UNAIDS 2021

GUIDANCE

Global AIDS Monitoring Framework 2022–2026

Framework for monitoring the 2021 Political Declaration on AIDS

Contents

Summary of components for 2022 Global AIDS Monitoring

Commitments of the 2021 Political Declaration on AIDS

Indicator number	Short indicator name
Reduce the annual number of people newly infected with HIV	
1.1	HIV incidence
Reduce the annual number of people dying from AIDS-related causes	
2.7	AIDS-related mortality
Commitment 1. Effective implementation of combination HIV prevention	
1.2	Estimates of the size of key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, prisoners)
1.3	HIV prevalence among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, prisoners)
1.4	HIV testing and knowledge of result among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)
1.5	Condom use among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)
1.6	Coverage of HIV prevention programmes among key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)
1.7	HIV prevention programmes in prisons
1.8	Safe injecting practices among people who inject drugs
1.9	Needles and syringes distributed per person who injects drugs
1.10	Coverage of opioid substitution therapy
1.11	People who received PrEP
1.12	Prevalence of male circumcision
1.13	Annual number of males voluntarily circumcised
1.14	Condom use at last high-risk sex
1.15	Annual number of condoms distributed
1.16	Young people: knowledge about HIV prevention
Commitment 2. HIV testing, treatment and viral suppression	
2.1	People living with HIV who know their HIV status
2.2	People living with HIV on antiretroviral therapy
2.3	People living with HIV who have suppressed viral loads
2.4	Late HIV diagnosis
2.5	HIV testing volume and positivity
2.6	Antiretroviral therapy coverage among people living with HIV in key populations
Commitment 3. Vertical transmission of HIV, syphilis and hepatitis B	
3.1	HIV testing in pregnant women
3.2	Early infant diagnosis
3.3	Vertical transmission of HIV
3.4	Preventing vertical transmission of HIV.[1]
3.5	Syphilis among pregnant women
3.6	Congenital syphilis rate
3.7	Hepatitis B among pregnant women
Commitment 4. Gender equality, and empowerment of women and girls	
4.1	New Physical and/or sexual violence experienced by key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)
4.2	New Attitudes towards violence against women

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

Indicator number	Short indicator name
Commitment 5. Community leadership	
A measure of community leadership in combination prevention programmes for key populations is captured in Indicator 1.6, and for specific elements of harm reduction programmes for people who inject drugs in Indicators 1.9 and 1.10. See page 33 for more details.	
Commitment 6. Realizing human rights and eliminating stigma and discrimination	
6.1	Discriminatory attitudes towards people living with HIV
6.2	New Internalized stigma reported by people living with HIV
6.3	New Stigma and discrimination experienced by people living with HIV in community settings
6.4	Experience of HIV-related discrimination in health-care settings
6.5	New Stigma and discrimination experienced by key populations
6.6	Avoidance of health care among key populations because of stigma and discrimination (Sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people)
6.7	New People living with HIV seeking redress for rights violations
Commitment 7. Universal health coverage and integration	
7.1	Viral hepatitis among key populations
7.2	Hepatitis C testing among those on antiretroviral therapy
7.3	People coinfected with HIV and Hepatitis C virus starting Hepatitis C virus treatment
7.4	Syphilis prevalence among key populations (sex workers, gay men and other men who have sex with men, transgender people)
7.5	Men with urethral discharge
7.6	Gonorrhoea among men
7.7	Co-management of tuberculosis and HIV treatment
7.8	People living with HIV with active tuberculosis disease
7.9	People living with HIV who started tuberculosis preventive treatment
7.10	People living with HIV on antiretroviral therapy who completed a course of tuberculosis preventive treatment
7.11	Cervical cancer screening among women living with HIV
7.12	New Treatment for pre-cervical cancer for women living with HIV
7.13	New Treatment for invasive cervical cancer for women living with HIV
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Commitment 8. Investments and resources	
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8.2	Antiretrovirals: unit prices and volume
8.3	HIV expenditure by origin of resources

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

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

Information from people in humanitarian situations through follow-up of sources as identified by individual countries.

For the detailed list of indicators and all GAM documents please see:
https://www.unaids.org/en/global-aids-monitoring

Introduction

1.1 Background

United Nations (UN) Member States adopted the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 at the *UN General Assembly High-Level Meeting on AIDS* in June 2021.[2] The 2021 Political Declaration on AIDS highlights the importance of identifying inequalities in order to end AIDS as a public health threat by 2030. If the international community achieves the full range of targets in the Declaration in all geographic areas and across all populations, then the global AIDS response will be on track to prevent 3.6 million new HIV infections and 1.7 million AIDS-related deaths by 2025.

The 2021 Political Declaration on AIDS is based on the Global AIDS Strategy 2021–2026: End Inequalities, End AIDS, a bold new approach that uses an inequalities lens to identify and close the gaps that are preventing progress towards ending AIDS.[3] Shifting to an inequalities lens aims to ensure that the global HIV response works for everyone and leaves no one behind. The focus of the Global AIDS Strategy 2021–2026 is to reduce the inequalities that drive the AIDS epidemic by prioritizing people who are not yet fully benefitting from life-saving HIV services and to remove the structural barriers that create or maintain those inequalities and prevent access to services. The Strategy sets out evidence-informed priority actions with ambitious 2025 targets to reduce inequalities and get every country and every community on track to end AIDS as a public health threat by 2030 (Annex 1).

A successful AIDS response should be measured by the achievement of concrete, time-bound targets, accompanied by careful monitoring of the progress in implementing the commitments of the 2021 Political Declaration on AIDS. This document relates to the new Global AIDS Monitoring (GAM) framework, which helps to structure and organize collective global monitoring efforts.

How to use this guidance

This framework document has been developed to help countries set up, modify and improve their data collection systems and report on their national HIV response as effectively as possible. It outlines the steps in the process of identifying sources, engaging national stakeholders, consulting on findings and reporting on them as part of GAM. Setting up such a mechanism serves two purposes: 1) it enables governments to monitor their progress towards ending AIDS by 2030; and 2) it engages national constituents in a multisectoral partnership and dialogue to address HIV and contribute to positive societal outcomes.

