please describe any conditions under which people living with HIV can access social protection benefits:** _____

113.1.c **Does it recognize any key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people or people in prisons and other closed settings) as key beneficiaries?**

- ☐ Yes
- ☐ No

113.1.c.i. **If yes, which key populations are recognized as key beneficiaries (select all that apply)?**

- ☐ Sex workers
- ☐ Gay men and other men who have sex with men
- ☐ Transgender people
- ☐ People who inject drugs
- ☐ People in prisons and other closed settings

113.1.c.ii **If no, please describe any conditions under which key populations can access social protection benefits:**_____

113.1.d **Does it recognize adolescent girls and young women as key beneficiaries?**

- ☐ Yes
- ☐ No

113.1.e **Does it recognize children affected by HIV as key beneficiaries?**

- ☐ Yes
- ☐ No

113.1.f **Does it recognize families affected by HIV as key beneficiaries?**

- ☐ Yes
- ☐ No

113.1.g **Does it address the issue of unpaid care work in the context of HIV?**

- ☐ Yes
- ☐ No

114. **Are representatives of the National AIDS Programme or equivalent included in any social protection* coordination mechanism or platform?**

- ☐ There is no social protection coordination mechanism or platform
- ☐ There is a social protection coordination mechanism or platform, but it does not include any representatives of the National AIDS Programme or equivalent
- ☐ There is a social protection coordination mechanism or platform, and it includes representatives of the National AIDS Programme or equivalent

115. **Are any cash transfer* programmes for young women aged 15–24 years being implemented in the country?**

- ☐ Yes
- ☐ No

8. Data, science and innovation

Information system

116. Are patient-level data routinely available within the health information system?

- ☐ Yes, fully electronic
- ☐ Yes, partially electronic
- ☐ Yes, paper-based only
- ☐ No health information system exists

116.1 If patient-level data exist, are antenatal care testing and treatment cascade data included in the health information system at the district level (select all that apply)?

- ☐ Pregnant women tested during antenatal care and outcome of test
- ☐ Women already on antiretroviral therapy at first antenatal care visit
- ☐ The number of people tested for HIV
- ☐ The number of people testing HIV-positive
- ☐ The number of people newly diagnosed with HIV who are on antiretroviral therapy
- ☐ The number of people on antiretroviral therapy who are virally suppressed

117. Are data from community-led organizations on services they delivered integrated in the national health information system or equivalent?

- ☐ Yes, community-led organizations are included as a type of provider for disaggregation of existing indicators
- ☐ Yes, specific indicators on service delivery by community-led organizations are included
- ☐ No
- ☐ Community-led organizations cannot provide services

Surveillance

118. Is HIV a nationally notifiable condition by law?

- ☐ Yes
- ☐ No

119. Does the country have a national HIV case surveillance* system?

- ☐ Yes
- ☐ No

119.1 If yes, does the national HIV case surveillance system include the following (select all that apply)?

- ☐ Individual-level data for each person diagnosed with HIV
- ☐ Collection of data from different sources (laboratories, testing and treatment records) to promote completeness of data on HIV case
- ☐ Linkage of individual-level data to remove duplicate records
- ☐ CD4 count at HIV diagnosis
- ☐ Initiation of antiretroviral therapy
- ☐ First and follow-up viral load test results
- ☐ Pregnancy in women living with HIV
- ☐ Death

Patient monitoring systems

120. Has the country updated the HIV testing and treatment indicators and tools using the 2022 World Health Organization (WHO) *Consolidated guidelines on person-centered HIV strategic information*?

- ☐ Yes, fully
- ☐ Yes, partially
- ☐ No
- ☐ Don't know

Unique identification codes for patients

121. Does the country have a method to identify and remove duplicate health information for patients within and between clinics —such as linking records using unique identifiers and/or personal identifiable information (including biometrics)—for the following services?

	Method to identify and remove duplicate health information	If yes, please specify how data are linked
Treatment services	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
Testing services	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
Laboratory services	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
HIV prevention services designed for any key population group to track combination prevention uptake		
Gay men and other men who have sex with men	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
Sex workers	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
Transgender people	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
People who inject drugs	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____
Other (please specify): _____	☐ Yes, nationally harmonized ☐ Yes, but varies across regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify) _____

121.1 If yes to any of the above, does the unique identifier policy also provide for legally enforceable data privacy protections?

☐ Yes

☐ No

95–95–95

122. **When was the most recent data quality review conducted to determine the accuracy of national-level numbers of people reported to be on treatment?**

- ☐ Currently being conducted (results expected next year)
- ☐ Completed in the last year and results available
- ☐ Completed 2 to 5 years ago
- ☐ Never conducted or conducted more than 5 years ago

122.1 **If a data quality review has been conducted in the last year, have the results been used to adjust the numbers of people on treatment reported in Indicator 2.2?**

- ☐ Yes
- ☐ No

123. **When was the most recent data quality review conducted to determine the accuracy of the number of people reported to have suppressed viral loads?**

- ☐ Currently being conducted (results expected next year)
- ☐ Completed in the last year and results available
- ☐ Completed 2 to 5 years ago
- ☐ Never conducted or conducted more than 5 years ago

