GLOBAL AIDS RESPONSE PROGRESS REPORTING 2013

Construction of Core Indicators for monitoring the 2011 UN Political Declaration on HIV/AIDS

Includes additional WHO/UNICEF Universal Access Health Sector Indicators

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Includes additional WHO/UNICEF Universal Access Health Sector Indicators

January 2013, Geneva, Switzerland

Please use the Global AIDS Response Progress Reporting website (www.unaids.org/AIDSReporting) to submit your indicator data by 31 March 2013.

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Foreword

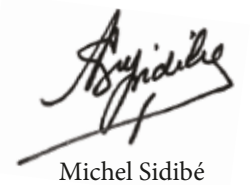
In the past two years, the AIDS response has recorded unprecedented gains in the prevention and treatment of HIV across the world. The *Global report: UNAIDS report on the global AIDS epidemic 2012*, shows that the pace of progress is accelerating.

These promising results were based on country reports that UNAIDS received from 186 out of 193 United Nations Member States—the highest response rate for any international health and development mechanism. This exceptional dedication by countries to reporting on the AIDS response demonstrates our strong global commitment to our shared vision of: zero new HIV infections, zero discrimination and zero AIDS-related deaths.

This year, the United Nations General Assembly will conduct a midterm review of progress towards reaching the bold targets and elimination commitments of the 2011 United Nations Political Declaration on HIV/AIDS. The United Nations Secretary-General will report to the General Assembly on progress achieved and what it will take to close the gap.

Collecting and reporting high-quality results on the AIDS response is an important element of our agenda for shared responsibility and global solidarity. UNAIDS is committed to supporting United Nations Member States in this endeavour. To this end, we have prepared these guidelines on monitoring progress towards the 2015 targets. To inform the midterm review, UNAIDS is requesting countries to provide their most recent data for 2012, using the indicators in this document. This data will serve countries in conducting their own midterm reviews, helping you to focus on the areas where action is most needed to reach your priority targets and elimination commitments by 2015.

Thank you for your determination to strengthen your national HIV monitoring and evaluation systems. We cannot get to zero without timely evidence that helps in steering the national HIV programmes. I look forward to continuing the stellar record of national reporting on the global AIDS epidemic, and you can rely on UNAIDS for its full support in this effort.



Michel Sidibé
Executive Director
UNAIDS

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic(s)
BSS	Behavioural Surveillance Survey
DHS	Demographic and Health Survey
EID	Early Infant Diagnosis
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user/people who inject drugs (latter preferred language)
ILO	International Labour Organization
MC	Male circumcision
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MSM	Men who have sex with men
NA	Not Applicable
NAC	National AIDS Committee(s)
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NGO	Nongovernmental Organization(s)
NSP	National Strategic Plan
NSP	Needle and Syringe Programmes
OECD	Organisation for Economic Co-operation and Development
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
STI	Sexually Transmitted Infection(s)
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

2011 United Nations General Assembly Political Declaration on HIV/AIDS:

Targets and elimination commitments

Introduction

Purpose

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

The "2011 UN Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS" (General Assembly resolution 65/277), which was adopted at the United Nations General Assembly High Level Meeting on AIDS in June 2011, mandated UNAIDS to support countries to report on the commitments in the 2011 UN Political Declaration on HIV/AIDS. In addition the 2011 Political Declaration called for a special report to the General Assembly on progress in accordance with global reporting on the Millennium Development Goals in the 2013 review of the Goals.

The Global AIDS Response Progress Reporting (GARPR) indicators (previously known as UNGASS indicators) used to be reported at the global level every second year. However, data will now be collected every year starting in 2013, including to inform the special midterm review in 2013.

To assess progress made against the targets, the collection and reporting of indicator data is an important part, but is just one part of the process. Countries are also encouraged to organize midterm reviews of the progress towards the 2015 global HIV/AIDS targets. Detailed guidance on how to conduct these reviews and the expected format to document their outcomes will be communicated separately and is outside the scope of these guidelines.

Countries are strongly encouraged to integrate these core indicators into their on-going monitoring and evaluation activities. These indicators are designed to help countries assess the current state of their national response and progress in achieving their national HIV targets. They will contribute to a better understanding of the global response to the AIDS pandemic, including progress towards the global targets set in the 2011 UN Political Declaration on HIV/AIDS and the Millennium Development Goals. These guidelines are designed to improve the quality and consistency of data collected at the country level, thus enhancing the accuracy of conclusions drawn from it, at national, as well as regional and global levels.

How to use these guidelines

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

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

Background

Mid-2013 marks the midpoint of the period identified to achieve the bold 2015 global HIV/AIDS targets outlined in the 2011 UN Political Declaration on HIV/AIDS and an opportunity to review progress.

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

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

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

The guidelines in this document have been developed to enhance reporting of key indicators for the AIDS response. The reported data are used to monitor progress against the commitments and targets of the 2011 UN Political Declaration on HIV/AIDS and form the basis of global midterm review of the 2011 UN Political Declaration on HIV/AIDS and the Secretary-General's reports to the General Assembly.

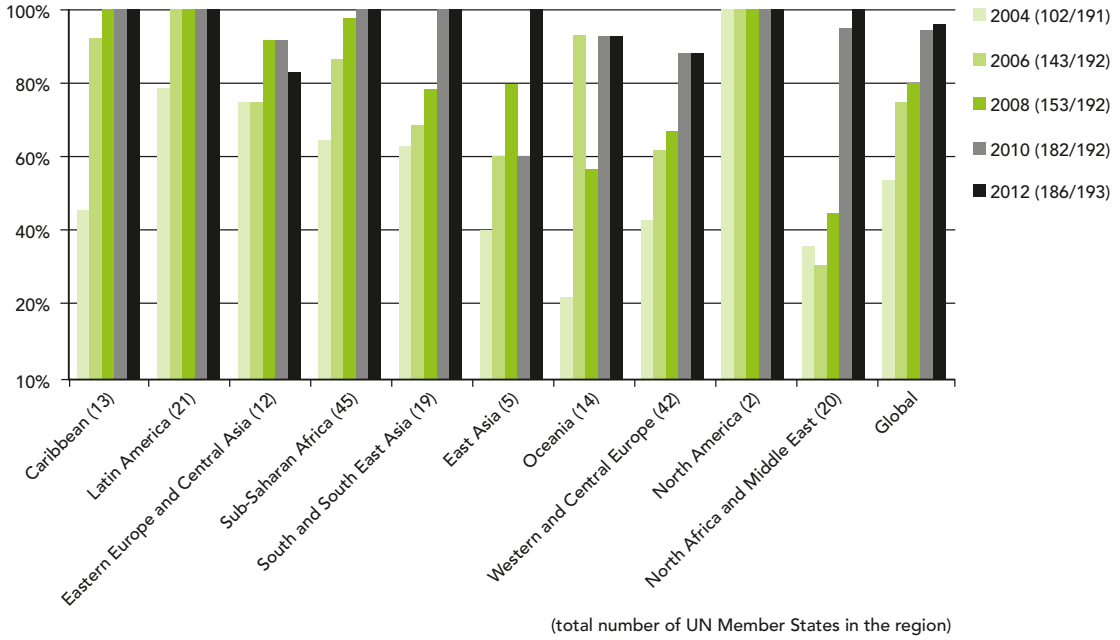
2011 UN Political Declaration on HIV/AIDS – Targets and elimination commitments

1. Reduce sexual transmission by 50% by 2015
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015
3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths
4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015
6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and middle-income countries
7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms
9. Eliminate HIV-related restrictions on entry, stay and residence
10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

Reporting History

UNAIDS has collected Country Progress Reports from Member States for the purpose of monitoring the various political declarations every two years since 2004. Response rates have increased from 102 (53%) Member States in 2004 to 186 (96%) in 2012 (see graph for regional response rates and trends over time).

Year of reporting (UN Member States reporting/ total number of UN Member States)



The information provided by country progress reports represents the most comprehensive data on both the status of, and response to the epidemic. The data from the five previous reporting rounds are available online through AIDSinfo; aidsinfo.unaids.org. The full data base is available at www.aidsinfoonline.org, that can be used to produce charts, maps and tables. Unedited country reports are available on www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries.

Reporting Format

In the special 2013 midterm review of the 2011 UN Political Declaration on HIV/AIDS there are two components: the reporting of indicators and a special midterm review. These guidelines provide information about the reporting of indicators. Guidance on the special midterm reviews and how these can be organized and reported is communicated separately.

Reporting on key indicators

Global AIDS response progress reporting indicators are important for two reasons. First, they can help individual countries evaluate the effectiveness of their national response and be the backbone of the midterm review of progress towards the 2015 targets in the 2011 UN Political Declaration on HIV/AIDS. Second, when data from multiple countries are analysed collectively, the indicators can provide critical information on the effectiveness of the response at regional and global levels, and will be the basis for the regional and global analyses of progress towards the 2015 targets. At the same time this provides countries with insights into other national-level responses.

Prior to the 2011 General Assembly meeting on HIV/AIDS, indicators used in previous reporting rounds were rigorously reviewed, using an extensive evidence-based consultation process led by the UNAIDS Monitoring and Evaluation Reference Group (MERG). Inclusion of indicators was based on explicit

objective criteria as described in the Indicator Standards: Operational Guidelines for Selecting Indicators for the HIV Response[1].

There are only three changes to the indicator set since the last reporting round:

- Small clarifications in the PMTCT coverage indicator (Indicator 3.1) to reflect the latest development in this area.
- Small clarifications in the ART coverage indicator (Indicator 4.1) to reflect the latest development in this area.
- A full National Commitments and Policies Instrument (NCPI) does not need to be reported in 2013, only a brief questionnaire. The NCPI will only be reported every second year.

Further, male circumcision is an important element of a comprehensive HIV prevention package in countries with high HIV prevalence and low levels of male circumcision. For this reason two indicators have been added for these 16 countries[2]: prevalence of male circumcision and number of men circumcised in the previous year. Descriptions of these two indicators can be found in annex 6.

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

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

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

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

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

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

Full definitions for all indicators used for the Global AIDS response progress reporting can be found in these guidelines. The indicators can also be found in the UNAIDS Indicator Registry at www.indicatorregistry.org. This online database provides complete definitions of the Global AIDS response progress reporting indicators as well as other HIV indicators used at country level. There are direct links from the Online Reporting Tool to the indicators in the Indicator Registry. The indicators can also be exported from the Indicator Registry to Excel, Word, or PDF.

1 UNAIDS MERG Indicator Standards Operational Guidelines for Selecting Indicators for the HIV Response, Geneva 2010, can also be found at www.unaids.org/en/media/unaids/contentassets/documents/document/2010/4_3_MERG_Indicator_Standards.pdf

2 Botswana, Ethiopia, Central African Republic, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

National indicators for high-income countries

In adopting the 2011 UN Political Declaration on HIV/AIDS, high-income countries have committed themselves to reporting on progress made in their national responses to HIV. It is recognized that high-income countries may use relatively complex information systems and a variety of data sources which can make the calculation of a single national indicator challenging. However, this does not remove the need for high-income country data for monitoring global progress towards the 2011 UN Political Declaration on HIV/AIDS. European Union countries have used innovative ways to link global HIV monitoring systems more closely to regional circumstances. UNAIDS encourages high-income countries to contact the UNAIDS Data for Action (DFA) Division (AIDSreporting@unaids.org) if they require further technical advice regarding reporting on their domestic programmes.

The deadline for report submission using the reporting website is 31 March 2013. If the website is not used for reporting, printed copies of reports must be submitted by 15 March 2013 to allow for the manual entry of data.

Implementation of progress reporting at national level

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

Indicator construction

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

- the purpose of the indicator;
- the frequency with which relevant data should be gathered;
- recommended measurement tools;
- recommended methods of measurement; and
- summary interpretation of the indicator.

Measurement tools and data sources

The primary measurement tools vary by indicator and include:

- nationally representative, population-based sample surveys;[3]
- behavioural surveillance surveys;
- specially-designed surveys and questionnaires, including surveys of specific population groups (e.g. specific service coverage surveys);
- patient tracking systems;
- health information systems;
- sentinel surveillance; and
- the National Commitments and Policy Instrument (NCPI) questionnaire.

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

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

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

3 such as the Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS), and Multiple Indicator Cluster Surveys (MICS)

Numerators and denominators

For each core indicator, detailed instructions for measuring the national response are provided. Most core national-level indicators use numerators and denominators to calculate the percentages that measure the current state of the national response.

Countries are strongly encouraged to pay close attention to the dates attached to specific data when calculating an indicator. If data used for the numerator and denominator are collected at different times, the accuracy and validity of that information will be compromised.

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

Disaggregated Data: sex and age

One of the key lessons learnt from previous rounds of reporting was the importance of obtaining disaggregated data, for example, breaking it down by sex and age. In 2010 more than 80% of countries submitted data files with at least some level of disaggregation. While this represents a great improvement over previous rounds of reporting, it appears that a number of countries are still unable to adequately monitor age and sex differences in key indicators of their response. It remains vital that countries collect data in their component parts and not simply in summary form. Without disaggregated data, it is difficult to monitor the breadth and depth of the response to the epidemic at both national and global levels. It is equally difficult to monitor access to activities, the equity of that access, the appropriateness of focusing on specific populations and meaningful change over time.

Countries are strongly encouraged to make the collection of disaggregated data, especially by sex and age, one of the cornerstones of their monitoring and evaluation efforts. If possible, equity analyses should also be done. Key ministries should review their information systems, surveys and other instruments for collecting data to ensure that they capture disaggregated data at subnational levels, including facility and project levels. Special efforts should be made to follow disaggregated data up to the national level. In addition, the private sector and/or civil society organizations involved in the country's AIDS response must be advised of the importance of disaggregated data, and make the collection and dissemination of the data a priority in their ongoing operations.

The Global AIDS Response Progress Reporting website (www.unaids.org/AIDSreporting) clearly identifies the disaggregated data that are required to accurately report on the numerator and denominator for each indicator (see the preceding subsection entitled 'Numerators and Denominators' for additional information). In general, where appropriate, all data should be disaggregated by sex and age. Where collecting disaggregated data has proved difficult, entry of partial data is possible, if necessary.

In situations where disaggregated data are not readily available, it may be possible to extract the information needed for core indicators from larger data sets, although the location of the data will vary from country to country. Countries should seek technical assistance from the United Nations System, (including the UNAIDS, WHO and UNICEF country offices), and its partners, for help with accessing the disaggregated data needed to properly complete the measurements of core indicators. Governments are encouraged to look beyond their internal information resources to both collect and validate data. In many cases, civil society organizations may be able to provide valuable primary and secondary data.

Recent and representative survey data

Use the most recently available nationally representative survey to calculate indicators that are based on general population surveys. This may mean that the data reported in this round will be the same as the data reported in the previous round, since such surveys are generally undertaken at five year intervals. **Survey data already reported in 2012 and where more recent data is not available will not need to be re-entered. These data points will be pre-filled and will only need to be confirmed.**

Ensuring that survey samples of key populations are truly representative is a great technical challenge. Methods are being developed to try to achieve representative sampling of these populations (e.g. respondent-driven sampling).While these are being refined, it is recognized that countries may not be confident that samples used for surveys of key populations at higher risk of HIV exposure are representative. Countries are advised to use the most recent survey of key populations that has been reviewed and endorsed by local technical experts, such as monitoring and evaluation technical working groups or national research councils.

Interpretation and analysis

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

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

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

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

Selection of indicators

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

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

When countries do not submit data for an indicator they are asked to state whether:

(i) data are not available to answer that indicator;

or

(ii) the indicator is not considered applicable to the epidemic situation in the country.

If it is felt that the area is relevant to the epidemic and response, but that the indicator itself is not relevant or appropriate for monitoring this issue, this should be stated in the online reporting tool comment boxes. If a country is using an alternative indicator to effectively monitor the issue in question the comment boxes may be used to describe it (including a full definition and method of measurement), along with any available data for the indicator.

Role of civil society

Civil society plays a key role in the response to the AIDS epidemic in countries around the world. The wide range of expertise within civil society organizations makes them ideal partners in the process of preparing Country Progress Reports. Specifically, civil society organizations are well positioned to provide quantitative and qualitative information to augment the data collected by governments.

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

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

Country-level UNAIDS staff are available to assist with civil society input throughout the process.

In particular, UNAIDS country-level staff should:

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

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

Report contents

In 2013, countries are expected to submit data on all of the national indicators that are applicable to their response.

National governments are responsible for reporting on national-level indicators with support from civil society and, where applicable, development partners. The procedures outlined in this manual should be used for collecting and calculating the necessary information for each indicator.

Countries are also requested, when possible, to submit copies of or links to primary reports from which data is drawn for the different indicators. These reports can be submitted through the online global

reporting tool. This will facilitate the analyses of the data including trend analyses and comparisons between countries.

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

The indicator data will be made available after a process of data cleaning, validation and reconciliation at AIDSinfo[4].

➡ If there are any questions, countries are advised to consult with UNAIDS locally or in Geneva at AIDSreporting@unaids.org. Updated information on Global AIDS Response Progress Reporting will be made available on the UNAIDS web site at: http://www.unaids.org/AIDSreporting.

Guidance on submission

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

Reporting tool

➡ Countries will submit their data using an online global reporting tool found at http://AIDSreportingtool.unaids.org. Each country has an assigned national focal point that will be responsible for accessing this tool and entering their country information for submission.

Users can access the tool as an editor or viewer. Editors are able to add and make changes to the information to be submitted. Viewers are able to see the information that will be submitted, yet make no changes to it. The country's focal point is responsible for sharing the appropriate credentials to access the tool.

As mentioned previously, where countries do not submit data on an indicator, they should indicate whether this was due to an absence of appropriate data or because the indicator was not considered relevant to the epidemic. There are comment boxes where short explanatory notes stating how the numerator and denominator were calculated and assessing the accuracy of the composite and disaggregated data can be added.

The country finalizes its submission by clicking the "submit" button. This closes the country's session in the online global reporting tool. The country will no longer be able to make editing changes or additions to its submission using this tool. UNAIDS will review the data and ask for clarifications if necessary. If there are queries to the data, the site will be opened again for the countries to edit their responses.

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

4 www.unaids.org/en/dataanalysis/tools/aidsinfo

Joint reporting with WHO and UNICEF on Health Sector Indicators

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

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

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

Data submission

The indicator data should be submitted online by 31 March 2013.

Wherever possible, data should be entered online, using the global reporting website (www.unaids.org/AIDSreporting). This will facilitate data processing and minimize errors.

Please note that countries not submitting their data online are asked to submit their reports by 15 March 2013 to allow time for the manual entry of data into the Global Response Database at UNAIDS in Geneva.

To facilitate follow-up, countries are requested to provide the name and contact details of the individual responsible for submitting the data.

Printed copies of reports may be sent to:

Division chief, Data for Action Division
UNAIDS, 20 Avenue Appia CH-1211 Geneva 27, Switzerland

The national-level reporting process: Necessary actions

Complete reporting on the core indicators is essential if the reporting is to contribute to the global response to the epidemic. Countries are strongly encouraged to establish timetables and milestones for completing the necessary tasks. Listed below are necessary actions to facilitate completion of the report. Under the direction of the National AIDS Committee or its equivalent, countries need to:

1. identify data needs in line with the national strategic plan requirements and these Global AIDS Response Progress Indicator guidelines;
2. develop and disseminate a plan for data collection, including timelines and the roles of the National AIDS Committee or equivalent, other government agencies and civil society;
3. identify relevant tools for data collection;
4. secure required funding for the entire process of collecting, analysing and reporting the data;
5. collect and collate data in coordination with partner organizations from government, civil society and the international community;
6. analyse data in coordination with partner organizations from government, civil society and the international community;
7. complete the appropriate data forms;
8. allow stakeholders, including government agencies and civil society, to comment on the draft data;
9. enter the data into the Global AIDS response progress reporting website (http://AIDSreportingtool.unaids.org);
10. submit the indicator data before **31 March 2013**, or by 15 March 2013 for countries not submitting data via online reporting; and
11. respond in a timely manner to queries on the submissions from UNAIDS, WHO or UNICEF.

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

A summary checklist which may be used in the preparation and submission of the Country Progress Report is included as Appendix 4.

Summary of changes for 2013 Global AIDS Response Progress Reporting

The indicators and reporting format will build on the successful work in previous rounds of reporting. The Global AIDS Response Progress Reporting indicators (previously known as UNGASS indicators) used to be reported only every second year. However, with the special midterm review in 2013 updated data is needed at country, regional and global level.

To minimize the reporting burden:

- The same set of indicators as in 2012 will be used, with the only changes being:
  - clarifications in the PMTCT coverage indicator (Indicator 3.1) to reflect the latest development in this area;
  - clarifications in the ART coverage indicator (Indicator 4.1) to reflect the latest developments in this area; and
  - a full National Commitments and Policies Instrument (NCPI) does not need to be reported in 2013, only a brief questionnaire. The NCPI will only be reported every second year.
- No narrative GARPR reports will be required.
- Survey data that have not been updated since the 2012 report do not need to be re-entered (i.e. indicator 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 2.2, 2.3, 2.4, 2.5, 7.1, 10.1, 10.2). Though countries will have a chance to validate their latest available data.

Two additional indicators about prevalence of male circumcision and number of men circumcised have been added, but only for the 16 countries with high HIV-prevalence and low prevalence of male circumcision.

Joint reporting of the Global AIDS Response Progress Reporting indicators and additional health sector indicators from WHO and UNICEF will continue. The additional health sector indicators can be found in Part II of these guidelines.

Core indicators for Global AIDS Response Progress Reporting

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

Targets	Indicators	
Target 1. Reduce sexual transmission of HIV by 50% by 2015	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*
General population	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results
	1.6	Percentage of young people aged 15-24 who are living with HIV*
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results
	1.10	Percentage of sex workers who are living with HIV
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results
	1.14	Percentage of men who have sex with men who are living with HIV
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results
	2.5	Percentage of people who inject drugs who are living with HIV
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths[7]	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth
	3.3	Mother-to-child transmission of HIV (modelled)

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy*
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources
Target 7. Eliminating gender inequalities	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months *All indicators with sex-disaggregated data can be used to measure progress towards target 7*
Target 8. Eliminating stigma and discrimination		*Indicator development, Stigma indicator for general population planned to be ready for 2014 reporting*
Target 9. Eliminate travel restrictions		*Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed*
Target 10. Strengthening HIV integration	10.1	Current school attendance among orphans and non-orphans aged 10–14*
	10.2	Proportion of the poorest households who received external economic support in the last 3 months *Indicator development*
Policy questions (relevant for all 10 targets)		***Special 2013 GARPR questionnaire.*** *The National Commitments and Policy Instruments (NCPI) will not be reported in 2013*

* Millennium Development Goals indicator

7 The *Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive* defines this target as:
1. Reduce the number of new HIV infections among children by 90%
2. Reduce the number of AIDS-related maternal deaths by 50%

For further information see: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

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

General Population

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

1.2 Percentage of young women and men who have had sexual intercourse before the age of 15

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

1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*

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

1.6 Percentage of young people aged 15-24 who are living with HIV*

Sex Workers

1.7 Percentage of sex workers reached with HIV prevention programmes

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

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

1.10 Percentage of sex workers who are living with HIV

Men who have Sex with Men

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

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

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

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

*Millennium Development Goals indicator

1.1 Young people: Knowledge about HIV prevention

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

What it Measures

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

Rationale

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

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

Explanation of Numerator

The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: "Can a person get HIV by hugging or shaking hands with a person who is infected?" and "Can a person get HIV through supernatural means?"