A separate document with the complete indicators for GAM 2022 is available to help structure and organize collective monitoring efforts in order to reach the global midterm targets set for 2025.[4] It lists the indicators for GAM and provides further details of each indicator, giving reasons for their inclusion and providing methods for collecting, constructing and measuring them. The respective strengths and weaknesses of the indicators are also discussed. Guidance on new indicators is included to monitor some aspects and consequences of inequalities, as advanced through the targets in the 2021 Political Declaration on AIDS and Global AIDS Strategy 2021–2026.

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

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

[4] For all GAM-related technical docuuments, please see: https://www.unaids.org/en/global-aids-monitoring

1.2 Purpose

The purpose of this document is to describe the new GAM framework and its use for national AIDS programmes and partners, and to provide recommendations on preparations to effectively measure and report on the country's HIV response.

Specifically, the document is intended to:

- Provide background to the monitoring approach, indicator selection and development, based on 2021 Political Declaration on AIDS.
- Show the alignment of the GAM framework with the Sustainable Development Goals (SDGs).
- Describe an approach to data collection for inequalities, including new indictors that reflect the Political Declaration commitments.
- Describe ways to strengthen data collection and reporting on the country HIV response.
- Provide a structure for stronger community involvement in data collection and reporting.
- Suggest ways to ameliorate the burden of data reporting.

While the information provided by countries through the GAM and other data collection efforts forms the basis for UNAIDS' annual publications on the HIV and AIDS response, the monitoring framework is also used by the UN Secretary-General (UNSG) when issuing annual progress reports to the UN General Assembly that compile the results from country reports. The annual UNSG progress reports are designed to identify challenges and constraints, and to recommend actions to accelerate the achievement of targets.

Figure 1
The Sustainable Development Goals

Source: Make the SDGs a Reality. In: SDGS.un.org [Internet]. United Nations Department of Economic and Social Affairs; c2021 (https://sustainabledevelopment.un.org/).

1.3 Links with the Sustainable Development Goals

Ending AIDS is an important aim of the Sustainable Development Goals (SDGs). It is addressed directly in Sustainable Development Target 3.3: that by 2030, countries should end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. Data provided through the GAM are used to report on progress towards this target, most specifically the indicator on HIV incidence.

Progress on all SDGs is interdependent, and so this target can only be achieved when it is linked with reaching other related SDGs through the integration of the global HIV response into the broader development agenda.

Besides SDG 3 (Ensure healthy lives and promote well-being for all at all ages), there are several of the SDGs that are particularly linked to the response to HIV and AIDS. Those SDGs are listed here and should be considered when taking a holistic view of a country's AIDS response and monitoring.

Goal 1: End poverty in all its forms everywhere.

Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

Goal 5: Achieve gender equality and empower all women and girls.

Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.

Goal 10: Reduce income inequality within and among countries.

Goal 11: Make cities and human settlements inclusive, safe, resilient, and sustainable.

Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

Goal 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development.

Linking these SDGs also contributes to the construction of the GAM framework. Data for these SDGs are reported through the SDG process, and they are not collected as part of GAM reporting. Other complementary data from external sources, including from other agencies, are available separately to support analysis and review of the national AIDS response. For the full list of SDG and other complementary reporting, please see Annex 2.

2. Measuring progress in the AIDS response

2.1 Focusing on ending inequalities

The 2016 Political Declaration on AIDS and the associated GAM monitoring framework (2016–2021) were structured around the 10 Fast-Track areas, with a focus on increasing the pace of scaling up services. The evidence behind the new global AIDS targets, the Global AIDS Strategy 2021–2026 and the 2021 Political Declaration on AIDS have all made it clear that without addressing inequalities in the AIDS response, the end of AIDS by 2030 will not be possible.[5]

The new GAM organizing framework for monitoring progress towards the global targets is based on the structure of the 2021 Political Declaration on AIDS. It uses eight core focus areas, which are linked to the three global AIDS strategic priorities (see Table 1).

The high-level targets from the 2021 Political Declaration on AIDS are provided in Annex 1 for easy reference.

Table 1.
Global AIDS Monitoring organizing framework

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

[5] For more on the evidence base for the Strategy, please see: Evidence review: implementation of the 2016–2021 UNAIDS Strategy on the Fast-Track to End AIDS. 47th Programme Coordinating Board meeting, 15–18 December 2020. Geneva: UNAIDS; 2020 (https://www.unaids.org/sites/default/files/media_asset/PCB47_CRP3_Evidence_Review_EN.pdf).

Monitoring of progress has often focused on national-level indicators, but these national indicators have masked inequalities. The new global AIDS targets, the Global AIDS Strategy 2021–2026 and the 2021 Political Declaration on AIDS clearly state that the end of AIDS by 2030 is not possible without addressing the inequalities between people and populations when it comes to accessing services and resources, and to enjoying their rights. Inequalities are evident if data are broken down and presented for each of the target areas by subpopulation.

Table 2 outlines examples of inequalities and the approach of the GAM monitoring framework to measuring them.

Table 2.
Approaches to monitoring inequalities in different strategic focus areas