123.1 **If a data quality review has been conducted in the last year, has this been used to adjust the number of people who have suppressed viral loads reported in Indicator 2.3?**

- ☐ Yes
- ☐ No

Data use

124. **Are data reviews of HIV treatment cascade data being conducted?**

- ☐ Yes
- ☐ No

124.1 **If yes, please select the frequency with which data reviews of HIV treatment cascade data are conducted.**

- ☐ Quarterly
- ☐ Every 6 months
- ☐ Annually
- ☐ Other, please specify: _____

124.2 **If yes, at which level are data reviews conducted (select all that apply)?**

- ☐ National
- ☐ District
- ☐ Facility

WHO/AIDS medicines and diagnostics survey on the use of antiretroviral medicines and laboratory technologies and implementation of WHO related guidelines

Survey to document the data situation in 2024

The WHO AIDS Medicine and Diagnostics Services of the Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes is conducting the nineteenth annual survey on antiretroviral therapy regimens used in low- and middle-income countries. The 2025 questionnaire covers the use of antiretroviral medicines in adults and children for antiretroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT); use of laboratory tests for ART initiation and monitoring; 2024 procurement data; and national 3-year (2025–2027) forecasts by regimen.

To complete the questionnaire, please ask relevant ART, PMTCT, national laboratory and procurement programme officers to gather the requested information for the period **1 January–31 December 2024**. Professional officers submitting the data should check the questionnaire's completeness, quality, accuracy and validity.

The results of this survey will be used to analyse regional and global trends of antiretroviral medicine use and produce global demand forecasts for antiretroviral medicines. These analyses and forecasts will be discussed with medicines and diagnostics manufacturers and donors to prevent global shortages.

WHO will analyse the responses of each country to produce country Procurement and Supply Management profiles that present country-specific strategic information and provide feedback to assist national programme managers to develop more cost-effective interventions.

For any queries concerning the questionnaire, please contact Mr Boniface Dongmo Nguimfack (dongmonguimfackb@who.int), Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes, WHO, Geneva.

Section 1A. Overview of treatment with antiretroviral medicines

Question 1. Total number of adults and children on ART at the end of 2024: _____

Section 1B. Treatment of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women

Question 2. Number of adults and adolescents (aged ≥10 years) living with HIV and on ART by treatment line at the end of 2024:

Treatment line	**Number of adults and adolescents (aged ≥10 years) living with HIV by treatment line at the end of 2024**
Dolutegravir (DTG) based regimens	
Protease inhibitor (PI) based regimens	
Other treatment regimens	
Total	

Question 3. Number of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women living with HIV, per dolutegravir (DTG) based regimens at the end of 2024 (start with regimens with higher numbers):

Dolutegravir (DTG) based regimens	**Number of adults and adolescents (aged ≥10 years) living with HIV receiving this ART regimen at the end of 2024** (start with regimens with higher numbers)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
Total	

Question 4. Number of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women living with HIV, on protease inhibitor (PI) based regimens at the end of 2024 (start with regimens with higher numbers):

Protease inhibitor (PI) based regimens	**Number of adults and adolescents (aged ≥10 years) living with HIV receiving this ART regimen at the end of 2024** (start with regimens with higher numbers)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
Total	

Question 5. Number of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women living with HIV, on other treatment regimens at the end of 2024 (start with regimens with higher numbers):

Other treatment regimens	**Number of adults and adolescents (aged ≥10 years) living with HIV receiving this ART regimen at the end of 2024** (start with regimens with higher numbers)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
Total	

Section 2. Treatment of children (aged <10 years) living with HIV

Question 6. Number of children (aged <10 years) living with HIV by treatment line at the end of 2024:

Treatment line	**Total number of children (aged <10 years) living with HIV by treatment line at the end of 2024**
Dolutegravir (DTG) based regimens	
Protease inhibitor (PI) based regimens	
Other treatment regimens	
Total	

Question 7. Number of infants and children (aged <10 years) living with HIV on dolutegravir (DTG) based regimens at the end of 2024 (start with regimens with higher numbers):

Dolutegravir (DTG) based regimens	Number of infants and children (aged <10 years) receiving this regimen at the end of 2024		
	<3 years (A)	≥3 to <10 years (B)	All children aged <10 years (A) + (B)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
Total			

Question 8. Number of children (aged <10 years) living with HIV on protease inhibitor (PI) based regimens at the end of 2024 (start with regimens with higher numbers)

Protease inhibitor (PI) based regimens	Number of children (aged <10 years) living with HIV receiving this regimen at the end of 2024
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
Total	

Question 9. Number of children (aged <10 years) living with HIV on other treatment regimens at the end of 2024 (start with regimens with higher numbers)

Other treatment regimens	Number of children (aged <10 years) living with HIV receiving this regimen at the end of 2024
1.	
2.	
3.	
4.	
5.	
6.	
Total	

Section 3. Prevention of mother to child transmission

Question 10. Number of pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission and various PMTCT options during 2024:_____

Question 11. Number of neonates per antiretroviral medicine used for HIV prophylaxis in neonates born to women living with HIV in 2024:

Antiretroviral medicine	Number of neonates starting this regimen in 2024
Total	

Section 4. Laboratory services

HIV testing

Question 12. Total number of HIV rapid diagnostic tests done between January and December 2024: ___