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

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

Strengths and Weaknesses

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

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

Further Information

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

1.2 Sex before the age of 15

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

What it Measures

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

Rationale

A major goal in many countries is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV. There is also evidence to suggest that first having sex at a later age reduces susceptibility to infection per act of sex, at least for women.

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

Strengths and Weaknesses

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

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

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

Further Information

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

1.3 Multiple sexual partnerships

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

What it Measures

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

Rationale

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

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

Strengths and Weaknesses

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

Further Information

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

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

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

What it Measures

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

Rationale

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

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

Strengths and Weaknesses

This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly). However, the broader significance of any given indicator value will depend upon the extent to which people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on the percentages of people that have had more than one sexual partner within the last year.

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

Further Information

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

1.5 HIV testing in the general population

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

What it Measures

It measures progress in implementing HIV testing and counselling.

Rationale

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

Numerator:	Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of all respondents aged 15-49 The denominator includes respondents who have never heard of HIV or AIDS
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents are asked: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you get the results of that test?
Measurement Frequency:	Every 3 to 5 years
Disaggregation:	• Sex • Age (15-19, 20-24 and 25-49)

Strengths and Weaknesses

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

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

Further Information

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

1.6 HIV prevalence in young people

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

What it Measures

It measures progress towards reducing HIV infection.

Rationale

The goal in the response to HIV is to reduce HIV infection.

HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in trends in HIV prevalence figures for 15–24 years olds (or even earlier in 15-19-year-olds if this age breakdown is available). Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence.

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

Strengths and Weaknesses

In countries where the age at which young people first have sexual intercourse is late and/or levels of contraception use are high, HIV prevalence among pregnant women of 15–24 years of age will differ from that among all women in the age group.

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

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

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

Further Information

For further information, please consult the following links:

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

http://data.unaids.org/publications/irc-pub06/jc954-anc-serosurveys_guidelines_en.pdf

1.7 Sex workers: prevention programmes

Percentage of sex workers reached with HIV prevention programmes

What it Measures

It measures progress in implementing basic elements of HIV prevention programmes for sex workers.[8]

Rationale

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

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

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

Strengths and Weaknesses

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

8. This indicator only covers two basic elements of prevention programmes for sex workers. It is recognized that the indicator does not measure the frequency with which members of these populations access services, nor the quality of these services. These limitations suggest that the indicator may overestimate the coverage of HIV prevention services or sex workers. While continued monitoring of this indicator is recommended in order to determine trends in coverage of minimum services, additional measures are required in order to accurately determine whether adequate HIV prevention services are being provided for these populations.

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

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

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

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

Further Information

For further information, please consult the following references:

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

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

1.8 Sex workers: condom use

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

What it Measures

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

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

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

Further Information

For further information, please consult the following references:

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

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

1.9 HIV testing in sex workers

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

What it Measures

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

Rationale

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

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

Strengths and Weaknesses

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

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

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

Further Information

For further information, please consult the following references:

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

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

1.10 HIV prevalence in sex workers

Percentage of sex workers who are living with HIV

What it Measures

It measures progress on reducing HIV prevalence among sex workers.

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

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

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

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

Further Information

For further information, please consult the following links:

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

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

1.11 Men who have sex with men: prevention programmes

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

What it Measures

It measures progress in implementing basic elements of HIV prevention programmes for MSM.[9]

Rationale

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

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

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

Strengths and Weaknesses

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

9 This indicator only covers two basic elements of prevention programmes for MSM. It is recognized that the indicator does not measure the frequency with which members of these populations access services, nor the quality of these services. These limitations suggest that the indicator may overestimate the coverage of HIV prevention services for MSM. While continued monitoring of this indicator is recommended in order to determine trends in coverage of minimum services, additional measures are required in order to accurately determine whether adequate HIV prevention services are being provided for these populations.

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

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

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

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

Further Information

For further information, please consult the following references:

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

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

1.12 Men who have sex with men: condom use

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

What it Measures

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

Rationale

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

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

Numerator:	Number of MSM who reported that a condom was used the last time they had anal sex
Denominator:	Number of MSM who reported having had anal sex with a male partner[10] in the last six months
Calculation:	Numerator / Denominator
Method of Measurement:	Behavioural surveillance or other special surveys In a behavioural survey of a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field Access to MSM as well as the data collected from them must remain confidential
Measurement Frequency:	Every two years
Disaggregation:	• Age (<25/25+)

Strengths and Weaknesses

For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. This indicator does not give any idea of risk behaviour in sex with women among men who have sex with both women and men. In countries where men in the sub-population surveyed are likely to have partners of both sexes, condom

10 This includes both regular and non-regular partners, and both paid and unpaid sex. As with all indicators this indicator only provides a limited piece of information. For a comprehensive assessment of patterns of risk associated with male to male sex further information is needed, including information on the types and numbers of partners and whether the individual is the receptive or insertive partner.

use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for female and male partners.

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

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

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

Further Information

For further information, please consult the following references:

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

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

1.13 HIV testing in men who have sex with men

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

What it Measures

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

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

Further Information

For further information, please consult the following references:

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

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

1.14 HIV prevalence in men who have sex with men

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

What it Measures

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

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

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

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

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

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

Further Information

For further information, please consult the following links:

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

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

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

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

2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

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

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

2.5 Percentage of people who inject drugs who are living with HIV

2.1 People who inject drugs: prevention programmes

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

What it Measures

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

Rationale

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

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

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

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

Strengths and Weaknesses

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

Estimating the size of IDU populations at country level is not without its challenges. Many different definitions of people who inject drugs exist in the literature and there are ranges of estimates. The reference group to the United Nations on HIV and injecting drug use undertakes reviews of the available literature to produce estimates of the number of people who inject drugs and these can be used in the absence of size estimates.

Countries can monitor this indicator against the following coverage levels:

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

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

Further Information

A full description of this indicator can be found in: WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/idu/targetsetting/en/index.html).

For further information, please consult the following references:

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

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

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

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

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

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

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

2.2 People who inject drugs: condom use

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

What it Measures

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

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

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

Further Information

For further information, please consult the following references:

WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/idu/targetsetting/en/index.html).

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

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

2.3 People who inject drugs: safe injecting practices

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

What it Measures

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

Rationale

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

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

Numerator:	Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs
Denominator:	Number of people who inject drugs who report injecting drugs in the last month
Calculation:	Numerator / Denominator
Method of Measurement:	Behavioural surveillance or other special surveys Respondents are asked the following questions: 1. Have you injected drugs at any time in the last month? 2. If yes: The last time you injected drugs, did you use a sterile needle and syringe[4]? Whenever possible, data for people who inject drugs should be collected through civil society organizations that have worked closely with this population in the field Access to people who inject drugs as well as the data collected from them must remain confidential
Measurement Frequency:	Every two years
Disaggregation:	• Sex • Age (<25/25+)

Strengths and Weaknesses

Surveying people who inject drugs can be challenging. Consequently, data obtained may not be based on a representative national sample of the people who inject drugs being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.

Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

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

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

Further Information

For further information, please consult the following references:

WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/idu/targetsetting/en/index.html).

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

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

2.4 HIV testing in people who inject drugs

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

What it Measures

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

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

Further Information

For further information, please consult the following references:

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

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

WHO, UNODC and UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/idu/targetsetting/en/index.html).

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

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

2.5 HIV prevalence in people who inject drugs

Percentage of people who inject drugs who are living with HIV

What it Measures

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

Rationale

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

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

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

Strengths and Weaknesses

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

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

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

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

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

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

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

Further Information

For further information, please consult the following links:

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

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

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

3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

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

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

3.1 Prevention of mother-to-child transmission

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

What it Measures

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

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

The postpartum regimen, including ARV to reduce the risk of transmission during breastfeeding, is not captured by this indicator, but by other indicators (see indicator 3.7 (Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks) and 3.8 (Percentage of infants born to HIV-infected women who are provided with antiretrovirals to reduce the risk of HIV transmission during breastfeeding) in Part 2, the additional universal access health sector part of these guidelines)).

Rationale

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

Numerator:	Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery. Global reports summarizing coverage of ARV for PMTCT will exclude women who received single dose nevirapine as it is considered a sub-optimal regimen. However the number of women who received only a single dose of nevirapine should be reported by the country.
Denominator:	Estimated number of HIV-positive pregnant women within the past 12 months
Calculation:	Numerator / Denominator
Method of Measurement:	For the numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms For the denominator: estimation models such as Spectrum, or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to coverage of ANC surveys Programme monitoring and HIV surveillance

Measurement Frequency:	Annual or more frequently, depending on a country's monitoring needs
Disaggregation:	The numerator should be disaggregated by the four general regimens described below

Explanation of Numerator

The numerator should be disaggregated by the four general regimens (the first three are recommended) for HIV-positive pregnant women for the prevention of mother-to-child transmission[11]:

1. Lifelong ART	
a. newly initiated on ART during the current pregnancy CD4 <350 CD4 >350	
CD4 not known	
b. already on ART at the beginning of the current pregnancy	
2. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B)	
3. Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines)	
4. Single dose nevirapine (with or without tail) ONLY	
5. Other (please comment: e.g. specify regimen, uncategorized, etc.)	

Category Description Examples

Disaggregation of regimen definitions

Categories	Further clarification	Common examples
1) Life-long antiretroviral therapy (including Option B+) disaggregated by 1a) newly initiated on treatment during the current pregnancy 1b) already on treatment at beginning of pregnancy	A three-drug regimen intended to provide ART for life 1a) Number of HIV-positive pregnant women identified in the reporting period newly initiated on ART for life 1b) Number of HIV-positive pregnant women identified in the reporting period who were already on ART at their first ANC visit. If a woman is initiating ART for life during labour, she would be counted in category 1a.	Standard national treatment regimen, for example: • TDF+3TC+EFV • AZT+3TC+NVP

11 While national PMTCT programmes are encouraged to move towards using more efficacious regimens, when SD-NVP is provided, it should be recorded and reported.

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

Explanation of Denominator

Two methods can be used to estimate the denominator:

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

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

Strengths and Weaknesses

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

This indicator does not capture the use of appropriate postpartum regimens for the mother (to reduce transmission and viral resistance) and for the infant (to reduce peripartum transmission) or during breastfeeding (to reduce postpartum transmission through breastfeeding) which should accompany antiretroviral drug regimens to reduce peripartum mother-to child transmission. See indicator 3.7 (Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks) for the tail and indicator 3.8 (Percentage of infants born to HIV-infected women who are provided with antiretrovirals to reduce the risk of HIV transmission during breastfeeding) for coverage during breastfeeding in Part 2, the additional universal access health sector part, of these guidelines.

Countries are encouraged to track and report the actual number (or estimated percentage if actual data are unavailable) of women receiving the various regimens, so that the impact of antiretroviral drugs on mother-to-child transmission can be modelled on the basis of the efficacy of the regimens. When countries do not have a system for collecting and reporting data on the provision and coverage of different antiretroviral drug regimens for the prevention of mother-to-child transmission of HIV, they should establish such a system.

Further Information

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

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

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

3.2 Early infant diagnosis

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

What it Measures

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

Rationale

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

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

Explanation of Numerator

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

If information is available about the test results (positive, negative, indeterminate, and rejected for testing by the laboratory) can also be reported. When reporting this information only the most recent test result for an infant tested in the first 2 months of life should be included.

Explanation of Denominator

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

Two methods can be used to estimate the denominator:

a) Using a projection model such as the one provided by Spectrum software use the output *"the number of pregnant woman needing PMTCT"* as a proxy,

or;

b) Multiplying the total number of women who gave birth in the last 12 months, (which can be obtained from central statistics office estimates of births or the UN Population Division estimates) *by* the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in ANC clinic and appropriate adjustments related to coverage of ANC surveys), if Spectrum projections are unavailable.

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

Strengths and Weaknesses

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

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

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

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

Further Information

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

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

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

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

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

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

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

What it Measures

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

Rationale

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

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

Numerator:	The numerator is the estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women
Denominator:	Estimated number of HIV positive women who delivered in the previous 12 months
Calculation:	Numerator / Denominator
Method of Measurement:	The mother-to-child transmission probability differs with the antiretroviral drug regimen received and infant-feeding practices. The transmission can be calculated by using the Spectrum model. The Spectrum[12] computer programme uses the information on: a. the distribution of HIV-positive pregnant women receiving different antiretroviral regimens prior to and during delivery (peripartum) by CD4 category of the mother b. the distribution of women and children receiving antiretrovirals after delivery (postpartum) by CD4 category of the mother c. the percent of infants who are not breastfeeding in PMTCT programmes by age of the child d. mother-to-child transmission of HIV probabilities based on various categories of antiretroviral drug regimen and infant feeding practices[13] The estimated national transmission rate is reported in the Children 0-14 summary display in Spectrum. This variable can also be calculated using the variables in Spectrum on "New HIV infections" for children 0-14 years[14] and dividing this by the variable "Women in need of PMTCT"

12 Spectrum software is a suite of models that can be used to project the impact of the HIV epidemic. Spectrum is developed by Futures Institute and can be downloaded from http://www.futuresinstitute.org/Pages/Spectrum.aspx.

13 Default values exist in Spectrum if data are not available from the country.

14 In the Spectrum model, children 0-14 can only become infected through mother to child transmission, and thus represents the estimated number of children newly infected with HIV, which is represented by the Spectrum output variable "New HIV infections (children 0-14)".

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

Measurement Frequency: Annual

Disaggregation: None

Strengths and Weaknesses

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

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

Further Information

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

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

4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*

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

**Millennium Development Goals indicator*

4.1 HIV treatment: antiretroviral therapy

Percentage of eligible adults and children currently receiving antiretroviral therapy

What it Measures

Progress towards providing antiretroviral therapy to all people eligible for treatment.

Rationale

As the HIV epidemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral therapy (ART) has been shown to reduce mortality amongst those infected and reduce transmission of HIV. Efforts are being made to make it more affordable and scale up ART within low- and middle-income countries. Antiretroviral therapy should always be provided in conjunction with broader care and support services including counseling for family caregivers.

Numerator:	Number of eligible adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period
Denominator:	Estimated number of eligible adults and children National criteria for ART eligibility varies by country. To make this indicator comparable across countries global reports present the ART coverage for adults based on the eligibility currently recommended by WHO. Enter into the online tool the number of adults eligible for ART for both situations 1) based on national eligibility criteria and 2) based on WHO eligibility criteria.
Calculation:	Numerator / Denominator Percentages should be given for 2012 to track annual trends in coverage
Method of Measurement:	Data should be collected continuously at the facility level. Data should be aggregated periodically. The most recent full year of data should be used for annual reporting. Programme monitoring and estimates of ART need. For the numerator: facility-based antiretroviral therapy registers and corresponding cross-sectional forms. For the denominator: HIV estimation models such as Spectrum
Measurement Frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting
Disaggregation:	• Sex • Age (<1, 1-4, 5-14, 15+) • Public/Private

Explanation of Numerator

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

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

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

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

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

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

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

Explanation of Denominator

The denominator is generated by estimating the number of people with HIV infection eligible for antiretroviral therapy. This estimation must take into consideration a variety of factors including, but not limited to, the current numbers of people with HIV, the current number of patients on antiretroviral therapy, and the natural history of HIV from infection to enrolment into antiretroviral therapy.

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

Strengths and Weaknesses

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

The proportion of people needing antiretroviral therapy varies with the stage of the HIV epidemic, eligibility criteria, and the cumulative coverage and effectiveness of antiretroviral \ therapy among adults and children. As mentioned above, national criteria for ART eligibility varies by country. To make this indicator comparable across countries global reports present the ART coverage for adults based on the eligibility currently recommended by WHO.

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

The indicator measures the number of people provided with medication but does no measure whether the individual imbibed the medication thus it is not a measure of adherence.

Further Information

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

15 http://www.who.int/hiv/pub/arv/adult2010/en/index.html

4.2 Twelve-month retention on antiretroviral therapy

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

What it Measures

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

Rationale

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

Numerator:	Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment
Denominator:	Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period,* including those who have died since starting antiretroviral therapy., those who have stopped antiretroviral therapy, and those recorded as lost to follow-up at month 12
Calculation:	Numerator / Denominator
Method of Measurement:	Programme monitoring tools; cohort/group analysis forms Antiretroviral therapy registers and antiretroviral therapy cohort analysis report form The reporting period is defined as any continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. The pre-defined number of months can be determined by national reporting requirements. If the reporting period is January 1 to December 31, 2012, countries will calculate this indicator by using all patients who started antiretroviral therapy. any time during the 12-month period from January 1 to December 31, 2011. If the reporting period is July 1, 2011 to June 30, 2012, countries will include patients who started antiretroviral therapy from July 1, 2010 to June 30, 2011 A 12-month outcome is defined as the outcome (i.e., whether the patient is still alive and on antiretroviral therapy, dead or lost to follow-up) at 12 months after starting antiretroviral therapy. For example, patients who started antiretroviral therapy during the 12-month period from January 1 to December 31, 2010 will have reached their 12-month outcomes for the reporting period of January 1 to December 31, 2012
Measurement Frequency:	As patients start antiretroviral therapy., monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated
Disaggregation:	• Sex • Age (<15, 15+)

Explanation of Numerator

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

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

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

For example, for those patients who started antiretroviral therapy in May 2010, if at any point during the period May 2010 to May 2011 these patients die, are lost to follow-up (and do not return), or stop treatment (and do not restart), then at month 12 (May 2011), they are not on antiretroviral therapy, and not included in the numerator. Conversely, a patient who started antiretroviral therapy in May 2010 and who missed an appointment in June 2010, but is recorded as on antiretroviral therapy in May 2011 (at month 12) is on antiretroviral therapy and will be included in the numerator. What is important is that the patient who has started antiretroviral therapy in May 2010 is recorded as being alive and on antiretroviral therapy after 12 months, regardless of what happens from May 2010 to May 2011.

Explanation of Denominator

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

For example, for the reporting period January 1 to December 31, 2010, this will include all patients who started antiretroviral therapy during the 12-month period from January 1 to December 31, 2009. This includes all patients, both those on antiretroviral therapy as well as those who are dead, have stopped treatment or are lost to follow-up at month 12.

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

Strengths and Weaknesses

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

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

Further Information

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

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

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

5.1 Co-management of tuberculosis and HIV treatment

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

What it Measures

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

Rationale

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

Numerator:	Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year
Denominator:	Estimated number of incident TB cases in people living with HIV Annual estimates of the number of incident TB cases in people living with HIV in high TB burden countries are calculated by WHO and are available at: http://www.who.int/tb/country/en
Calculation:	Numerator / Denominator
Method of Measurement:	Facility antiretroviral therapy registers and reports; programme monitoring tools Programme data and estimates of incident TB cases in people living with HIV
Measurement Frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here

Strengths and Weaknesses

Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. WHO provides annual estimates of the burden of TB among people living with HIV, based on the best available country estimates of HIV prevalence and TB incidence. All incident TB cases among people living with HIV should be started on TB treatment and depending on country specific eligibility criteria. Incident TB cases are defined as new cases that have occurred in that year.

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

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

Further Information

For further information, please consult the following reference:

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

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

6.1 Domestic and international AIDS spending by categories and financing sources

6.1 AIDS spending

Domestic and international AIDS spending by categories and financing sources

What it Measures

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

Rationale

As the national and international response to AIDS continues to scale up, it is increasingly important to accurately track in detail: i) how funds are spent at the national level and ii) where the funds originate. The data are used to measure annual global HIV expenditures, which is an important component of Monitoring the 2011 UN Political Declaration on HIV/AIDS. In addition, the data help national-level decision-makers monitor the scope and effectiveness of their programmes. When aggregated across multiple countries, the data also help the international community evaluate the status of the global response. This piece of strategic information supports the coordination role of the National AIDS Authority in each country and provides the basis for resource allocation and improved strategic planning processes.

Since different countries can choose among different methodologies and tools to monitor the flow of AIDS funding – i.e. National AIDS Spending Assessments (NASA), AIDS sub-account of the National Health Accounts (NHA) and ad hoc Resource Flows Surveys – the National Funding Matrix includes a spreadsheet that allows financial data from any of these three methodologies to be easily entered, reviewed and reported.

Measurement Tool:

Primary tool/method:

1) National AIDS Spending Assessment (NASA)

Alternative tools/methods:

2) National Health Accounts – AIDS sub-accounts. There should not be any difference in the AIDS health spending measured by NASA or by the NHA sub-accounts. However, some activities performed outside the health sector might not be included in National Health Accounts
3) Resource Flows (RF) Survey. There has been an alignment process and countries that have been selected in the sample of this survey and have responded to the questionnaires may enter the information in the funding matrix at the aggregated level by main activities. Some activities performed outside the health sector might not be included in this RF Survey. In addition, some population-related actions should be excluded from the total for AIDS

The outputs from any of these measurement tools are to be used to complete the National Funding Matrix, which is to be submitted as part of the Country Progress Report (see Appendix 2).

Method of Measurement:

The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix. Appendix 2 provides further instructions on how to submit the report of this indicator via the completed National Funding Matrix. The cover sheet as well as the information indicated in Appendix 2 needs to be submitted with the Country Progress Report.

Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources:

1. Prevention;
2. Care and treatment;
3. Orphans and vulnerable children[16];
4. Programme management and administration strengthening;
5. Incentives for human resources;
6. Social protection and social services (excluding orphans and vulnerable children);
7. Enabling environment and community development
8. Research (excluding operations research included under programme management)

(There are multiple sub-categories in each AIDS Spending Category; see Appendix 2)

Three main groups of financing sources:

1. Domestic public;
2. International;
3. Domestic private (optional for global AIDS progress report reporting)

(There are multiple sub-categories for each source; see Appendix 6)

Measurement Frequency:

2010, 2011 and 2012 (as available)

Calendar or fiscal year data (as available)

Countries that have submitted data for 2010 already in their last report (GARPR 2012) do not need to fill in data for 2010 again, unless data in the last report were missing, incomplete or there have been changes to the 2010 data as more information has become available since. In this case, we will replace the data in our database reported for 2010 in the last submission (GARPR 2012) with the newer data reported in the 2013 submission.

Strengths and Weaknesses

The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. For example, the diagnosis and treatment of opportunistic infections would require a special costing estimate to track the specific resources allocated to AIDS-related diagnosis and treatment. Similarly, prevention activities in schools may benefit from a detailed estimation to calculate actual expenditures on AIDS activities. The AIDS expenditures might occur outside the health system given the nature of expanded responses to AIDS.