Political Declaration on AIDS strategic focus areas		Examples of inequality	Solutions in monitoring
1	Combination HIV prevention for all	Insufficient resources and inequitable focus on preventing new HIV infections among key populations and their sexual partners and adolescent girls and young women in sub-Saharan Africa	Measure funding and service delivery and behaviour changes with available disaggregations, including geographical locations, age groups and for different key populations
2	95–95–95 for HIV testing and treatment	Inequalities in resource allocation and treatment access and outcomes to meet specific needs of underserved populations	Measure funding and service delivery with available disaggregations including geographical locations, age groups and for different key populations
3	End paediatric AIDS and eliminate vertical transmission	Inequitable service provision, engagement and access for pregnant women, newborns and children	Measure service delivery with available disaggregations including geographical locations and age groups
4	Gender equality and empowerment of women and girls	High level of gender-based violence, unequal gender norms and poor access to sexual and reproductive health services	Measure differences between and within countries with available disaggregations, including geographical locations, age groups and for different key populations
5	Community leadership	Community-led organizations are not able to meaningfully participate in programme development, implementation and monitoring	Ensure participation in filling out NCPI Part B and the narrative report, and report on legal and policy barriers or enablers for civil society space and community-led organizations' meaningful participation, including key population-led and women-led organizations[6]
6	Realize human rights and eliminate stigma and discrimination	Restrictive legal and policy frameworks and stigma and discrimination that pose barriers to services	Reporting on laws and policies, actions to reform them, and increased reporting on stigma and discrimination
7	Universal health coverage and integration	Multiple structural barriers and health issues produce a cumulative negative effect for people living with and affected by HIV	Reporting on laws, policies and practice that promote access to services that integrate prevention and management of HIV with other diseases
8	Investments and resources	Low investments in the AIDS response and key population programmes, and high drug prices and out-of-pocket expenditures for health	Disaggregated analysis of AIDS spending and donor dependency, and monitoring of drug prices and costs to people

[6] NCPI Part B is included in the GAM in alternate years.

2.2 Indicators and reporting volume

Each strategic focus area is measured by a set of quantitative indicators and through questions about laws and policies, including qualitative reporting, as collected though the NCPI.

Over the past 20 years, the indicators used for global monitoring have evolved as our collective knowledge of effective HIV responses and the barriers to this have improved. This will continue in the coming years. The indicators will be reviewed annually and revised by an advisory body: the UNAIDS Monitoring Technical Advisory Group (MTAG). Members of this group include international, country and community representatives, human rights experts and technical experts in HIV monitoring. The MTAG was integral to the monitoring update in response to the Global AIDS Strategy 2021–2026 and the 2021 Political Declaration on AIDS.

Within the GAM framework, the majority of indicators (63) are directly matched to targets. Additionally, the framework includes related indicators (13) that provide important insights and context for the national response to support data interpretation. These are all to be reported by the national rapporteurs, with some of the data prefilled for their verification.[7]

Multisectoral approach

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

[7] The national AIDS rapporteur is a person formally nominated by the government who is responsible for submitting the annual report to UNAIDS on a country's progress towards ending AIDS by 2030. UNAIDS grants the rapporteur access to the online reporting tool, which is used to submit the report and data.

Table 3.
Share of indicators by Political Declaration strategic focus areas

Political Declaration strategic focus areas		Indicators fully matching the target	Related indicators	Related data from other sources, outside of GAM reporting	Total number	% share
1	Combination HIV prevention for all	14	4	3	21	23%
2	95–95–95 for HIV testing and treatment	7	2	2	11	12%
3	End paediatric AIDS and eliminate vertical transmission	8	2	2	12	13%
4	Gender equality and empowerment of women and girls	3	0	1	4	4%
5	Community leadership	3	0	0	3	3%
6	Realize human rights and eliminate stigma and discrimination	13	2	0	15	16%
7	Universal health coverage and integration	12	3	8	23	25%
8	Investment and resources	3	0	0	3	3%
# of indicators		63	13	16	92	
% share		68%	14%	17%	100%	

The indicators specified as "Related data from other sources" include data from other SDGs or other programme data that are highly relevant to the AIDS response. Such data are compiled from external sources and do not require data collection by the national rapporteurs. They are used to support and inform the national AIDS reviews and consultations (see the list of indicators in Annex 2).

2.3 Role of communities and community-led organizations

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

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

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

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

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

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

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

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

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

3. Reporting process and timelines

The annual GAM cycle follows specific, well-established steps. This enables different stakeholders, both national and international, to rely on the availability of recent data and to use them to assess progress towards the established global and national AIDS targets.

At the end of each year, UNAIDS provides countries with updated information on the indicators to use. This enables countries to coordinate and manage the national reporting process, submitting their AIDS reporting by 31 March each year. Based on the data reported, in July, UNAIDS publishes the Global AIDS Update report, which is used in different international fora and for programmatic and financial decisions (such as by the Global Fund to Fight AIDS, Tuberculosis and Malaria [the Global Fund], the United States President's Emergency Plan for AIDS Relief [PEPFAR] and others). At the end of September, UNAIDS invites countries to share their mid-year (June) antiretroviral therapy data, which will then inform the World AIDS Day update of 1 December. The World AIDS Day update often highlights thematic issues of specific importance to the global AIDS response.

Figure 2
Principal activities in data reporting and use by UNAIDS

One of the key factors to setting up a successful national AIDS reporting structure is to have clarity on roles and responsibilities within a comprehensive group of partners. This will reduce the burden on individuals and ensure timely reporting. In the following section, we use the point of view of the national AIDS rapporteur to walk through the three main phases—preparation, reporting and follow-up—to show the specific steps of monitoring and reporting on the national AIDS response.

To understand the full reporting process, reference is also made to the complementary global actions and to the production of the HIV epidemiological estimates data. These steps are presented in the form of a flowchart representing the actions at different levels, with some explanatory notes on each step.