Question 13. Total number of HIV enzyme-linked immunosorbent assay (ELISA) tests done between January and December 2024: ___

Question 14. Total number of HIV serology antibody tests, including rapid diagnostic tests and ELISA tests, done between January and December 2024:___

CD4 testing

Question 15. Total number of CD4 tests done between January and December 2024:___

Question 16. Total number of people on ART who had at least one CD4 test between January and December 2024: ___

Question 17. Total number of pregnant women living with HIV who had at least one CD4 test between January and December 2024: ____

Viral load (VL) testing

Question 18. Total number of VL tests done between January and December 2024: ____

Question 19. Total number of people on ART who had at least one VL test between January and December 2024: ____

Question 20. Total number of pregnant women living with HIV who had at least one VL test between January and December 2024: ____

Infant diagnosis

Question 21. Total number of infant diagnosis tests done between January and December 2024: ___

Question 22. Total number of infants (aged <12 months) born to women living with HIV who had at least one infant diagnosis test between January and December 2024: ____

Testing and screening for sexually transmitted infections, advanced HIV and hepatitis

Question 23. Total number of sexually transmitted infection diagnostic tests done between January and December 2024: ___

Question 24. Total number of CrAg tests done between January and December 2024: ___

Question 25. Total number of TB LAM tests done between January and December 2024:___

Question 26. Total number of hepatitis B screening tests done between January and December 2024: ___

Question 27. Total number of hepatitis C (rapid diagnostic) tests done between January and December 2024: ___

Question 28. Total number of laboratories or sites by types of test in your country in 2024:

Type of test	Number of laboratories or sites where samples are collected (sites with testing and sites without testing)	Number of laboratories or sites where testing is performed	Number of laboratories or sites where testing is performed and that participate in an external quality assessment (EQA) scheme	Number of laboratories or sites that need quality improvement activities based on most recent EQA exercise	Main activities required for quality improvement
HIV serology antibody testing, including rapid test and ELISA					
Infant diagnosis					
CD4 testing					
Viral load testing					
HIV drug resistance genotype testing					
GeneXpert (tuberculosis test)					
AHD testing services CrAg					
AHD testing services TB LAM					
Sexually transmitted infection testing services					
HCV PCR testing services					
HBV PCR testing services					

Section 5. Country targets

Question 29. National targets for ART, PMTCT and laboratory tests in the next 5 years:

Target	End of 2025	End of 2026	End of 2027	End of 2028	End of 2029
1. Number of adults and children on ART					
1.1 Number of adults and adolescents (aged ≥10 years) on ART					
1.2 Number of children (aged <10 years) on ART					
1.2.1 Number of children (aged <3 years) on ART					
1.2.2 Number of children (aged ≥3 to <10 years) on ART					
2. Number of pregnant women on ART					
3. Number of people tested for HIV					
4. Number of people taking a CD4 test					
5. Number of people taking a VL test					
6. Number of children born to women living with HIV having an infant diagnosis test					
7. Number of HIV serology tests					
8. Number of CD4 tests					
9. Number of VL tests					
10. Number of early infant diagnosis tests					
11. Number of HIV AHD tests CrAg					
12. Number of HIV AHD tests TB LAM					
13. Number of sexually transmitted infection tests					

Question 30. National 3-year forecasts by antiretroviral medicine regimen for adults:

First-line antiretroviral medicine regimen	Number of people on regimen			Second-line antiretroviral medicine regimen	Number of people on regimen			Third-line antiretroviral medicine regimen	Number of people on regimen		
	2025	2026	2027		2025	2026	2027		2025	2026	2027
1.											
2.											
3.											
4.											
5.											
Etc…											
Subtotal											

Question 31. National 3-year forecasts by antiretroviral medicine regimen for children:

First-line antiretroviral medicine regimen	Number of people on regimen			Second-line antiretroviral medicine regimen	Number of people on regimen			Third-line antiretroviral medicine regimen	Number of people on regimen		
	2025	2026	2027		2025	2026	2027		2025	2026	2027
1.											
2.											
3.											
4.											
Etc…											
Subtotal											

Question 32. National 3-year forecasts of HIV tests, CD4 tests, VL tests and early infant diagnostic tests:

Type of test	Number of tests procured in 2024 and planned for the next three years			
	Procured for 2024	Planned for 2025	Planned for 2026	Planned for 2027
HIV diagnosis test (rapid diagnostic tests, self-tests)				
CD4 tests				
Viral Load tests				
Early infant HIV diagnosis tests				

