UNAIDS 2026

GUIDANCE

Global AIDS Monitoring 2026

Indicators and questions to monitor progress towards the Global AIDS Strategy 2026-2031 targets

Contents

Introduction

Background

In 2015, United Nations Member States adopted the 2030 Agenda for Sustainable Development, committing to ending AIDS as a public health threat by 2030. This commitment was reaffirmed in the political declarations on HIV and AIDS adopted at the United Nations General Assembly High-Level Meetings on AIDS in June 2016 and June 2021.

There have been remarkable successes in the HIV response, but there are still important barriers to achieving the 2030 goals.

A set of targets has been recommended by a global task team of experts across government, civil society, donors, academic and public health institutes convened by UNAIDS. These targets define what is required to reach the global goal of ending AIDS as a public health threat by 2030 and sustaining the HIV response after 2030. These will be proposed for adoption by United Nations Member States at the 2026 United Nations High-level Meeting on HIV/AIDS and form the basis for the Global AIDS Strategy 2026–2031.

Within the recommended 2030 targets, 16 topline targets and two impact targets have been defined across six priority areas. A further 50 second-line targets have been recommended that countries should consider in national HIV response strategies and programmes if the 16 topline targets are not being reached.

A successful HIV response should be accompanied by careful monitoring of the progress in implementing targets and commitments. UNAIDS has been mandated to support countries in this monitoring in subsequent political declarations on HIV and AIDS. The Global AIDS Monitoring (GAM) framework helps to structure and organize collective global monitoring efforts.

Data reported globally on the GAM framework will be released by UNAIDS annually through the AIDSinfo website (https://aidsinfo.unaids.org/) and the Global AIDS Update Report. These data will also inform the United Nations Secretary-General's annual progress reports to the United Nations General Assembly, which are designed to identify challenges and constraints, and to recommend actions to accelerate the achievement of targets.

Purpose and principles of GAM

GAM, previously known as United Nations General Assembly Special Session (UNGASS) reporting and Global AIDS Response Progress Reporting (GARPR), has provided the global framework for tracking progress towards global targets and commitments in the HIV response since 2003. The framework has evolved over time as collective knowledge of effective HIV responses and the barriers to this have improved.

Since 2003, countries have been invited to report globally on progress towards these global targets and commitments in the HIV response, initially every two years and annually since 2012.

The indicators and policy questions in this document are designed for use by national AIDS programmes and other government entities and partners to assess a country's HIV response, and to measure progress towards achieving national HIV targets in a standardized way aligned with international standards to enable global aggregation.

UNAIDS is working with key organizations under the umbrella of the Monitoring Technical Advisory Group (MTAG) to review the GAM framework annually. Members of this group include international, country and community representatives, human rights experts and technical experts in HIV monitoring.

GAM reflects key principles that have also defined the HIV response more broadly:

- a multisectoral approach
- country ownership
- community engagement.

2026 GAM framework

The GAM framework has been revised for 2026 reporting to align to the recommended 2030 targets. These reflect the evolution of national HIV epidemics and responses in the context of greater integration of HIV in broader health and development agendas and reduced HIV-specific funding and human resources.

The key changes made to the GAM framework for 2026 are:

- Indicators have been renumbered to reflect the updated framework. Countries will be invited to report globally on the indicators and policy questions corresponding to the 16 topline and two impact targets. A set of indicators is also proposed that countries can use to monitor progress towards the second-line targets (see Annex 2).
- Data sources recommended for collecting data have been expanded for several indicators, providing more routine and sustainable options for countries to monitor key elements of the response reflected in the 2030 targets as data investments are prioritized and integrated into broader monitoring efforts.
- Qualitative data are integrated further, including from community monitoring, to complement quantitative and policy data.

Figure 1:
Summary of components for 2026 Global AIDS Monitoring

Figure available at: https://www.unaids.org/sites/default/files/2026-02/2026_GAM_summary_of_components_en.pdf

95% of people living with HIV who know their status are on treatment

1.4 People living with HIV on ART
1.5 People living with HIV receiving multi-month dispensing of ARVs
1.6 Estimates of the size of key populations (A-E)
1.7 HIV prevalence among key populations (A-E)
1.8 ART coverage among people living with HIV in key populations (A-E)
1.9 People living with HIV on ART who started TB preventive treatment
1.10 Percentage of people living with HIV on ART who completed a course of TPT among those who initiated TPT

5: Ensure community leadership in the HIV response

80% HIV prevention programmes delivered by community-led organizations

NCPI
Indicators **2.2**, **2.5**, **2.6** Disaggregation by type of provider

60% of programmes that support achievementof the societal enablers to be delivered by community-led organizations including key populations-led and women-led organisations

NCPI

30% Testing and supportive treatment services provided by community-led organizations

NCPI

<10% of women, girls, PLHIV and key populations experience gender inequality and violence

SDG 5.2.1 Prevalence of intimate partner violence
4.4 Physical and/or sexual violence experienced by key populations (A–D)

By 2030, reduce new HIV infections by 90% from 2010 and incremental 5% decline per year after 2030

0.1 HIV incidence

Reduce AIDS-related deaths by 90% from 2010

0.2 AIDS mortality

Sustainability of HIV response after 2030

National Commitments and Policy Instrument (NCPI): collects information on national laws and policies and their implementation across the target areas.

WHO/AIDS Medicines and Diagnostics Survey on the Use of ARV Medicines and Laboratory Technologies: collects information on antiretroviral regimens.

Qualitative data and community data, including from community-led monitoring: provide complementary insights on the status of the HIV epidemic and response.

Narrative summaries, or a national narrative report: assessment of progress and challenges across target areas.

The letters next to certain indicator numbers (e.g. A-D) reflect that there are separate sub-indicators for various key populations.

Changes to the indicator set for 2026 global reporting

Based on a review by the MTAG and other stakeholders, some indicator definitions have been modified to reflect updates in guidance, to expand options of sources that countries can use to collect data on the indicators, and for clarification based on feedback from previous GAM reporting rounds.

The changes for the 2026 reporting round are as follows:

- To reduce duplicate reporting and promote use of standardized methods for global aggregation, the following indicators will be exclusively extracted directly from country-submitted final Spectrum files. The sections on the method of measurement for the indicator definitions have been updated to provide further clarifications[1]:
  - 0.1 HIV incidence
  - 0.2 AIDS mortality
  - 1.1 People living with HIV who know their HIV status
  - 1.11 People living with HIV who have a suppressed viral load
  - 3.3 Vertical transmission of HIV
  - 3.4 Prevention of vertical transmission of HIV
  - 3.5 HIV testing in pregnant women
- The indicator on People who received pre-exposure prophylaxis has been modified to also include pre-exposure prophylaxis (PrEP) need met. A denominator of the estimated PrEP need has been added:
  - 2.1 PrEP need met
- The indicator on Annual number of condoms distributed has been modified to expand its scope to include condom needs met. This is achieved by introducing a denominator of the estimated number of condoms needed. The indicator has been consolidated to refer to the total number of condoms, including male and female condoms, rather than requesting separate reporting. The disaggregation by type of provider has been aligned to similar disaggregation for Indicator 1.9 (needles and syringes distributed per person who injects drugs) and Indicator 1.10 (coverage of opioid agonist maintenance therapy) to include community-led organizations as a category:
  - 2.2 Condom need met
- A simpler bio-behavioural survey (BBS-lite) has been included as a complementary option for measuring the following indicators:
  - 1.2 HIV testing and status awareness among key populations (A–D)
  - 2.3 Condom use among key populations (A–D)
  - 2.4 Safe injecting practices among people who inject drugs
  - 1.8 Antiretroviral therapy coverage among people living with HIV from key populations (A–E)

1 Data from countries not using Spectrum will not be included in global reporting due to different methods.

  - 4.4 Physical and/or sexual violence experienced by key populations (A–D)
  - 4.2 Stigma and discrimination experienced by key populations (A–D)
  - 2.7 Syphilis prevalence among key populations (A, B, D)
- The request for additional data on the number of people living with HIV currently on antiretroviral therapy who have ever received tuberculosis preventive treatment before the reporting period has been removed, due to limited data availability:
  - 1.9 People living with HIV on antiretroviral therapy who started tuberculosis preventive treatment
- Other surveys among people living with HIV have been included as a complementary option for measuring the following indicator:
  - 4.1 Experience of HIV-related discrimination in health-care settings
- For the following indicator, the disaggregations have been revised. Transgender people have been added in the disaggregation by gender. Disaggregations by testing modality have been streamlined:
  - 1.3 HIV testing volume and positivity

The NCPI questionnaire for reporting in 2026 consists of two parts—Part A to be completed by national authorities, and Part B to be completed by community representatives. The questionnaire has been modified to align with the 2030 topline targets. The overall number of questions has been reduced. The wording of some of the questions retained from previous rounds has been refined, based on experiences in previous reporting and to reflect developments in policy recommendations and available technologies. A few new questions have been introduced to address areas not previously covered.

Reporting process

A multisectoral process: engaging communities

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

Communities of people living with or affected by HIV play a key role in the response to HIV around the world. 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, 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 or 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 it will be useful to reach out to other civil society players, including faith-based organizations, trade unions and other nongovernmental organizations.

National AIDS committees or their equivalents should ensure opportunities for community-led organizations to engage with and contribute to data collection plans and for the necessary space and resources so they can convene and coordinate their inputs. A straightforward multidisciplinary mechanism for submitting and evaluating information should be developed. As part of this 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 be widely disseminated to ensure community-led organizations have ready access to it.