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

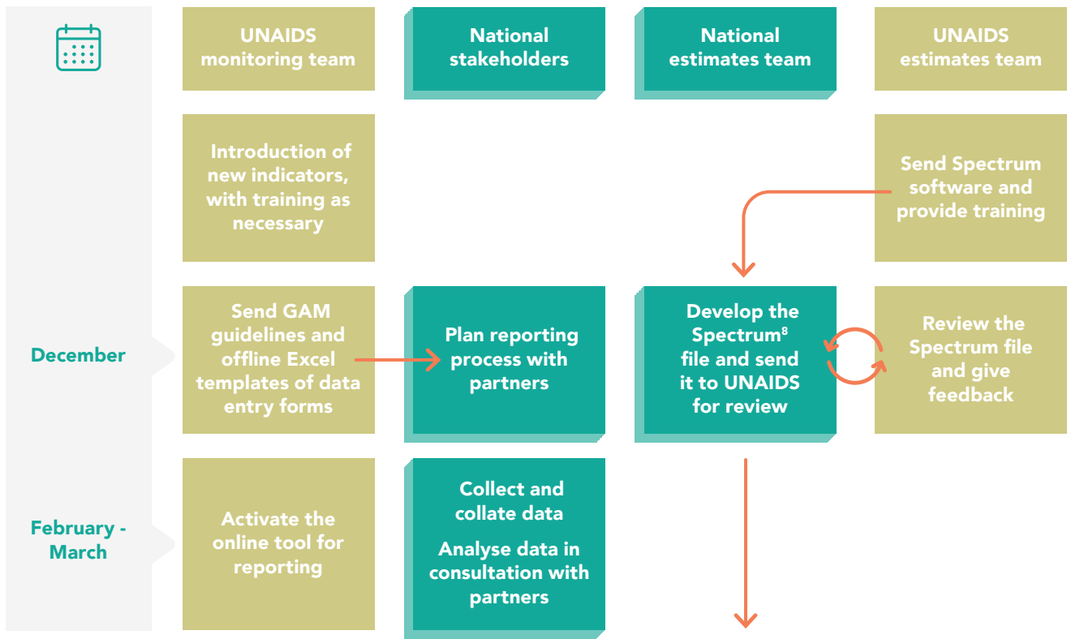
1. The national rapporteur receives a confirmation message from UNAIDS on the reporting process (through AIDSreporting@unaids.org) before 1 February 2022.
2. Identify the indicators where data are available for reporting .
3. Identify focal points to coordinate the completion of the NCPI Parts A (national authority) and B (community representative) in the alternate years that both NCPI parts are included. Ensure access to the guidance provided on reporting the NCPI, especially for questions on laws and policies. Encourage engagement through explaining the significance and use of reported data.
4. Develop and disseminate a plan for collecting data for GAM indicators, the NCPI and the AIDS Medicines and Diagnostics Survey, including timelines and the roles of the national AIDS committee (or equivalent), other government agencies, community and other relevant partners.
5. Identify relevant tools for data collection and sources for each report component, including by:
   - Meeting with the national HIV estimates team.
   - Aligning the data collection timeline with the following as feasible:
     - That of other data collection efforts, including those through funding agencies such as the Global Fund, PEPFAR and UN agencies.
     - The timeline for the aggregation of data at the national level for facility-based indicators.
6. Collect and collate data in coordination with partner organizations from government, communities and international partners, including:
   - Establishing protocols for data processing and management:
     - Basic data cleaning and validation.
     - One database for analysis and reporting purposes.
   - Data vetting.
   - Completing the NCPI (see page xxx for further guidance).

Selecting national indicators

The GAM indicator guidance provides the information needed to construct each indicator, including the following:

- A summary of what the indicator measures.
- A rationale for the indicator.
- A numerator, denominator and calculation.
- Disaggregation of the indicator.
- Recommended measurement tools.
- Measurement frequency.
- Strengths and weaknesses of the indicator (including summary interpretation of the indicator).

Figure 3
Phase 1. Tasks for preparation of data reporting, and data collection



[8] Spectrum is a modelling software supported by UNAIDS to develop estimates of the impact of HIV on populations (see https://hivtools.unaids.org/ for more information). Some of the indicators produced in the software are used in the GAM process.

3.2 National rapporteur's tasks in reporting (March)

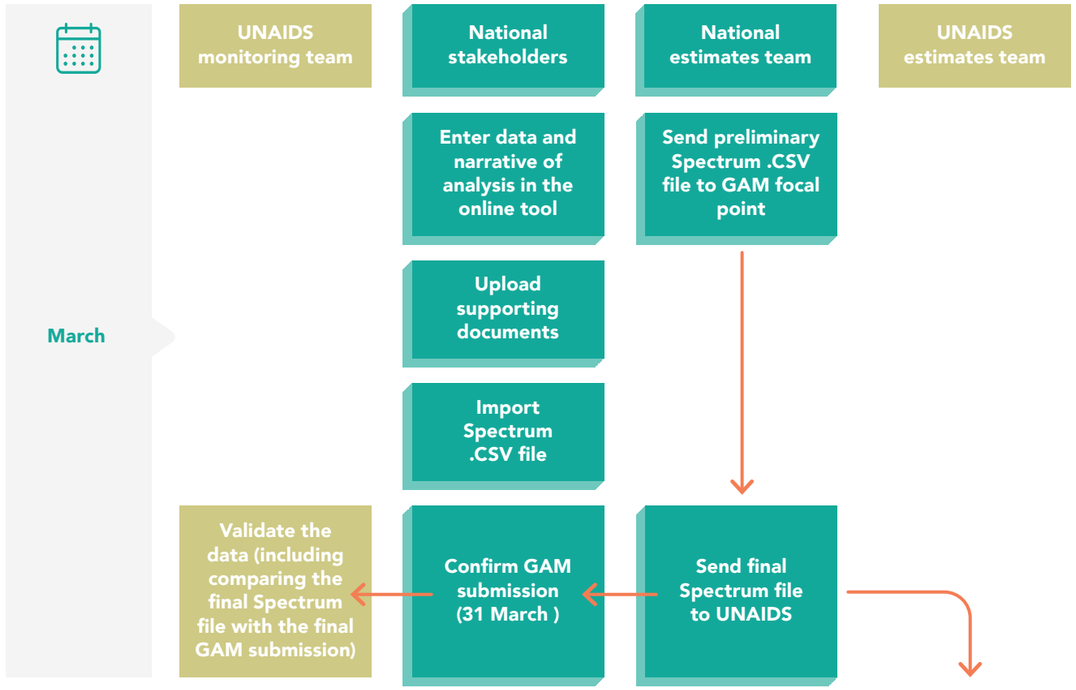
1. Ask the national estimates team to provide the final .CSV file with the estimates from Spectrum.
2. Enter the indicator, NCPI and AIDS Medicines and Diagnostics Survey data into the GAM online reporting tool (https://AIDSreportingtool.unaids.org).
3. Enable stakeholders, including government agencies and communities living with and affected by HIV, to comment on the draft data. Use the online reporting tool ability to share credentials for data viewers.
4. Conduct a validation workshop to analyse indicator data, including on AIDS expenditure and the NCPI, jointly with partner organizations from government, community-led organizations, civil society, and international partners. This is done in order to: (a) identify progress, gaps, challenges and next steps towards achieving each of the commitments and expanded targets to end AIDS by 2030; and (b) reach consensus on the national GAM submission.
5. Summarize the results of this analysis to use when producing the narrative report in the online reporting tool.
6. Upload the final Spectrum file to the designated national estimates folder on or before 1 March 2022.
7. Submit all indicator data, NCPI responses, AIDS Medicines and Diagnostics Survey responses, and narrative summaries by commitment on or before **31 March 2022.**
8. Send the entered data.