Annex 1. Selected bibliography

1. 12 components monitoring and evaluation system assessment: guidelines to support preparation, implementation and follow-up activities. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
2. 12 components monitoring and evaluation system strengthening tool. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
3. Glossary: monitoring and evaluation terms. Geneva: UNAIDS; 2011 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
4. Guidance on capacity building for HIV monitoring and evaluation. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
5. Indicator standards: operational guidelines for selecting indicators for the HIV response. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
6. A national evaluation agenda for HIV. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
7. An introduction to triangulation. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
8. An introduction to indicators. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
9. Basic terminology and frameworks for monitoring and evaluation. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
10. Organizing framework for a functional national HIV monitoring and evaluation system. Geneva: UNAIDS; 2008 (http://www.unaids.org/en/dataanalysis/monitoringandevaluationguidance).
11. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030. Geneva 2021 https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf
12. The Global AIDS Strategy 2021–2026: End Inequalities, End AIDS. Geneva 2021 https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf
13. Confronting inequalities. Geneva: UNAIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf).
14. Strategic guidance for evaluating HIV prevention programmes. Geneva: UNAIDS; 2010 (http://www.unaids.org/sites/default/files/sub_landing/files/12_7_MERG_Guidance_Evaluating%20HIV_PreventionProgrammes.pdf).
15. Consolidated HIV strategic information guidelines: Driving impact through programme monitoring and management. Geneva: World Health Organization, 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf?sequence=1&isAllowed=y)
16. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. 2nd ed. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/9789240031593).
17. Consolidated guidelines on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization; 2017 (https://www.aidsdatahub.org/sites/default/files/resource/consolidated-guideline-sexual-and-reproductive-health-and-rights-women-living-hiv-2017-full-report.pdf).
18. The state of the world's children 2021. New York: UNICEF; 2021 (https://www.unicef.org/media/108161/file/SOWC-2021-full-report-English.pdf).
19. Segone M, ed. Country-led monitoring and evaluation systems: better evidence, better policies, better development results. New York: UNICEF; 2009 (mics.unicef.org/files).
20. Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/325892/WHO-CDS-HIV-19.15-eng.pdf?ua=1).
21. Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization, 2022 (https://www.who.int/publications/i/item/9789240055315).

Annex 2.
Expected levels of earmarked domestic public budget for HIV

To fill in the form, please consider the following:

1. Indication of a fiscal year is required. A fiscal year may or may not align with the calendar year (use the fiscal year that starts on the calendar year specified in the field).
2. Choose the reporting currency. This could be filled in local currency or converted into US dollars when an official exchange rate is specified.
3. It is required to express the amounts in currency units in thousands or millions.
4. Fill the approved and executed budget in the corresponding fiscal year. The approved budget includes the domestic budget that is approved by the government. Budget allocations using government loans (non-official development assistance loans) are also considered to be part of the domestic budget. The executed budget is the spending of the approved budget; it should not be more than the approved budget unless there were additional funds provided (if so, please specify). The totality of the expenditures can exceed the approved budget because some incurred expenditures were not funded by HIV-specific earmarked budgets.
5. Indicate the perception of a budget increase, maintenance at the same level or a budget decrease for the next fiscal year.
6. It is necessary to provide the aggregate subtotals for budgets at each level of government, and for under-segmented and independent budget structures. For the levels of government, report the subtotals for the national/central/federal, provincial/state/district and municipal/city/local levels in each country (as appropriate). Separately report the public budgets for institutions that pertain to different systems—such as security institutions or other national bodies (e.g., the national AIDS commission)—if those systems are independent from the government levels mentioned above.

Annex 3. Volume and unit prices of antiretrovirals medicines and other HIV-related regimens procured and distributed

As part of Indicator 8.2, it is mandatory to complete the information on the volume and unit prices of antiretroviral medicines and other HIV-related regimens procured and distributed.

Antiretroviral regimen/formulation	Posology	Pills or smallest dose per pack	Total number of packs procured in the fiscal year	Average price per pack (in US$) (exclude freight and other administrative costs)	Total number of packs picked up by beneficiaries in the fiscal year
Tenofovir + Emtricitabine + Efavirenz [TDF + FTC + EFV]	300 mg + 200 mg + 600 mg				
Tenofovir + Lamivudine + Efavirenz [TDF + 3TC + EFV]	300 mg + 300 mg + 600 mg				
Tenofovir + Lamivudine + Nevirapine [TDF + 3TC] + NVP	300 mg + 300 mg + 200 mg				
Zidovudine + Lamivudine + Efavirenz [ZVD + 3TC] + EFV	300 mg + 150 mg + 200 mg				
Abacavir + Lamivudine + Zidovudine [ABC + 3TC + ZDV]	300 mg + 150 mg + 300 mg				
Zidovudine + Lamivudine + Nevirapine [ZVD + 3TC + NVP]	300 mg + 150 mg + 200 mg				
Zidovudine + Lamivudine + Nevirapine [ZVD + 3TC + NVP]	60 mg + 30 mg + 50 mg				
Tenofovir + Emtricitabine [TDF + FTC]	300 mg + 200 mg				
Zidovudine + Lamivudine [ZDV + 3TC]	300 mg + 150 mg				
Lopinavir + Ritonavir [LPV + RTV]	200 mg + 50 mg				
Lopinavir + Ritonavir [LPV + RTV]	80 mg + 20 mg/ml				
Abacavir + Lamivudine [ABC + 3TC]	860 mg + 30 mg				
Tenofovir + Lamivudine [TDF + 3TC]	300 mg + 300 mg				
Darunavir [DRV]	300 mg				
Dolutegravir [DTG]	50 mg				
Others (please specify):					