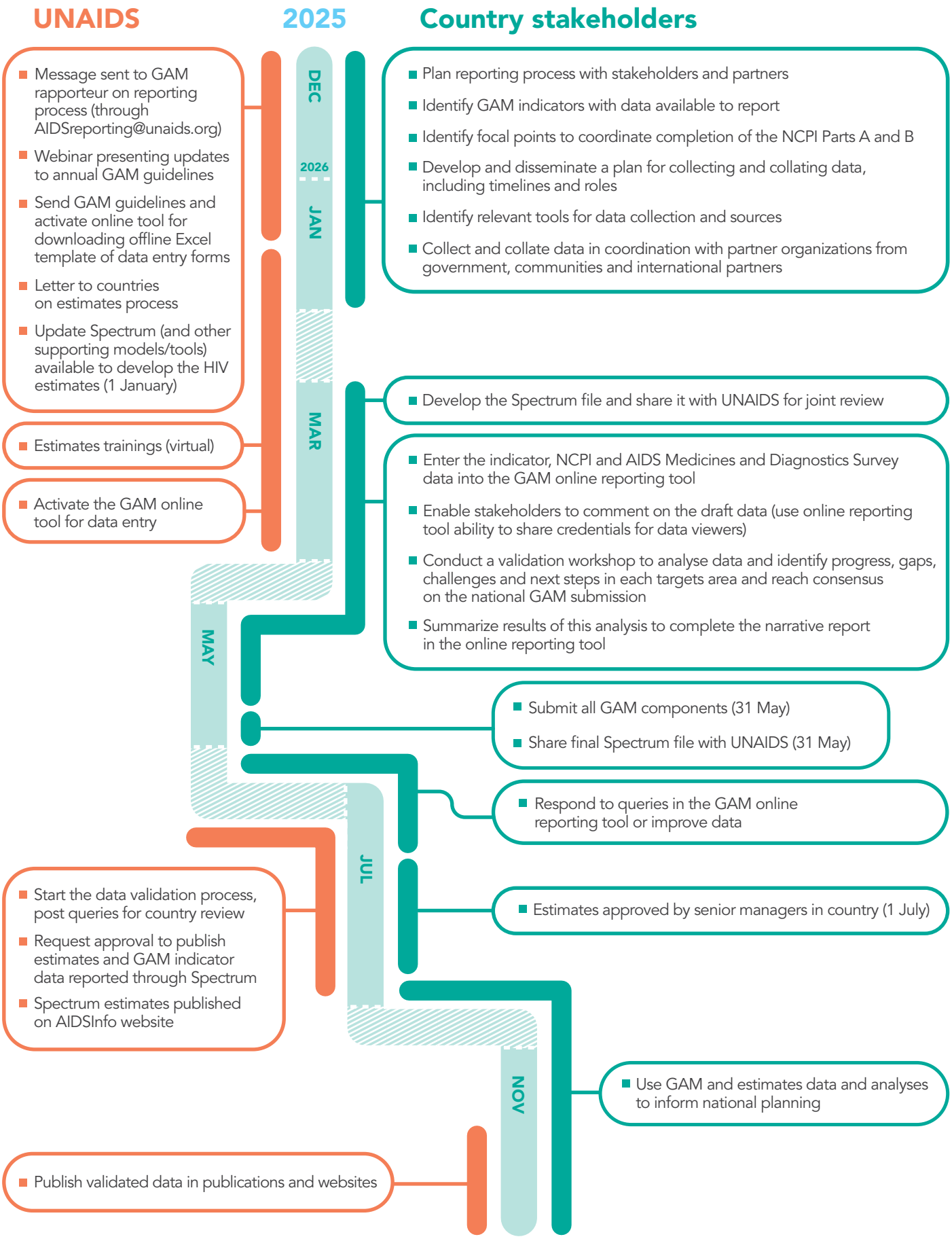
As in previous reporting rounds, UNAIDS will accept shadow reports. Shadow reports are not intended to be a parallel reporting process for communities living with or affected by HIV. Whenever possible, UNAIDS encourages integrating community-led organizations into national reporting processes, as described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

Reporting steps and timelines

The annual GAM cycle follows specific, well-established steps. At the end of each year, UNAIDS provides countries with updated information on indicators to use. This enables countries to coordinate and manage the national reporting process. **To allow for additional time to prepare and analyse data for reporting, the deadline for submitting GAM reports in 2026 has been shifted to 31 May.** The Global AIDS Update Report, published annually by UNAIDS, which is used in different international fora and for programmatic and financial decisions, will be released during the last quarter of the year.

Figure 2 outlines the specific steps of monitoring and reporting on the national HIV response in three main phases—preparation, reporting and follow-up.

Figure 2:
Tasks for completing GAM and estimates processes



Data validation process

After countries submit GAM reports through the online reporting tool, UNAIDS, UNICEF and WHO review the data submitted to support countries in reviewing any errors in entering data, to look for potential outliers or inconsistencies, and to verify the data submitted respond to the indicator definitions (as outlined in these guidelines).

Data submitted through GAM will be published on AIDSinfo and used for global and regional analyses. For this reason, data must be comparable across countries and respond to the globally agreed definitions of the indicators used for monitoring global political commitments. If countries do not have data that correspond to the indicator definition available, they are encouraged during the reporting process to consider other data that may be relevant to the commitment area to assess progress. For the reasons mentioned above, these data will not be published on AIDSinfo or included in the global analysis. During the review, UNAIDS liaises with national GAM focal points to request clarification or to revise the data submitted in the tool.

Data validation is conducted in several steps:

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

The validation process considers the following points across indicators:

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

The comments from countries are reviewed for all indicators.

For indicators entered through or estimated by Spectrum, validation of data will be done during the Spectrum estimation process.

Technical preparations for reporting

GAM reporting consists of providing data on the following:

- quantitative indicators
- NCPI questionnaire
- AIDS Medicines and Diagnostics Survey
- available community data
- narrative progress summaries by target areas or a national report (optional).

GAM reporting should be submitted through the reporting website (https://aidsreportingtool.unaids.org) to enhance the completeness and quality of the data, and to facilitate processing and analysis at the country, regional and global levels. Countries are encouraged to submit a narrative progress report when submitting GAM data. The online tool incorporates a template for creating a narrative report that consists of brief narrative summaries for each target area. If readily available, countries can instead submit a recent national epidemiology and response overview report.

Measurement tools and data sources

The primary measurement tools vary by indicator and are specified in the indicator definitions. They include:

- 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, such as the People Living with HIV Stigma Index and community-led monitoring.

Spectrum estimates

Spectrum software allows countries to create population-level estimates of people living with HIV, pregnant women who need antiretroviral medicine to prevent vertical HIV transmission, and children with perinatal HIV exposure who need virological testing, among other indicators.[2] In addition, Spectrum allows countries to estimate difficult-to-measure indicators such as the number of new HIV infections, HIV incidence (SDG indicator 3.3.1), the number of AIDS-related deaths, and the vertical transmission rate. Spectrum is also a tool for collecting programmatic data related to these estimations and informing GAM reporting.

Country teams update their Spectrum files every year using the most recent programmatic and surveillance data. Spectrum files are created by a team of national experts trained in using the software. These files are reviewed and validated by UNAIDS to ensure data quality and coherence and compliance with recommended definitions, methods and quality standards. Once completed, some indicators from this

2 For more on the national HIV estimates file and Spectrum, see https://hivtools.unaids.org/.

process constitute the result for GAM indicators. Country teams receive information on the estimates process by early December each year.

In the 2026 round, countries will report on selected indicators that are Spectrum inputs or outputs through the HIV estimates process rather than through the GAM online reporting tool. This reduces the data entry required and the chance of errors, and improves the consistency of data.

Most of the measurement tools and data sources listed above are important inputs to Spectrum modeling and continue to be needed for high quality estimates.

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.

Disaggregate the data, especially by age and gender

It is vital that countries collect data in their component parts and not simply in summary form. Without disaggregated data, monitoring the breadth and depth of the response to the epidemic at the population, national and global levels is difficult. It is equally difficult to monitor access to services, the equity of that access, the appropriateness of focusing on specific populations, and meaningful change over time.

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 key populations. If possible, equity analysis should be conducted.[3] Key ministries should review their information systems, surveys and other instruments for collecting data to ensure they capture disaggregated data at the subnational level, including facility and project levels.

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 key population surveys, ensuring 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). 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. When survey data are collected at subnational level, extrapolating results to derive national estimates may require the application of appropriate weighting and extrapolation methods, and cannot always be achieved through simple aggregation of numerators and denominators.

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

Qualitative data

Qualitative data provide crucial insights to understanding the "who", "what", "when", "how" and "why" of observations from quantitative data. These data are an important complement in national and global monitoring of the HIV epidemic and response. Qualitative data reflect the lived realities of people living with and affected by HIV and support identifying intersectional experiences and facilitators and barriers to service uptake. Countries are encouraged to collect and use qualitative data to complement routine HIV monitoring.

Qualitative data may be collected in different ways, including through interviews, focus groups, observations and case studies. Qualitative data must be interpreted within the context of the people who participated in the data collection and how they were selected. These data are not representative at the national level, and therefore findings cannot be generalized for a country.

In the GAM online reporting tool, comment sections are included in the data entry pages for all quantitative indicators where complementary qualitative data related to the indicator topic can be included. The NCPI questionnaire is another qualitative reporting component in GAM.

Listed below are some of the tools that can be implemented to gather qualitative data related to the HIV response:

UNAIDS gender assessment tool: towards a gender-transformative HIV response. Geneva: Joint United Nations Programme on HIV/AIDS; 2018 (https://www.unaids.org/sites/default/files/media_asset/unaids-gender-assessment-tool_en.pdf) (updated version forthcoming).

HIV and social protection assessment tool: generating evidence for policy and action on HIV and social protection. Geneva: Joint United Nations Programme on HIV/AIDS; 2017 (https://www.unaids.org/sites/default/files/media_asset/HIV-social-protection-assessment-tool_en.pdf).

National stigma and discrimination review and planning tool: a user guide. Geneva: International AIDS Society; 2025 (https://plus.iasociety.org/webcasts/national-stigma-and-discrimination-review-and-planning-tool).

Undertaking a rapid assessment of information on human rights-related barriers to HIV and TB services: guidance and tools. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2023 (https://resources.theglobalfund.org/media/14347/cr_rapid-assessment-human-rights-barriers-hiv-tb-services_guidance_en.pdf).

Who counts, what counts, and who counts what? An advocates' guide to monitoring stigma and discrimination reduction in the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination. Johannesburg: Global Network of People Living with HIV; 2023 (https://gnpplus.net/wp-content/uploads/2023/10/GNP-Who-counts-what-counts-and-who-counts-what_-ENG-FINAL.pdf).

Is your health system adolescent- and gender-responsive? A participatory tool for analysis and action planning. Washington, DC: United States Agency for International Development; 2022 (https://resourcecentre.savethechildren.net/pdf/English-tool-MCGL_Adolescent-responsive-health-systems-tool.pdf).

Community monitoring

Strong accountability mechanisms are essential for improving health services and health outcomes. Community participation mechanisms in the context of health service decentralization have been identified as a promising approach to enhance responsiveness of service providers to the needs of communities.

Community-led monitoring (CLM) is a community participation and accountability mechanism that, in the context of the HIV response, has been led and implemented by local community-led organizations or networks of people living with HIV or people from key populations or other priority populations. CLM uses a structured platform and rigorously trained peer monitors to systematically and routinely collect and analyse qualitative and quantitative data on HIV service delivery—including data from people in community settings who might not be accessing health care—and to establish rapid feedback loops with programme managers and health decision-makers.[4] CLM can be used to collect quantitative and qualitative data. Other community monitoring and accountability mechanisms also exist.