The role of communities

Communities play a key role in the response to the AIDS epidemic in countries around the world, and the wide range of expertise within community-led organizations makes them ideal partners in the process of preparing country progress reports. Together with UNAIDS country-level staff members, the national rapporteur is expected to:

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

Figure 4
Phase 2.Tasks in reporting data to UNAIDS

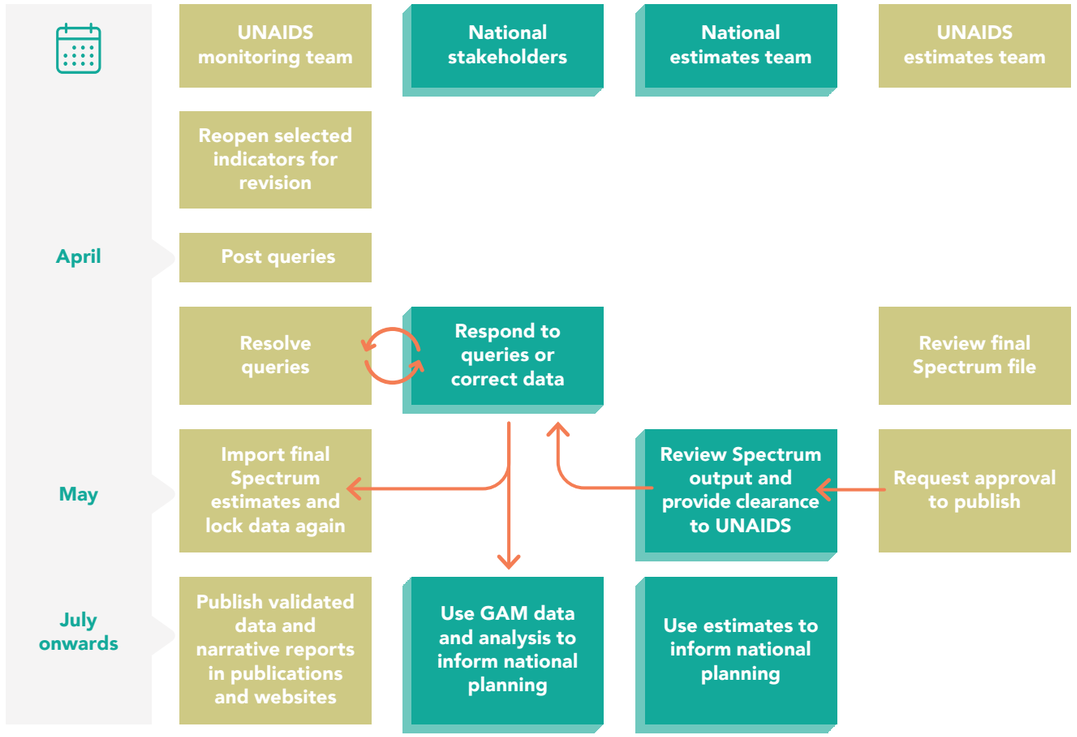


3.3 National rapporteur's tasks in follow-up actions (April–July)

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

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

Figure 5
Phase 3. Tasks in follow-up actions



4. Technical preparations for reporting

The GAM reporting consists of providing data on the following:

- The indicators, including the financial data.
- The NCPI questionnaire.
- The AIDS Medicines and Diagnostics Survey.

A narrative progress report can also be submitted.

GAM reporting should be submitted through the reporting website (https://aidsreportingtool.unaids.org) to enhance the completeness and quality of the data, and to facilitate processing and analysis at the country, regional and global levels.

Countries are encouraged to submit a narrative progress report when submitting GAM data. The online tool incorporates a template for creating a narrative report that consists of brief narrative summaries for each political declaration area. If readily available, countries can instead submit a recent national epidemiology and response overview report. With the approval of the country, UNAIDS will publish the narrative report on its website.

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

The reporting platform supports preparing a narrative report

Once the data is entered, the platform facilitates producing a narrative report, which can ease the consultative process of interpreting the results. This is an important step in the reporting process for communicating progress, identifying gaps and timely course correction in areas where different constituents are engaged.

4.1 Measurement tools and data sources

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

- Nationally representative population-based surveys.
- Behavioural surveillance surveys.
- Specially designed surveys and questionnaires, including surveys of specific population groups (such as specific service coverage surveys).
- Patient tracking systems.
- Health information systems.
- Sentinel surveillance.
- National HIV estimates from Spectrum software (mathematical models).
- Community-led data gathering, for example the stigma index, or community-led monitoring of rights violations.

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

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

In many countries, much of the data required for the national-level indicators may not be available from routine sources. Gathering indicator data may require adapting existing monitoring tools or adding specific surveys. Countries that conduct regular, nationally representative population-based surveys—such as Population-based HIV Impact Assessments or the Demographic and Health Surveys—will collect important information, including behavioural data on young people. In countries where other types of population-based surveys are conducted, including those for purposes other than HIV, surveys can be adapted, in collaboration with community, to collect data for selected indicators.

4.2 Spectrum estimates

A major tool for generating denominators used in GAM reporting is the Spectrum computer package. Spectrum allows countries to create population-level estimates of people living with HIV, pregnant women who need antiretroviral medicine to prevent vertical HIV transmission[9] and HIV-exposed children who need virological testing.[10] In addition, Spectrum allows countries to estimate difficult to measure indicators such as new HIV infections, HIV incidence (the SDG indicator), deaths from AIDS-related illness and the vertical transmission rate. Country teams update their Spectrum files every year using the most recent programmatic and surveillance data. Once completed some of the indicators from this process are submitted through the GAM system. Spectrum files are created by a team of national experts trained on the software. These files are then reviewed by UNAIDS for quality control. Country teams receive information on the estimates process by early December each year.