Completing the National Funding Matrix will provide a more detailed picture of the situation at the country level, which is useful for both national and global decision-making.

16 In the context of resource needs estimates and AIDS Spending Assessments, vulnerable children are defined as those that have at least one parent who is alive but seriously ill (mainly because of HIV) and unable to take care of them.

Further Information

For further information, please consult the following references:

National AIDS Spending Assessment (NASA): classification, taxonomy and definitions. Geneva, UNAIDS, 2009 (http://www.unaids.org/en/dataanalysis/tools/nasapublications):

UNFPA/UNAIDS/NIDI. Details on resource flow surveys, survey instruments, countries sampled and more details on this tool are available at: www.resourceflows.org.

World Bank, WHO and USAID. *Guide to producing national health accounts*. Geneva, World Health Organization, This publication and other tools for national health accounts and AIDS sub-accounts can be found at: http://www.who.int/nha.

Health Systems 20/20 and USAID. *Methodological guidelines for conducting a national health accounts sub-analysis for HIV/AIDS* (http://www.healthsystems2020.org).

USAID, Health Systems 20/20 and UNAIDS. *Linking NASA and NHA concepts and mechanics*. Geneva, UNAIDS, 2009 (http://www.unaids.org/en/dataanalysis/tools/nasapublications).

TARGET 7: ELIMINATING GENDER INEQUALITIES

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

7.1 Prevalence of recent intimate partner violence

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

What it Measures

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

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

Rationale

Globally, and particularly in sub-Saharan Africa, the observed high rates of HIV infection in women have brought into sharp focus the problem of violence against women. There is growing recognition that women and girls' risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. Studies conducted in many countries indicate that a substantial proportion of women have experienced violence in some form or another at some point in their life. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not.[17]

Numerator:	Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of these partners in the past 12 months
Denominator:	Total women surveyed aged 15-49 who currently have or had an intimate partner
Calculation:	Numerator / Denominator
Method of Measurement:	Population based surveys that are already being used within countries, such as WHO multi-country surveys, DHS/AIS (domestic violence module)[18], International Violence against Women Surveys (IVAWS) Data collection on violence against women requires special methodologies that adhere to the ethical and safety standards[19] to ensure that information is gathered in an ethical manner that does not pose a risk to study subjects, and in a way that maximizes data validity and reliability
Measurement Frequency	3-5 years
Disaggregation:	• Age (15-19, 20-24 and 25-49) • HIV status (if available)

17 http://www.who.int/gender/violence/en/vawinformationbrief.pdf

18 The questions asked in the DHS module on domestic violence and the WHO multi-country study on domestic violence and women's health are slightly different. However, the estimates produced from either methodology are comparable.

19 WHO ethical and safety guidelines for collecting data on violence against women. 2003, http://www.who.int/gender/documents/en/final%20recommendations%2023%20oct.pdf.

Explanation of Numerator

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

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

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

Explanation of Denominator

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

Strengths and Weaknesses

This indicator assesses progress in reducing the proportion of women who have experienced recent IPV, as an outcome in of itself. Further, the indicator should also be interpreted as a proxy for gender equality. A change in the prevalence level of recent violence over time will indicate a change in the level of gender equality—which is one of the structural factors driving the HIV epidemic. Gender equality has a clear, inverse relationship with IPV: In countries where IPV is high, gender equality, women's rates of education, and women's reproductive health and rights are low.[20]

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

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

20 Investing in gender equality: ending violence against women and girls. UNIFEM Brief, Oct. 2010.

The complex relationship between violence against women and HIV has been conceptually illustrated in a comprehensive review of the current state of evidence and practice in developing and implementing interventions and strategies to address the intersection of violence against women and HIV.[21] For over a decade, research world-wide has documented the undeniable link between violence against women (VAW) and HIV. Studies have demonstrated an association between VAW and HIV as both a contributing factor for infection as well as a consequence of infection.[22] This relationship operates through a variety of direct and indirect mechanisms.[23] For example:

- fear of violence may keep women from insisting on condom use by a male partner whom they suspect is HIV infected;
- fear of IPV may keep women from disclosing their HIV status or seeking treatment;[24]
- forced vaginal penetration increases the likelihood of HIV transmission;
- rape is one manifestation of gender inequality and can result in HIV infection, although this represents a minority of cases; and
- rape, other sexual and physical abuse can result in psychological distress that is manifested in risky sexual behaviour, with the result of becoming infected with HIV.

Further Information

Investing in gender equality: ending violence against women and girls. UNIFEM Brief, October 2010. Geneva, World Health Organization, 2010.

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

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

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

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

21 WHO (2010). Addressing violence against women and HIV/AIDS: What works? Geneva, WHO.

22 Dunkle KL, Head S, Garcia Moreno C. Current intervention strategies at the intersection of gender-based violence and HIV: A systematic review of the peer-reviewed literature describing evaluations of interventions addressing the interface between gender, violence and HIV. Geneva, WHO, 2009 (in press), and Program on International Health and Human Rights at Harvard School of Public Health (2009). Gender-Based Violence and HIV, final draft report.

23 Maman, Suzanne, Jacquelyn Campbell, Michael D. Sweat, Andrea C. Gielen. (2000) The intersections of HIV and violence: directions for future research and interventions Social Science & Medicine 50 459-478.

24 Program on International Health and Human Rights at Harvard School of Public Health (2009). Gender-Based Violence and HIV, final draft report.

TARGET 8: ELIMINATING STIGMA AND DISCRIMINATION

Indicator development: a stigma indicator for the general population is planned to be ready for 2014 reporting.

TARGET 9: ELIMINATE TRAVEL RESTRICTIONS

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

TARGET 10: STRENGTHENING HIV INTEGRATION

10.1 Current school attendance among orphans and non-orphans aged 10–14*

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

*Millennium Development Goals indicator

10.1 Orphans school attendance

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

What it Measures

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

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

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

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

Rationale

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

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

Explanation of Numerator

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

Strengths and Weaknesses

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

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

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

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

Further Information

For further information, please consult the following website:

http://www.unicef.org/aids/index_documents.html

10.2 External economic support to the poorest households

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

What it Measures

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

Rationale

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

Numerator:	Number of the poorest households that received any form of external economic support in the last 3 months *External economic support* is defined as free economic help (cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter) that comes from a source other than friends, family or neighbours unless they are working for a community-based group or organization. This source is most likely to be the national government or a civil society organization
Denominator:	Total number of poorest households *Poorest households* are defined as a household in the bottom wealth quintile. Countries should use the exact indicator definition and method of measurement for standardized progress monitoring and reporting at national and global levels. This will allow monitoring of changes over time and comparisons across different countries. However, countries can add or exclude other categories locally (for example, other wealth quintiles) depending on the country needs with respect to national programme planning and implementation
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys such as Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile to identify the poorest 20% of households. However, since it is not possible to identify the poorest households at the time of data collection, questions on economic support should be asked to all households. Only those who fall in the lowest wealth quintile will be included in the indicator

As part of a household survey, a household roster should be used to list all members of the household together with their ages, and identify all households with children less than 18 years of age, and with orphans, in the last year before the survey. Questions are then asked for each such household about the types of economic support received in the last 3 months, and the primary source of the help

The household heads or respondents are asked the following questions about the type of external economic support they have received in the last 3 months

Has your household received any of the following forms of external economic support in the last 3 months:

a) Cash transfer (e.g., pensions, disability grant, child grant, to be adapted according to country context)
b) Assistance for school fees
c) Material support for education (e.g., uniforms, school books etc)
d) Income generation support in cash or kind e.g. agricultural inputs
e) Food assistance provided at the household or external institution (e.g., at school)
f) Material or financial support for shelter
g) Other form of economic support (specify)

An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile at which point it will possible to assess the extent to which the poorest households are receiving external support

Measurement Frequency: Every 4–5 years

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

Strengths and Weaknesses

This indicator reflects new evidence of the need for a greater focus on wealth dimensions of vulnerability and the fact that that targeting on the basis of extreme poverty in high prevalence contexts ensures good coverage of poor households affected by HIV[25]. Proxy indicators of AIDS affectedness (such as "chronic illness") have often been poorly associated with HIV, have weak associations with adverse developmental outcomes, and have proven difficult to define in household questionnaires.

25 Evidence from social assistance programmes in Malawi and Zambia has shown the effectiveness of using vulnerability criteria without specific reference to AIDS to target children and families affected by AIDS. These programmes target the ultra poor and labour constrained and in using these criteria researchers found that 80% of all households directly affected by HIV and AIDS that are ultra poor and labour constrained were reached. (UNICEF 2007).

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

The indicator does not measure directly economic support to HIV infected and affected households, which is difficult to establish during a survey, but implicitly suggests that households living in the bottom wealth quintile in high prevalence contexts are more likely to be negatively impacted by HIV and AIDS and in need of economic assistance. In order to keep measurement as simple as possible, the indicator does not attempt to identify the different sources of support to households but this should be partly captured in National AIDS Spending Assessments (NASA).

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

Further Information

For further information, please consult the following website:

http://www.unicef.org/aids/index_documents.html

Government HIV and AIDS policies

Special 2013 GARPR questionnaire

A full National Commitments and Policies Instrument (NCPI) does not need to be reported in 2013, only a brief questionnaire is requested.

The NCPI will be continued to only be reported every second year.

In the final two questions (question 3 and 4) key policy changes in the AIDS response since early 2012, when your last NCPI was submitted, can be highlighted. Question 3 is for governmental sources and question 4 for non-governmental sources.

APPENDICES

Appendix 1. Country Progress Report template
Appendix 2. National Funding Matrix 2012
Appendix 3. Special 2013 GARPR questionnaire
Appendix 4. Sample checklist for Country Progress Report
Appendix 5. Selected bibliography
Appendix 6. Male circumcision indicators

Appendix 1. Country Progress Report template

In 2013, no GARPR narrative reports are asked to be submitted.

Appendix 2. National Funding Matrix – 2013

Cover Sheet

Please provide the following information when submitting the completed National Funding Matrix.

Country:

Contact Person at the National AIDS Authority/Committee (or equivalent):

Name: _____

Title: _____

Contact Information for the National AIDS Authority/Committee (or equivalent):

Address: _____

Email: _____

Telephone: _____

Fax: _____

Reporting Cycle 2010: calendar year _____ or fiscal year _____

Reporting Cycle 2011: calendar year _____ or fiscal year _____

Reporting Cycle 2012: calendar year _____ or fiscal year _____

For a fiscal year reporting cycle, please provide the start and end month/year: ___ / ___ to ___ / ___

Local Currency:

Average exchange rate with US dollars during the reporting cycle: 2010: _____ / 2011: _____ / 2012: _____

Methodology:

(Please confirm which methodology – National AIDS Spending Assessments, National Health Accounts or Resource Flows Surveys – supplied the data for the National Funding Matrix. In addition, please provide information on how and where to access the full report from whichever methodology was used to collect the data.)

Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or sub-categories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

Countries that have submitted data for 2010 already in their last report (GARPR 2012) do not need to fill in data for 2010 again, unless data in the last report were missing, incomplete or there have been changes to the 2010 data as more information has become available since. In this case, we will replace the data in our database reported for 2010 in the last submission (GARPR 2012) with the newer data reported in the 2013 submission.

2010: _____

2011: _____

2012: _____

Budget Support: Is budget support from an international source (e.g. a bilateral donor) included under the Central/National and/or Subnational sub-categories under Public Sources of financing?

2010: _____ Yes _____ No / 2011: _____ Yes _____ No / 2012: _____ Yes _____ No

AIDS spending National Funding Matrix – 2013

Background

The AIDS Spending indicator is used to measure target # 6 of the 2011 UN Political Declaration on HIV/AIDS: "Reach a significant level of annual global expenditure (between $22 billion and $24 billion) in low and middle-income countries". AIDS Spending is reported completing the National Funding Matrix: AIDS Spending by category and by financing Source. The matrix is a spreadsheet that enables countries to record AIDS spending within eight categories across three funding sources. This indicator provides critical information that is valuable at both national and global levels of the AIDS response. The National Funding Matrix has been designed to be compatible with different data collection and tracking systems, i.e. National AIDS Spending Assessments (NASA), National Health Accounts and Resource Flows Surveys, so as to transfer information from these tools to the matrix. For countries using the NASA, the matrix is one of the outputs of this tool. (Countries interested in implementing the NASA are encouraged to contact UNAIDS for additional information on this tool.)

Structure of the matrix

The National Funding Matrix has two basic components:

- AIDS Spending Categories (How funds allocated to the national response are spent)
- Financing Sources (Where funds allocated to the national response are obtained)

There are eight AIDS Spending Categories: Prevention; Care and Treatment; Orphans and Vulnerable Children; Programme Management and Administration Strengthening; Incentives for Human Resources; Social Protection and Social Services (excluding Orphans and Vulnerable Children); Enabling Environment and Community Development; and Research.

Each spending category includes multiple sub-categories. Across the eight spending categories there are a total of 91 sub-categories. It is important to note that all of the spending categories and sub-categories are AIDS-specific; for example, expenditures listed under Enabling Environment and Community Development should only be those that are directly attributable to the AIDS response.

Prevention is the largest category with 22 sub-categories, ranging from voluntary counselling and testing to condom social marketing to blood safety; seven of the remaining eight spending categories have fewer than 10 sub-categories each. The purpose of the categories and sub-categories is to help national governments break out their spending as rationally and consistently as possible. As mentioned above, the matrix was designed to be compatible with common data collection and tracking systems in order to reduce the burden of reporting on national governments.

> There are three major groups of Financing Sources: Domestic Public; International and Domestic Private (optional for the Global AIDS Progress reporting).

Similar to the spending categories, each financing source has multiple sub-categories. Public Sources has four sub-categories: Central/National, Subnational, Development Bank Reimbursable (loans) and All Other Public. International Sources has five subcategories: Bilaterals, UN Agencies, Global Fund, Development Bank Grants (Non-reimbursable) and All Other International. Private Sources has two sub-categories: Corporations and Consumer/Out-of-Pocket. *(Note: The data on Private Sources are optional for the Global AIDS Response Progress Reporting. However, countries are strongly encouraged to collect and report available data in this area because they can be useful in managing the national response to the epidemic.).*

Instructions

- The National AIDS Authority/Committee or equivalent should designate a technical coordinator to manage the collection and input of relevant data for the National Funding Matrix. It is recommended that this coordinator have good knowledge of tools and methodologies currently in use in the country for collecting this type of financial data (i.e. National AIDS Spending Assessment, National

Health Accounts, Resource Flows Survey). Also, it is encouraged that the coordinator contact other national resource tracking point persons, such as those in the Ministry of Health, who have been involved in reporting expenditures for HIV. The purpose of their involvement is to engender agreement on the national estimate for HIV expenditures and to avoid duplicate initiatives.

- Countries are requested to include as much detail in the National Funding Matrix as possible, including breakdowns by all applicable AIDS Spending and Funding Source Categories and sub-categories. Any categories or sub-categories that are not applicable in a country should be clearly identified; explanations for categories or sub-categories that do not include estimates for any other reason should be provided as part of the cover sheet to the matrix.
- The financial data in the matrix must be actual expenditures. They should not include budget figures that have not been validated as actual expenditures nor should the data reflect commitment or obligation figures. The actual expenditures must correspond to the calendar or fiscal years(s) of 2010, 2011 and/or 2012 (as available).
- The total for each line item should include funding from all sources listed for that item. In addition, there should be a sub-total for each of the eight AIDS Spending Categories, which captures all funding from all sources for all sub-categories in a given category.
- Amounts in each category or sub-category should be reported in local currency. However, it is also important to report the average exchange rate to US dollars for the calendar or fiscal year being reported; see the National Funding Matrix cover sheet on page 104.
- Spending categories and sub-categories are designed to be self-explanatory. Expenditures that do not clearly fit a specific sub-category should be listed in the Other/Not Classified Elsewhere sub-category that appears in each of the eight AIDS Spending Categories. (Detailed descriptions of the categories and sub-categories are available in the UNAIDS-published *National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions*. See reference below.)
- Expenditures should only be counted in a single category or sub-category; they should never be double counted. For example, expenditures on activities for Orphans and Vulnerable Children should not be listed again under Social Protection and Social Services.
- Financing Sources categories and sub-categories are designed to be self-explanatory. Expenditures that do not clearly fit a specific sub-category should be listed in the All Other sub-category that appears under both Public and International Sources. Please note that the list of Financing Sources categories and sub-categories is not exhaustive; however, it is indicative of the main sources of financing.
- Financing in the Central/National and Subnational sub-categories under Public Sources should only include revenue generated by the government and allocated to the AIDS response. It should not include development assistance of any type from international sources; the only possible exception would be budget support from donor organizations that cannot be differentiated from domestic revenues. If the total amount of budget support can be identified, it should appear under the proper International Sources sub-category (e.g. Bilaterals). If any budget support is included in the Central/National and/or Subnational sub-categories, please indicate this fact on the cover sheet (see above).
- Financing provided by a development bank should be designated either as Reimbursable (e.g. loans), which appears under Public Sources, or Non-reimbursable (e.g. grants), which appears under International Sources. Countries that receive both loans and grants from development banks should be careful to allocate these funds to the correct categories.
- Financing provided by individual bilateral donors does not need to be disaggregated by donor agency in the funding matrix.
- Financing provided by international foundations should be listed in the All Other sub-category in the International category. Funds received from domestic foundations should be listed in the All Other sub-category in the Public category.
- Providing information on financing from Private Sources is optional. However, countries are strongly encouraged to collect and report available data in this area in order to provide a more complete picture of the funds available for the AIDS response.

- Key Populations at higher risk: all programmes targeting populations at higher risk, including risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs) and programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection should be coded and cross-classified under the corresponding AIDS Spending Category: *ASC.01.08 Prevention programmes for sex workers and their clients: ASC.01.09, Programmes for men who have sex with men (MSM)* or *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs).*
- All programmes targeting other specific populations (e.g. Indigenous groups, Migrants/mobile populations, Military, Police and other uniformed services, etc.), including risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs) and programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection should be coded and cross-classified under the corresponding AIDS Spending Category: *ASC.01.04Risk-reduction programmes for vulnerable and accessible populations.*
- Programmes targeting the General Populations: all programmes targeting the general population, including risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs) and programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection should be coded and cross-classified under the corresponding AIDS Spending Category: *ASC.01.01 Communication for social and behaviour change, ASC.01.02 Community mobilization, ASC.01.03 HIV testing and counselling (HCT), ASC.01.12 Condom social marketing, ASC.01.13 Public and commercial sector male condom provision and ASC.01.14 Public and commercial sector female condom provision.*
- Incentives for Human resources: These expenditures are aimed at ensuring the availability of human resources for the AIDS response. Incentives for human resources refer to training, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories. For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions—*ASC.01 Prevention* and *ASC.02 Care and treatment*—and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well—ASC.04 (Programme Management). Thus, the salary of a doctor should be accounted on the programmatic intervention where this doctor directly intervenes. Only the additional monetary incentive for the doctor, to work in a specific geographical area or for working on HIV, is to be classified under *ASC.05 Incentives for Human Resources*. Incentives for human resources covers mainly nurses and doctors.
- The Private Sources column for Corporations should list funds spent in-country by companies in the various AIDS Spending Categories and sub-categories; the adjacent Consumer/Out-of-pocket column should list funds spent by individuals and/or families in the AIDS Spending Categories and sub-categories. (Note: It is likely that most entries in the Consumer/Out-of-pocket column will be in the Care and Treatment and selected Prevention categories and sub-categories.)
- If a country has a National Health Accounts - AIDS sub-accounts, it should implement a NASA-NHA Crosswalk in order to fill the Funding Matrix with the NHA – AIDS sub-accounts results. The document Linking NASA and NHA Concepts and Mechanics is a comprehensive guide that shows how to crosswalk the spending categories from NHA-AIDS sub-accounts to the National Funding Matrix. Countries can contact the monitoring and evaluation officer in their UNAIDS country office or the Response Monitoring and Analyses Team at UNAIDS headquarters in Geneva.
- If a country is working from a Resource Flows Survey, it may be able to correlate information from sub-totals in the survey to the eight AIDS Spending Categories in the National Funding Matrix.

- Electronic versions of the *Notebook to Produce National AIDS Spending Assessment* and the *National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions* may be downloaded from the following page on the UNAIDS website: http://www.unaids.org/en/dataanalysis/tools/nasapublications/. An electronic version of the National Funding Matrix may be downloaded as an Excel file from the same website.
- The UNAIDS Secretariat strongly recommends the NAC or equivalent organize a one-day workshop of relevant stakeholders to review the National Funding Matrix before it is submitted as part of the Global AIDS Progress reporting process. Relevant stakeholders should include federal and provincial/regional/state government ministries and departments, local and international civil society organizations, multilateral agencies, bilateral donors, foundations and commercial sector entities, as well as representatives from other relevant resource tracking initiatives.

The National Funding Matrix is available on the Global AIDS Progress reporting tool (http://AIDSreportingtool.unaids.org).

Once the National Funding Matrix is filled, it has to be submitted through the Global AIDS Progress online reporting tool.

If you do not have access to the Global AIDS Progress reporting tool, please submit the National Funding Matrix by email to UNAIDS (AIDSreporting@unaids.org).