A section has been added in the GAM online reporting tool to include summaries of data available from community monitoring efforts, including CLM, on the quality of HIV services, stigma and discrimination, and the experiences of women living with HIV. Please upload relevant reports and questionnaires to the online tool corresponding to the data reported.

In the context of GAM, it is important to balance nationally representative reporting with respect for, and valuing of, local contributions. Extrapolating locally generated data nationally requires careful attention to data quality, representativeness, contextual differences, analytical methods and communication to ensure valid and actionable insights at the national level. Key areas to consider include sample size and the criteria applied in the selection of individual respondents or facilities.

Interpretation and analysis

Indicator definitions in these guidelines discuss each indicator, taking into account their strengths and weaknesses in ways designed to improve the accuracy and consistency of the data submitted to UNAIDS. Countries should review this document carefully before beginning to collect and analyse data, since it explains how to analyse each indicator and any potential issues related to interpretation.

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 the response. Countries should look 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 funded sufficiently 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 the country?

Further guidance on submitting data

Countries should seek technical assistance from their UNAIDS, UNICEF or WHO offices, or the HIV monitoring and evaluation working groups in their country or region, for additional information on collecting data for GAM indicators, the reporting

4 For more information, see Establishing community-led monitoring of HIV services. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf).

tool or submission mechanisms. The UNAIDS Data and Evidence Department (aidsreporting@unaids.org) can also provide support.

Reporting tool and submitting data

National rapporteurs may access the reporting tool using the same credentials they used in the previous reporting round; they may also 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 allow other people to view the data, enabling broader country consultation. Viewers can see but not change the information to be submitted.

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

The behaviour indicators for key populations are relevant in all countries, regardless of the national HIV prevalence. For example, a country with a higher prevalence epidemic 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.

UNAIDS strongly recommends 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.

Service provider definitions

Monitoring the proportion of selected prevention services delivered by community-led organizations in GAM

Indicators on the provision of prevention services sourced from programme data can indicate the proportion of total services delivered by different types of provider. The options include public services, community-led organizations, key population-led organizations, nongovernmental organizations (including faith-based, national and international nongovernmental organizations), and other entities such as private profit-making organizations. The purpose of this disaggregation is to track the proportion of prevention services provided by community-led organizations, including for distribution of condoms and lubricants, distribution of needles and syringes, and provision of opioid agonist maintenance therapy.

Reporting on community leadership in service provision should be conducted in close consultation with communities of people living with or affected by HIV, including key populations, at the national, subnational and local levels.

UNAIDS recognizes that the disaggregated data reported for these indicators are a subset of the full picture of all service delivery led by communities, but they do provide valuable preliminary information for monitoring community-led service delivery targets.

Members of community-led organizations and networks may face harassment, intimidation, smear campaigns, legal threats or physical attacks simply for providing or demanding essential services and information relating to HIV prevention, treatment, care and support. 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 extended to people receiving services.

Community-led organizations

Community-led organizations, groups and networks, whether formally or informally organized, are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies and that have transparent mechanisms of accountability to their constituencies.

Organizations led by key populations, women or youth are seen as different types of community-led organization, and therefore all the details included in this definition of community-led organizations also apply to them.

When determining which of the organizations or networks providing the services described in Indicator 2.2 are community-led, countries should consider the following criteria (which build on the above definitions):

- The majority of the organization's governance structure is comprised of people who identify as belonging to the community they serve.
- The majority of the leadership, staff, spokespeople and volunteers of the organization or network are members of the community they serve.

- The majority of the clients, members or constituents of the organization or network are from the community they serve.
- The organization or network has one or more mechanisms for holding itself accountable to the community it serves.

Key population-led organizations

Key population-led organizations and networks are led by people living with HIV; female, male and transgender sex workers; gay men and other men who have sex with men; people who use drugs; and transgender people. People from key populations share experiences of stigma and discrimination, criminalization and violence, and they shoulder a disproportionate HIV burden in all parts of the world.

When determining which of the organizations or networks providing the services described in Indicators 2.5 and 2.6 are key population-led, countries should consider the following criteria (which build on the above definitions):

- The majority of the organization's governance structure is comprised of people 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 from key populations.
- The majority of the clients, members or constituents of the organization or network are from one or more key populations.
- The organization or network has one or more mechanisms for holding itself accountable to the key population communities it serves.

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 people from key populations, UNAIDS acknowledges that people may belong to more than one group. Furthermore, people living with HIV, people in prisons and other closed settings, people with a history of incarceration, migrants, women and young people may also be included within each of the key populations named above.

Definitions for other response categories

Nongovernmental organizations

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

Other

It is recommended to choose the option Other if a service provider is not a public or nongovernmental entity (e.g. if it is a private profit-making organization).

Additional text field: name of the organizations

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

Indicator definitions

0.1 HIV incidence

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

What it measures
Progress towards ending the AIDS epidemic

Rationale
The overarching goal of the global HIV response is to reduce the number of people newly infected by 90% from 2010 levels by 2030. Monitoring the rate of people newly infected over time measures the progress towards achieving this goal. While the SDG indicator is for HIV incidence rate, the numerator of new HIV infections is also used to measure global targets.

Numerator
Number of people newly infected during the reporting period

Denominator
Total number of uninfected population the year prior to the reporting period

Calculation
Rate: (Numerator x 1000)/denominator

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

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

Instead of direct measurement, the recommended source is the Spectrum AIDS impact module. Depending on the country's epidemic setting and structure of surveillance data, Spectrum fits the national incidence trend from epidemic start to current year, considering population-based household HIV serosurveys, seroprevalence from sentinel surveillance and/or routine HIV testing in antenatal care, HIV case and AIDS-related death surveillance programme and clinical data, and in some instances data about risk behaviour and prevention coverage.

Note that case surveillance data counting new diagnoses of HIV should not be interpreted as a direct measure of people newly infected with HIV in the reporting year. As a result of reporting delays and underdiagnosis, the number of newly reported cases may not accurately reflect the actual number of people who were newly infected during the same period. Case reports may be useful, however, for triangulating or validating a Spectrum estimate—and in the case surveillance and vital registration (CSAVR) option within Spectrum, used by countries with strong case surveillance systems, it could be a model input.

Measurement frequency
Annually

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

Additional information requested
None.

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

Further information
SDG indicator 3.3.1 metadata (https://unstats.un.org/sdgs/metadata/files/Metadata-03-03-01.pdf). Consolidated guidelines on person-centered HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240055315).

Spectrum software. Glastonbury (CT): Avenir Health; 2025 (http://www.avenirhealth.org/software-spectrum.php).

0.2 AIDS mortality

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

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

Rationale
Efforts to scale up access to life-saving antiretroviral therapy, including the 2016 WHO guidelines that recommend treatment for all, should significantly reduce the number of people dying from AIDS-related causes, if these services are accessible and delivered effectively. The impact of the HIV response should be assessed by monitoring changes in AIDS-related mortality over time. The numerator of AIDS-related deaths is also used to measure global targets.

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

Denominator
Total population regardless of HIV status

Calculation
Numerator/denominator times 100 000

Method of measurement
Spectrum estimates of AIDS-related deaths are used as the source for this indicator for global monitoring. The number of people dying from AIDS-related causes can be obtained from a variety of sources, including vital registrations, ideally with adjustment for underreporting and misclassification of causes of death; as part of a facility- or population-based survey, including verbal autopsy; or through a mathematical epidemic model such as Spectrum. Epidemic models use demographic data, numbers of people receiving antiretroviral therapy over time, and assumptions around clinical progression and survival patterns to estimate the number of people living with HIV and dying from AIDS-related causes. Depending on the epidemic setting and surveillance system in the country, the Spectrum model can fit the epidemic historic trend to either prevalence data (from serosurveys, sentinel surveillance and/or routine programmatic HIV testing) or—in countries with strong HIV case-based surveillance and vital registration systems—HIV diagnoses and reported AIDS-related deaths. In the latter case, UNAIDS recommends adjusting the input number of AIDS-related deaths for underreporting and misclassification of causes of deaths for years applicable (e.g. early years) before fitting the Spectrum CSAVR incidence option to them. Spectrum-estimated deaths but not raw death counts are accepted as national AIDS-related death data.

Measurement frequency
Annual

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

Additional information requested
None.

Strengths and weaknesses
The Spectrum model is recommended as the standardized source of AIDS-related mortality numbers for all countries, because it considers and synthesizes all available representative surveillance and programme data. Where applicable, the Spectrum model accounts for underreporting and lagged reporting of numbers of HIV diagnoses and AIDS-related deaths, region- or country-specific patterns of clinical progression and survival among people living with HIV with and without antiretroviral therapy, and the evolving age and sex profile of people living with and newly infected with HIV.

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

Spectrum software. Glastonbury (CT): Avenir Health; 2025 (https://www.avenirhealth.org/software-spectrum.php).

1.1 People living with HIV who know their HIV status

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

What it measures

Progress towards increasing the proportion of people living with HIV who know their HIV status via effective and accessible HIV testing services

Rationale

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

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

Numerator

Number of people living with HIV who know their HIV status

Denominator

Number of people living with HIV

Calculation

Numerator/denominator

Method of measurement

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

Direct estimates from HIV case surveillance systems:

- ***For the numerator:*** In countries with well-functioning HIV case surveillance systems, the number of people living with HIV who know their status is the same as the number of people diagnosed with HIV and reported to the surveillance system who are still alive.
- ***For the denominator:*** Estimation models such as Spectrum are the recommended source for the number of people living with HIV. If a model other than Spectrum is used, documentation of the estimation method and uncertainty bounds should be provided.
- ***On case surveillance methods:*** An HIV case surveillance system is considered to be well functioning if reporting from all facilities providing confirmatory HIV testing, care and treatment services has been in place for at least five years, and if people who have died, been lost to follow-up or emigrated are removed from the numerator. Only confirmed diagnoses of HIV should be counted, although countries should adjust for reporting delays by including an estimate of the number of people diagnosed but not yet reported during the latest calendar year (if necessary). Mechanisms should be in place to de-duplicate people diagnosed and reported multiple times or from multiple facilities.