4.3 Importing Spectrum data into Global AIDS Monitoring

As in previous years, there is the option of importing Spectrum data into the GAM online tool for certain indicators, thereby simplifying the process of completing data entry in the online tool. This step reduces both the data entry required and the chance for errors, and it improves the consistency of data between the two systems.

It is critical that the final set of estimates developed and agreed by the national HIV estimates team is imported into the online reporting tool. Spectrum includes a simple tool to export the estimates required for GAM. The national estimates teams should export their Spectrum results into a .CSV file that the GAM focal point can import into the GAM online reporting tool. Importing the Spectrum estimates into the GAM online tool can be done at any point, and even at multiple times during data entry.

Importing the estimates into the GAM tool requires communication between the national estimates teams and the GAM focal point (if they are separate individuals) to ensure the final file is used.

Tips on importing Spectrum results:

- Before the import process, the GAM focal point should identify which indicators should be imported by responding **Yes** to the question **Take data from the final Spectrum file**. Any data already entered for these selected indicators will be cleared out and replaced by Spectrum data during the import process.
- Even if the national figures for testing, treatment and viral load suppression are imported from Spectrum, the GAM focal point should review the data entry pages for these indicators to enter additional city-specific data, as available.

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

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

Table 4.
Indicative timeline for both Spectrum estimates and Global AIDS Monitoring reporting

Dates*	Activity	Responsible party
December–February	Develop the Spectrum file and have it reviewed by UNAIDS	National estimates team
1 March	Send Spectrum file to UNAIDS	National estimates team
Mid-March	send Spectrum estimates .CSV file to GAM focal point	National estimates team
Mid-March	Import Spectrum estimates into GAM online reporting tool for final review	GAM focal point
Mid-March	Hold stakeholders meeting to approve GAM submission	GAM focal point
31 March	Submit GAM data	GAM focal point
Early April	UNAIDS meets with Global Fund and PEPFAR to review data submitted on treatment and vertical transmission to identify discrepancies.	UNAIDS estimates team
End April	Update Spectrum .CSV file import, if needed	GAM focal point or global estimates team
1 May	Summary of estimates results sent to national AIDS coordinator for sign-off	Global estimates team
Early May	Review output from Spectrum and send clearance to UNAIDS	National estimates team

* This timeline is slightly different for select countries that require early reporting for planning purposes.

Steps for the national estimates team when exporting data from Spectrum:

1. Open the Spectrum software, but do not open your country file.
2. Select **Tools** from the tabs at the top of the page, then select **More tools.**
3. Under **AIM**, select **GAM**. Spectrum will open a dialog box.
4. Click **Add**, select your national file (or subnational files, if available), then click **Open**.
5. Select **Set GAM results file name**. Select the directory where you want to save the .CSV file. Give the file a clear name that reflects the Spectrum file name, then click **Save**.
6. Click **Process** to generate the .CSV file.
7. Email the .CSV file to your GAM focal point, or follow the next set of instructions if you are the GAM focal point.

Steps for the *GAM focal point/national rapporteur* when importing the Spectrum extract into GAM:

8. Log into the GAM online reporting tool (https://aidsreportingtool.unaids.org).
9. Select **Spectrum import** from the top menu.
10. Select **Choose file** and choose the .CSV file to be exported from Spectrum.
11. Click **Preview**.
12. The system will list all of the indicator data from the imported file, side-by-side with any data that have been entered in the system. You may select which set of data to use by ticking **Use entered data** or **Take imported data from Spectrum**.
13. Click **Save** to save the settings and data sets that you have chosen to import, or click **Cancel** to abort the import process.
14. If you have chosen to use the entered data instead of taking data from Spectrum, please be sure to go back to the data entry screens of those indicators to review and enter any missing data.

Indicators that can be imported from Spectrum include the following:

- 1.1 HIV incidence.
  - 0–99+, 15–49, 15–24, 50+ by sex.
  - All ages, <15.
- 2.1 People living with HIV who know their HIV status.
  - All, <15, 15+ by sex, detailed age groups (<5, 5–9, 10–14, 15–19, 20–24, 25–49, 50+).
- 2.2 People living with HIV on antiretroviral therapy.
  - All, <15, 15+ by sex, detailed age groups (<5, 5–9, 10–14, 15–19, 20–24, 25–49, 50+).
- 2.3 People living with HIV who have supressed viral loads.
  - All, <15, 15+ by sex, detailed age groups (<5, 5–9, 10–14, 15–19, 20–24, 25–49, 50+).
- 2.7 AIDS mortality.
  - All, <5, 5–14, 15+ by sex.
- 3.2 Early infant diagnosis
  - Denominator only (estimated number of births to women living with HIV).
- 3.3 Vertical transmission of HIV.
- 3.4 Preventing vertical transmission of HIV.
  - Regimens and coverage.

4.4 Numerators and denominators

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

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

4.5 Disaggregate the data, especially by gender and age

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

Countries are strongly encouraged to make collecting disaggregated data—especially by gender and age, and for specific key populations—one of the cornerstones of their monitoring and evaluation efforts where this can be done in ways that respect the rights and safety of members of key populations. If possible, equity analysis should also be conducted.[11]

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

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

[11] **See:** World Health Organization, UNAIDS. A tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems. Geneva: WHO; 2016. https://www.who.int/reproductivehealth/publications/gender_rights/hiv-srhr-monitoring-systems/en/

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

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

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

4.6 Subnational data

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

Since mid-2014, the online reporting tool has allowed users to submit subnational data or site-specific data for selected indicators. For certain indicators, the tool also prompts users to submit data on high-burden cities or those identified as Fast-Track cities that have committed to ending AIDS by 2030. These data are used to assess progress in the HIV response in these cities. When gathering city-level data for submission, it is highly recommended that relevant city counterparts be consulted.