National Funding Matrix — 2013

AIDS Spending Categories	TOTAL (Local Currency)	Public Sub-Total	Central / National	Sub- National	Dev. Banks Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
TOTAL (Local Currency)																		
1. Prevention (sub-total)																		
1.01 Communication for social and behavioural change																		
1.02 Community mobilization																		
1.03 Voluntary counseling and testing (VCT)																		
1.04 Risk-reduction for vulnerable and accessible populations																		
1.05. Prevention - Youth in school																		
1.06 Prevention - Youth out-of-school																		
1.07 Prevention of HIV transmission aimed at people living with HIV																		
1.08 Prevention programmes for sex workers and their clients																		
1.09 Programmes for men who have sex with men																		
1.10 Harm-reduction programmes for injecting drug users																		
1.11 Prevention programmes in the workplace																		
1.12 Condom social marketing																		
1.13 Public and commercial sector male condom provision																		
1.14 Public and commercial sector female condom provision																		
1.15 Microbicides																		
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)																		
1.17 Prevention of mother-to-child transmission																		
1.18 Male Circumcision																		
1.19 Blood safety																		
1.20 Safe medical injections																		
1.21 Universal precautions																		
1.22 Post-exposure prophylaxis																		
1.98 Prevention activities not disaggregated by intervention																		
1.99 Prevention activities not elsewhere classified																		
2. Care and Treatment (sub-total)																		
2.01 Outpatient care (sub-total)																		
2.01.01 Provider- initiated testing and counseling																		
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment																		
2.01.03 Antiretroviral therapy																		
2.01.04 Nutritional support associated to ARV therapy																		
2.01.05 Specific HIV-related laboratory monitoring																		
2.01.06 Dental programmes for PLHIV																		
2.01.07 Psychological treatment and support services																		
2.01.08 Outpatient palliative care																		
2.01.09 Home-based care																		
2.01.10 Traditional medicine and informal care and treatment services																		
2.01.98 Outpatient care services not disaggregated by intervention																		
2.01.99 Outpatient Care services not elsewhere classified																		
2.02 In-patient care (sub-total)																		
2.02.01 Inpatient treatment of opportunistic infections (OI)																		
2.02.02 Inpatient palliative care																		
2.02.98 Inpatient care services not disaggregated by intervention																		
2.02.99 In-patient services not elsewhere classified																		
2.03 Patient transport and emergency rescue																		

2.98 Care and treatment services not disaggregated by intervention																		
2.99 Care and treatment services not-elsewhere classified																		
3. Orphans and Vulnerable Children (sub-total)																		
3.01 OVC Education																		
3.02 OVC Basic health care																		
3.03 OVC Family/home support																		
3.04 OVC Community support																		
3.05 OVC Social services and Administrative costs																		
3.06 OVC Institutional Care																		
3.98 OVC services not disaggregated by intervention																		
3.99 OVC services not-elsewhere classified																		
4. Program Management and Administration Strengthening (sub-total)																		
4.01 Planning, coordination and programme management																		
4.02 Administration and transaction costs associated with managing and disbursing funds																		
4.03 Monitoring and evaluation																		
4.04 Operations research																		
4.05 Serological-surveillance (Serosurveillance)																		
4.06 HIV drug-resistance surveillance																		
4.07 Drug supply systems																		
4.08 Information technology																		
4.09 Patient tracking																		
4.10 Upgrading and construction of infrastructure																		
4.11 Mandatory HIV testing (not VCT)																		
4.98 Program Management and Administration Strengthening not disaggregated by type																		
4.99 Program Management and Administration Strengthening not-elsewhere classified																		
5. Incentives for human resources (sub-total)																		
5.01 Monetary incentives for human resources																		
5.02 Formative education to build-up an HIV workforce																		
5.03 Training																		
5.98 Incentives for Human Resources not specified by kind																		
5.99 Incentives for Human Resources not elsewhere classified																		
6. Social Protection and Social Services (excluding OVC) (sub-total)																		
6.01 Social protection through monetary benefits																		
6.02 Social protection through in-kind benefits																		
6.03 Social protection through provision of social services																		
6.04 HIV-specific income generation projects																		
6.98 Social protection services and social services not disaggregated by type																		
6.99 Social protection services and social services not elsewhere classified																		
7. Enabling Environment (sub-total)																		
7.01 Advocacy																		
7.02 Human rights programmes																		
7.03 AIDS-specific institutional development																		
7.04 AIDS-specific programmes focused on women																		
7.05 Programmes to reduce Gender Based Violence																		
7.98 Enabling Environment and Community Development not disaggregated by type																		
7.99 Enabling Environment and Community Development not elsewhere classified																		
8. Research excluding operations research which is included under (sub-total)																		
8.01 Biomedical research																		
8.02 Clinical research																		
8.03 Epidemiological research																		
8.04 Social science research																		
8.05 Vaccine-related research																		
8.98 Research not disaggregated by type																		
8.99 Research not elsewhere classified																		

Appendix 3. Special 2013 GARPR questionnaire

A full National Commitments and Policies Instrument (NCPI) does not need to be reported in 2013, only this brief questionnaire is requested.

In the final two questions (question 3 and 4) key policy changes in the AIDS response since early 2012, when your last NCPI was submitted, can be highlighted. Question 3 is for governmental sources and question 4 for non-governmental sources.

PART A: GOVERNMENTAL SOURCES

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

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

2) Are health facilities providing HIV services integrated with other health services?

Area	**Many**	**Few**	**None**
a) HIV Counselling & Testing with Sexual & Reproductive Health			
b) HIV Counselling & Testing and Tuberculosis			
c) HIV Counselling & Testing and general outpatient care			
d) HIV Counselling & Testing and chronic Non-Communicable Diseases			
e) ART and Tuberculosis			
f) ART and general outpatient care			
g) ART and chronic Non-Communicable Diseases			
h) PMTCT with Antenatal Care/Maternal & Child Health			
i) Other comments on HIV integration:			

3) Are there any key policy changes in the AIDS response since early 2012 when your last NCPI (National Commitments and Policies Instrument) was submitted? If yes, please highlight these here. (Government sources)

PART B: Non-government sources, e.g. civil society, private sector, bilaterals, multi-laterals.

4) Are there any key policy changes in the AIDS response since early 2012 when your last NCPI (National Commitments and Policies Instrument) was submitted? If yes, please highlight these here.

Appendix 4. Sample checklist for Country Progress Report

- ☐ Reporting process established, including timelines and milestones, and roles of NAC, government agencies, UN agencies, civil society and other relevant partners.
- ☐ Funding secured for all aspects of the reporting process.
- ☐ Data collection, vetting and analysis process established, including:
  - Identification of relevant tools and sources for data collection for each indicator
  - Timeline for data collection in line with other data collection efforts, including those via funding agencies such as the Global Fund, PEPFAR and UN agencies
  - Reporting timeline for facility-based indicators for national level aggregation
  - Data vetting and triangulation workshops with the aim of reaching consensus on the correct value for each indicator
- ☐ Protocols established for data processing and management, including:
  - Basic data cleaning and validation
  - One database for analysis and reporting purposes
- ☐ Relevant data analysed in coordination with partner organizations from government, civil society and the international community
- ☐ Indicator data entered into recommended reporting tool
- ☐ Consensus reached with stakeholders, including government agencies and civil society, on the final report to be submitted
- ☐ Report and required data forms submitted to UNAIDS Geneva (AIDSreporting@unaids.org) by 31 March 2013
- ☐ Focal point established in country for communications between UNAIDS Secretariat in case of any queries related to the report and/or the data submitted.

Appendix 5. Selected bibliography

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

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WHO (2010) Antiretroviral therapy for HIV infection in adults and adolescents. Geneva; WHO

UNICEF (2011). *The State of the World's Children Report*. New York: UNICEF

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

Appendix 6. Male circumcision indicators

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

1.22 Proportion of males circumcised

Percentage of men 15-49 that are circumcised

What it Measures

It measures progress towards increased coverage of male circumcision.

Rationale

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

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

Strengths and Weaknesses

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

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

Further Information

For further information on Male Circumcision indicators, see
A guide to indicators for male circumcision programmes in the formal health care system, WHO, UNAIDS, 2009

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

1.23 Number of male circumcisions performed

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

What it Measures

It measures progress in scaling up male circumcision services.

Rationale

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

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

Strengths and Weaknesses

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

Further disaggregations are recommended at country level:

i) HIV positive by test(s) on site; HIV negative by test(s) on site; HIV indeterminate result by test(s) on site; Unknown/refused HIV test;

ii) Type and location of health facility

iii) Cadre of provider

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

Some programmes will work closely with voluntary HIV counselling and testing services to provide HIV testing. A patient desiring male circumcision may have been recently tested, in which event an on-site HIV test may be unnecessary. In these cases, a written 'verified result' may be requested at the facility to verify

HIV status. There is no specific length of time before male circumcision that the test should have been done, but within three months is suggested (the purpose of testing is not to identify every man who might be infected but to provide HIV testing to men seeking health care and to identify HIV-positive men who, if they choose to be circumcised, are likely to be at higher risk of surgical complications, i.e. men who are chronically infected and with low CD4 counts).

Further Information

For further information on Male Circumcision indicators, see
A guide to indicators for male circumcision programmes in the formal health care system, WHO, UNAIDS, 2009

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

PART 2

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

World Health Organization
unicef
UNAIDS

Abbreviations

ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral drug
CTX	co-trimoxazole
EBF	exclusive breastfeeding
GARPR	Global AIDS Response Progress Reporting
HIV	human immunodeficiency virus
IDP	internally displaced persons
IPT	isoniazid preventive therapy. Also can be termed TBPT (TB preventive therapy)
L&D	labour and delivery
M&E	monitoring & evaluation
MDG	Millennium Development Goal
MTCT	mother-to-child transmission
NSP	needle and syringe programme
OST	opioid substitution therapy
PCR	polymerase chain reaction
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counselling
PMTCT	prevention of mother-to-child transmission
STI	sexually transmitted infections
SW	sex workers
TB	tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNPD	United Nations Population Division
VCT	voluntary counselling and testing

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Number of adults newly enrolled in HIV care (pre-ART or ART) during the reporting period (2012)

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5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT) 174

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I. Introduction

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

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

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

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

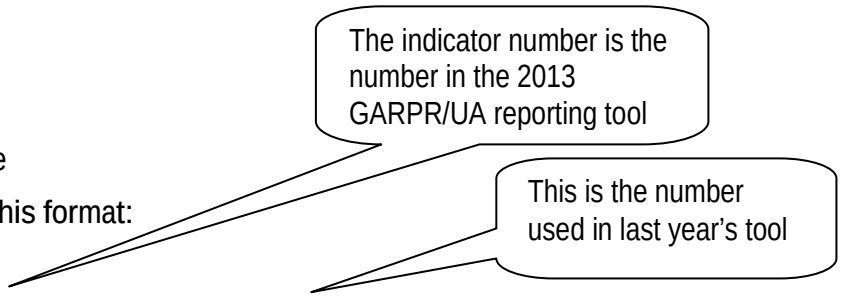
- *Global Reporting:* This part of the guide complements the UNAIDS *Global AIDS Response Progress Reporting 2013: guidelines. Construction of core indicators for monitoring the 2011 Political Declaration on HIV/AIDS*. The overall recommended country reporting process is described in detail in the global reporting guidelines.[2.] This section aims to support and facilitate data collection using the Joint Online Reporting Tool with a focus on the additional indicators of the 2013 health sector reporting requested which are not part of the GARPR indicators. The online data collection tool, disseminated to all countries, is the main tool to enable annual global reporting on the health sector progress towards universal access to HIV prevention, care, and treatment.

- *National Monitoring:* This guide can also be used for national monitoring of the health sector's response to HIV/AIDS. It can be adapted to the epidemic context of each country. For example, countries should select indicators that would support monitoring of their own nationally-set targets. They may also add or remove some of the indicators depending on the importance of intervention areas to their country epidemic.

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

Indicator descriptions in this guide

The indicator descriptions follow this format:



X. INDICATOR TITLE (# y.y)	
Rationale	Why this indicator is important
What it measures	What the indicator measures
Numerator	Definition of the numerator
Denominator	Definition of the denominator (sources of information must be specified: for some indicators, estimates only are possible and/ or required)
How to Measure and Measurement Tools	What is included in the numerator and denominator Method of measurement Tools used for measurement
Disaggregation	Recommended disaggregation. Even if not included for breakdown in the Reporting Tool, disaggregation is recommended to be collected for national monitoring and reporting as appropriate.
Strengths and weaknesses	Description of the strengths and weaknesses of the indicator
Additional considerations	Other points for countries to note
Data utilization	How this indicator can be used and some implications
Data Quality Control and Notes for the Reporting Tool	Additional information on issues to consider when filling in the reporting tool. Includes elements of: • *Double Reporting:* What to pay attention to in order to assess possible double reporting. • *National Representativeness*: What to pay attention to in order to assess the national representativeness of the value reported. • *Denominator Issues*: Issues to note about the denominator • *Triangulation Options*: Other data sources that can be reviewed to assess the validity of the indicator value
Other References	References related to the indicator, e.g.: *PMTCT:* Indicator in the updated Monitoring and Evaluating the PMTCT of HIV A guide for national programmes *(2011)* *HIV/TB:* Indicators in the updated A guide to monitoring and evaluation for collaborative TB/HIV M&E activities *(2009)* *People who inject drugs:* Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users *(2009)*

Technical Support and Contact for Questions

WHO, UNICEF and UNAIDS are committed to support countries improve their strategic information system, including and not limited to the review of health sector M&E systems; data quality and validation; evaluating impact; surveillance; operational research; and training in various aspects of strategic information.

Please do not hesitate to contact WHO at hivstrategicinfo@who.int for any questions or requests, or to send any comments and suggestions for improving this guidance.

Acknowledgements

WHO and UNICEF would like to especially thank staff members from government ministries at all levels who collect, validate and provide this information every year.

WHO and UNICEF thank WHO, UNICEF and UNAIDS staff who work at the country and regional levels to facilitate the process of data transfer and reporting.

WHO and UNICEF appreciate the contribution of MACRO-DHS to provide the latest DHS (Demographic and Health Survey) results available.

II. INDICATOR DESCRIPTIONS

The present table gives an overview of the indicators described in the Global AIDS Response Progress Reporting 2013 guidelines and those described in this guide for the 2013 health sector reporting for universal access (UA 2013).

GARPR	UA 2013	
		Target 1. Reduce sexual transmission of HIV by 50% by 2015
		Indicators for the general population
x		1.1 Young People: Knowledge about HIV Prevention
x		1.2 Sex Before the Age of 15
x		1.3 Multiple sexual partners
x		1.4 Condom Use During Higher-Risk Sex
x		1.5 HIV Testing in the General Population
x		1.6 Reduction in HIV Prevalence
		Indicators for sex workers
x		1.7 Sex Workers: Prevention programmes
x	x	1.8 Sex Workers: Condom Use
x	x	1.9 Sex Workers: HIV Testing
x	x	1.10 Sex Workers: HIV Prevalence
		Indicators for men who have sex with men
x		1.11 Men who have sex with men: Prevention programmes

GARPR	UA 2013	
x	x	1.12 Men who have sex with men: Condom Use
x	x	1.13 Men who have sex with men: HIV Testing
x	x	1.14. Men who have sex with men: HIV Prevalence
		Testing and Counselling
	x	1.16 HIV Testing in 15+ (from programme records)
		Sexually Transmitted Infections
	x	1.17 Sexually Transmitted Infections (STIs)
		Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit
		Percentage of antenatal care attendees who were positive for syphilis
		Percentage of antenatal care attendees positive for syphilis who received treatment
		Percentage of sex workers with active syphilis
		Percentage of men who have sex with men with active syphilis
		Number of adults reported with syphilis (primary/secondary and latent) during the reporting period (to be field tested in PAHO and EMRO)
		Number of reported congenital syphilis cases (live births and stillbirth) during the reporting period (to be field tested in PAHO and EMRO)
		Number of men reported with gonorrhoea during the reporting period (to be field tested in PAHO and EMRO)
		Number of men reported with urethral discharge during the reporting period (to be field tested in PAHO and EMRO)
		Number of adults reported with genital ulcer disease during the reporting period (to be field tested in PAHO and EMRO)

GARPR	UA 2013	
		Male circumcision
x	x	*1.22 Male circumcision, prevalence*
x	x	*1.23 Number of men circumcised last year*
		Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015
x	x	2.1 People who inject drugs: Number of needles/person who injects drugs
x	x	2.2. People who inject drugs: Condom Use
x	x	2.3 People who inject drugs: Safe Injecting Practices
x	x	2.4 People who inject drugs: HIV Testing
x	x	2.5 People who inject drugs: HIV Prevalence
	x	2.6 People on opioid substitution therapy
	x	2.7 NSP and OST sites
		Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths
x	x	3.1 Prevention of Mother-to-Child Transmission
x	x	3.2 Early Infant Diagnosis
x	x	3.3 Mother-to-Child transmission rate (modelled)
	x	3.4 Pregnant women who know their HIV status
	x	3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months

GARPR	UA 2013	
	x	3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing
	x	3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks
x	x	3.8 Percentage of infants born to HIV-infected women who are provided with ARVs to reduce the risk of HIV transmission during breastfeeding
	x	3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth
	x	3.10 Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit
	x	3.11 Number of pregnant women attending ANC at least once during the reporting period
	x	*3.13 EURO-specific PMTCT Indicator (pregnant women who inject drugs)*
		Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015
x	x	4.1 ART coverage (adults and children), including number of eligible adults and children who newly enrolled on antiretroviral therapy during the reporting period (2012)
x	x	4.2a HIV Treatment: 12 months retention
	x	4.2b HIV Treatment: 24 months retention
	x	4.2c HIV Treatment: 60 months retention
	x	4.3 Health facilities that offer antiretroviral therapy
	x	4.4 ARV stock-outs
	x	*4.5 Late HIV diagnoses (EURO and PAHO only)*
	x	*4.6 HIV care*
		Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

GARPR	UA 2013	
x	x	5.1 Co-Management of Tuberculosis and HIV Treatment
	x	5.2 Health care facilities providing ART for people living with HIV with demonstrable infection control practices that include TB control
	x	5.3 Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT))
	x	5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit
		Target 6. Reach a significant level of annual global expenditure (US$ 22–24 billion) in low and middle-income countries
x		6.1 AIDS Spending - Domestic and international AIDS spending by categories and financing sources
		Target 7. Eliminating gender inequalities
x		7.1 Prevalence of Recent Intimate Partner Violence (IPV) (old 7.2)
		Target 8. Eliminating stigma and discrimination
		Indicator development, Stigma indicator for general population planned to be ready for 2014 reporting
		Target 9. Eliminate Travel restrictions

GARPR	UA 2013	
		Travel restriction data collected by Human Rights and Law Division at UNAIDS HQ, no data collected needed
		Target 10. Strengthening HIV integration
x		10.1 Orphans and non-orphans school attendance (old 7.3)
x		10.2 Economic support for eligible households (old 7.4)
		Policy questions, relevant questions for all 10 targets.
x		P.1 Special 2013 GARPR questionnaire
	x	P.1b WHO policy questions (old 7.1b)

Note on Defining “Health Facility”

A frequently asked question is what we are defining as a **health facility**. For the purposes of this reporting process, we are excluding health facilities that provide specialized care which would never provide any HIV services (e.g. an eye clinic). If you have difficulties trying to define what is counted as a health facility for this exercise, please provide any comments you have in the Comment box or e-mail WHO at hivstrategicinfo@who.int.

Target 1: Reduce Sexual transmission of HIV by 50% by 2015

Testing and Counselling

1.16 Number of women and men aged 15 and older who received HIV testing and counselling in the last 12 months and know their results	
Rationale	Knowledge of HIV status is critical for access to HIV treatment, care and support, and prevention. There are different models for delivery of the testing and counselling services such as client-initiated testing and counselling (CITC) and provider-initiated testing and counselling (PITC). The essential elements of TC are that those who are tested are appropriately counselled and know the results.
What it measures	Number of people aged 15 and older who received HIV T&C through any method or setting (excluding mandatory T&C) in the past 12 months and know their results (Note: Although not required for the purposes of this indicator the denominator may be gauged by using the general population as the denominator in generalized epidemics, and the key populations at higher risk and other groups for low-level and concentrated epidemics. These data can be reviewed along with an estimate of what percentage of the HIV+ population already know their status, and what the recommended HIV testing policy or frequency is. Programmatic progress for testing and counselling. Tracking the number of individuals who are tested and counselled and know their status provides an indication of uptake of T&C in the country.
How to Measure and Measurement Tools	Programme service statistics compiled from routine reports of the number of people tested and know the results from all service points, including CITC sites, clinics, hospitals, and NGO outreach points, etc. (excluding mandatory T&C) which are often aggregated at the district levels and subsequently at the national level. This indicator is not measured through population-based surveys.
Disaggregation	Sex: male, female, pregnancy Serostatus: HIV positive, HIV negative If possible: Age: 15-19, 20-24, 25+ Test: New test , Repeated test
Strengths and weaknesses	This indicator permits comparison of trends of the quantity of TC services delivered and the strength of scaling up TC services over time. This indicator may provide information on the number of times T&C occurred, and not necessarily the number of people who received T&C services unless countries have a mechanism to avoid double-counting of repeat testers. The indicator does not provide information on whether those who were tested were adequately referred to and receiving follow-up services to benefit from knowing their status.
Data utilization	To review the number of tests conducted in the country, data can be compared with previous years to look at trends while considering the percentage of the population that may have already been tested recently. It can be useful to explore

	any patterns in testing, for example whether there were more tests conducted in a particular season or month when there were campaigns, or whether many more people are being tested in particular health facilities or in the communities.
Additional considerations for countries	In some countries, a significant proportion of testing and counselling services are provided by community-based organizations or unregistered organizations, which often may not be included as part of national statistics. These organizations should be encouraged to register with national authorities so all data on testing and counselling could be reflected in the national statistics.
Data Quality Control and Notes for Reporting	Double Reporting: Countries will need to estimate the extent of repeat testers in order to determine the true number of persons tested over the period. If countries have a mechanism to make such a meaningful assessment (e.g. record of the number of repeat tests or re-testers within a year), please do so and note how this was done. Otherwise, please report the total number of tests reported and clarify that repeat tests are likely included. National Representativeness: Try to ensure information from non-governmental and private facilities is also available at the central level. If significant information is missing, note it down in the comments section. Denominator Issues: Although not required for the purposes of this indictor the validity of the numerator may be gauged by comparing the general population as the denominator in generalized epidemics, and the size of the key populations at higher risk and other groups for low-level and concentrated epidemics. Triangulation Options: In generalized epidemics, data from population-based surveys asking for the number (and calculating the percentage) of people tested can be compared to with this indicator value to assess and discuss any major differences.

1.17.1 STIs: Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit (part of UA 2012 1.17)	
Rationale	Testing pregnant women for syphilis early in pregnancy is important both for their health and the health of the fetus, and for second generation surveillance purposes. It also contributes to monitoring of the quality of ANC services.
What it measures	Coverage of syphilis testing in women attending first ANC services
Numerator	Number of women attending first visit ANC services who were tested for syphilis
Denominator	Number of women attending first visit ANC services
How to Measure and Measurement Tools	How to measure: All pregnant women should be tested ("screened") for syphilis at their first antenatal care visit. Countries unable to distinguish first visit from subsequent visits can still report data on this indicator, but should clearly comment on this difference when reporting the data. This indicator should be measured annually. Either non-treponemal tests that measure reaginic antibody (e.g., VDRL or RPR) or treponemal tests that measure treponemal antibody (e.g., TPHA, TPPA, EIA or rapid treponemal tests) may be used for screening. For this indicator simply being tested by either type of test is sufficient, although being tested with both is preferred. Please indicate in the "Comments" section what test type is generally used in your country. Measurement tools: Ideally national programme records aggregated from health facility data should be used. However, if national programme data are not available, data from sentinel surveillance or special studies can be reported if it is felt to be representative of the national situation. Please specify the source and coverage of your data (for example, national programme data from all 12 provinces) in the "Comments" section.
Disaggregation	None
Additional considerations	Countries may wish to also monitor the week of pregnancy that each woman is tested. Preventing congenital syphilis requires testing early in pregnancy, as stillbirth may occur in the second trimester. Knowing that women are being tested late in pregnancy will indicate either that women are not accessing ANC early or that testing is not occurring early in pregnancy. Programmes that test pregnant women for syphilis and those that test pregnant women for HIV should work together to enhance the effectiveness of their individual programme work.
Data utilization	Global: Examine trends over time to assess progress towards target levels of testing coverage required for elimination of mother-to-child transmission of syphilis. Knowledge of testing policies and practices should be used to assist with interpretation of trends in coverage. Local: Data can be used to identify clinics not fully implementing national policy.
Data Quality Control and Notes for the Reporting Tool	Please comment on if the data you are providing is routine programme data, and if it is felt to be representative of the entire country.