Modelled estimates:

- ***For the numerator:*** the approach to modelling the estimate of the number of people who know their HIV-positive status among people living with HIV depends on the availability of data in the country:
  - For countries with robust case surveillance and vital registration systems, the number of people who know their HIV-positive status can be derived using the case surveillance and vital registration (CSAVR) incidence estimation option in Spectrum or the European Centre for Disease Control (ECDC) HIV Modelling Tool (https://ecdc.europa.eu/en/publications-data/hiv-modelling-tool) importable to Spectrum. Alternatively, estimates from other country-specific models based on case surveillance and clinical data may be input to the national Spectrum epidemic file if the methods have been peer-reviewed and published.
  - For countries with one or more national household population serosurveys that reported the number of respondents living with HIV who know their HIV-positive status or have ever been tested for HIV, UNAIDS recommends modelling knowledge of HIV-positive status using the Shiny90 model, integrated in Spectrum.
  - Knowledge of HIV-positive status based on only self-reported data or historical household population survey data about testing history but without HIV serology should not be used.
- ***For the denominator:*** estimation models such as Spectrum are the preferred source for the number of people living with HIV. If a non-Spectrum model is used, UNAIDS will work with the country to emulate the external estimate of people living with HIV in Spectrum, for validation and for inclusion in regional and global estimates.
- ***On estimating the number of children who know their status in countries with modelled estimates based on household survey data:*** Household surveys are often restricted to respondents of reproductive age, but Spectrum offers a standardized method to estimate knowledge of HIV status among children aged 0–14 years, considering national annual data on children on antiretroviral therapy and treatment interruptions, alongside estimated mortality among children on antiretroviral therapy and ageing-out from the child cohort.

Measurement frequency

Annually

Disaggregation

- 0–14 years for children and 15 years and older by sex (men and women) for adults.
- As available: Disaggregation by detailed age and sex: <1 year, 1–4 years, 5–9 years and 10–14 years for children and 15–19 years, 20–24 years, 25–49 years and 50+ years by sex (men and women) for adults; by gender (men, women, other gender) for adults.
- If a country has sub-national estimates developed using Naomi, these data will be obtained directly from the final Naomi file.

Additional information requested

None.

Strengths and weaknesses

Case-based reporting method

Case-based surveillance provides reasonable measures of knowledge of HIV status in the following instances:

- The system has been in place for long enough that all people diagnosed and still alive have been reported.
- There are timely and complete mechanisms for reporting newly diagnosed cases to the system from all facilities that offer HIV diagnostic testing.
- Mechanisms are in place to de-duplicate repeat diagnoses among individuals reported multiple times and/or from multiple facilities.
- There is sufficient continuous or periodic follow-up of individuals to identify that they are still alive, as opposed to having died or moved out of the country. Countries relying on weak systems may overestimate or underestimate knowledge of HIV status in the following cases:
- De-duplication of case reports has not occurred (leading to overestimation).
- Deaths or out-migration among people diagnosed and reported to the system have not been removed (overestimation).
- Case reporting is not routine from all HIV testing facilities with confirmatory capacity (underestimation).

Modelled estimates

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

Further information

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

Spectrum. In: Avenir Health [Internet]. Glastonbury (CT): Avenir health; 2025 (http://www.avenirhealth.org/software-spectrum.php). The DHS Program: Demographic and Health Surveys [webpage]. Rockville (MD): ICF; c2025 (http://dhsprogram.com).

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

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

This indicator is divided into four sub-indicators:

A. HIV testing and status awareness among sex workers.

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

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

D. HIV testing and status awareness among transgender people.

What it measures

Progress providing HIV testing services to members of key populations.

Rationale

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

Numerator

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

plus

Respondent reports having tested for HIV in last 12 months and result was negative (answer to Question 2 is "a" or "b"; answer to Question 3 is "negative").

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

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

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

Denominator

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

Calculation

Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-Lite)

Respondents are asked the following questions:

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

Measurement frequency
Every two years.

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

Additional information requested
If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. An Excel spreadsheet of these data can also be uploaded instead of entering them in the online tool.

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

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

Surveying key populations can be challenging. Consequently, the data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

1.3 HIV testing volume and positivity

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

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

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

In addition to programme monitoring activities, annual testing volumes and positivity rates are inputs into the UNAIDS model that estimates progress towards the first 95 (95% of people living with HIV know their HIV status). This model is used primarily in countries that have national surveys to measure the population's historic testing coverage by HIV serostatus, but weak HIV case reporting systems (see Indicator 1.1).

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

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

Calculation
Numerator/denominator

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

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

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

Measurement frequency
Annually

Disaggregation
- Age 0–14 years for children, and age 15 years and older by gender (men, women, transgender people) for adults.
- Testing modality for all populations, including key population services:
  - Community-level HIV testing services
  - Facility-level HIV testing services:
    - Non-antenatal care clinic testing;
    - Antenatal care clinic testing (including during labour and delivery).

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

Additional information requested

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

Strengths and weaknesses

Not all countries have unique identifiers or underlying systems to deduplicate first and repeat testing among individuals nor to differentiate by HIV status of the person re-testing. As a result, this indicator is not directly comparable to knowledge of status (as measured in Indicator 1.1).

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

Further information

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

1.4 People living with HIV on antiretroviral therapy

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

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

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

The percentage of people on antiretroviral therapy among all people living with HIV provides a benchmark for monitoring global targets over time and comparing progress across countries. When considered as a proportion of Indicator 1.1, this indicator monitors progress toward the second 95 of the UNAIDS 95–95–95 targets: that 95% of people who know their HIV-positive status are accessing treatment.

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

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

OR

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

Calculation
Numerator/denominator

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

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

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

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

For the denominator: models such as Spectrum are the preferred source for estimating the number of people living with HIV. If a non-Spectrum model is used, UNAIDS will work with the country to emulate the external estimate of people living with HIV in Spectrum, for validation and for inclusion in regional and global estimates.

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

Disaggregation

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

Additional information requested

None.

Strengths and weaknesses

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

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

Further information

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

1.5 People living with HIV receiving multimonth dispensing of antiretroviral medicine

Proportion of people living with HIV and currently on antiretroviral therapy who are receiving multimonth dispensing of antiretroviral medicine

What it measures

The proportion of all people living with HIV and currently on antiretroviral therapy, who received a multimonth (as specified below) supply of antiretroviral medicine at their most recent antiretroviral medicine pick-up.

Rationale

The option for people living with HIV who are established on antiretroviral therapy to receive multiple months of antiretroviral medicines is a key component of care that responds to the needs and preferences of people living with HIV (known as differentiated service delivery – see "Definitions," below). For people living with HIV who are established on antiretroviral therapy, multimonth dispensing has the potential to improve health outcomes and support long term treatment adherence, while also reducing unnecessary clinic attendance, thus contributing to system efficiency. Broadly, multimonth dispensing can contribute to efforts to achieve the 95–95–95 targets.

Adoption and roll-out of multimonth dispensing as part of national government strategies and plans are increasing. Since 2016, differentiated service delivery—including the option of multimonth dispensing—has been recommended in World Health Organization (WHO) HIV treatment and public health guidelines. The COVID-19 pandemic has particularly exposed the fragility of health systems and, in response, finding ways to maintain service delivery and reduce unnecessary clinic attendance has been prioritised.

The extent to which these models of care have been scaled up in many countries is uncertain and reporting on this indicator will support efforts to expand the offer of multimonth dispensing.

Numerator

Number of people living with HIV and currently on antiretroviral therapy who received 3 – <6 or 6+ months of antiretroviral medicine at their most recent antiretroviral medicine pick-up.

(The number receiving <3 months of antiretroviral supply is also collected for validation purposes)

If countries cannot report on the number of months of antiretroviral medicine dispensed by the disaggregation described above, they could, as an alternative, report the total number of people currently on antiretroviral therapy and receiving ≥3 months of antiretroviral medicine at their last medicine pick-up.

Denominator

Number of people living with HIV and currently on antiretroviral therapy.

Calculation

Numerator / Denominator

Method of measurement

The data for this indicator are collected at the end of the reporting period from facility antiretroviral therapy registers (including antiretroviral medicine dispensed outside the facility), programme monitoring tools or other databases. (If data are available from the private sector these should be included).

All people currently on antiretroviral therapy should be identified. People who have not received antiretroviral medicine within 28 days of their scheduled medicine pick-up are considered lost to follow-up and should not be counted in the denominator or the numerator. For example, if antiretroviral medicine was provided for three months (12 weeks), the time since the last medicine pick-up should be no longer than 16 weeks (12 weeks plus 28 days).

For the numerator: registers should capture the duration of antiretroviral medicine dispensed for each patient currently on antiretroviral therapy at their most recent medicine pick-up visit. If possible, this should be categorized as <3 months, 3- <6 months, or 6+ months and summarized for each age/sex group.

The denominator should match the total number of people currently on antiretroviral therapy at the end of the year, and be aligned with the national values submitted through the Global AIDS Monitoring tool.

If this indicator result is only available for a proportion of people currently on treatment, please enter the number of people that the percentage is based on, as well as the national denominator value, so that it is clear what proportion of the population currently on treatment is represented in the calculation.

Please note: multimonth dispensing should not be confused with multimonth prescriptions. Someone who receives a six-month antiretroviral medicine prescription but needs to attend clinic every one or two months for refills would not be counted as receiving multimonth dispensing.

Measurement frequency

Annual

Disaggregation

- Age 0–14
- Age 15+ by gender (male, female and transgender).

Additional information requested

None.

Strengths and weaknesses

An indicator focused on the scale of multimonth dispensing is a pragmatic way of capturing one important aspect of differentiated service delivery. The indicator gives an overall sense of how widely a differentiated service delivery approach to HIV treatment is being adopted and the extent of possible individual benefit. It also suggests the potential for further improvements in system efficiency through increased spacing of antiretroviral medicine dispensing.

The presence of this indicator does not imply that all individuals living with HIV should be provided multimonth supplies of antiretroviral medicines. In addition to considering the clinical needs of people living with HIV – multimonth dispensing is proposed only for people who are established on antiretroviral therapy – dispensing frequency should also be guided by the needs and preferences of affected individuals and populations. Other factors that influence the capacity to provide multimonth supplies of antiretroviral medicines include supply chain issues, policy considerations and health care staff readiness. The fact that 100% coverage should not be seen as the target for multimonth dispensing highlights the importance of having some contextual information to guide the interpretation of results.

Focusing only on the duration of antiretroviral medicine dispensed provides an incomplete picture of differentiated service delivery. Monitoring of outcomes such as viral load suppression, patient satisfaction and retention in care would add to this picture, as would information on the quality and extent of social and other support being provided as part of differentiated service delivery. Ideally, the proportion of people living with HIV who were offered a choice of a differentiated treatment model would be captured, but this may not be feasible.