4.7 Recent and representative survey data

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

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

When calculating indicators based on key population surveys, ensuring that samples are representative of the broader group is a known technical challenge. Methods are being developed to achieve representative sampling of these populations (such as respondent-driven sampling), but while these are being refined, countries may not be confident that the samples used for surveying key populations at higher risk of HIV exposure are representative. Countries are advised to use the most recent survey of key populations that has been reviewed and endorsed by local technical experts (such as monitoring and evaluation technical working groups or national research councils). Countries are encouraged to report all recent high-quality surveys of key populations, by site, in the GAM online reporting tool, along with the numerator, denominator and sample size.

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

New guidance from WHO and UNAIDS suggests that size estimates for gay men and other men who have sex with men should not represent less than 1% of the adult male population.[12] If the size estimate is calculated as less than 1%, the results should be reviewed, as per the guidance.

4.8 Interpretation and analysis

The accompanying GAM guidance[13] (which is updated annually) discusses each indicator, taking into account their strengths and weaknesses in ways designed to improve the accuracy and consistency of the data submitted to UNAIDS. Countries should carefully review this indicator guidance document before beginning to collect and analyse data, since it explains how to analyse each indicator and any potential issues related to interpretation. Specific guidance on responding to the NCPI is provided, including a focus on the laws and policies sections. The points raised in the guidance should be reviewed to confirm the appropriateness of the findings for each indicator before finalizing the reporting and writing the narrative report.

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

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

4.9 Further guidance on submitting data

Countries needing additional information on collecting data for GAM indicators, the reporting tool and/or submission mechanisms should seek technical assistance from their UNAIDS strategic information advisers, UNICEF or WHO offices, or the HIV

[12] **See:** Technical brief: recommended population size estimates of men who have sex with men. Geneva: World Health Organization and UNAIDS; 2020 (https://www.who.int/publications/i/item/9789240015357).

[13] For all GAM-related technical documents please see: https://www.unaids.org/en/global-aids-monitoring

monitoring and evaluation working groups in their country. The UNAIDS Strategic Information Department is also available to provide support, and can be reached via email at AIDSreporting@unaids.org

4.10 Reporting tool and submitting data

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

Similar to previous years, the national rapporteur can also allow other people to view the data, enabling broader country consultation. Viewers can see the information to be submitted, but they cannot change it. The e-tutorials on how to register for a user account or manage user accounts are available on the GAM website (https://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting).

Countries are encouraged to submit data for all indicators where data are available. If countries are not submitting data on an indicator, they should indicate whether it is because the indicator is not considered relevant to the epidemic or because recent, appropriate data are not available. Countries may quickly define the relevance or data availability of each indicator through the Select **relevant indicators screen**.

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

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

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

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

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

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

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

5. Key population-led organizations and responses

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

5.1 Monitoring the proportion of selected prevention services that are key population-led in Global AIDS Monitoring 2022

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

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

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

5.2 Definitions

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

For reporting on these indicators, the focus is on key population-led organizations and networks that are defined as being led by the following groups: female, male and transgender sex workers; gay men and other men who have sex with men; people who use drugs, including women who use drugs; and transgender people. Although the specific focus is on obtaining better information about the proportion of prevention services being delivered by organizations that are led by members of key populations, UNAIDS acknowledges that people may belong to more than one group. Furthermore, people living with HIV, prisoners, people with a history of incarceration, migrants, women and young people also may be included within each of the key populations named here.

The reporting on Indicators 1.6, 1.9 and 1.10[14], as well as a number of questions in the NCPI, focuses on these four key populations—sex workers, gay men and other men who have sex with men, people who use drugs and transgender people—and their involvement in the delivery of the selected HIV prevention services, as well as the societal barriers and enablers that prevent or enable access to services and affect risk of acquisition. UNAIDS recognizes that the disaggregated data reported here are a subset of the full picture of all service delivery led by communities, but they do provide valuable preliminary information for monitoring the commitment in the 2021 Political Declaration on AIDS.

[14] Indicator 1.6 Coverage of HIV prevention programmes among key populations
Indicator 1.9 Needles and syringes distributed per person who injects drugs
Indicator 1.10 Coverage of opioid substitution therapy

5.3 How to select the appropriate response category or categories

Key population-led organizations

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

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

Nongovernmental organizations

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

Other

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

5.4 Additional text field: name of the organizations

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

Annex 1.
Commitments and high-level targets from the 2021 Political Declaration on AIDS, organized by strategic focus areas

1. Combination HIV prevention for all

Reduce new HIV infections to under 370 000 by 2025.

Ensure that 95% of people at risk of HIV infection—within all epidemiologically relevant groups, age groups and geographic settings—have access to and use appropriate, prioritized, person-centred and effective combination prevention options.

Reduce the number of new HIV infections among adolescent girls and young women to below 50 000 by 2025.

Ensure availability of PrEP for 10 million people at substantial risk of HIV and PEP for people recently exposed to HIV by 2025.

Ensure 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options.

2. 95–95–95 for HIV testing and treatment

Reduce annual AIDS-related deaths to under 250 000 by 2025.

Ensure that 34 million people are on HIV treatment by 2025.

Achieve the 95–95–95 testing, treatment and viral suppression targets within all demographics and groups and geographic settings, including children and adolescents living with HIV:

- 95% of people living with HIV know their HIV status.
- 95% of people who know their HIV-positive status are accessing treatment.
- 95% of people on treatment have suppressed viral loads.

Ensure that 90% of people living with HIV receive preventive treatment for tuberculosis by 2025.

Reduce tuberculosis-related deaths among people living with HIV by 80% by 2025 (compared to a 2010 baseline).

3. End paediatric AIDS and eliminate vertical transmission

Ensure that 75% of all children living with HIV have suppressed viral loads by 2023 and 86% by 2025, in line with the 95–95–95 HIV treatment targets.

Ensure that 95% of pregnant women have access to testing for HIV, syphilis, hepatitis B and other sexually transmitted infections by 2025.