Other References	Recommended indicator in "National-Level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and practical considerations and related indicators" and "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems".

1.17.2 STIs: Percentage of antenatal care attendees who were positive for syphilis (part of UA 2012 1.17)	
Rationale	Syphilis infection in antenatal care attendees can be used to guide STI prevention programme needs, and may provide early warning of potential changes in HIV transmission in the general population.
What it measures	The percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology
Numerator	Number of antenatal care attendees who tested positive for syphilis
Denominator	Number of antenatal care attendees who were tested for syphilis
How to Measure and Measurement Tools	How to measure: Syphilis positivity can be measured using either non-treponemal tests (e.g., RPR or VDRL), treponemal tests (e.g. TPHA, TPPA, EIA, or a variety of available rapid tests), or ideally a combination of both. A reactive non-treponemal test, particularly if the titre is high, is suggestive of active infection, whereas positivity with a treponemal test indicates any previous infection even if treated successfully. For the purposes of this indicator (intended to measure seropositivity), it is acceptable to report positivity based on a single test result. If both treponemal and non-treponemal test results on an individual patient are available, then syphilis positivity should be defined as having positive results on both tests. Use of rapid treponemal test has allowed syphilis testing to occur in settings without laboratory capacity, greatly increasing the number of women who can be tested and treated for syphilis in pregnancy. Data should be collected annually. Measurement tools: National programme records aggregated from health facility data, sentinel surveillance, or special surveys, using serologic tests to detect reaginic and/or treponemal antibody may be used. Please specify the source and coverage of your data (for example, sentinel surveillance of all ANC attendees in 2 of 10 provinces) as well as what test type is generally used in your country in the "Comments" section.
Disaggregation	Age groups: Total, 15--24 years, 25 years and over
Strengths and weaknesses	Strengths: Data on syphilis positivity in pregnant women are available in most countries through routine health system reporting. Weaknesses: Differences in test type used or changes in testing practices may affect data. Knowledge of testing practices within the country (e.g., proportion of treponemal vs. non-treponemal testing used) should be used to assist with interpretation of disease trends.
Additional considerations	• Countries are encouraged to use unique identifiers or registers that separate first and subsequent tests so that the data reflect syphilis true prevalence or incidence rather than test positivity. • Since most countries will have data from a variety of test types, sub-analysis (disaggregation) in 15 to 24 year old women may increase the likelihood that test positivity reflects recent infection.

Data utilization	Global/regional: Estimate perinatal mortality and morbidity caused by syphilis that could be averted with effective programmes to eliminate MTCT of syphilis. Identify areas at greatest need of comprehensive congenital syphilis prevention interventions. Local: Follow trends over time to assess changes in burden of disease and STI prevention programme needs. All levels: Compare data on trends of syphilis and HIV to look for early warning of increased risk of HIV transmission.
Data Quality Control and Notes for the Reporting Tool	Please comment on if the data you are providing is routine programme data, if it is felt to be representative of the entire country, and what test type was used to define positivity (e.g., non-treponemal, treponemal, patients positive on both, or mixed/unknown).
Other References	Recommended indicator in "National-Level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and practical considerations and related indicators" and "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems".

1.17.3 STIs: Percentage of antenatal care attendees positive for syphilis who received treatment (part of UA 2012 1.17)	
Rationale	Treatment of antenatal care attendees positive for syphilis is a direct measure of the elimination of mother-to-child transmission of syphilis programme efforts and efforts to strengthen primary HIV prevention.
What it measures	Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately.
Numerator	Number of antenatal care attendees with a positive syphilis serology who received at least one dose of benzathine penicillin 2.4 mU IM
Denominator	Number of antenatal care attendees with a positive syphilis serology
How to Measure and Measurement Tools	How to measure: Data should be collected annually. Seropositivity on either treponemal or non-treponemal test is sufficient for being considered positive for syphilis for this indicator. Measurement tools: Ideally national programme records aggregated from health facility data should be used. However, if national programme data are not available, data from sentinel surveillance or special studies can be reported if it is felt to be representative of the national situation. Please specify the source and coverage of your data (for example, national programme data from all 12 provinces) in the "Comments" section.
Disaggregation	None
Strengths and weaknesses	Strengths: Data on treatment of syphilis in antenatal care attendees is often routinely monitored in health facilities. Weaknesses: Collection of treatment data may require collaboration with MCH programmes to ensure that it is available at a national level.
Additional considerations	For purposes of this indicator, documentation of a single dose of penicillin is sufficient. Treatment of a pregnant woman positive for syphilis with a single injection of 2.4 mU benzathine penicillin prior to 24 weeks gestational age is

	sufficient to prevent transmission of syphilis from mother to infant. However, three injections spaced at weekly intervals are recommended to treat latent syphilis and prevent tertiary syphilis in the mother.
Data utilization	Global/regional/local: Estimate programme effectiveness in reducing syphilis-associated perinatal morbidity and mortality. Local: Identify areas in need of assistance with programme implementation or additional resources. All levels: Knowledge of treatment policies and practices should be used to assist with interpretation of trends in treatment.
Data Quality Control and Notes for the Reporting Tool	If the data you are providing does not cover the entire country, please comment.
Other References	Recommended indicator in "National-Level Monitoring of the Achievement of Universal Access to Reproductive Health: Conceptual and practical considerations and related indicators"; recommended indicator in "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems".

1.17.4 STIs: Percentage of sex workers (SWs) with active syphilis (part of UA 2012 1.17)	
Rationale	Testing sex workers (SWs) for syphilis is important for their health, and for second generation surveillance purposes.
What it measures	Progress in decreasing high-risk sexual behaviour, and intervention efforts to control syphilis among sex workers.
Numerator	Number of sex workers who tested positive for active syphilis
Denominator	Number of sex workers who were tested for active syphilis
How to Measure and Measurement Tools	Measurement tools: Data from routine health information systems, sentinel surveillance or special surveys may be used. How to measure: The traditional approach to determining seroprevalence has been to screen with a non-treponemal test that measures reaginic antibody (e.g., VDRL or RPR) and confirm positive results with a treponemal test that measures treponemal antibody (e.g., TPHA, TPPA, EIA, or rapid treponemal test). Newer, rapid treponemal tests are comparatively easy to use, a feature which encourages the use of these tests for screening, ideally paired with a non-treponemal test that detects reaginic antibody. Whichever approach is used, the proposed indicator requires both a positive non-treponemal test AND a positive treponemal test to give a proxy for active infection. If RPR testing is performed, it should be titrated and be ≥1:8 to be certain of active syphilis. Just a non-treponemal test, or just a treponemal test, while useful in some situations for therapeutic purposes, is not sufficiently specific for surveillance of sex workers. The requirement for both a positive non-treponemal test and a positive treponemal test in sex workers differs from the indicator on syphilis testing in antenatal care attendees because sex workers are more likely to have a history of previous infection. A positive treponemal test measures lifetime exposure, whereas the non-treponemal test is a better indicator of active infection.

Disaggregation	Sex: total, male, female
Strengths and weaknesses	Strengths: Requiring testing by both tests enhances specificity of the reported numbers of positive tests. In addition, requiring testing by both tests will increase the likelihood of identifying active disease. Weaknesses: Requiring testing by both tests increases the difficulty of acquiring data for this indicator.
Additional considerations	Quality assurance and quality control should be an integral part of syphilis testing to ensure reliable results.
Data utilization	Look at trends in comparable groups over time. Compare with data on trends of syphilis and HIV where available.
Data Quality Control and Notes for the Reporting Tool	It is important NOT to count multiple tests run on the same patient. That is, if a person has been tested more than once in the past 12 months, they should not be counted more than once.

1.17.5 STIs: Percentage of men who have sex with men with active syphilis (part of UA 2012 1.17)	
Rationale	Testing of syphilis among men who have sex with men is important for their health, and for second generation surveillance purposes.
What it measures	Progress in decreasing high-risk sexual behaviour, and intervention efforts to control syphilis among men who have sex with men.
Numerator	Number of men who have sex with men who tested positive for syphilis
Denominator	Number of men who have sex with men who were tested for syphilis
How to Measure and Measurement Tools	Measurement tools: Routine health information systems, sentinel surveillance or special surveys. How to measure: The traditional approach to determining seroprevalence has been to screen with a non-treponemal test that measures reaginic antibody (e.g., VDRL or RPR) and confirm positive results with a treponemal test that measures treponemal antibody (e.g., TPHA, TPPA, EIA, or rapid treponemal test). Newer, rapid treponemal tests are comparatively easy to use, which encourages the use of these tests for screening, ideally paired with a non-treponemal test that detects reaginic antibody. Whichever approach is used, the proposed indicator requires both a positive non-treponemal test AND a positive treponemal test to give a proxy for active infection. If RPR testing is performed, itshould be titrated and be ≥1:8 to be certain of active syphilis. Just a non-treponemal test, or just a treponemal test, while useful in some situations for therapeutic purposes, is not sufficiently specific for surveillance of men who have sex with men. The requirement for both a positive non-treponemal test and a positive treponemal test in men who have sex with men differs from the indicator on syphilis testing in antenatal care attendees because men who have sex with men are more likely to have a history of previous infection. A positive treponemal test measures lifetime exposure, whereas the non-treponemal test is a better indicator of active infection.
Disaggregation	None
Strengths and weaknesses	Strengths: Requiring testing by both tests enhances specificity of the reported numbers of positive tests. In addition, requiring testing by both tests will increase

	the likelihood of identifying active disease. Weaknesses: Requiring testing by both tests increases the difficulty of acquiring data for this indicator.
Additional considerations	Quality assurance and quality control should be an integral part of syphilis testing to ensure reliable results.
Data utilization	Look at trends in comparable groups over time. Compare with data on trends of syphilis and HIV where available.
Data Quality Control and Notes for the Reporting Tool	It is important NOT to count multiple tests run on the same patient. That is, if a person has been tested more than once in the past 12 months, they should not be counted more than once.

STI Pilot Indicators (to be reported by PAHO and EMRO countries only)

1.17.6 STIs: Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	
Rationale	Infection with an acute bacterial STI such as primary/secondary syphilis is a marker of unprotected sexual intercourse and facilitates HIV transmission and acquisition. Therefore, surveillance for primary/secondary syphilis contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated syphilis causes stillbirths and neonatal disease, and can progress to debilitating or fatal outcomes in adults.
What it measures	Progress in reducing unprotected sex in the general population.
Numerator	Number of adults reported with syphilis during the reporting period
Denominator	Number of individuals aged 15 and older per UNPD
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	Sex, Primary/secondary vs. latent/unknown: Total, Total Female, Total Male, Female primary/secondary, Male primary/secondary
Strengths and weaknesses	Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.
Additional considerations	It is important that countries when reporting on syphilis communicate on the extent to which the data are felt to be representative of the national population.
Data utilization	Look at trends in comparable groups over time.
Data Quality Control and Notes for the Reporting Tool	Recommended indicator in: “Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012”

1.17.7 STIs: Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months	
Rationale	Untreated syphilis infection in pregnancy can not only increase risk of HIV transmission and acquisition in the mother and the infant, but also lead to stillbirth, neonatal death, and congenital disease (collectively defined as “congenital syphilis”). Given the high efficacy, simplicity, and low cost of syphilis testing and treatment, global and regional initiatives to eliminate MTCT of syphilis have been launched. The rate of congenital syphilis is a measure of the impact of programmatic interventions to eliminate MTCT of syphilis.
What it measures	Progress in elimination of mother-to-child transmission (MTCT) of syphilis.
Numerator	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months
Denominator	Number of live births per UNPD
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	None
Strengths and weaknesses	Diagnosis of congenital syphilis is most reliable when using specific diagnostic tests that are seldom available even in developed countries. Therefore, in most countries diagnosis of congenital syphilis relies on clinical history and examination, making surveillance challenging. Although WHO has a global case definition for surveillance purposes, actual case definition may vary between and within countries and regions.
Additional considerations	It is important that countries when reporting on syphilis communicate on the extent to which the data are felt to be representative of the national population.
Data utilization	Given the difficulties in diagnosing congenital syphilis, and depending on the case definition used, either underreporting or overreporting can be a problem. The likely magnitude of such reporting errors should always be considered when looking at rates of congenital syphilis. However, with use of a consistent case definition, trends over time may be useful.
Data Quality Control and Notes for the Reporting Tool	Recommended indicator in "Methods for Surveillance and Monitoring of Congenital Syphilis Elimination within Existing Systems".

1.17.8 STIs: Number of men reported with gonorrhoea in the past 12 months	
Rationale	Infection with an acute bacterial STI such as gonorrhoea is a marker of unprotected sexual intercourse and facilitates HIV transmission and acquisition. Therefore, surveillance for gonorrhoea contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated gonorrhoea can result in pelvic inflammatory disease, ectopic pregnancy, infertility, blindness, and disseminated disease. Increasing resistance to currently recommended treatment options may render this infection untreatable.
What it measures	Progress in reducing unprotected sex in men.

Numerator	Number of men reported with gonorrhoea during the reporting period
Denominator	Number of males aged 15 and older per UNPD
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	None
Strengths and weaknesses	Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.
Additional considerations	It is important that countries when reporting on gonorrhoea communicate on the extent to which the data are felt to be representative of the national population. Data on gonorrhoea among women, although useful for monitoring purposes at a local and national level, are not requested at the global level because the majority of women infected with *Neisseria gonorrhoeae* are asymptomatic and sensitive diagnostic tests for gonorrhoea in women are not widely available in developing countries. Therefore data on gonorrhoea among women are felt to be too dependent on diagnostic resources and screening practices to be monitored appropriately at the global level.
Data utilization	Look at trends in comparable groups over time.
Data Quality Control and Notes for the Reporting Tool	Recommended indicator in: "Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012"

1.17.9 STIs: Number of men reported with urethral discharge in the past 12 months	
Rationale	Urethral discharge in men is an STI syndrome generally most commonly caused by *Neisseria gonorrhoeae* or *Chlamydia trachomatis*. Presentation with an acute STI syndrome such as urethral discharge is a marker of unprotected sexual intercourse and urethral discharge facilitates HIV transmission and acquisition. Therefore, surveillance for urethral discharge contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated urethral discharge can result in infertility, blindness, and disseminated disease. Increasing resistance to currently recommended treatment options for *Neisseria gonorrhoeae* may render this infection untreatable.
What it measures	Progress in reducing unprotected sex in men.
Numerator	Number of men reported with urethral discharge during the reporting period
Denominator	Number of males aged 15 and older per UNPD
How to Measure and Measurement Tools	Routine health information systems.
Disaggregation	None

Strengths and weaknesses	Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, clinical diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.
Additional considerations	It is important that countries when reporting on urethral discharge communicate on the extent to which the data are felt to be representative of the national population. Following trends in urethral discharge is a feasible means to monitor incident STI in a population. Data on vaginal discharge among women, although useful for monitoring purposes at a local and national level, are not requested at the global level because in many settings the majority of vaginal discharge cases are not due to sexually transmitted infections. Countries should conduct periodic assessments of the etiology of urethral discharge syndrome in order to understand the predominant causes of urethral discharge and therefore appropriate therapy.
Data utilization	Look at trends in comparable groups over time.
Data Quality Control and Notes for the Reporting Tool	Recommended indicator in: “Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012”

1.17.10 STIs: Number of adults reported with genital ulcer disease in the past 12 months	
Rationale	Genital ulcer disease is an STI syndrome generally most commonly caused by syphilis, chancroid, or herpes simplex virus. Presentation with an acute STI syndrome such genital ulcer disease is a marker of unprotected sexual intercourse and facilitates HIV transmission and acquisition. Therefore, surveillance for genital ulcer disease contributes to second-generation HIV surveillance through providing early warning of the epidemic potential of HIV from sexual transmission and on-going high-risk sexual activity that may need more aggressive programme interventions to reduce risk. Furthermore, untreated genital ulcer diseases can cause stillbirths and neonatal disease, and can progress to debilitating or fatal outcomes in adults.
What it measures	Progress in reducing unprotected sex in the general population.
Numerator	Number of adults reported with genital ulcer disease during the reporting period
Denominator	Number of individuals aged 15 and older per UNPD
How to Measure and Measurement Tools	Routine health information systems
Disaggregation	Sex: total, men, women
Strengths and weaknesses	Although WHO has provided a global case definition, actual case definition may vary between and within countries. Furthermore, clinical diagnostic capacity may vary between and within countries. Although underreporting of this indicator may occur, in the absence of changes in case definition or major changes in screening practices, these data can generally be used for following trends over time within a country.

Additional considerations	It is important that countries when reporting on genital ulcer disease communicate on the extent to which the data are felt to be representative of the national population. Countries should conduct periodic assessments of the etiology of genital ulcer disease in order to ensure appropriate drug selection for syndromic management and to understand the extent to which genital ulcer disease reflects incident infection due to recurrent HSV infection versus acute infection with syphilis, chancroid, or HSV.
Data utilization	Look at trends in comparable groups over time.
Data Quality Control and Notes for the Reporting Tool	Recommended indicator in: “Strategies and laboratory methods for strengthening surveillance of sexually transmitted infection 2012”

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

2.6 Number of people on opioid substitution therapy (OST)	
Rationale	Opioid substitution therapy represents a commitment to treat opioid dependence and to reduce the frequency of injecting, preferably to zero. OST is the most effective public health tool for reducing injecting drug use among opioid injectors. OST also provides a crucial support for the treatment of other health conditions, including HIV, TB and viral hepatitis.
What it measures	National commitment and progress towards the treatment of opioid dependence and reduction of HIV transmission probabilities among people who inject drugs.
How to Measure and Measurement Tools	Programme data
Disaggregation	Administrative units: urban, rural
Strengths and weaknesses	Number of people on OST should be readily available and valid since they are typically licensed by the relevant authorities.
Additional considerations	Please refer to the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html) for a proposed complete set of globally agreed indicators for people who inject drugs.
Data utilization	Try to assess whether sufficient OSTs are available for the number and distribution of people who are dependent on opiods in the country.
Other References	WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html)

2.7 Number of NSP and OST sites: - Number of needle and syringe programme (NSP) sites	
Rationale	Needle and syringe distribution programmes are among the most effective interventions for preventing transmission of HIV among people who inject drugs. Sufficient access to clean needles for the injecting population is measured with this indicator.
What it measures	Number of NSP sites (including pharmacy sites providing at no cost needles and syringes). Availability of sites that can provide clean needles and syringes to injection drug users.
How to Measure and Measurement Tools	National programme data
Disaggregation	Administrative unit Urban, rural
Strengths and weaknesses	Many NSPs are not "official" and therefore not counted among national programme data

Additional considerations	Needle and syringe programmes (NSPs) are any programmes that include access to clean equipment and safe disposal through fixed or mobile exchange programmes and/or through pharmacies where equipment is available free of charge. In many countries pharmacy sales of injecting equipment are an important and sometimes the most significant source of clean injecting equipment accessible to drug users. However, pharmacies that sell needles and syringes are typically not counted in a retrievable database as part of a public health or harm reduction programme. If they are available, they should be counted and highlighted, if possible. Pharmacies that distribute needles and syringes free of cost typically do maintain records of needles distributed as part of the programme and should be included. Please refer to the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html) for a proposed complete set of globally agreed indicators for people who inject drugs.
Data utilization	Get an idea of the availability of NSP sites, and trends over time. Also try to analyse data based on geographical location of the NSP sites and geographical distribution and population density of people who inject drugs in the country. Try to assess whether sufficient NSPs are available for the number and distribution of people who inject drugs in the country.
Data Quality Control and Notes for the Reporting Tool	National Representativeness: Many NSP sites are not "official" and may be run by NGOs, which the government may not have information on. Please try to assess the national representativeness of the number you are reporting.
Other References	WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html)

2.7 Number of NSP and OST sites: - Number of opioid substitution therapy (OSP) sites	
Rationale	Opioid substitution therapy represents a commitment to treat opiate users and to reduce the frequency of injection, preferably to zero. OST is the single most effective public health tool for reducing injection drug use.
What it measures	National commitment and progress towards the treatment of opiate users and reduction of HIV transmission probabilities among people who inject drugs. The number of OST sites and the availability of sites that can provide OST to injecting drug users.
How to Measure and Measurement Tools	National programme data
Disaggregation	Administrative unit Urban, rural
Strengths and weaknesses	OST sites should be readily available and valid since they are typically licensed by the relevant authorities. However, the number of sites does not indicate the number of *slots* that may be available. Obtaining subgroup population size estimates will be difficult and add extra uncertainty.

Additional considerations	Please refer to the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/topics/idu/en/index.html) for a complete set of globally agreed indicators for people who inject drugs.
Data utilization	Get an idea of the availability of OST sites and trends over time in relation to the population size of opiate injectors in the country. Also try to analyse data based on geographical location of the OST sites and geographical distribution and population density of people who inject opioid drugs in the country. If possible, try to interpret this indicator considering information available on the number of OST slots in various sites. Try to assess whether sufficient OSTs are available for the number and distribution of opiate injectors in the country.
Data Quality Control and Notes for the Reporting Tool	National Representativeness: Many OST sites are not "official" and may be run by NGOs, which the government may not have information on. Please try to assess the national representativeness of the number you are reporting.
Other References	WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf)

Target 3: Eliminate mother-to-child transmission on HIV by 2015 and substantially reduce AIDS-related maternal deaths

3.4. Percentage of pregnant women who know their HIV status (tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status)	
Rationale	Identification of a pregnant woman's HIV serological status provides an entry point for other services for PMTCT and to tailor prevention, care and treatment to her needs.
What it measures	This indicator assesses efforts to identify the HIV serological status of pregnant women in the previous 12 months.
Numerator	Number of pregnant women of known HIV status. This is compiled from the number of women of unknown HIV serological status attending antenatal care, labour and delivery and postpartum services, who have been tested for HIV and know their results and women with known HIV infection attending antenatal care for a new pregnancy in the past 12 months. Pregnant women with known HIV infection: women who were tested and confirmed to be HIV-positive at any time before the current pregnancy, who are attending antenatal care for a new pregnancy. These women may not need to be retested if there is documented proof of their positive status[3], and in line with national guidelines on testing pregnant women. These women do, however, need services for PMTCT and are counted in the numerator. Pregnant (and postpartum) women of unknown serological status: women who were not tested during antenatal care or at labour and delivery for this pregnancy or do not have documented proof of having been tested during this pregnancy. The numerator is the sum of categories a–c below: (a-1) pregnant women who have an HIV test and receive their result during antenatal care; (a-2) pregnant women with known HIV infection attending antenatal care for a new pregnancy; (b) pregnant women of unknown HIV serological status attending labour and delivery who were tested and received results; and (c) women of unknown HIV serological status attending postpartum services within 72 hours of delivery who were tested and received results. Categories a-1, b and c include all women who were tested and received results, irrespective of the HIV test result. Category a-2 includes women with previously known HIV-positive status.