Definitions

Differentiated service delivery for HIV is defined by the WHO as a person-centred approach that simplifies and adapts HIV services to better serve the needs of people living with HIV and to optimize the available resources in health systems.

Multi-month dispensing refers to the provision of multiple months' supply of antiretroviral medicine and/or other medicines at single time point. Multimonth dispensing is frequently offered as a component of differentiated service delivery. WHO recommends that people who are established on antiretroviral therapy should be offered antiretroviral medicine refills lasting three to six months, preferably six months where feasible.

Established on antiretroviral therapy. The criteria for determining that a person is successfully established on antiretroviral therapy are a) receiving antiretroviral therapy for at least six months; b) no current illness, [which does not include well-controlled chronic health conditions]; c) good understanding of lifelong adherence: adequate adherence counselling provided; and d) evidence of treatment success: at least one suppressed viral load result within the past six months (if viral load is not available: CD4 count >200 cells/mm3 (CD4 count >350 cells/mm3 for children 3-5 years old) or weight gain, absence of symptoms and concurrent infections).

The definition of being established on antiretroviral therapy should be applied to all populations, including those receiving second- and third-line regimens, those with controlled comorbidities, children, adolescents, pregnant and breastfeeding women and key populations.

Further information

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

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

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

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

A. Sex workers.

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

C. People who inject drugs.

D. Transgender people.

E. People in prisons and other closed settings.

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

Numerator
Not applicable

Denominator
Not applicable

Calculation
Not applicable

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

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

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

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

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

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

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

Strengths and weaknesses

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

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

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

Further information

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

1.7 HIV prevalence among key populations (A-E)

Percentage of specific key populations living with HIV

This indicator is divided into five sub-indicators:

A. HIV prevalence among sex workers.

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

C. HIV prevalence among people who inject drugs.

D. HIV prevalence among transgender people.

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

What it measures

HIV prevalence and need for treatment among key populations.

Rationale

Sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people and people in prisons and other closed settings often have high HIV prevalence. In many cases, HIV prevalence among these populations can be higher than the prevalence among the general population. Reducing the prevalence among key populations is a critical measure of a national-level response to HIV.

Countries with generalized epidemics may also have a concentrated subepidemic among one or more key populations at higher risk. If so, calculating and reporting on this indicator for these populations would be valuable for them.

Numerator

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

Denominator

Number of people in a specific key population tested for HIV

Calculation

Numerator/denominator

Method of measurement

A–D. This indicator is calculated:

- Using data from HIV tests conducted among participants in sentinel surveillance site(s);
- Biobehavioural surveys, or
- Other special surveys (e.g., BBS-Lite).

Sentinel surveillance sites used for calculating this indicator should be sampled repeatedly over time, to allow for tracking changes over time.

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

Measurement frequency

Every two years (biobehavioural survey and sentinel surveillance) or annual (routine programme data).

Disaggregation

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

Additional information requested

A–E: If there are subnational data available, please provide the disaggregation by administrative area, city, or site in the space provided. You may also upload an Excel spreadsheet of these data instead of entering them in the online tool.

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

Strengths and weaknesses

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

If prevalence estimates are available, disaggregated by greater than and less than one year in sex work, one year of sexual activity with other men or one year of injecting drugs, 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.

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

Surveying key populations can be challenging. Consequently, the data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

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

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

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

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

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

Further information

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

WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance. Guidelines on surveillance among populations most at risk for HIV. Geneva: World Health Organization; 2011 (http://www.unaids.org/sites/default/files/sub_landing/files/20110518_Surveillance_among_most_at_risk.pdf).

Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men, and transgender people. Chapel Hill (NC): MEASURE Evaluation; 2012 (https://www.measureevaluation.org/resources/publications/ms-11-49a.html).

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

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

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

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

This indicator is divided into five sub-indicators:

A. Antiretroviral therapy coverage among sex workers living with HIV

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

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

D. Antiretroviral therapy coverage among transgender people living with HIV

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

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

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

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

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Denominator
Number of respondents living with HIV

Calculation
Numerator/denominator

Method of measurement
Biobehavioural surveillance surveys, other special surveys (e.g. BBS-Lite)

Measurement frequency
Every two years for biobehavioural surveys or other special surveys

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

Additional information requested
Please specify the timeframe for having been on antiretroviral therapy included in the survey question.

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

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

Strengths and weaknesses

This indicator recognizes the importance of antiretroviral therapy for all populations and the need to achieve equity in access to antiretroviral therapy. It is increasingly asked in both household (general population) and biobehavioural surveys. Some but not all treatment programmes collect data on risk behaviour and modes of transmission. Data on treatment coverage and progress towards the second "95" of the 95–95–95 targets for key populations individually provide information to advocate for equity for treatment access for all key and vulnerable populations and communities.

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

Surveying key populations can be challenging. Consequently, the data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive biobehavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

Further information

World Health Organization, Centers for Disease Control and Prevention, Joint United Nations Programme on HIV/AIDS, FHI 360. Biobehavioral survey guidelines for populations at risk for HIV. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/258924/9789241513012-eng.pdf).

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

1.9 People living with HIV on antiretroviral therapy who started tuberculosis preventive treatment

Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment during the reporting period

What it measures
The extent to which people who are on antiretroviral therapy started TB preventive treatment

Rationale
TB preventive treatment reduces the risk of developing TB disease and improves survival among all people living with HIV. People living with HIV should be screened for TB at every clinic visit using a clinical algorithm recommended by the World Health Organization (WHO). Adults and adolescents living with HIV who do not report any of the symptoms of TB —current cough, fever, weight loss or night sweats—are unlikely to have TB disease and should be offered TB preventive treatment. WHO recommends a number of screening tools that can also be used to rule out TB disease (eg. chest x-ray, c-reactive protein).

Children living with HIV who do not have poor weight gain, fever or current cough should be offered TB preventive treatment regardless of whether or not they are receiving antiretroviral therapy.

Numerator
1. Total number of people newly enrolled on antiretroviral therapy during the reporting period who also started TB preventive treatment during the reporting period.

2. Total number of people currently on antiretroviral therapy who started TB preventive treatment during the reporting period.

Denominator
1. Total number of people newly enrolled on antiretroviral therapy during the reporting period.

2. Total number of people currently on antiretroviral therapy during the reporting period.

Calculation
Numerator/denominator

Method of measurement
TB preventive treatment should be started for all eligible people living with HIV, and the start date should be recorded on the HIV care/antiretroviral therapy card (in the Encounter section). Those who accept treatment and receive at least the first dose should then be recorded in the antiretroviral therapy registers (under the TB preventive treatment start month and year column).

1. ***Numerator.*** Count the total number of people living with HIV newly enrolled on antiretroviral therapy during the reporting period who also started TB preventive treatment during the same reporting period (i.e., those who received at least one dose of the regimen)

Denominator. Count the total number of people living with HIV newly enrolled on antiretroviral therapy during the reporting period.

2. ***Numerator.*** Count the total number of people currently on antiretroviral therapy (regardless of when they started antiretroviral therapy) who also started TB preventive treatment during the current reporting period (i.e., those who received at least one dose of the regimen). Indicator 2 includes people who are newly enrolled on ART and those who were previously enrolled on ART.

Denominator. Count the total number of people living with HIV currently on antiretroviral therapy (regardless of when they started antiretroviral therapy).

Countries are asked to report on 1 and 2, as available.

Measurement frequency
Data on people who started antiretroviral therapy and TB preventive treatment should be recorded daily and reported quarterly to the national or subnational level. They should be consolidated annually and reported to UNAIDS.

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

Additional information requested
None.

Strengths and weaknesses

This indicator provides insight on progress towards provision of TB preventive treatment among all people living with HIV. Unless further data are collected, this indicator provides no information on the number of individuals who adhere to or complete the course of treatment.

For accurate planning and drug management, more detailed information needs to be collected in addition to this indicator. A pharmacy-based register may be used to record client attendance and drug collection. Alternatively, the HIV treatment facility may maintain a TB preventive treatment register in parallel with the antiretroviral therapy register. Such a record may provide valuable information on the number of new and continuing patients on TB preventive treatment, as well as treatment completion rates and adverse events.

Further information

WHO consolidated guidelines on tuberculosis. Module 1: Prevention - tuberculosis preventive treatment, second edition. Geneva: World Health Organization, 2024 (https://iris.who.int/handle/10665/378536).

WHO operational handbook on tuberculosis. Module 1: Prevention - tuberculosis preventive treatment, second edition. Geneva, World Health Organization, 2024 (https://iris.who.int/handle/10665/378535).

1.10 Percentage of people living with HIV on antiretroviral therapy who completed a course of tuberculosis preventive treatment among those who initiated tuberculosis preventive treatment

Percentage of people living with HIV currently on antiretroviral therapy initiating tuberculosis (TB) preventive treatment and who completed a course of TB preventive treatment

What it measures

This indicator measures the effectiveness of scaled-up TB preventive treatment programmes by assessing the proportion of people living with HIV on antiretroviral therapy who completed a recommended course of TB preventive treatment during the reporting period.

Rationale

TB preventive treatment reduces the risk of developing TB disease and improves survival of all people living with HIV. Completing TB preventive treatment as prescribed optimizes its efficacy. All people on antiretroviral therapy should be screened for TB at every visit, using a clinical algorithm recommended by the World Health Organization (WHO). Adults and adolescents living with HIV who do not report any of the symptoms of TB — current cough, fever, weight loss or night sweats—are unlikely to have TB disease and should be offered TB preventive treatment. Similarly, children living with HIV who do not have poor weight gain, fever or current cough should be offered TB preventive treatment; extra care is needed to exclude TB disease in children who are also malnourished before starting TB preventive treatment.

While many countries have made progress in initiating TB preventive treatment among eligible people living with HIV, completion rates remain poor or unknown. Assessing completion of TB preventive treatment is a critical element of the TB/HIV cascade of services and essential to ensuring impact.

Numerator

Among people living with HIV who initiated any course of TB preventive treatment in 2024, the number of people on antiretroviral therapy who completed TB preventive treatment (Figures 1 and 2).

Denominator

Number of people on antiretroviral therapy who initiated any course of TB preventive treatment during 2024.

Note: The denominator should be the same as the number of people reported through the 2025 GAM to have started TB preventive treatment in 2024.

Calculation

Numerator/denominator.

Method of measurement

Numerator: Programme records (for example, antiretroviral therapy registers or electronic medical records (EMRs)). Count the total number of people living with HIV on antiretroviral therapy initiating TB preventive treatment during the cohort reporting year who completed the course of TB preventive treatment. The cohort reporting year would usually be the last calendar year during which all people who initiate TB preventive treatment can be assessed for treatment completion. As mentioned above, for the 2026 reporting cycle, the cohort would comprise those initiating TB preventive treatment during 2024.