Regimen/formulation related to the management of advanced HIV disease	Posology	Pills or smallest dose per pack	Total number of packs procured in the fiscal year	Average price per pack (in US$) (exclude freight and other administrative costs)	Total number of packs picked up by beneficiaries in the fiscal year
Ambisome (high dose liposomal amphotericin B) injection	50 mg/vial	1 vial			
Conventional liposomal amphotericin	50 mg/ml				
Amphotericin B deoxycholate injection	5 mg/ml	1 vial			
Flucytosine tablet (5FC)	500 mg				
Flucytosine injection	10 mg/ml	5 bottles			
Fluconazole capsule	50 mg				
Fluconazole capsule	200 mg	100			
Fluconazole solution for parentral injection	2 mg/ml	100 ml bag			
Itraconazole Capsule	200 mg				
Cotrimoxazole (Sulfamethoxazole and Trimethoprim) tablet	800 mg/160mg				
Isoniazid/cotrimoxazole/vitamin B6 tablet	300/960/25 mg	30			

Notes:

1. Please express volume in the number of packs procured and unit prices in local currency units or current US$ for the reporting year.
2. The data on the number of packages picked up by beneficiaries correspond to the regimen/formulations without need to disaggregate by procurement process.
3. By choosing the "Other" option, the rapporteur will be able to provide custom data on the regimen and posology combination in case the regimen information is not found in the standard list shown above.
4. Information on patients per regimen will be captured as part of the WHO/AIDS Medicines and Diagnostics Service Survey on the Use of ARV Medicines and Laboratory Technologies and in the implementation of the WHO *Related guidelines*, hosted on the Global AIDS Monitoring online tool.

Annex 4.
The national funding matrix for Indicator 8.3: HIV expenditure by origin of the resources

As in previous reporting cycles, the national funding matrix suggested for the Global AIDS Monitoring 2025 cycle contains a set of key core programmes and services by financing source. Each of the programme categories are divided into sets of sub-indicators. The set of the core sub-indicators comprise the following key programmes or services:

- Combination prevention, including condoms, PrEP, voluntary medical male circumcision, harm reduction services, empowering young women and girls, and providing essential service packages for key populations.
- Prevention of mother-to-child transmission of HIV.
- HIV testing and counselling.
- HIV-specific laboratory monitoring.
- Antiretroviral therapy.
- HIV and tuberculosis (TB).
- Social enablers, including reducing stigma and discrimination.
- Instituting human rights programmes.

The reporting framework of Indicator 8.3—"Total HIV expenditure by origin of the resources"—is organized around a two-dimensional system for recording HIV expenditure by programme and financing source. The form of reporting therefore has the format of a matrix.

The table below (Table 1) provides a complete set of programmes or services and a residual category that account for the totality of possible use of resources in countries, including financing sources. Countries are requested to report on the applicable programmes or services as appropriate (i.e., countries should only report on the relevant rows of the matrix, not on each one). The same is true for the financing sources: they need to be completed as they exist in each country. It is important to differentiate when the expenditure is non-existent (i.e., it has a value of "0"), unavailable or not applicable.

The total HIV expenditure is the sum of the core programmes and services from reported figures from Commitments 1 to 10 Table 1, plus the residual category of "Other essential programmes outside of the suggested framework" to account for total HIV expenditure and not just for the expenditures derived from earmarked budgets.

Further guidance will be provided in the Global AIDS Monitoring online reporting tool on how to complete the reporting forms and submit expenditure indicators to UNAIDS. The total amount of resources should include the totality of financing flows and expenditures by all programmes or services and by all sources. The sub-indicators would represent only a subset of the total that corresponds to parts of the specific commitments. The amounts reported will be compared to the number of people receiving the same services reported in Global AIDS Monitoring or elsewhere.

The National AIDS Spending Assessment (NASA) guidelines are being updated. A crosswalk on the new AIDS Spending Categories (ASCs) and the Global AIDS Monitoring funding matrix requested for Indicator 8.3 will be made available in time for Global AIDS Monitoring reporting. When a NASA—an in-depth HIV resource tracking exercise—is performed in countries, one can extract a Excel report from the resource tracking tool (RTT) and upload it into the Global AIDS Monitoring AIDS spending module.

Table 1

List of HIV programmes or services in the national funding matrix[1]