3 Documentation of HIV infection (care and treatment card, maternal card from previous pregnancy or other reliable written documentation of HIV status) is generally required in most settings. Without proof of existing HIV infection, women are usually considered as being of 'unknown' status and are often retested. National guidelines should be consulted.

	Data reported from facilities may be disaggregated into: (a) women with known (positive) HIV infection at antenatal care; (b) women newly identified as HIV positive; and (c) women testing HIV negative (the remainder). See below for Disaggregation for Global Reporting.
Denominator	Estimated number of pregnant women in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers for antenatal care, labour and delivery and postpartum care. In countries with high rates of facility attendance for labour and delivery, data can be collected from labour and delivery registers only, as the results of HIV testing will be available for most pregnant women from this one source. Health facility registers should record known HIV infection in pregnant women coming to antenatal care clinics for a new pregnancy, so that they receive services for PMTCT. All public, private and nongovernmental organization-run health facilities that are providing testing and counselling for pregnant women should be included. The denominator is derived from a population estimate of the number of pregnant women giving birth in the past 12 months. This can be obtained from estimates of births from the central statistics office or from the United Nations Population Division or pregnancy registration systems with complete data.
Disaggregation	Pregnancy stages: ANC, L&D, postpartum Receipt of results: tested, tested and received results HIV serostatus: number HIV+
Strengths and weaknesses	This indicator enables a country to monitor trends in HIV testing among pregnant women. The points at which drop-outs occur during the testing and counselling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counselling. It also does not capture the number of women who received pre-test counselling.
Additional considerations for countries	Health facility registers should reflect known HIV infection among HIV-infected pregnant women coming to the ANC for a new pregnancy (even if they are not tested at that site), such as through a code, circle, or other method, in order for them to receive subsequent PMTCT interventions. Not all categories will be applicable or significant to all settings (e.g. women of unknown status tested within 72 hours postpartum). Countries may want to prioritize investment of resources (revision of tools, time, money) for measuring the categories that are appropriate to their country context. It may be important for programme managers to use additional sub-national and facility level indicators to measure trends and progress in the testing and counselling process, such as uptake of testing and receipt of results. It is also important to know the number of women whose HIV status has been identified at each service, i.e. % ANC attendees whose HIV status is known; % L&D attendees whose HIV status is known, etc. This indicator could be triangulated and validated using population-based surveys, such as the DHS, which generally occurs every five years, or the AIDS Indicator

	Survey, a population-based survey that can be done on a more periodic basis.
Data utilization	Look at trends over time. If disaggregated data is available by region, see whether any lower performing areas can be identified. Review if data is available on % of ANC attendees who know their status (including those with previously confirmed HIV status and those tested) and % of L&D attendees who know their status.
Data Quality Control and Notes for the Reporting Tool	Double Reporting: There is a risk of double counting with this indicator, as a pregnant woman can be tested a few times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, countries should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place. Please do not add *all* the number of women tested from ANC *and* L&D to get the *total* number of women tested. We are interested in knowing the number of *women* tested, and not the total number of tests (i.e. if a women is tested at ANC and again at L&D, try to only count her once). It is important to include those with previously known HIV infection in the numerator – even if they do not receive an HIV test, their HIV infection is identified for subsequent PMTCT interventions. Number tested, as well as tested and received results: If available, please report the number of pregnant women tested, as well as the number of pregnant women tested and received results (latter should not exceed the former). If your data collection system does not currently separate those with known and unknown HIV status and you are unable to provide the specific disaggregated data, please review the data available, and derive the best data for the number of *pregnant women whose HIV status has been identified* during pregnancy, L&D, or during the post-partum period within 72 hours. Please provide any details that would help to interpret your data in the *Comment* section. Please comment on the source of your denominator.
Other References	PMTCT M&E Core Indicator #3

3.5 Percentage of pregnant women attending antenatal care (ANC) whose male partner was tested for HIV in the last 12 months	
Rationale	Male involvement is a critical element in providing family-focused services to HIV-infected pregnant mothers, their infants and family members. It is also important in the prevention of HIV infection and can help couples who are seronegative to remain seronegative. Partner testing is the first step in involving the male partner, regardless of the couple's HIV status.
What it measures	The percentage of pregnant women attending antenatal care whose male partner was tested during their female partner's pregnancy in the past 12 months.
Numerator	Number of pregnant women attending antenatal care whose male partner was tested in the last 12 months
Denominator	Number of pregnant women attending antenatal care
How to Measure and Measurement Tools	The numerator can be calculated from national programme records compiled from facility registers. Male partners can be tested with the woman at the first antenatal care visit or at a follow-up visit or tested alone on a separate visit, such as a day reserved for male partner testing. Data can be aggregated from antenatal care or testing and counselling register, depending on the context. All public, private and nongovernmental organization-run health facilities that provide antenatal care services should be included. If feasible, programmes may consider collecting data on whether or not the male and female partner disclosed their HIV status to each other in the presence of a clinic staff member.
Strengths and weaknesses	This indicator allows countries to monitor efforts at increasing testing of male partners of pregnant women attending ANC services. It does not measure whether the male partner received his result or any follow-up services. The indicator does not take into account ANC clients that have more than one partner or that may change partners over time. It also may not include partners that received HIV testing at non-ANC settings and which are not linked to ANC (e.g. general VCT or provider initiated testing). Not all sites may be collecting data on male partner testing or routinely aggregating and reporting the data. Measuring this indicator may require additional investment and resources to revise data collection tools and summary reporting forms.
Additional considerations	Although testing male partners is an important tool for increasing male involvement and preventing infection during pregnancy, it is also a critical entry point into ongoing and family-focused care for the man. Health providers should ensure and document that appropriate follow-up services are provided to all male partners who test HIV-positive, as part of a comprehensive care and treatment programme.
Data utilization	Interpret based on country context and applicability. Discuss how to increase coverage.

Data Quality Control and Notes for the Reporting Tool	Please provide any comments that would help to interpret the representativeness of the data. If the number of discordant couples is easily available, please provide data in the comments section with any supporting comments.
Other References	PMTCT Additional Indicator # A-3

3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	
Rationale	HIV-infected pregnant women who meet the clinical and (when available) immunological criteria for antiretroviral therapy should receive it. Antiretroviral therapy preserves maternal health and reduces the risk for mother-to-child transmission. Services for the prevention of mother-to-child transmission of HIV should undertake such assessments. Women who are not yet eligible for antiretroviral therapy should receive antiretroviral drug prophylaxis for PMTCT according to the national guidelines and recommendations.
What it measures	Coverage of eligibility assessment for antiretroviral therapy among HIV-infected pregnant women, either clinically by WHO clinical staging criteria or immunologically by CD4 testing. Assessments can be made on site or by referral.
Numerator	Number of HIV-infected pregnant women assessed for eligibility for antiretroviral therapy by either clinical staging or CD4 testing, on site or by referral, in the past 12 months. 'On site' means that the service is offered in a health facility structure or compound. For instance, HIV clinical staging may be available in the antenatal care unit, while blood draw for CD4 testing is available at the HIV care and treatment unit in the same health facility. Both these services are considered to be on site. Referral can be made on site or off site and is defined as sending a patient to a different service unit, health provider or health facility. Often, patients return to the original health facility, service unit or provider, where the services received at the referral site are fed back to the original site, and the patient continues with follow-up care. Referral facilities should document the services provided and patient outcomes. This indicator should be disaggregated by type of assessment (clinical staging or CD4 testing). Women who were assessed by CD4 testing and clinical staging should be counted only once as having been assessed by CD4 testing.
Denominator	Estimated number of HIV-infected pregnant women in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Assessment can be conducted in antenatal care clinics and HIV care and treatment units, on site or by referral. Data should be aggregated from the appropriate register, with consideration of which registers capture the data, where the assessment actually took place, possible double-counting or under-counting and the need for accurate data for the national level.

	All public, private and nongovernmental organization-run health facilities that assess eligibility of HIV-infected pregnant women for antiretroviral therapy, either on site or by referral, should be included. Two methods can be used to calculate the denominator: • a projection model such as that provided by Spectrum software: use the output "number of pregnant woman needing prevention of mother-to-child transmission of HIV"; or • multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates of the central statistics office or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics), if Spectrum projections are unavailable.
Disaggregation	Method of ART eligibility assessment: Clinical staging, CD4 testing
Strengths and weaknesses	The strength of this indicator is that it enables countries to monitor the extent to which HIV-infected pregnant women are receiving an intervention that is critical for accessing ART for their own health. It does not capture whether HIV-infected pregnant women who were eligible for ART actually received it. Although each category is mutually exclusive, there is a risk of double counting this indicator where HIV-infected pregnant women have been assessed both clinically and immunologically, as well as where women are assessed in different units or in a different facility. Countries should ensure systems are in place to minimize the risk of double counting. This indicator does not capture women who may have been identified HIV-positive at labour and delivery and subsequently assessed for ART eligibility.
Additional considerations	It is recommended that countries disaggregate by eligibility status for additional information on national trends in the percentage of pregnant women who are eligible for ART. In settings where HIV-infected pregnant women are referred out to another health facility or another service unit within the same health facility, health providers should make an effort to document referrals made and services received for these women in the ANC/PMTCT register for better patient tracking and monitoring of HIV-infected pregnant women.
Data utilization	The goal would be to aim for 100%; once 100% is reached routinely, this indicator may become obsolete. Explore further information on disaggregated data on whether eligibility was assessed through clinical staging or CD4 tests and any data available on how long it takes to receive a CD4 test result in various places.
Data Quality Control and Notes for the Reporting Tool	Please provide any comments that would help to interpret the data.
Other References	PMTCT M&E Core Indicator #4

3.7 Percentage of infants born to HIV-infected women provided with antiretroviral (ARV) prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks (i.e. early postpartum transmission around 6 weeks of age)	
Rationale	The risk for mother-to-child transmission can be significantly reduced by the complementary approaches of providing antiretroviral drugs (as treatment or as prophylaxis) for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretrovirals to the mother or child during breastfeeding (if breastfeeding), and use of safe delivery practices and safer infant feeding.
What it measures	Progress in the prevention of early postpartum mother-to-child transmission by the provision of antiretroviral prophylaxis for HIV-exposed infants
Numerator	Number of infants born to HIV-infected women during the past 12 months who received antiretroviral prophylaxis to reduce early mother-to- child transmission (i.e. early postpartum, in the first 6 weeks).
Denominator	Estimated number of live births to pregnant HIV-infected women in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Antiretroviral drugs can be given to HIV-exposed infants shortly after delivery, at facilities for labour and delivery for infants born at facilities, at outpatient postnatal care or child clinics for infants born at home and brought to the facility, or at HIV care and treatment or other sites, depending on the country. Three methods for calculating the numerator can be considered: • Counting at the point of antiretroviral drug provision: In settings with low facility delivery rates, data for the numerator should be compiled from the sites where antiretroviral drugs are dispensed and where the data are recorded. There is a risk of double-counting when antiretroviral drugs are provided during more than one visit or at different health facilities. Countries should establish data collection and reporting systems to minimize double-counting. • Counting around time of delivery: In settings where a high proportion of women give birth in health facilities, countries can estimate the numerator from only the labour and delivery register by counting the number of HIV-exposed infants who received a specific antiretroviral drug regimen before discharge from the labour and delivery ward. This may be the most reliable and accurate method for calculating this indicator in settings with a high proportion of facility deliveries and low follow-up, as the corresponding antiretroviral drug regimen dispensed is counted at the time of provision to the infant. • Counting at postnatal or child health sites: Countries can also count and aggregate the number of HIV-exposed infants who received antiretroviral prophylaxis recorded at postnatal or child health clinics if attendance is high and the exposure status of the child is likely to be known (e.g. from postnatal registers, stand-alone registers or integrated HIV-exposed infant registers). All public, private and nongovernmental organization-run health facilities that provide antiretroviral drugs to HIV-exposed infants for the prevention of mother-to-child transmission of HIV should be included.

	Two methods can be used to estimate the denominator: • a projection model, such as that provided by Spectrum software; use the output "number of pregnant woman needing prevention of mother-to-child transmission of HIV" as a proxy; or • multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates by central statistics office or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics), if Spectrum projections are unavailable. • If there are data on the number of live births, they should be adjusted to derive a better proxy.
Disaggregation	None requested
Strengths and weaknesses	This indicator allows countries to monitor the coverage of antiretrovirals regimens dispensed or initiated among HIV-exposed infants to reduce the risk of early maternal HIV transmission. The indicator measures the extent to which ARVs were dispensed for infants as prophylaxis. It does not capture whether the ARVs were consumed; thus it is not possible to determine adherence to the ARV regimen, nor whether ARV regimens were completed.
Additional considerations	Countries that have developed mechanisms for reaching HIV-exposed infants at the community level with ARVs will want to ensure a system of data collection is in place for reporting infants receiving ARV regimens at the community level.
Data utilization	Compare the indicator value with coverage of the maternal ARV regimen (Indicator I-10) and discuss what the data may mean in the country context. Some countries may want to explore further and do a linked review of the infant ARV prophylaxis regimen vis-à-vis the maternal ARV regimen can be assessed.
Data Quality Control and Notes for the Tool	Please provide any comments that would help to interpret the data.
Other References	PMTCT M&E Core Indicator #6

3.8 Percentage of infants born to HIV-infected women who are provided with antiretrovirals to reduce the risk of HIV transmission during breastfeeding	
Rationale	The risk for mother-to-child transmission can be significantly reduced by providing antiretroviral drugs (as lifelong therapy or as prophylaxis) for the mother during pregnancy and delivery, with antiretroviral prophylaxis for the infant, and antiretrovirals to the mother or child during breastfeeding (if breastfeeding), and use of safe delivery practices and safer infant feeding. In breastfeeding populations, antiretrovirals interventions to mothers or infants can specifically reduce the risk of transmission through breastfeeding and should be monitored.
What it measures	Progress in the prevention of mother-to-child transmission in breastfeeding populations by the provision of antiretroviral drugs to reduce the risk of HIV transmission during the breastfeeding period.

Numerator	Number of infants born to HIV-infected women who, during the past 12 months, are breastfeeding and provided an antiretroviral intervention (i.e. maternal or infant ARVs) to reduce mother-to-child transmission through breastfeeding.
Denominator	Estimated number of infants born to HIV-infected women (HIV-exposed infants) who are breastfeeding during the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Antiretroviral drug interventions to reduce HIV transmission through breastfeeding can be initiated shortly after delivery at facilities for labour and delivery if infants are born at facilities, at outpatient postnatal care or child clinics for infants born at home and brought to the facility, or at HIV care and treatment or other sites, depending on the country. In breastfeeding populations, antiretrovirals are recommended until one week after the cessation of breastfeeding. ARV coverage should be monitored throughout the duration. Currently, the proposed time point for a national indicator for ARV coverage during the breastfeeding is at or around 2-3 months to time it around the time of an infant's 6 week EID visit or DTP3 immunization visit and to capture the information at a time where loss to follow up may be minimal. The collection of this indicator is being field-tested and guidance may change in the future. Countries are encouraged to include the monitoring of ARV coverage during the breastfeeding period in their existing M&E system (please contact pmtctmoneval@who.int for further information). The data for the numerator should be collected at the infant's 6 week EID visit or DTP3 immunization visit (2-3 months) and distinguished from ARV interventions given to prevent peripartum transmission. Data on whether maternal or infant antiretrovirals to reduce post-natal transmission were provided should be recorded for breastfeeding infants. HIV-infected pregnant women who are eligible for lifelong antiretroviral therapy and are receiving a treatment regimen and whose infants therefore benefit from the prophylactic effect of ART in reducing the risk of transmission through breastfeeding are also included in this indicator. The denominator should represent the number of HIV-exposed infants who are breastfeeding. In settings where most exposed-infants would be breastfeeding, the estimated number of HIV-exposed infants could be a proxy for the denominator (with some adjustment of infant deaths before the time point for measurement if available). In other settings, where a sizable population of HIV-exposed infants may not be breastfeeding), it will be necessary to estimate the number of HIV-exposed infants who are breastfeeding. Three methods for calculating the denominator can be considered: • Counting at the time of labour and delivery: In settings where a high proportion of women give birth in health facilities, countries can estimate the denominator from only the labour and delivery register, by recording and counting the number of HIV exposed-infants whose initial feeding practice was breastfeeding, as a proxy for the denominator. • Counting at postnatal or child health sites: In settings where a high proportion of women and children attend post-natal and child health sites, countries can count and aggregate the number of HIV-exposed infants who are breastfeeding recorded at postnatal or child health clinics if the exposure status of the child is likely to be known (e.g. from postnatal registers or stand-alone or integrated

	HIV-exposed infant registers). Estimated number of women needing PMTCT as a proxy: In settings where almost all HIV+ women are likely to be breastfeeding, the estimated number of HIV+ women giving birth (e.g. women needing PMTCT from Spectrum) can be reviewed as a proxy, adjusting for any estimated deaths, if data exists. This proxy can also be reviewed with data collected from facilities to get a better idea of what proportion of the population is being captured in the numerator. All public, private and nongovernmental organization-run health facilities that provide antiretroviral drugs for PMTCT should be included.
Disaggregation	Data on whether 1) maternal or 2) infant antiretrovirals were provided to reduce post-natal transmission from breastfeeding should be recorded for breastfeeding infants. The time point (e.g. 3 months) the data represents should also be recorded in the *Comment* Box.
Strengths and weaknesses	This indicator allows countries to monitor their coverage of antiretrovirals prophylaxis provided among HIV-exposed infants to reduce the risk of post-natal HIV transmission in breastfeeding populations during a specific time point. This indicator does not capture whether the drugs were taken or for how long, so it is not possible to determine adherence to the regimen or whether the regimen was completed. Ideally, it is important to assess antiretroviral coverage throughout the breastfeeding period, but in many settings there is significant loss to follow-up after the 6 -week visit so it is difficult to get an accurate estimate of antiretroviral coverage at a later time point. In breastfeeding populations, effort should be made to ensure antiretroviral coverage during the breastfeeding period beyond 6 weeks or DTP3 as captured by this indicator.
Additional considerations	Countries that have mechanisms for giving antiretroviral drugs to HIV positive breastfeeding women or HIV-exposed infants during the postnatal period at Countries should periodically review data to assess whether ARV prophylaxis for the recommended full duration (until cessation of breastfeeding) was taken.
Data utilization	Compare the indicator value with coverage of the maternal ARV regimen (Indicator I-10) and discuss what the data may mean in the country context. Some countries may want to explore further and do a linked review of the breastfeeding ARV prophylaxis regimen vis-à-vis the maternal ARV regimen.
Data Quality Control and Notes for the Tool	Please provide any comments that would help to interpret the data.
Other References	PMTCT M&E Core Indicator #7

3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth	
Rationale	Co-trimoxazole prophylaxis is a simple, cost-effective intervention to prevent *Pneumocystis jiroveci* pneumonia in HIV-infected infants. This infection is the leading cause of serious respiratory disease in these infants in resource-constrained countries and often occurs before HIV infection can be diagnosed. Owing to resource and logistical constraints in diagnosing HIV infection in young infants, all infants born to HIV-infected women should receive co-trimoxazole prophylaxis, starting 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
What it measures	The provision and coverage of co-trimoxazole prophylaxis for HIV-exposed infants in line with international guidelines[4]
Numerator	Number of infants born to HIV-infected women started on co-trimoxazole prophylaxis within 2 months of birth in the past 12 months
Denominator	Estimated number of HIV-infected pregnant women who gave birth in the past 12 months
How to Measure and Measurement Tools	The numerator is calculated from national programme records aggregated from facility registers. Data should be aggregated from the appropriate facility registers, such as a stand-alone or integrated HIV-exposed infant register. The register used may depend on where services are offered. For example, where HIV-exposed infants are followed by health workers in HIV care and treatment facilities, countries could aggregate information from a register based at that site. All public, private and nongovernmental organization-run health facilities that provide co-trimoxazole prophylaxis for HIV-exposed infants should be included. Two methods can be used to estimate the denominator: • a projection model such as that provided by Spectrum software; use the output "number of pregnant woman needing PMTCT (prevention of mother-to-child transmission of HIV)" as a proxy; or • multiply the total number of women who gave birth in the past 12 months (which can be obtained from central statistics offices or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women[5] (which can be derived from HIV sentinel surveillance in antenatal care clinic), if Spectrum projections are unavailable. If there are data on the number of live births, they should be adjusted to derive a better proxy.
Disaggregation	None requested
Strengths and weaknesses	This indicator allows countries to monitor progress in the early follow-up of exposed infants by measuring provision of co-trimoxazole in line with international guidelines. It can also be used as a proxy indicator for early follow-up visits of

4 WHO. Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults: Recommendations for a public health approach. Geneva, World Health Organization, 2006.

5 National estimates of HIV-infected pregnant women should be derived by adjusting surveillance data from sentinel sites at antenatal clinics and other sources, taking into consideration characteristics such as age distribution and rural and urban patterns of HIV prevalence.

	exposed infants within the recommended first 4-6 weeks of life. The indicator captures only those infants who return for HIV-exposed infant follow-up services within two months of birth. It does not measure *actual* coverage of co-trimoxazole prophylaxis for HIV-exposed infants as some infants may have been started on treatment after 2 months. A low value of the indicator could signal potential bottlenecks in the system, including poor management of CTX supplies in the country, poor data collection, and inadequate distribution systems.
Additional considerations	Countries may also wish to document provision of CTX for HIV-exposed infants older than 2 months as a way to monitor overall progress of the programme, identify existing challenges with early initiation of CTX, and to monitor consumption for procurement needs. Inappropriate management of supplies can negatively affect the value of the indicator and significantly reduce access to CTX for HIV-exposed infants. Countries should ensure appropriate systems and tools, particularly tools for LMIS, are in place to adequately procure, distribute, and manage supplies at facility, district and central levels.
Data utilization	Data can also be reviewed as an indication of the number of exposed infants who are seen at a facility within 2 months of birth. If indicator value is low, explore reasons why (e.g. whether exposed-infants are not attending facilities within 2 months, or if there are stock-outs of CTX, etc.).
Data Quality Control and Notes for the Reporting Tool	National Representativeness: If this indicator is obtained from a sub-set of facilities, comments should be added regarding the representativeness. Triangulation Options: pharmacy registers If the data reported represents CTX provided in infants beyond 2 months of age, please note it in the Comments section.
Other References	PMTCT M&E Core Indicator #8

3.10 Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DPT3 visit	
Rationale	HIV can be transmitted during breastfeeding even in settings where 100% of HIV-infected pregnant women receive either lifelong antiretroviral therapy or antiretroviral medicines as prophylaxis for the prevention of mother-to child transmission of HIV. Mixed feeding before 6 months of age increases the risk for HIV transmission when compared with exclusive breastfeeding. WHO therefore recommends that when mothers known to be HIV-infected breastfeed, they should be given ARVs to reduce the risk of transmission and also exclusively breastfeed for the first 6 months, introduce complementary feeds from 6 months and continue breastfeeding until 12 months of age. Coverage with the third dose of diphtheria, pertussis and tetanus vaccine close to the recommended age of 14 weeks is relatively high in most countries. It is proposed to collect data at this time because most infants are seen then and it is mid-way between birth and the time at which exclusive breastfeeding would stop, making it comparable to the way that exclusive breastfeeding is usually reported for the general population in demographic and health surveys.