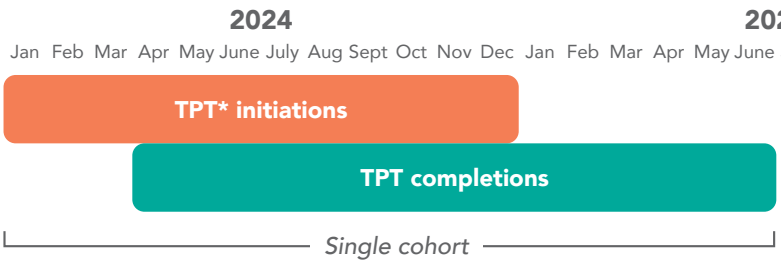
This includes all those eligible for TB preventive treatment who started TB preventive treatment (including those newly on antiretroviral therapy and currently on treatment) and who completed TB preventive treatment during the same year or the following year. Completion of TB preventive treatment should be determined on the basis of national clinical guidelines using criteria that relate to the specific regimen duration and composition (see the WHO operational handbook on tuberculosis—module 1: prevention).

Denominator: Programme records (for example, antiretroviral therapy registers or EMRs). Count the total number of people living with HIV who were on antiretroviral therapy and initiated a course of TB preventive treatment during the cohort (2024 for 2026 reporting). If a person who is initiated on TB preventive treatment dies before TB preventive treatment completion, they should be recorded in the denominator, but not in the numerator.

This reflects an annual cohort approach where 2026 reporting is based on those who initiated TB preventive treatment in 2024, regardless of whether they completed in 2024 or 2025.

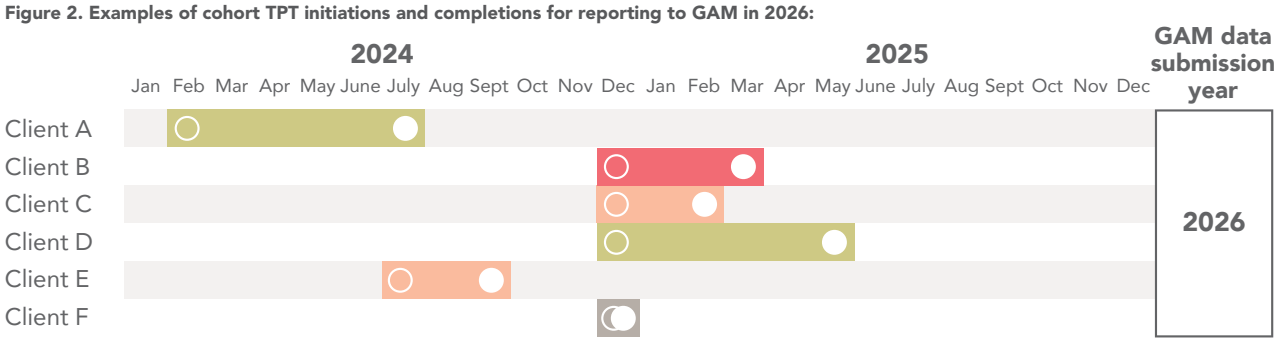
Illustration of completion cohort

Figure 1. Cohort TPT initiation and TPT completion for reporting to GAM in 2026



*TPT = TB preventive treatment

Figure 2. Examples of cohort TPT initiations and completions for reporting to GAM in 2026:



Legend

- Initiated TPT
- Completed TPT
- 6 INH (six months of isoniazid monotherapy), 6Lfx (6 months of daily levofloxacin monotherapy)
- 4R (four months of daily rifampin)
- 3HP (3 months of once-weekly isoniazid plus rifapentine), 3HR (3 months of daily rifampicin plus isoniazid)
- 1HP (1 month of daily rifapentine plus isoniazid)

Measurement frequency

Annually. A periodicity more frequent than annual may be expedient (e.g., quarterly reporting for more timely reporting of patients on a new TB preventive treatment regimen)

Disaggregation

- Gender (female, male, transgender).
- Age (<5 years, 5–14 years, 15+ years).
- Type of TB preventive treatment regimen (if the country is able to report on disaggregation).

Strengths and weaknesses

This indicator would more accurately provide information on people living with HIV who have received this intervention to reduce TB incidence and mortality among people living with HIV. It has already been field tested by United States President's Emergency Plan for AIDS Relief (PEPFAR) programmes for a number of years and reported through the monitoring, evaluation and reporting (MER) system.

Challenges include incomplete recording and reporting, information systems that may not capture TB preventive treatment completion, use of different criteria to determine completion and account for TB preventive treatment interruptions, and suboptimal programme implementation.

Further information

WHO operational handbook on tuberculosis. Module 1: prevention – tuberculosis preventive treatment, second edition. Geneva: World Health Organization; 2024 (https://iris.who.int/bitstream/handle/10665/378535/9789240097773-eng.pdf).

1.11 People living with HIV who have suppressed viral loads

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

What it measures

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

Rationale

Viral suppression among people living with HIV provides a benchmark for monitoring global targets over time and a standardized indicator of HIV treatment and prevention success, critical to ending the AIDS epidemic. When considered as a proportion of the number of people on treatment (the numerator of Indicator 1.4), this indicator monitors the third 95 of the UNAIDS 95–95–95 targets: that 95% of the people receiving antiretroviral therapy will have suppressed viral loads.

Numerator

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

Denominator

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

OR

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

Calculation

Numerator/denominator

Method of measurement

Viral suppression is defined as <1000 copies/mL. Some countries use other thresholds (such as undetectable, <50 copies/mL or <400 copies/mL), which require adjustment for comparability with other countries and for monitoring the global 95-95-95 targets. This is done within Spectrum, applying to the country's entered data the following formula[1]:

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

Here, y is the standard (1000 copies/mL) viral suppression level, t1 is the country's alternative threshold that was used, and ϕ is the region- specific adjustment factor.

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

1. Routine viral load suppression tests from people on antiretroviral treatment collected through clinical or laboratory registers or case surveillance.

For the numerator. Countries should report the estimated number of people nationally who have suppressed viral loads during the reporting period if viral load testing coverage (i.e., the number of people routinely tested during the reporting period, as per WHO guidance, among all people on treatment) is 50% or greater.

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

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

For countries where annual viral load testing coverage is 50% or over, the number of people with suppressed viral loads in the larger population of people on ART could be estimated. Based on the national data entries, Spectrum will calculate the proportion of people with viral suppression among those tested, and extrapolate that viral load suppression percentage to all people on treatment, assuming equal levels of suppression for people not tested as for those tested. This assumption is supported by evidence from South Africa, which shows that although viral load information was frequently missing, estimates of viral suppression did not change substantially after adjusting for missing data.

1 Johnson, L et al. 2021. Achieving consistency in measures of HIV-1 viral suppression across countries: derivation of an adjustment based on international antiretroviral treatment cohort data (https://pubmed.ncbi.nlm.nih.gov/34546623/).

In case there is evidence that viral load suppression in the untested population on treatment is likely to not equal that in the tested population, please contact UNAIDS for further discussion about approaches for estimating the national viral suppression proportion and counts.

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

For more information on estimating the number of people living with HIV who are on treatment, as part of calculating the third 95, please see Indicator 1.4.

2. Recent nationally representative population surveys (including household, acquired HIV drug resistance surveys or early warning indicators (EWI) surveys of HIV drug resistance)

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

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

OR

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

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

For the denominator. Estimation models such as Spectrum are the preferred source for the number of people living with HIV. If a non-Spectrum model is used, UNAIDS will work with the country to emulate the external estimate of people living with HIV in Spectrum, for validation and for inclusion into regional and global estimates.

Measurement frequency
Annually

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

Additional information requested
None.

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

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

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

Further information

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

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

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

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

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

1.12 Advanced HIV disease and late HIV diagnosis

Percentage and number of adults and children with CD4 cell count <200 cells/mm3 (or <15%) at initial diagnosis and initiation/reinitiation of antiretroviral therapy during the reporting period

What it measures
People living with HIV identified to have a CD4 cell count <200 cells/mm3, a criterion for advanced HIV disease.

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

Numerator
At initial HIV diagnosis or at initiation/re-initiation of antiretroviral therapy, the number of:

- Adults (aged ≥15 years) living with HIV with CD4 cell count <200 cells/mm3 recorded at that time; and,
- Children aged 5–14 years living with HIV with CD4 cell count <200 cells/mm3 or CD4 <15% recorded at that time; and,
- Children 0–59 months living with HIV.

Denominator
Number of people diagnosed with HIV for the first time or initiating/re-initiating antiretroviral therapy during the reporting period with:

- Adults (aged ≥15 years): a CD4 cell count recorded within one month of initial diagnosis or initiation/re-initiation of ART; and,
- Children aged 5–14 years: a CD4 cell count (or percentage) recorded within one month of initial diagnosis or initiation/re-initiation of ART;
- Children 0–59 months: all living with HIV

Calculation
Numerator/denominator.

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

Measurement frequency
Annually.

Disaggregation
- Aged 0–14 years (disaggregated by ages 0–59 months and 5–14 years) for children, and aged ≥15 years by sex (men and women) for adults.

Explanation of the numerator
Adults living with HIV whose CD4 lymphocyte count was <200 cells/mm3 at initial diagnosis, or at initiation/reinitiation of antiretroviral therapy in the reporting period.

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

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

Additional information requested
The total number of people who received a CD4 test at initial diagnosis or at initiation/reinitiation of antiretroviral therapy in four mutually exclusive CD4 cell count categories (<200 cells/mm3, 200 to <350 cells/mm3, 350 to <500 cells/mm3, ≥500 cells/mm3), and the total number of people newly diagnosed with HIV, or initiating and reinitiating ART during the reporting period are requested.

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

Strengths and weaknesses

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

If the coverage of CD4 count measurement (of all new diagnoses, or of antiretroviral therapy enrolments and re-enrolments) is far below 100%, the results may not be representative for the full population of clients.

1.13 Management of cryptococcal infection

Percentage of people living with HIV with a CD4 count below 200 cells/mm3 who were screened for, diagnosed with and treated for cryptococcal infection.

What it measures

This indicator measures the screening and treatment cascade for cryptococcal infection among people with advanced HIV disease: the proportion of people with CD4 count below 200 cells/mm3 screened for cryptococcal infection; the proportion of people who screened positive for cryptococcal infection; and the proportion of people who were treated for cryptococcal infection among those who screened positive.