Codes in the Global AIDS Monitoring national funding matrix	Global AIDS Monitoring 2022 programme categories: complete set of interventions	Global AIDS Monitoring 2022 programme categories: core sub-indicators
1 Treatment, care and support (subtotal)		
1.1	HIV testing and counselling (HTC) for populations other than key populations	Expenditure on HTC (non-targeted), disaggregated by commodities and other direct/indirect costs. Including: vulnerable and accessible populations, general population, provider-initiated testing and counseling, testing in blood centers, etc.
1.2	Antiretroviral treatment (subtotal)	Expenditure on antiretroviral therapy (adults and paediatric).
1.2.1.	Adult antiretroviral treatment	Expenditure on antiretroviral therapy for adults disaggregated by commodities and other direct/indirect costs.
1.2.2.	Paediatric antiretroviral treatment	Expenditure on antiretroviral therapy for paediatric use, disaggregated by commodities and other direct/indirect costs.
1.2.3.	Antiretroviral therapy not broken down by either age or line of treatment	Expenditure on antiretroviral therapy not broken down by either age or line of treatment, disaggregated by commodities and other direct/indirect costs.
1.3	Specific HIV-related laboratory monitoring (CD4, viral load)	Expenditure on HIV-specific laboratory monitoring (CD4 cell count, viral load and other lab/tests) disaggregated by commodities and other direct/indirect costs.
1.4	Opportunistic infections (OI) prophylaxis and treatment, excluding treatment and prevention of TB for people living with HIV	
1.5	Palliative care	
1.6	Support and retention	
1.98	Programmatic activities for treatment, care and support not disaggregated by type	
2 Prevention of vertical transmission of HIV (subtotal)		
2.1	HIV testing and counselling (HTC) for pregnant women	Expenditure on prevention of vertical transmission of HIV disaggregated by commodities and other direct/indirect costs.
2.2	Early infant diagnosis	Expenditure on prevention of vertical transmission of HIV disaggregated by commodities and other direct/indirect costs.
2.3	Antiretroviral treatment to reduce vertical transmission of HIV	Expenditure on prevention of vertical transmission of HIV disaggregated by commodities and other direct/indirect costs.
2.4	Non-ARV antiretroviral medicine-related component of prevention of mother-to-child transmission	Expenditure on prevention of vertical transmission of HIV other than the expenditures on the antiretroviral treatment provided to the pregnant women if a regimen as an adult living with HIV is provided.
2.98	Prevention of vertical transmission of HIV not disaggregated	

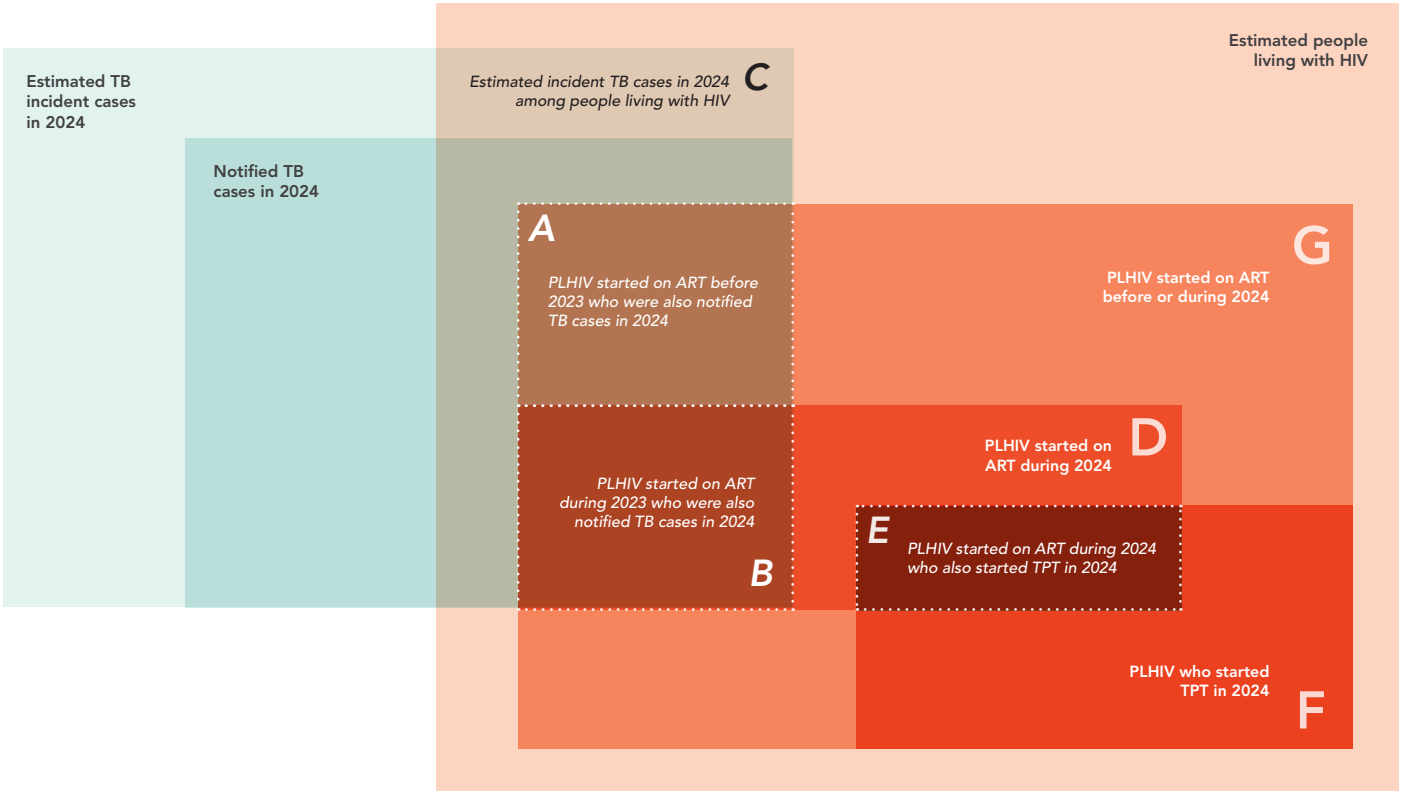
[1] Please note that the code numbering convention represented in this table for the national funding matrix is unchanged from 2021, and does not directly align with the 2022 GAM monitoring indicator numbers. This is because the programme categories are mapped with several other stakeholders and should therefore remain aligned.