What it measures	Feeding[6] of HIV-exposed infants, derived from 24-h recall, measured at the time of the third dose of diphtheria, pertussis and tetanus vaccine (DPT3), which is often around 3 months of age or at the closest visit after 3 months.
Numerator	The numerators are disaggregated as follows: I12a number of HIV-exposed infants who were exclusively breastfeeding at or around the DPT3 visit; I12b number of HIV-exposed infants who received replacement feeding at or around the DPT3 visit; and I12c number of HIV-exposed infants who received mixed feeding at or around the DPT3 visit. The numerators capture feeding practices only for known HIV-exposed infants who visit a health facility.
Denominator	The denominator is the same for all three indicators: the number of HIV exposed infants whose feeding practice has been assessed at a DPT3 visit. Infants will be aged around 3 months or more.
How to Measure and Measurement Tools	The numerators are calculated from national programme records aggregated from facility registers. Ideally, data from appropriate sites and registers such as a stand-alone or integrated HIV-exposed infant registers should be aggregated, depending on where the services are and where data are recorded. At each visit, the health-care provider should enquire about infant-feeding practices during the previous 24 hours, by asking: "What did you give your infant to eat or drink yesterday during the day and during the night?" After each response, the health provider should ask: "Anything else?" The response will be recorded as exclusive breastfeeding, replacement feeding or mixed feeding. While this information is collected and recorded on the child health card at every visit, providers should record it in the register only once, during the third visit for diphtheria, pertussis and tetanus vaccination. This record will be used for compilation and reporting to national level. In settings where HIV-exposed infants are seen in HIV care and treatment facilities, data should be collected at a visit when the infant is around 3 months. The denominator is calculated from the total number of exposed infants whose feeding was assessed. Exposed infants who did not attend facilities are not included in the denominator. All public, private and nongovernmental organization-run health facilities that provide HIV-exposed infant follow-up services should be included.
Disaggregation	Report distribution of IF practice: EBF, RF, MF/Other; Uncategorized/other
Strengths and	The indicators measure important progress in safer infant feeding practices

6 The infant feeding practices measured with this indicator are defined as follows:

Exclusive breastfeeding: An infant receives only breast milk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines, for up to 6 months. Breast milk is defined as including milk from a wet nurse and a mother's expressed milk.

Replacement feeding (no breast milk at all): Feeding an infant who is not receiving any breast milk a diet that provides all the necessary nutrients until the child is fully fed on family foods. During the first 6 months, the food should be a suitable breast-milk substitute, which is usually a commercial infant formula, as home modified animal milk is no longer recommended for feeding infants during the entire first 6 months of life,
except as an emergency measure.

Mixed feeding (=partial breastfeeding): Feeding both breast milk and other foods or liquids to infants for 0–6 months.

weaknesses	among HIV-infected women and their exposed infants. They can also be used to indicate the quality of infant feeding counselling (with low rates of mixed feeding likely to indicate adequate infant feeding counselling and support), and can also be used to model the impact of the intervention in a country (see Core Indicator 12 in the PMTCT M&E guide, or GARPR 3.3 - modelled MTCT rate). It should be noted that the indicator says nothing about the quality of replacement feeding given, nor the impact of the feeding practices on child survival. The information can be compared with population surveys (e.g. DHS), which monitor infant feeding practices in the general population. The indicators may not reflect the actual distribution of infant feeding practices of HIV-exposed infants at the national level, as it does not include HIV-exposed infants who may have already died, infants whose exposure status is unknown, nor HIV-exposed infants whose mothers did not attend a facility with their infant for DPT3 or for another reason at or around 3 months.
Additional considerations	To fully understand the extent and type of infant feeding practices, countries may consider carrying out special studies with a cohort of HIV-infected women who choose to replacement feed and exclusively breastfeed. As well as measuring infant feeding practices, these studies could examine the reasons why women who have chosen either breastfeeding or replacement feeding are or are not practicing the chosen option exclusively, and whether the AFASS criteria were present. It could also examine the types of foods and liquids given to infants in addition to breast milk or formula before six months, and issues around cessation of exclusive breastfeeding at six months and complementary feeding after that time. Another issue to be examined is the impact of early infant diagnosis on infant feeding practices, and if the impact is negative, what can be done to better support mothers at this time. In countries where exposed infant follow-up has been integrated into community outreach services, programmes should consider identifying a system for collecting data at the community level for this indicator. Countries may wish to consider collecting this information at other time points, for example at both 6 weeks and 6 months. They may also wish to calculate the indicators using different denominators, such as the estimated number of HIV-exposed infants who should have been followed-up.
Data utilization	Review the distribution of infant feeding practice and discuss strategies to move towards safer practices.
Data Quality Control and Notes for the Reporting Tool	Please provide any relevant information that would allow to better interpret the data reported. If this data is not available, please provide an estimate of the distribution of IF practice among HIV+ women in the country in the *Comments* section.
Other References	PMTCT M&E Core Indicator #10

3.11 Number of pregnant women attending ANC at least once during the reporting period	
Notes for the Reporting Tool	Please report the number of ANC attendees with at least one visit during the reporting period. Please note that this counts the number of *people*, and not the number of *attendances*, meaning that a pregnant woman making 3 ANC visits will only be counted once. If the number does not represent the national number (e.g. if you only have data from 65% of the districts or facilities; or if the number represents multiple visits instead of "at least one visit"), please comment on the representativeness of the number you are reporting.

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015

4.1. Percentage of eligible adults and children currently receiving antiretroviral therapy (UA 2011 G2a)

Note that the above indicator is described in the first part of the Guidelines whereas the following indicator on people newly initiating ART is additional to section 4.1 and not included in the GARPR Guidelines:

4.1 – additional: HIV treatment: Antiretroviral therapy Number of eligible adults and children who newly initiated antiretroviral therapy (ART) during the reporting period (2012)	
Rationale	In addition to coverage it is important to monitor ART initiation. Comparing the evolution of the number of people on ART at the end of the years (indicator G2) does not inform about the number newly initiated, especially since ART attrition is high in the first year and thus the patients newly initiating during the reporting year are not all continuing at the end of the year. Therefore this indicator captures the number of patients newly initiated on ART during a reporting year.
What it measures	Number of eligible adults and children who newly initiated antiretroviral therapy during the reporting period (2011) Yearly evolution of the number of patients newly enrolled in antiretroviral therapy
How to Measure and Measurement Tools	Facility ART registers and drug supply management forms. By counting the number of patients who are newly enrolled in ART within the reporting period. Patients with records that transfer in from another facility or who temporarily stopped therapy and have started again in the reporting period should not be counted (risk of double counting). ARV drugs taken for purpose of PMTCT (except ART for the mother's own health) and post-exposure prophylaxis are not included in this indicator.
Disaggregation	By male and female By age groups: <1, 1-4, 5-14, 15+ By public and private These and other disaggregations to be included if available in the Comments box
Strengths and weaknesses	This indicator permits monitoring trends in initiation but does not attempt to distinguish between different forms of antiretroviral therapy or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. The degree of initiation of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, and perceptions of effectiveness and possible side effects of treatment.
Additional considerations	This indicator should be analysed in view of the 'waiting list' i.e. patients eligible for ART and not initiated.
Data utilization	In addition to the number of old patients retained on ART (retention on ART) the number of patients newly initiated is necessary for accurate planning of resources and drug stocks (avoiding shortage and wastage)
Data Quality Control	Double Reporting: If patients transferred in and out are not correctly registered

and Notes for the Reporting Tool	and if patients followed in different ART sites are not identified, there is a risk for double reporting which could lead to an overestimation of ART initiation. If this is the case, please comment. Similarly if patients temporarily stopping ART and restarting are coded as new patients, this will overestimate the true number of patients newly initiated. National Representativeness: the numerator is a national cumulative indicator, usually produced by all health facilities, otherwise it may estimate ART initiation. Please comment on your data as necessary. Triangulation Options: Pharmacy report, comparing the number of new patients in the pharmacy register and the ART register
Other References	PEPFAR indicator and guidelines

4.2 Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy (b) 24 months after initiating treatment among patients initiating antiretroviral therapy during 2010, (UA 2012 4.2b) (c) 60 months after initiating treatment among patients initiating antiretroviral therapy during 2007 (UA 2012 4.2c)	
Rationale	Antiretroviral is a life-long intervention. Measuring retention on ART is critical for determining the effectiveness of programmes, inferring their impact and to highlight obstacles to expanding and improving them.
What it measures	This indicator measures the retention on ART related to the increase in survival and willingness to continue ART. It should be produced at 12 months and for longer duration of follow-up; the 24 and 60 months retention are described here (the 12 months retention is included in the GARPR indicator guidance). It completes programme coverage as a measure of the effectiveness.
Numerator	Number of adults and children who are still alive and on ART at b) 24 months, c) 60 months, after initiating treatment (among those who initiated ART in b) 2010 and c) 2007).
Denominator	(b) at 24 months: Total number of adults and children who initiated ART in 2010 (or another specified period), who were expected to achieve 24-month outcomes within the 2012 reporting period (or 24 months after the specified initiation period), including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 24. (c) at 60 months: Total number of adults and children who initiated ART in 2007 (or another specified period), who were expected to achieve 60-month outcomes within the 2012 reporting period (or 60 months after the specified initiation period, including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 60.
How to Measure and Measurement Tools	Numerator and denominator: Programme monitoring tools; ART register; cohort analysis forms. In measuring retention, it is important to carefully select the patients according to the period they have initiated ART and to check their outcomes when they reached the expected duration of follow-up. Assessing outcomes at 24 months should include all patients started 2 years ago

	and at 60 months, all patients started 5 years ago. If the data available does not really fit this standard yearly period, it is important to specify the period the patients have initiated ART.
Disaggregation	Among the people who started (denominator), in addition to reporting the (1) number of people alive and on treatment (numerator), it is also important to report the number (2) lost to follow-up, (3) stopped therapy, and (4) died. These 4 outcomes should sum to the number of people who started ART. When generating information at site level, patients transferred in should be included in the statistics and patients transferred out should be excluded. From the compilation of site reports, if the number of patients transferred in and transferred out is summed at the national level, these statistics should be reported for 12-month analysis.
Strengths and weaknesses	The continuation of ART is mostly related to survival (but also willingness to continue). Survival might reflect the services offered but also depends on the baseline characteristics of the patients started on ART. Clinical, immunological and virological staging are independent predictors of survival under ART. Baseline characteristics of the cohort of patients should help in interpreting the results and, in particular, comparing ART sites.
Additional considerations	If data on 24-month or 60-month retention are not available for patients that initiated antiretroviral therapy in 2010 or 2007, respectively, but available for patients that initiated antiretroviral therapy during an earlier time period (e.g. 2009 or 2008, or 2006 or 2005), please specify the period in the comment field: e.g. "Started antiretroviral therapy between [month]/[year] and [month]/[year]". The numerator does not require patients to have been on antiretroviral therapy continuously for the 24 month or 60 month period. For example, patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment since initiating treatment but are recorded as still being on treatment at month 24 or 60 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 24 or 60 months since starting treatment are not included in the numerator. In countries where this indicator is not produced in all ART sites but in a sub-set of facilities, data should be interpreted keeping in mind the representativeness, and this should be stated in the *Comments* box.
Data utilization	Note any particularly low retention and assess reasons behind it, by analysing the distribution of those who are not on ART: dead, stopped, loss to follow up. If data is available, try to assess the lost-to-follow-up population to see if they are likely to be dead, stopped, or transferred out. Compare cohorts.
Data Quality Control and Notes for the Reporting Tool	National Representativeness: If this indicator is only produced in a sub-set of facilities, comment should be added on the source of information and whether the information is representative of all ART sites.

4.3.a Number of health facilities that offer antiretroviral therapy (ART)	
Rationale	Antiretroviral therapy is a cornerstone of effective HIV treatment, and measuring the percentage of health facilities that offer ART provides valuable information about ART availability.
What it measures	Number of health facilities that offer ART (i.e., prescribe and/or provide clinical follow-up). Capacity of health facilities to provide antiretroviral therapy (ART), expressed as percentage of health facilities that offer ART (i.e., prescribe and/or provide clinical follow-up). Health facilities include public and private facilities, health centres and clinics (including TB centres), as well as health facilities that are run by faith-based or nongovernmental organizations.
How to Measure and Measurement Tools	The numerator is calculated by summing of the number of facilities reporting availability of ART services. Information on the availability of specific services is usually kept at the national or sub-national level. National AIDS Programmes should have a record of all health facilities offering ART services. A health facility census or survey can also provide this information, along with more in-depth information on available services, provided the information is collected from a representative sample of health facilities in the country. Responses to a series of questions establish whether providers in that facility provide ART services directly (i.e., prescribe ART and/or provide clinical follow-up for ART patients) or refer patients to other health facilities for these services. In addition, facility records documenting the current status of service provision should be consulted. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years. Countries should regularly update their programme records on health facilities offering ART services, and supplement these data with those obtained through a health facility survey or census every few years. For health facility surveys or censuses, tools such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) can be used.
Disaggregation	Sector: public, private By type: hospital, health centre, ANC facility, TB facility, STI facility.
Strengths and weaknesses	This indicator provides valuable information about the availability of ART services in health facilities, but it does not capture information about the quality of services provided. Antiretroviral therapy itself is complex, and it should be delivered as part of a package of care interventions, including the provision of co-trimoxazole prophylaxis, the management of opportunistic infections and comorbidities, nutritional support and palliative care. Simple monitoring of ART availability does not ensure that all ART-related services are adequately provided to those who need them. Nevertheless, it is important to know what percentage of health facilities provide ART services in order to plan for service expansion as needed to meet universal access targets.
Additional considerations	One strategy to scale up ART services is to make ART available in more health facilities. This may be achieved by decentralizing ART services from tertiary facilities (e.g., hospitals) to primary or secondary-level health facilities. Greater availability of ART services provides crucial support to the goal of universal access to HIV treatment.

	Depending on the country's epidemic type, the denominator may not be as relevant if the HIV programme strategy aims to target a limited number of sites to offer ART in.
Data utilization	To look at progress in the percentage of health facilities which provide antiretroviral therapy. Analyzing the data geographically and by type of health facilities, and triangulating the data with estimates of HIV density can provide insight into where there is a need to increase availability of ART services.
Data Quality Control and Notes for the Reporting Tool	Please comment on whether the data reported is from a national facility listing or census, or from a survey. If data from the private or other sectors is missing, please comment. If it is possible to easily report any additional information on the geographical distribution of facilities offering ART (e.g. urban/rural, % facilities with ART in areas with a high concentration of people living with HIV), please provide extra details.
Other References	Additional Recommended Indicators for NAP #5

4.3.b Health facilities Number of health facilities that offer paediatric antiretroviral therapy (ART) (part of UA 2012 indicator 3.12)	
Rationale	Antiretroviral therapy is a cornerstone of effective HIV treatment, and measuring the percentage of health facilities that offer paediatric ART provides valuable informatio about capacity to address HIV care in children.
What it measures	Number of health facilities that offer paediatric ART. Capacity of health facilities to provide paediatric antiretroviral therapy (ART), expressed as percentage of health facilities that offer paediatric ART. Health facilitie include public and private facilities, health centres and clinics (including TB centres) as well as health facilities that are run by faith-based or nongovernmental organizations.
How to Measure and Measurement Tools	The numerator is calculated by summing the number of facilities reporting availability of paediatric ART services. Information on the availability of specific services is usually kept at the national or subnational level. National AIDS Programmes should have a record of all health facilities offering ART services. A health facility census or survey can also provide this information, along with more in-depth information on available services, provided the information is collected from a representative sample of health facilities in the country. Responses to a series of questions establish whether providers in that facility provide paediatric ART services directly or refer patients to other health facilities for these services. In addition, facility records documenting the current status of service provision should be consulted. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years. Countries should regularly update their programme records on health facilities offering paediatric ART services, and supplement these data with those obtained through a health facility survey or census every few years. For health facility surveys or censuses, tools such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) can be used.

	A denominator is not requested in the UA reporting tool but some countries trying to expand paediatric ART nationally can consider Total number of health facilities, excluding specialized facilities where paediatric ART services are/will never be relevant, which can be calculated by summing the total number of health facilities included in the sample. Information for construction of the denominator may come from programme records, facility listings, and/or national strategy or planning documents. It should exclude specialized facilities where paediatric ART services are/will never be relevant. (e.g. facilities specializing in eye care where ART will never be introduced)
Disaggregation	Sector: public, private
Strengths and weaknesses	This indicator provides valuable information about the availability of paediatric ART services in health facilities, but it does not capture information about the quality of services provided. Antiretroviral therapy itself is complex, and it should be delivered as part of a package of care interventions, including the provision of co-trimoxazole prophylaxis, the management of opportunistic infections and comorbidities, nutrition support and palliative care. Simple monitoring of ART availability does not ensure that all ART-related services are adequately provided to those who need them. Nevertheless, it is important to know what percentage of health facilities provide ART services in order to plan for service expansion as needed to meet universal access targets. One potential limitation to facility surveys or censuses is that they are usually only conducted once every few years and may not capture the latest information especia in setting with recent intensified scale-up.
Additional considerations	One strategy to scale up ART services is to make ART including paediatric ART services available in more health facilities. This may be achieved by decentralizing ART services from tertiary facilities (e.g. hospitals) to primary or secondary-level health facilities. Greater availability of paediatric ART services provides crucial support to the goal of universal access to HIV treatment. Depending on the country's epidemic type, the denominator may not be as relevant if the HIV programme strategy aims to target a limited number of sites to offer paediatric ART in.
Data utilization	Look at trends over time. Explore the number of facilities that provide ART in relation the estimated number of children in need of ART.
Data Quality Control and Notes for the Reporting Tool	Please comment on whether the data reported is from a national facility listing or census, or from a survey. If a survey, please remember to report the year of the survey. If data from the private or other sectors is missing, please comment. If it is possible to easily report any additional information on the geographical distribution of facilities offering paediatric ART (e.g. urban/rural, %facilities with ART in areas with a high concentration of people living with HIV), please provide extra details.
Other References	UNAIDS Additional Recommended Indicators for NAP #5

4.4 Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months	
Rationale	As countries scale-up ART services, it is important to ensure that ARVs are available to those who need them. ART is a long-term treatment strategy for people living with advanced HIV infection, and treatment interruptions may lead to treatment failure and HIV drug resistance. Efficient supply management is needed to ensure an uninterrupted supply of ARVs.
What it measures	This indicator measures a key aspect of antiretroviral (ARV) drug supply management: whether health facilities dispensing ARV drugs have run out of stock of at least one required ARV in the last 12 months.
Numerator	Number of health facilities dispensing ARVs that experienced a stock-out of one or more required ARV drug in the last 12 months.
Denominator	Total number of health facilities dispensing ARVs.
How to Measure and Measurement Tools	This information is collected at central level, where health facilities submit their inventory control reports or requisition forms for ARVs. These forms have information on patients on ART, consumption data, and stock on hand with stock out information if any. This indicator requires the following tools: • stock inventory control reports from health facilities indicating also the stock level of each item in the report; • requisition forms submitted from facilities during a defined period of time (e.g. last order period, last quarter, last year) for ARVs; and • list of ARVs that each facility is expected to dispense, if not already included in the inventory control reports or requisition forms. All the above work if the national logistics management information systems (LMIS) is operational. If the national LMIS is not operational, or health facility surveys such as the Service Provision Assessment (SPA) or the Service Availability Mapping (SAM) may be used provided they include questions on ARV stock-outs. If there is one national logistics management information system (LMIS) with details on ARV availability at the health facility level, information should be extracted from this system to construct this indicator. Alternatively, the information may need to be collected through a special survey or site visits. If there are only a limited number of health facilities where ARVs are dispensed in the country, all health facilities dispensing ARVs should be included in the survey or site visits. If the number of health facilities dispensing ARVs is large, it may be necessary to select a representative sample from the total number of health facilities dispensing ARVs (the full list should be available at the national level). When sampling, it is important to ensure that the sample includes facilities at different levels (such as central, district, and peripheral levels). In countries where ARV drugs are dispensed at pharmacies or other non-health facility delivery points, stock-outs should also be monitored in these venues; feasibility will depend on the coverage of the Logistics Management Information System.
Disaggregation	Sector: public, private
Strengths and weaknesses	This indicator captures a crucial component of the ART programme: whether or not there is a continuous, uninterrupted supply of ARV drugs at the health facility level.

	This indicator does not, however, provide information on why stock-out problems occur; which ARV drug(s) are/were out of stock; or how long the stock-out lasted for a particular ARV drug. It also does not provide information on the quality of ARV drug storage, delivery, and distribution.
Additional considerations	In some situations, simply monitoring stock-outs could be misleading because a facility may keep reserve stock but maintains a policy of not issuing the reserve stock. These facilities would not be counted as having experienced a stock-out using this indicator definition, even though a patient would not be receiving a required ARV drug for treatment. In settings where reserve stock is not issued during ARV stock-outs, it is preferable to collect information on a functional stock-out (i.e., the inability to access or make use of a required ARV drug).
Data utilization	If stock-outs exist, assess whether the problem lies in the national distribution system or if it is a financial flow problem or a global ARV shortage problem. Find out whether the reason is due to projections of supply order or the distribution system or any other issue. Use this as an opportunity to see whether LMIS is functioning.
Data Quality Control and Notes for the Reporting Tool	Comment on whether the data is based on national data or survey data from a sample of facilities. Please provide any other comments that would help the interpretation of data (e.g. if only public or private sector data is included, and whether it may be an over- or underestimate).
Other References	Harmonized monitoring and evaluation indicators for procurement and supply management systems.