Rationale

To reduce AIDS-related deaths, HIV programmes must emphasize identification of people with advanced HIV disease, prevention of opportunistic infections, and treatment of opportunistic infections. Cryptococcal infections are responsible for substantial mortality and morbidity among people living with HIV, particularly in people with a CD4 cell count below 200 cells/mm3 (advanced HIV disease). This indicator supports the surveillance of screening, diagnosis and treatment of cryptococcal infection, one of the most common opportunistic infections among people with advanced HIV disease.

Numerator

A. Number of people living with HIV with CD4 count below 200 cells/mm3 with cryptococcal infection who received treatment.

B. Number of people living with HIV and CD4 count below 200 cells/mm3 who tested positive for cryptococcal infection.

C. Number of people living with HIV and CD4 count below 200 cells/mm3 who were tested for cryptococcal infection.

Denominator

A. Number of people living with HIV and CD4 count below 200 cells/mm3 who tested positive for cryptococcal infection.

B. Number of people living with HIV and CD4 count below 200 cells/mm3 who were tested for cryptococcal infection.

C. Number of people living with HIV with CD4 count below 200 cells/mm3.

Calculation

Numerator A/Denominator A

Numerator B/Denominator B

Numerator C/Denominator C

Method of measurement

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

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

Measurement frequency

Annually.

Disaggregation

None.

Additional information requested

None.

Strengths and weaknesses

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

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

Further information

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

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

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

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

2.1 PrEP need met

Ratio of the estimated number of people in need of pre-exposure prophylaxis (PrEP) per 1000 people per year who received it at least once during the reporting period

What it measures
Progress towards scaling up PrEP and meeting the estimated need for PrEP.

Rationale
This indicator is key to assessing the availability and uptake of PrEP, especially among people at substantial risk of HIV infection. Through data disaggregation, this indicator also attempts to monitor the availability and use by population (based on age, gender and key population). The use of antiretroviral medicines by people who are HIV-negative before they are exposed to HIV can prevent HIV infection. In 2015, the World Health Organization (WHO) recommended that oral PrEP containing tenofovir (TDF) be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches. In 2021, WHO recommended the dapivirine vaginal ring (DVR) as an additional PrEP option to be offered to cisgender women at substantial risk of HIV. In 2022, WHO recommended that long-acting injectable cabotegravir (CAB-LA) may be offered as an additional PrEP option to people at substantial risk of HIV, and, in 2025, injectable lenacapavir (LEN) was also recommended.

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

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

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

Note: The denominator in the Spectrum model is expressed as person-years of PrEP. Therefore, the numerator needs to be adjusted downwards for an assumed average duration of use. For example, for oral PrEP, an average duration of six months could be assumed. Therefore, 1000 people who used oral PrEP at least once would translate into an average of 500 users at any given time (or 500 person years). For a six-monthly injectable with 80% continuation rate for a second dose, the adjustment can be made as follows: 1000 people who ever used the injectable translates into 500 person-years for the first six months and 400 person-years for the second six months (80% × 1000 × 0.5)—that is, 900 people who were protected at any given time (or 900 person-years). For GAM reporting, the number of people who received PrEP should be reported.

Denominator
Estimated number of people in need of PrEP per 1000 people per year

Calculation
Numerator/denominator

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

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

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

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

The denominator is the estimated number of people in need of PrEP per 1000 people per year (person-years of PrEP need). PrEP needs estimates will be available through the Spectrum software package as of 2026. If the country has conducted estimations of PrEP needs using another tool or methodology, please report these estimates and the source.

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

PrEP need is recommended to be estimated annually.

Disaggregation

- Sex (male, female)
- Age (15–24 years, 25+ years)
- PrEP product (oral PrEP, DVR, CAB-LA, LEN)
- Population (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people, pregnant and breastfeeding women)

Additional information requested

None

Strengths and weaknesses

This indicator will not measure the treatment cost, quality, effectiveness or adherence, which vary within and among countries and are likely to change over time.

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

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

The conversion of the number of people who received PrEP to person-years of protection is based on an assumed duration of PrEP use from available studies. Duration of protection will vary, depending on the type of PrEP used, and when PrEP use was started during the reporting period. As additional information becomes available on duration of PrEP use for long-acting PrEP, guidance for these conversion calculations will be refined further. Countries are encouraged to analyse the ratio of PrEP need met by population, to better understand whether PrEP programmes are effectively reaching people in need of PrEP.

PrEP needs estimates are based on assumptions around HIV incidence that is model-estimated and sexual behaviour that is self-reported. PrEP needs estimates provide a rough estimate of epidemiological need and serve to ensure comparability of PrEP coverage within and across countries. They should be interpreted with caution.

Further information

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

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

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

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

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

PrEP target-setting for key and high-priority populations: estimating the number at risk. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/1.PrEP-target-setting_online.pdf).

2.2 Condom need met

Percentage of the estimated number of condoms needed that were distributed during the past 12 months

What it measures
Progress in scaling up distribution of male and female condoms and meeting the estimated need for condoms.

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

Numerator
Number of condoms distributed in the past 12 months

Denominator
Estimated number of condoms needed

Calculation
Numerator/denominator

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

For the denominator, calculate the estimated number of condoms needed using tools such as the Condom Needs Estimation Tool (CNET). Condom need estimates will be available through the Spectrum software package in the AIM module as of 2026. If the country has conducted estimations of condom needs using another tool or methodology, please also report these estimates and the source.

Measurement frequency
Annual

Disaggregation
- Type of provider (public provider, private provider, community-led organization, non-profit-making social marketing and social enterprises)

Additional information requested
None

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

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

Condom needs estimates have a number of limitations in relation to the underlying assumptions, in particular in relation to self-reported sexual behaviour, sexual frequency in different demographic segments, and wastage at facility and individual levels.

Further information

United Nations Population Fund, World Health Organization, Joint United Nations Programme on HIV/AIDS. Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy. New York: United Nations Population Fund; 2015 (https://www.unfpa.org/resources/condoms-and-hiv-prevention-position-statement-unaids-unfpa-and-world-health-organization).

Condoms: the prevention of HIV, other sexually transmitted infections and unintended pregnancies. Geneva: Global HIV Prevention Coalition; 2016 (https://hivpreventioncoalition.unaids.org/en/resources/condoms-prevention-hiv-other-sexually-transmitted-infections-and-unintended-pregnancies).

Condom needs estimation tool. Geneva: Global HIV Prevention Coalition (https://hivpreventioncoalition.unaids.org/en/resources/condom-needs-estimation-tool).

2.3A Condom use among sex workers

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

What it measures
Progress in preventing exposure to HIV among sex workers through unprotected sex with clients

Rationale
Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, by consistently and correctly using condoms.

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

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

Denominator
Number of sex workers who reported having commercial sex in the past 12 months

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-lite)

Respondents are asked the following question:

Did you use a condom with your most recent client with whom you had sexual intercourse?

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

Measurement frequency
Every two years

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

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

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

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

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

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

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

Further information

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

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

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

2.3B Condom use among gay men and other men who have sex with men

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

What it measures
Progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner

Rationale
Condoms can substantially reduce the risk of sexually transmitting HIV. Consistently and correctly using condoms is therefore important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with the most recent male partner is considered a reliable indicator of longer term behaviour.

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

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

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

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-lite)

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

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

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

Measurement frequency
Every two years

Disaggregation
Age (<25 and 25+ years).

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

Strengths and weaknesses

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

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

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

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

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

Further information

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

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

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey “lite”: a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

2.3C Condom use among people who inject drugs

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

What it measures
Progress in preventing sexual transmission of HIV among people who inject drugs

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

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

Numerator
Number of people who inject drugs who reported using a condom the last time they had sex

Denominator
Number of people who inject drugs who report having injected drugs and having had sexual intercourse in the past month

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-lite)

People who inject drugs are asked the following sequence of questions:

1. Have you injected drugs at any time in the past month?

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

If they answer yes to both 1 and 2:

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

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

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

Measurement frequency
Every two years

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

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

Strengths and weaknesses

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

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

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

Further information

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

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

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

2.3D Condom use among transgender people

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

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

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

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

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

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

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-lite)

Respondents are asked the following question:

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

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

Measurement frequency
Every two years

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

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

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

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

Surveying transgender people can be challenging. Consequently, the data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

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

Further information

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

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

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

2.4 Safe injecting practices among people who inject drugs

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

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

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

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

Numerator
Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs

Denominator
Number of people who inject drugs who report injecting drugs in the past month

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-Lite)

Respondents are asked the following questions:

1. Have you injected drugs at any time in the past month?

If yes:

2. The last time you injected drugs, did you use a sterile needle and syringe?

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

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

Measurement frequency
Every two years

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

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

Strengths and weaknesses
Surveying people who inject drugs can be challenging. The data obtained may therefore not be based on a representative national sample of the people who inject drugs being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used. The report submitted with this indicator should include information on the sample size, the quality and reliability of the data and any related issues.

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

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

Further information

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

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

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

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey “lite”: a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

2.5 Needles and syringes distributed per person who injects drugs

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

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

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

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

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

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

Denominator
Number of people who inject drugs in the country

Calculation
Numerator/denominator

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

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

Measurement frequency
Annual.

Disaggregation
- Type of provider (public services, key population-led organization, NGOs, or other entities).

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

If provision by key population-led organizations is reported, please provide the name of the organization/s. Please provide the name and URL/website (if available) of the key population-led organization, NGOs, or other entities that are providing these services.

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

Estimating the number of people who inject drugs at the country level presents challenges. People who inject drugs are defined in many ways, and the estimates have ranges. The UNODC publishes estimates of the number of people who inject drugs in the World Drug Report. These estimates may be used. If there is a reason not to use them, please provide the rationale in the comment field.

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

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

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

Further information

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

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

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

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

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

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

2.6 Coverage of opioid agonist maintenance therapy

Percentage of people who inject drugs receiving opioid agonist maintenance therapy

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

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

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

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

Calculation
Numerator/denominator

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

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

Measurement frequency
Annual

Disaggregation
- Gender (male, female and transgender).
- Age (<25 and 25+ years).
- Type of provider (public services, key population-led organization, NGOs, or other entities).

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

Please provide the name and URL/website (if available) of the key population-led organization, NGOs, or other entities that are providing these services.

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

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

Further information

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

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

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

2.7 Syphilis prevalence among key populations (A, B, D)

Prevalence of syphilis in specific key populations

This indicator is divided into three sub-indicators:

A. Syphilis prevalence among sex workers.

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

D. Syphilis prevalence among transgender people.

What it measures
Progress towards reducing syphilis prevalence among key populations

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Rationale
The prevalence of syphilis is typically much higher in key populations than in the general population. Reducing the prevalence of syphilis among key populations is important for the health of the populations and also a critical measure of the national-level response to syphilis.