3 Prevention (subtotal)		
3.1	Social and behaviour change (SBC) programmes for populations other than key populations	Non-targeted.
3.2	Condoms (for HIV prevention) for the general population	Condoms (non-targeted) disaggregated by commodities and other direct/indirect costs.
3.3	Pre-exposure exposure prophylaxis (PrEP) disaggregated by key populations (subtotal)	PrEP stratified by key population.
3.3.1.	PrEP for gay men and other men who have sex with men (MSM)	PrEP stratified by key population.
3.2.2.	PrEP for sex workers	PrEP stratified by key population.
3.3.3.	PrEP for persons who inject drugs (PWID)	PrEP stratified by key population.
3.3.4.	PrEP for transgender persons	PrEP stratified by key population.
3.3.5.	PrEP for key populations	PrEP stratified by key population.
3.3.6.	PrEP for young women and adolescent girls in high-prevalence countries	PrEP stratified by key population.
3.3.7	PrEP for serodiscordant couples	Pre-exposure prophylaxis(PrEP)
3.3.98	Pre-exposure prophylaxis PrEP not disaggregated by population type	
3.4	Voluntary medical male circumcision (VMMC) in high-prevalence countries	Voluntary medical male circumcision (VMMC).
3.5	Prevention, promotion of testing and linkage to care programmes for gay men and other men who have sex with men (MSM)	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.6	Prevention, promotion of testing and linkage to care programmes for sex workers and their clients	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.7	Prevention, promotion of testing and linkage to care programmes for persons who inject drugs (subtotal)	Prevention among people who inject drugs
3.7.1.	Needle–syringe exchange, and prevention and promotion of testing, and linkage to care programmes for people who inject drugs	Prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.7.2.	Substitution therapy	Prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.7.3	HIV testing and counseling (HTC) for people who inject drugs	HIV testing and counseling activities disaggregated by commodities and other direct/indirect costs.

3.8	Prevention and promotion of testing and linkage to care programmes for transgender persons	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.9	Prevention and promotion of testing and linkage to care programmes for prisoners	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.10	Prevention and promotion of testing and linkage to care programmes for young women and adolescent girls (high-prevalence countries)	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs. This category also includes expenditures on cash transfers for young women and girls (age 10–24 years in high-prevalence countries) from HIV earmarked budgets.
3.11	Prevention programmes for vulnerable and accessible populations	
3.12	Post-exposure prophylaxis (PEP)	
3.13	Workplace	
3.14	Synergies with health sector	
3.15	Prevention of HIV transmission aimed at people living with HIV (PLHIV) not disaggregated	
3.98	Prevention (five pillars) not disaggregated	
3.99	Prevention of HIV transmission not disaggregated	Do not include other activities in this code if not explicitly listed. If there are additional activities, list them individually in mutually exclusive categories (ensuring no double-counting); avoid using a category already included above.
4 Gender programmes		
5 Programmes for children and adolescents		
6 Social protection and economic support		
7 Community mobilization and system strengthening		Expenditures on strengthening community organizations through education, training, and support for workers. It includes resource mobilization, financial sustainability activities, volunteer recruitment and retention, and community-led monitoring to ensure effective service delivery and long-term growth.
8 Governance and sustainability (subtotal)		
8.1	Programme administration and management	
8.2	Strategic information	
8.3	Planning and coordination	

8.4	Procurement and logistics (procurement and supply chain)	
8.5	Health systems strengthening	
8.6	Education	
8.7	HIV- and AIDS-related research	
8.98	Governance and sustainability not disaggregated	
9 Critical social enablers (subtotal)		
9.1	Policy dialogue	
9.2	Key human rights programmes and advocacy activities	
9.3	AIDS-specific institutional development	
9.98	Critical social enablers not disaggregated	
10 TB–HIV coinfection, diagnosis and treatment (subtotal)		
10.1	TB screening and diagnosis among people living with HIV (PLHIV)	Expenditure on TB and HIV.
10.2	TB prevention and treatment for people living with HIV (PLHIV)	Expenditure on TB and HIV.
10.98	TB–HIV coinfection, diagnosis and treatment not disaggregated	
11.99	Other essential programmes outside the suggested framework of core HIV and AIDS programmes (please list below and specify)	All other HIV expenditure not elsewhere classified in any of the above categories (codes 1 through 10). Please ensure that none of the programmes or activities listed here are duplicated with any of the previous categories. Any programme or service listed below should be mutually exclusive with any of the codes listed above (codes 1 through 10).

Annex 5.
Additional guidance on constructing Global AIDS Monitoring indicators on HIV and tuberculosis 7.6–7.9



Indicator 7.6 = (A+B) / C
Note: The numerator for Indicator 7.6 should be equal to the number of HIV-positive new and relapse TB patients who started antiretroviral therapy as reported by the National Tuberculosis Programme. Please reconcile data with the National Tuberculosis Programme.

Indicator 7.7 = B / D
Note: Numerator for Indicator 7.6 will be greater than for Indicator 7.7. For the numerator, notified TB cases should include new, relapse and retreatment cases.

Indicator 7.8 (among people newly enrolled on ART) = E / D

Indicator 7.8 (among people currently enrolled on ART) = F / G

Please note for indicator 7.9 guidance is provided in the indicator definition sheet on page 100 of these guidelines.