For PAHO:

4.5 Late HIV diagnoses: Percentage of HIV positive persons with first CD4 cell count < 200 cells/µL in 2012 (new for global reporting)	
Rationale	As countries scale-up HIV services, it is important to monitor whether people are diagnosed at an earlier stage (or what percentage is still diagnosed at a late stage).
What it measures	This indicator measures the proportion of people with a CD4 cell count <200 cells/µl out of those who had a first CD4 count during the reporting period.
Numerator	Number of HIV-positive people with first CD4 cell count <200 cells/µl in 2012
Denominator	Total number of HIV-positive people with first CD4 cell count in 2012

4.6.a HIV care Number of adults newly enrolled in pre-antiretroviral therapy (pre-ART) during the reporting period (2012)	
Rationale	In addition to ART, it is important to monitor pre-ART initiation. There are a significant number of people who are diagnosed with HIV but may not be eligible to start ART according to the national criteria. Enrolling this population in longitudinal pre-ART care is important and people in pre-ART will eventually progress to need ART and should be enrolled in pre-ART.
What it measures	Number of adults newly enrolled in pre-antiretroviral therapy during the reporting period (2012) Yearly evolution of the number of patients newly enrolled in pre-ART.
How to Measure and Measurement Tools	Facility pre-ART registers. By counting the number of patients who are newly enrolled in pre-ART within the reporting period.
Disaggregation	By male and female By public and private These and other disaggregations to be included if available in the Comments box
Strengths and weaknesses	This indicator permits monitoring trends in enrolment in pre-ART but does not attempt to measure the details nor the quality of pre-ART care provided. It also does not capture retention during the pre-ART period.
Additional considerations	People on the ART 'waiting list', i.e. patients eligible for ART and not initiated, are often listed in the pre-ART register. The number of people retained on pre-ART is also important to review when possible, to ensure people with HIV are engaged in care even if ART has not been initiated. Some countries record all patients in pre-ART even if they are eligible to start ART by enrolling them, and then transferring them to the ART register; in other cases, patients eligible for ART may be immediately recorded only in ART registers, for example if pre-ART registers do not exist. This is important to keeping in mind when reviewing related data.
Data utilization	Reviewing the number of people initiating pre-ART with the number of people diagnosed HIV+, and the number of people initiating ART (previous question) provides information on trends in initiation to pre-ART and ART programmes.

Data Quality Control and Notes for the Reporting Tool	Double Reporting: If patients transferred in and out are not correctly registered, there is a risk for double reporting which could lead to an overestimation of pre-ART initiation. If this is the case, please comment. Similarly if patients temporarily stopping pre-ART and restarting are coded as new patients, this will overestimate the true number of patients newly enrolled in pre-ART. National Representativeness: the numerator is a national cumulative indicator, usually produced by all health facilities. Please comment on your data as necessary. Triangulation Options: Reviewing the number of people diagnosed with HIV.
Other References	

4.6.b HIV care Number of adults newly enrolled in HIV care (pre-ART or ART) during the reporting period (2012)	
Rationale	The total number of people newly enrolled in HIV care (pre-ART or ART) provides information on how many HIV+ people are initiating HIV care in the health system. The number can be compared with the number of people newly diagnosed with HIV to assess uptake of care and treatment services in people newly diagnosed with HIV.
What it measures	Number of adults newly enrolled in pre-ART or ART during the reporting period (2012) The number should represent the number of people who have accessed pre-ART/ART services for the first time in the year
How to Measure and Measurement Tools	Facility pre-ART and ART registers, depending on the country's monitoring system. Count the number of patients who are newly enrolled in pre-ART/ ART within the reporting period. If the country's HIV monitoring systems are set up so that all patients are entered into the pre-ART registers even when they are ready to start ART, then only the number of new patients enrolled in pre-ART need to be counted (and the number would be the same as the previous question- the number of adults newly enrolled in pre-ART). If this is not the case, then available data needs to be reviewed and aggregated accordingly.
Disaggregation	By male and female By public and private These and other disaggregations to be included if available in the Comments box
Strengths and weaknesses	This indicator permits monitoring trends in enrolment in HIV care (pre-ART and ART) but does not attempt to measure the quality nor retention in HIV care.
Additional considerations	Most countries report the number of people newly initiated on ART as part of the number newly enrolled in pre-ART; then those needing ART are transferred from the pre-ART register to the ART register. If people starting ART are not recorded in the pre-ART register, then one possible

	way to calculate the numerator is by adding the number newly enrolled in pre-ART with the number newly enrolled in ART and subtracting the number of people who transferred from pre-ART to ART in a given year. However, in many settings with paper-based monitoring systems, it may not be feasible to easily know the number of people who transferred from pre-ART to ART at the national level unless the national cross-sectional reporting form is set up to report up this information.
Data utilization	Reviewing the number of people newly enrolled in HIV care (initiating pre-ART/ ART) with the number of people newly diagnosed HIV+ can provide an indication of uptake of HIV care among those diagnosed HIV+.
Data Quality Control and Notes for the Reporting Tool	Double Reporting: Please comment if there is a strong possibility of double-counting. National Representativeness: Please comment on your data as necessary. Triangulation Options: Reviewing with the number of people diagnosed with HIV, or comparing with previous years.
Other References	This is a new indicator for global reporting, and is the numerator of indicator D-1 in the *HIV testing and counselling M&E guide (field-test version).*

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

5.2 Number of health-care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control	
Rationale	TB infection control is part of the "3 I's" strategy in controlling the TB/HIV epidemics (together with intensified TB case finding and isoniazid preventive therapy)
What it measures	This indicator measures if health facilities receiving a large number of people living with HIV have implemented measures to prevent the risk of person to person transmission of TB
Numerator	Number of health care facilities providing ART services for people living with HIV with demonstrable TB infection control practices consistent with international guidelines
How to Measure and Measurement Tools	Methodology: Facility-level review of written IC policy with yes/no to the following questions. • Is there a written infection control plan? • Is there a person responsible for implementing TB infection control plan? • Is the waiting area well ventilated (e.g. windows and doors open)? • Are TB suspects identified on arrival at the facility and separated from other patients? • Are TB cases reported among health care workers routinely monitored and reported? A positive response to all questions is required for a facility to be identified as having a TB infection control policy that is consistent with international guidelines. A positive answer to the question asking for a written infection control plan requires that a hard copy of the plan be available. Documentation for other components should also be sought Periodicity: collected annually from each facility at the time of supervisory visits and/or external review of TB/HIV activities or HIV programmes review. Measurement tools: facility review checklist
Disaggregation	None
Strengths and weaknesses	The existence of a written infection control policy that addresses TB and is consistent with international guidelines is the first basic step in ensuring TB infection control in health-care facilities providing (ART) services for people living with HIV. However, the existence of a policy does not mean that it is effectively implemented. Further inquiry will be needed to establish whether the infection control policy is implemented and adhered to. Analysis of policy involves subjective judgment, which can limit its use in cross-national comparisons and for capturing trends over time. This indicator goes a step beyond measuring the simple existence of an infection

	control policy by defining the standards that must be met in order for there to be an acceptable practice that addresses the issue of control of TB infection in health-care facilities providing (ART) services for people living with HIV according to international guidelines, thus eliminating some, though not all, subjective judgment.
Additional considerations	Responsibility: HIV programmes
Data utilization	100% target; all health facilities that offer antiretroviral therapy should have implemented TB infection control to prevent the transmission of TB from person to person
Data Quality Control and Notes for the Reporting Tool	Supervision visits and health facility surveys
Other References	Guide to monitoring and evaluation for collaborative TB/HIV activities available at: http://whqlibdoc.who.int/publications/2009/9789241598194_eng.pdf

5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	
Rationale	To ensure that eligible HIV-positive individuals are given treatment for latent TB infection and thus to reduce the incidence of TB in people living with HIV.
What it measures	Number of adults and children newly-enrolled in HIV care who started on treatment for latent TB infection, isoniazid preventative therapy (IPT)) expressed as a proportion of the total number of adults and children newly-enrolled in HIV care over a given time period.
Numerator	Number of adults and children newly enrolled (i.e. started) in HIV care (pre-ART and ART) who also start (i.e. given at least one dose) isoniazid preventive therapy treatment during the reporting period *HIV care* includes pre-ART and ART.
Denominator	Number of adults and children newly enrolled (i.e. started) in HIV care during the reporting period.
How to Measure and Measurement Tools	HIV treatment card and modified HIV care register. The data needed for this indicator is collected from pre ART and ART registers at the HIV care service sites, depending on where isoniazid preventive therapy (IPT) is to be administered. HIV-positive clients should be screened for TB. Those clients found *not* to have evidence of active TB will be offered IPT according to nationally determined guidelines. All those accepting IPT and receiving at least the first dose of treatment should be recorded. This information is being recorded in an extra column in the HIV care registers. Accurately predicting drug requirements for supply management requires the collection of more detailed information.
Disaggregation	None
Strengths and weaknesses	Treatment of latent TB infection will reduce the incidence of developing TB disease in People living with HIV who are infected with TB but who have no active TB disease. To include clients who are given at least one dose is relatively easy,

	even in resource-limited settings. This information is the minimum necessary to ensure that TB preventive therapy is being offered to HIV-positive clients without evidence of active TB. However, unless further data are collected, this indicator provides no information about how many clients adhere to or complete the TB preventive therapy course. Much greater resources are required to collect more complete data on adherence or completion, but programmes may wish to undertake periodic studies to establish, for example, adherence rates, and the accuracy of the screening questionnaire.
Additional considerations	A pharmacy based TB preventive therapy (INH) register should record client attendance to collect further drug supplies (usually monthly). From this register, facilities would be able to report the number of new, and continuing cases and treatment completion on a quarterly basis. If such information is collected routinely, the indicator of choice would be 'the number of HIV-positive clients completing treatment of latent TB infection, as a proportion of the total number of HIV-positive clients started on such treatment". From pilot testing sites it is apparent that many clients who test HIV-positive can be expected to start TB preventive therapy; some will not meet the eligibility criteria, some will decline and some will drop out during the screening process. The proportion likely to start TB preventive therapy depends on the screening algorithm used (for example, using tuberculin skin test as a screening tool reduces the number that are eligible) and also on the type of facility at which HIV diagnosis is made.
Data utilization	If low value, explore reasons why and compare disaggregated data with the national average to identify places needing special attention and reasons for suboptimal coverage. Explore further available data on completion of TBPT/IPT.
Data Quality Control and Notes for the Reporting Tool	Please provide any comments on whether the data you provide covers the entire country, or is from a selected sample (if so, please provide details on what the data represents, as well as any assumptions made to extrapolate the data to a national figure)
Other References	° A guide to monitoring and evaluation for collaborative TB/HIV activities

5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	
Rationale	This is a process indicator for an activity intended to reduce the impact of TB among people living with HIV. It will demonstrate the level of implementation of the recommendation that people living with HIV are screened for TB at diagnosis and at follow-up visits using their last visit as proxy measure.
What it measures	Number of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit.
Numerator	Number of adults and children in HIV care, who had their TB status assessed and recorded during their last visit. *HIV care* includes pre-ART and ART.
Denominator	Total number of adults and children in HIV care in the reporting period.
How to Measure and	WHO recommends the use of a simplified screening algorithm for intensified TB

Measurement Tools	case findings that includes 4 clinical symptoms: (1) current cough, (2) fever, (3) weight loss and (4) night sweats. Using this simplified algorithm assessment of TB status at every visit during the reporting period ('Yes' if 'no signs', 'suspect' or 'on treatment' and 'No' if TB status not assessed) should be recorded on the patient HIV care/ART card, and transferred onto the pre-ART or ART registers as appropriate at all facilities providing routine HIV care. Enrolled in care includes all those continuing in care and those newly enrolled during the reporting period This data should be analysed and reported together with other cross sectional data at national level. The numerator is taken from the pre ART and ART registers by counting the number of patients who had their TB status assessed during the reporting period. For patients who started on ART during the reporting period, care should be taken to count them in the ART register and not in the pre-ART register. The denominator for pre-ART patients will be those seen for care during the reporting period. The denominator for ART patients will be those current on ART during the reporting period. The denominator is taken from the pre-ART and ART registers by counting the number of patients with a visit during the reporting period. This is then recorded on the cross sectional reporting form. TB and HIV programmes should collaborate to ensure that agreed criteria for identifying a TB suspect and methods of TB screening are used that are consistent with TB control programme protocols.[7]
Disaggregation	None
Strengths and weaknesses	TB status assessment among people living with HIV, followed by prompt referral for diagnosis and treatment, increases the chances of survival, improves quality of life and reduces transmission of TB in the community. TB status assessment identifies HIV-positive clients who show no evidence of active TB and would benefit from treatment with isoniazid for latent TB infection. The indicator does not measure the quality of intensified TB case-finding nor does it reveal whether those identified as suspects are investigated further or effectively for TB. However, it does emphasize the importance of intensified TB case-finding for people living with HIV at diagnosis and at every contact they have with HIV treatment and care services. Programmes should aim for a high value for this indicator (close to 100%) but should interpret it in conjunction with values of indicators related to the % of people in HIV care who are: a) on TB treatment and b) who were given treatment for latent TB infection, to ensure that appropriate action follows the screening process. A low value will demonstrate that Objective B - reducing the impact of TB among people living with HIV - is unlikely to be met.
Data utilization	See section on Strengths and Weaknesses for interpretation of data and further areas to explore. If low value, review disaggregated data and explore reasons why.
Data Quality Control	Please provide any comments on how this data was collected and any

7 A suggested method of conducting the screening would be to ask HIV-positive clients whether they are currently on TB treatment. If not, they are then asked about the key symptoms of TB disease (e.g. cough > 2 weeks, persistent fever, night sweats, unexplained weight loss and lymphadenopathy). A simple checklist could be used and any positive response would indicate that the individual may be a TB suspect. If on questioning they are defined as a TB suspect (as per national protocols) they should be investigated for TB (or referred to TB service for investigation) and treated appropriately. Those found not to have TB should be offered six months of isoniazid preventive therapy (IPT))

and Notes for the Reporting Tool	assumptions made in establishing a national estimate.
Other References	A guide to monitoring and evaluation for collaborative TB/HIV activities

Policy questions, relevant questions for all 10 targets

P.1b WHO Policy Questions (UA 2012 indicator 7.1b)	
Surveillance	Ia. Does the country carry out sentinel surveillance in: Indicate: systematic surveillance conducted, periodicity (every X years), location, year last survey (i) ANC attendees? (ii a) key populations at higher risk: sex workers? (ii b) key populations at higher risk: people who inject drugs? (ii c) key populations at higher risk: men who have sex with men? (iii) Other specific populations (please specify below)? Other: adolescents (10-19) Ib. Does the country carry out DHS surveys with HIV testing? (Yes/No) When was the last survey done?
Monitoring and evaluation	IIa. Does the country have a national M&E plan covering HIV/AIDS response in the health sector? (with identified collection tools and clear indication of data flow to collect national indicators based on, and harmonized where appropriate with, internationally recognized indicators) (Yes/No) IIb. When was a review of the M&E system last conducted for (i) ART? Year: (ii) PMTCT? Year: (iii) HIV T&C? Year: IIc. Does the country have a national M&E plan covering HIV/AIDS response in the health sector?(with identified collection tools and clear indication of data flow to collect national indicators based on, and harmonized where appropriate with, internationally recognized indicators (Yes/No). Please share your national M&E plans and monitoring tools (registers, patient cards, reporting forms). Please upload or send them via e-mail to WHO at hivstrategicinfo@who.int. Do you have plans to review your M&E system in the future? (yes/no) If yes, year: What are key challenges related to health sector HIV M&E in your country? What kind of guidance, tools, assistance, can help support your M&E system?
HIV drug resistance (HIVDR)	IIIa. Does the country have an HIV drug resistance prevention and assessment strategy in place? (Yes/No) IIIb. Does the HIVDR prevention and assessment strategy include the following elements: (i) Regular evaluation of HIVDR "early warning" indicators from ART sites? (ii) Surveys to monitor HIVDR prevention and associated factors in sentinel ART sites?

	(iii) Surveys to monitor performance against the HIVDR "early warning" indicators in all ART sites? (iv) Surveys of HIVDR among people newly infected with HIV (threshold surveys) or among treatment-naïve people about to start ART in one or more areas where ART has been widespread for 3 years or more? (v) Preparation of national annual HIVDR report and recommendations?
Comments and suggestions	Please add comments regarding HIV surveillance or M&E systems.
Policy and programmatic questions related to testing and counselling	Does the country have a national policy on HIV testing and counselling (TC)? If yes, does the policy promote provider-initiated TC in health facilities? Does the country have national guidelines on how to implement provider-initiated testing and counselling (PITC) at health facilities? For generalized epidemic countries: Does your policy/guidelines state that providers should initiate TC in all patient encounters (regardless of presenting symptoms or facility type)? For low-level or concentrated epidemic countries: Does your policy/guidelines indicate that providers should target most-at-risk and vulnerable populations with TC (according to the country's epidemic profile)? Does the country have a policy that states that HTC should be recommended but must not be mandatory? Does the country conduct community-based testing approaches? Does the country have policies that support HIV rapid testing (point of care) done by lay workers? Was HIV testing done systematically under any circumstance? (please specify) Was HIV testing done systematically for any group? (please specify)
Policy and programmatic questions related to women and children	PMTCT guidelines revision: As of the end of December 2012, have the PMTCT ARV guidelines been revised to consider the WHO 2010 guidelines or the WHO 2012 programmatic update: If yes, what is the prophylaxis option (Option A/ Option B/ Option B+/other)? If 'other', please specify: Comment: Please also share an electronic copy if possible at hivstrategicinfo@who.int. Have you reviewed your M&E indicators, registers and forms to align them with the new PMTCT guidelines? If yes, are you monitoring ARV coverage during the breastfeeding period? Please explain: What is the national policy for infant feeding in the context of HIV? PMTCT and PITC: As of the end of December 2012, is there a national policy/guideline in place for PITC for pregnant women (provider-initiated testing and counselling, i.e. routine offer, with right to refuse)? PITC in children: Was there a national policy on the routine offer of testing

	children in the following settings? Mark all that are relevant: • Inpatient settings • Nutritional intervention settings at facility and community level: • ART centres: • TB clinics: • Immunization settings: • Stand-alone VCT sites: • Other: • Please specify 'other': • No, not yet implemented: Age: Child card: Was HIV information included on the maternal and/or child health cards by end of 2012? Maternal card: Child card: Please also share an electronic copy, if possible at hivstrategicinfo@who.int. Do you have targets for elimination of MTCT of HIV, for example, a target transmission rate or a target percentage to reduce new infections among young children? (e.g. less than 5% transmission of HIV from mother-to-child by 2015, 90% reduction of new infections among young children by 2015). Please share the indicator(s), target(s), and target year(s)." What are some challenges faced in scaling up PMTCT towards the elimination of new paediatric HIV infections and keeping mothers alive (E-MTCT)? Do you have a national plan for elimination of MTCT of syphilis? Please share any specific plans, indicators, targets and target year(s).
Policy and programmatic questions related to people who inject drugs, sex workers and men who have sex with men	Which of the following components of the comprehensive package of HIV prevention, treatment and care interventions for people who inject drugs are implemented in the country? (Yes/No) (1) Needle and syringe programmes (NSP) (2a) Opioid substitution therapy (OST) (2b) Other drug dependence treatment (3) HIV testing and counselling (4) Antiretroviral therapy (5) Sexually transmitted infection (STI) prevention and treatment (6) Condom programming for injecting drug users and their sexual partners (7) Targeted information, education and communication (IEC) (8) Viral hepatitis diagnosis, treatment and vaccination

	(9) Prevention, diagnosis and treatment of tuberculosis among people who inject drugs Which of the following components of the comprehensive package of HIV prevention, treatment and care interventions for sex workers are implemented in the country? (Yes/No) (1) Targeted condom programming (2) HIV testing and counselling (3) Antiretroviral therapy and care (4a) Symptomatic STI treatment (4b) Asymptomatic STI treatment (4c) Periodic presumptive STI treatment (5) Comprehensive package of interventions for SW who inject drugs, including evidence based interventions for non-opioid dependence such as alcohol and ATS (6) Empowerment of sex workers (participation in planning and implementation of HIV/AIDS/STI prevention and care activities) Which of the following components of the comprehensive package of HIV prevention, treatment and care interventions for men who have sex with men are implemented in the country? (Yes/No) (1) Consistent condom use promotion (2) Individual level and community level interventions (3) Sex venue-based prevention interventions (4) Social marketing campaigns (5) Internet-based prevention (6) HIV testing and counselling (7) Antiretroviral therapy and care (8) STI management; including screening for asymptomatic gonorrhoea, chlamydia and syphilis (9) Hepatitis B vaccination (10) Comprehensive package of interventions for men who have sex with men who inject drugs, including evidence based interventions for non-opioid dependence such as ATS
Policy and programmatic questions related to human resources	Please elaborate: • How many physicians in your country are involved in HIV/AIDS treatment and care? • Does the country have a policy for nurse/non-physician initiation of ART? • Does the country have a policy for nurse/non-physician maintenance of ART? • Does the country have a policy to engage community health workers in patient support?
Policy and programmatic questions	Does your country have a policy (in the public sector) to provide for free the

related to health financing	following: • Drugs for ART? • CTX? • Laboratory monitoring? • HIV testing? • Drugs for OI management? Does your country and international donors in your country (Global Fund, etc) have enough financial resources to procure ARVs for all who need it? How is the need for ART calculated for procurement?
Policy and programmatic questions related to antiretroviral therapy	When were the national ART guidelines last updated? Please also share an electronic copy if possible. Is there a mechanism for updating guidelines to respond to 'Rapid Advice' Does the country have a phase out plan for d4T use (following WHO 2010 recommendations) Does the country use fixed-dose ART combinations in preference Does the country have a phase in plan for viral load access (following WHO 2010 recommendations) Does the country use Point-of-Care CD4 technology?
TB/HIV policy and programmatic questions	Does the country have guidelines on isoniazid preventive therapy (IPT) for people living with HIV? Does the HIV programme include IPT as part of its essential approach to HIV care? Is ART provided in TB clinics? Is TB medication provided in ART clinics? Is there a policy to provide ART to TB patients irrespective of CD4?
Policy and programmatic question related to care	Are there national guidelines on CTX provision for HIV patients? If yes, when were they last updated? Has your country established a national policy for nutritional support for people living with HIV and their families? If yes, does the policy include: • Nutritional counselling? • Supplementary food support? • Food security?
Hepatitis B and C (HBV, HCV)	Number and percentage of HIV+ tested for HBV Number and percentage of HIV+ tested for HCV Number and percentage of HIV+/HBV coinfected that received ART (and other treatment for HBV) Number and percentage of HIV+/HCV coinfected who receive ART (and HCV treatment)

Notes

Notes

The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners to maximize results for the AIDS response. Learn more at unaids.org and connect with us on Facebook and Twitter.

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The purpose of these guidelines is to provide countries with technical guidance on how to measure the core indicators for the monitoring of the 2011 UN Political Declaration on HIV/AIDS. These guidelines provide technical guidance on the detailed specifications of the core indicators, on the information required and the basis of their construction, and on their interpretation. The guidelines also aim to maximize the validity, internal consistency and comparability across countries and over time of the indicator estimates obtained. In particular, the guidelines aim to ensure consistency in the types of data and methods of calculation employed.

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