Ensure that 95% of pregnant and breastfeeding women in high HIV burden settings have access to retesting during late pregnancy and in the post-partum period by 2025.

Ensure that all pregnant and breastfeeding women living with HIV are receiving lifelong antiretroviral therapy, with 95% achieving and sustaining viral suppression before delivery and during breastfeeding by 2025.

Ensure that all HIV-negative pregnant and breastfeeding women in high HIV burden settings—or who have male partners at high risk of HIV in all settings—have access to combination prevention, including PREP, and that 90% of their male partners who are living with HIV are continuously receiving antiretroviral therapy.

Ensure that 95% of HIV-exposed children are tested by two months of age and after the cessation of breastfeeding.

4. Gender equality and empowerment of women and girls

Reduce to no more than 10% the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence.

Ensure that 95% of women and girls of reproductive age have their HIV and sexual and reproductive health-care service needs met, including antenatal and maternal care, information and counselling.

5. Community leadership

Ensure that community-led organizations deliver 30% of testing and treatment services by 2025, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy.

Ensure that community-led organizations deliver 80% of HIV prevention services for populations at high risk of HIV infection by 2025, including for women within those populations.

Ensure that community-led organizations deliver 60% of programmes to support the achievement of societal enablers by 2025.

6. Realize human rights and eliminate stigma and discrimination

Ensure that less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025, through review and reform of discriminatory laws and practices that create barriers or reinforce stigma and discrimination.

Invest US$ 3.1 billion in societal enablers—including law reform, protection of human rights, reduction of stigma and discrimination, promotion of gender equality and elimination of gender-based violence, where appropriate—in low- and middle-income countries by 2025.

Ensure that less than 10% of people living with, at risk of and affected by HIV experience stigma and discrimination by 2025.

7. Universal health coverage and integration

Invest in robust, resilient, equitable and publicly funded systems for health and social protection systems that provide 90% of people living with, at risk of and affected by HIV with people-centred and context-specific integrated services for: HIV and other communicable diseases; noncommunicable diseases; sexual and reproductive health care; gender-based violence; mental health; palliative care; treatment of alcohol dependence; drug use legal services; and other services they need for their overall health and well-being.

Ensure that by 2025, 45% of people living with, at risk of and affected by HIV and AIDS have access to social protection benefits.

Ensure that 90% of people in humanitarian settings have access to integrated HIV services.

Ensure the systematic engagement of HIV responses in pandemic response infrastructure and arrangements, leveraging national HIV strategic plans to guide key elements of pandemic preparedness planning and ensuring that 95% of people living with, at risk of and affected by HIV are protected against pandemics, including COVID-19.

8. Investments and resources

Fully fund the HIV response by increasing annual HIV investments in low- and middle-income countries to US$ 29 billion by 2025 by:

- Mobilizing additional sustainable domestic resources for HIV responses through a wide range of strategies and approaches, including public–private partnerships, debt financing, debt relief, debt restructuring and sound debt management, progressive taxation, tackling corruption and ending illicit financial flows, and identifying, freezing and recovering stolen assets and returning them to their countries of origin.
- Ensuring progressive integration of financing for HIV responses within domestic financing for health, social protection, emergency responses and pandemic responses.
- Fulfilling official development assistance commitments, including the commitment to achieve the target of 0.7% of gross national income as official development assistance and 0.15–0.20% of gross national income as official development assistance to least developed countries and increasing the percentage of official development assistance for the HIV response.

Annex 2.
Related data from other sources

	Data directly related to the political declaration strategic focus areas and reported from sources outside of Global AIDS Monitoring
Combination HIV prevention for all	Percentage of schools that provide life skills-based HIV and sexuality education (SDG 4.7.2, reported by UNESCO)
95–95–95 for HIV testing and treatment	Tuberculosis deaths among people living with HIV (reported by WHO)
End paediatric AIDS and eliminate vertical transmission	Viral suppression at labour and delivery (Reported by WHO)
Gender equality and empowerment of women and girls	Prevalence of recent intimate partner violence (reported through SDG)
Universal health coverage and integration	Proportion of registered new and relapse tuberculosis patients with documented HIV status (reported by WHO)
	Detection of new and relapse tuberculosis cases among people living with HIV (reported through WHO)
	Prevalence of hepatitis C, tuberculosis and HIV in people who inject drugs in prison (reported by UNODC)
	Access to HPV vaccination among school-aged girls in priority countries (reported by WHO)
	Demand for family planning satisfied by modern methods (reported through SDG)
	Adolescent girls, young women and adult women seeking family planning who received an HIV test (Reported by WHO)
	Percentage of people living with, at risk of and affected by HIV and AIDS who have access to one or more social protection benefits (to be finalized; data available through MICS6 and PHIA survey datasets)

Other linked reporting through the SDG process

SDG 1.2.1 Proportion of population living below the national poverty line, by sex and age

SDG 1.3.1 Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable

SDG 1.4.1 Proportion of population living in households with access to basic services

SDG 2.1.1 Prevalence of undernourishment

SDG 4.1.2 School completion rate (lower secondary education)

SDG 4.7.2 Proportion of schools that provided life skills-based HIV and sexuality education in the previous academic year.

SDG 5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

SDG 5.a.1 (a) Proportion of total agricultural population with ownership or secure rights over agricultural land, by sex; and (b) share of women among owners or rights-bearers of agricultural land, by type of tenure

SDG 5.a.2 Proportion of countries where the legal framework (including customary law) guarantees women's equal rights to land ownership and/or control

SDG 5.b.1 Proportion of individuals who own a mobile telephone, by sex

SDG 5.c.1 Proportion of countries with systems to track and make public allocations for gender equality and women's empowerment

SDG 8.1.1 Annual growth rate of real GDP per capita

SDG 8.3.1 Proportion of informal employment in total employment, by sector and sex

SDG 10.2.1 Proportion of people living below 50 per cent of median income, by sex, age and persons with disabilities

SDG Indicator 11.1.1 Proportion of urban population living in slums, informal settlements or inadequate housing

SDG 11.2.1 Proportion of population that has convenient access to public transport, by sex, age and persons with disabilities

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