Annex 6.
Global AIDS Monitoring 2025 interim National Commitments and Policy Instruments (NCPI) Guidance on Law-related Questions

The NCPI asks a number of questions regarding laws and regulations relating to HIV as well as key populations and vulnerable groups. The way in which various aspects of public and private life are regulated or criminalized differs widely between and within countries. This document provides further guidance and some examples to assist countries in answering those questions. Examples given are illustrative only, and should not be seen as exhaustive, they may not necessarily reflect the reality in your country.

This guidance covers the following questions from the interim NCPI:

90

102

103

104

105

106

Explanations of law-related questions in the interim NCPI

Section 5

90. Are there any laws, regulations or policies that provide for the registration of community-led organizations in your country (please select all that apply)?

Community-led organisations are organisations where the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies. Laws and regulations can influence whether or not different groups can form legal associations and the ease with which these associations can operate, provide health-services, meet reporting requirements and so forth. The response options in question 90 relate to laws and policies that determine what types of entities can register an association. The laws and regulations may not specifically mention community-led organisations, but may, by interpretation, include them, for example under not-for-profit laws.

Section 6

102, 103, 104, 105, 106

Have there been any legal actions to decriminalize?

Although law reform can take a long time, there are some specific concrete actions that can be taken as steps towards law reform. This question is aimed at capturing substantial concrete actions that lead to, or could lead to, decriminalization. Although strategic litigation and proposals discussed by parliament are two main forms, there may be others in your country, such as a national consultation on a proposed bill, a draft decree being discussed, a referendum proposed. The action must be legal in nature, that is, it must involve parliamentary, governmental or judicial processes. It excludes practices that, while important, are not legal steps towards change. For example, it would not include sensitization or training activities.

If there are no laws criminalizing HIV nondisclosure, exposure or transmission (question 102), transgender people (question 103), sex work (question 104), same-sex sexual acts (question 105), or drug use or possession for personal use (question 106), the corresponding response option to indicate that no criminalizing law exists should be selected for that question.

Below is the guidance from the 2024 GAM for whether a country has one of the above criminalizing laws.

- Criminalization of HIV nondisclosure, exposure or transmission—it is considered that a country has a law criminalizing HIV nondisclosure, exposure or transmission if:
  - The country has laws that specifically criminalize HIV nondisclosure, exposure or transmission. This may be in a penal or criminal code or act, or in legislation related to public health or to HIV.
  - The country has laws that criminalize the spread of communicable diseases or sexually transmitted infections, and HIV is specifically mentioned in the text of the law.
  - The country laws that criminalize the spread of communicable diseases or sexually transmitted infections that covers HIV, but HIV is not specifically mentioned in the text of the law.
- Criminalization of transgender people—it is considered that a country has a law criminalizing transgender people if the country has laws that target people based on their gender identity or expression. Although it is rare to have a law that criminalizes being transgender, there are laws that criminalize the gender expression of transgender and gender diverse people. These are primarily expressed as laws against cross-dressing or criminalizing the opposite sex. Relevant laws may be found in legislation or personal or religious laws. This does not include broader laws, such as morality or vagrancy laws, that may be used in a discriminatory manner against transgender people.

- Criminalization of sex work—it is considered that a country has laws criminalizing sex work if:
  - The country has laws that specifically criminalize the provision of sexual services, where the person personally providing such services (the sex worker) is criminalized (i.e. the sex worker is criminally liable).
  - The country has laws that specifically criminalize the purchase of the services of a sex worker (i.e. the client is liable). (This is different from buying the services for a third person, which is included under "profiting from").
  - The country has laws that criminalize ancillary activities associated with selling sexual services, including sex work-related advertising and soliciting (offering sexual services), sex workers congregating in one place, sex workers living with each other, and sex workers working too close to a school or place of worship.
  - The country has laws that criminalize ancillary activities associated with buying sexual services, such as soliciting (looking for sexual services) and curb-crawling.
  - The country has laws that criminalize profiting from organizing or managing sexual services (third parties profiting from the proceeds of sex work).
- Criminalization of same-sex sexual acts—laws criminalizing consensual same-sex sexual acts in private are generally found in criminal codes and penal codes. They may also exist in military codes, even if they do not exist in general national law. The precise crimes may be known as "sodomy", "buggery" or "sexual acts against the order of nature", or the law may simply say that sexual acts between two adults of the same sex are illegal. Where the law mandates a particular sentence or length of imprisonment, this may include a fine, a few months in prison, life imprisonment or the death penalty. In other cases, the law may not prescribe a sentence but may leave it to the courts to determine.
- Criminalization of drug use or possession for personal use—a country is considered to have laws criminalizing drug use or possession for personal use if use or possession of illicit drugs for personal use is a criminal offence for any drugs. This is also the case if the country has decriminalized or legalized some drugs, such as marijuana, but not all drugs. The country is considered to have decriminalized drug use or possession for personal use if it allows possession of a small amount of any drug. Criminal penalties may be replaced by administrative penalties or voluntary referrals to treatment or counselling, or there may be no sanctions at all.

A country is considered to have any of the above criminalizing laws if these exist at the national or subnational level.

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