The increasing use of rapid tests for testing (screening) individuals for syphilis has increased access to syphilis testing in settings that were previously without capacity. As a result, this indicator has been expanded to syphilis prevalence rather than focusing solely on active syphilis.

Testing for syphilis in key populations is a component of second-generation HIV surveillance.

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

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Denominator
Number of people in a key population tested for syphilis

Calculation
Numerator/denominator

Method of measurement
This indicator is calculated using data from syphilis tests conducted among respondents in sentinel site(s) or participants in biobehavioural surveys or regular sexually transmitted infection screening services. The sentinel surveillance sites used for calculating this indicator should remain constant to allow for tracking changes over time.

Screening may be done with either a nontreponemal test (e.g., venereal disease research laboratory [VDRL] or rapid plasma reagin [RPR]) or a treponemal test (e.g., Treponema pallidum haemagglutination assay [TPHA], Treponema pallidum particle agglutination assay [TPPA], enzyme immunoassay or rapid treponemal test). While nontreponemal serologic tests are sensitive, they lack specificity and can result in false positive cases. Treponemal tests are more specific, but cannot differentiate between current and past infection or treated and untreated infection. For the purpose of this indicator (intended to measure seropositivity), reporting positivity based on a single test result is acceptable. However, if both treponemal and nontreponemal test results for an individual person are available, then syphilis positivity should be defined as having positive results on both tests.

Countries are required to report the testing algorithm used to determine positivity so prevalence estimates can be adjusted to look at trends over time and generate regional and global estimates.

Frequency of measurement
Annual (programme data) or every two years (biobehavioural survey or BBS-Lite).

Disaggregation

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

Additional information requested
Please document in the comments section if the testing algorithm has changed since the last Global AIDS Monitoring report.

Please comment on the extent to which the data are deemed representative of the national population.

Strengths and weaknesses

Surveying key populations can be challenging. Consequently, the data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used.

Trends in syphilis prevalence among key populations in the capital city provide a useful indication of the performance of HIV and sexually transmitted infection prevention programmes in that city, but they may not be representative of the situation in the country as a whole. The addition of new sentinel sites increases the sample's representativeness and therefore provides a more robust point estimate of syphilis prevalence. However, adding new sentinel sites reduces the comparability of values over time. As such, any changes in number of sites providing data needs to be documented in the comments section.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

Surveys exclusively covering transgender people are rare. Most data for transgender communities are drawn from surveys of gay men and other men who have sex with men or sex workers. The risk environment reported for most transgender communities is high, placing transgender women at especially high risk of acquiring a sexually transmitted infection and of transmitting that infection. If transgender women are respondents in surveys of sex workers, include the data with sex workers as a disaggregation. If transgender people are respondents in surveys of gay men and other men who have sex with men, include the data under the transgender tab.

Testing using both nontreponemal and treponemal tests enhances the likelihood that the reported numbers of positive tests represent active infection. Some countries, however, only have information for one test type. Please note in the comment fields if syphilis testing practices have changed, as this will need to be considered when interpreting the disease trends.

Further information

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

Joint United Nations Programme on HIV/AIDS,World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

2.8 Annual number of males voluntarily circumcised

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

What it measures
Progress in scaling up male circumcision services

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

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

Denominator
Not applicable

Calculation
Not applicable

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

Measurement frequency
Annual

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

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

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

Strengths and weaknesses

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

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

Further disaggregation is recommended at the country level:

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

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

Some programmes will work closely with voluntary HIV testing services to provide HIV testing. A man desiring circumcision may have been recently tested, and an on-site HIV test may be unnecessary. In these cases, the facility may request a written verified result to verify HIV status. There is no specific length of time before male circumcision that the test should have been done, but within three months is suggested. The purpose of testing is not to identify every man who might be HIV-positive, but to provide HIV testing to men seeking health care and to identify men living with HIV who, if they choose to be circumcised, are likely to be at higher risk of surgical complications (men with chronic infections and low CD4 counts).

Further information

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

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

3.1 Number of women living with HIV who were screened for cervical cancer using any screening test

The number of women living with HIV who were screened for cervical cancer in the last 12 months using any screening test

What it measures
Progress towards scaling up population-based screening for the prevention of cervical cancer among women living with HIV

Rationale
The purpose of this indicator is to assess the availability and uptake of screening to prevent cervical cancer among women living with HIV. To prevent invasive cervical cancer, women can be screened using various tests to identify those who have or are at risk of cervical precancer. Low cost and appropriate technology screening methods are available that make most precancerous lesions identifiable at stages when they can easily be treated and cured. Achieving high coverage of screening of women—with treatment of precancerous lesions detected by screening—can lead to a low incidence of invasive cervical cancer.

The traditional method to screen women for cervical cancer has been cytology (the Papanicolaou test, also known as the Pap or smear test). Newer screening tests include visual inspection with acetic acid (VIA) and molecular tests, mainly high-risk HPV DNA-based tests, which are suitable for use in all settings. Other molecular tests—as well as more advanced visual inspection tests based on artificial intelligence/machine learning platforms—have also been developed. Cervical cancer screening can be done using different primary screening and triage tests, and there are numerous combinations or algorithms in use in different settings.

Numerator
Number of women living with HIV who had a screening test for cervical cancer using any screening test

Denominator
N/A

Calculation
N/A

Method of measurement
The number is generated by counting the number of women living with HIV among all women who were screened for cervical cancer in the last 12 months, using cervical cancer programme screening and/or HIV programme data as the source.

Each individual should only be counted once within the reporting period. If a second triage test or a follow-up test was performed as part of the screening strategy, that individual should only be counted once.

Measurement frequency
Annual

Disaggregation
- Age (15–19, 20–24, 25–29, 30–49, 50+ years).
- People who were screened for the first time in their lives.

Additional information requested
None.

Strengths and weaknesses
Since the screening interval between tests depends on the test used, the number of women screened may vary from year to year.

Coverage levels of screening for all women living with HIV is not possible without an estimate of the population size.

Changes in this indicator as measures of progress over time should be interpreted in light of related data, including the number of women known to be living with HIV.

Further information

Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA Cancer J Clin. 2021;71:209-249.

Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240014107).

Comprehensive cervical cancer control: a guide to essential practice. 2nd ed. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf).

Guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240030824).

Introducing and scaling up testing for human papillomavirus as part of a comprehensive programme for prevention and control of cervical cancer. A step-by-step guide. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240015166).

WHO technical guidance and specifications of medical devices for screening and treatment of precancerous lesions in the prevention of cervical cancer. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240002630).

3.2 Cervical precancer treatment in women living with HIV

Percentage of women living with HIV, who screened positive for cervical precancer who received treatment for precancerous lesions in the last 12 months

What it measures
Progress towards the treatment coverage target of 90% of women with a positive screening test, receiving treatment.

Rationale
The purpose of this indicator is to assess availability, access and coverage of precancer treatment among women living with HIV who were diagnosed with precancerous lesions upon screening and were deemed eligible for precancer treatment in line with the World Health Organization (WHO) Recommendations for screening and treatment to prevent cervical cancer.

The WHO Global Strategy targets to eliminate cervical cancer are to vaccinate 90% of eligible girls against human papillomavirus (HPV), to screen 70% of eligible women at least twice in their lifetimes and to effectively treat 90% of those with a positive screening test or a cervical lesion, including palliative care when needed, all by 2030.

Numerator
Number of women living with HIV who received treatment for precancerous lesions after screening positive for cervical precancer.

Denominator
Number of women living with HIV who screened positive for cervical precancer

Calculation
Numerator/denominator

Method of measurement
The numerator and denominator are generated from programmatic data from HIV or cervical cancer screening programmes. Women who screened positive, but were ineligible for treatment of precancerous lesions, for example because they were referred for evaluation of potential invasive cervical cancer, should not be counted.

Measurement frequency
Annual

Disaggregation
- Age (15–19, 20–24, 25–29, 30–49, 50+ years).
- Cervical precancer treatment episode (1st in lifetime, 2nd, 3rd, 4th, etc.).
- Treatment method (cryotherapy, thermal ablation, large-loop excision of the transformation zone [LLETZ], other).

Additional information requested
None.

Strengths and weaknesses
Variation in the denominator over time may reflect the changing skill of healthcare workers to evaluate eligibility for precancerous treatment, the screening test used and its accuracy, and whether a triage test is used

Further information
Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, Bray F. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. CA Cancer J Clin. 2021;71:209-249.

Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240014107).

Comprehensive cervical cancer control: a guide to essential practice. 2nd ed. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/144785/9789241548953_eng.pdf).

Guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240030824).

WHO technical guidance and specifications of medical devices for screening and treatment of precancerous lesions in the prevention of cervical cancer. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240002630).

3.3 Vertical transmission of HIV

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

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

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

For a given prevalence of HIV among pregnant women, the number of children living with HIV and the prevalence of HIV among children should decrease as the coverage of interventions for preventing vertical transmission and the use of more effective regimens increase.

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

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

Calculation
Numerator/denominator

Method of measurement
Modelled estimates are used for global reporting, using standardized regional and global probabilities of vertical transmission based on global evidence, applied to national population-level estimates of pregnant women living with HIV annually.

The probability of vertical transmission differs depending on the coverage of prevention of vertical transmission and antiretroviral therapy among pregnant and breastfeeding women, and (for women accessing prevention of vertical transmission services) the timing of initiating antiretroviral therapy, the antiretroviral therapy regimen received, and infant feeding practices. The respective transmission probabilities are embedded and applied in the Spectrum model.

Spectrum requires the following national data inputs, for years applicable, for the estimation:

- The number of pregnant women living with HIV receiving antiretroviral medicines, by the timing of treatment initiation (before conception, early in the pregnancy or late in the pregnancy);
- The proportion of pregnant women retained on antiretroviral medicines at the time of delivery;
- The number of women receiving antiretroviral medicines after delivery during breastfeeding (postpartum);
- For women living with HIV and receiving antiretroviral medicines, the percentage whose infants have stopped breastfeeding by age of the child in months (0–35 months);
- For women living with HIV but not receiving antiretroviral medicines, the percentage whose infants have stopped breastfeeding by age of the child in months (0–35 months);
- Among breastfeeding women receiving antiretroviral medicines, the percentage who drop out each month.
- Spectrum outputs the following epidemic estimates, for all years:
- Incidence among breastfeeding women;
- Number and rate of vertical transmission of HIV, stratified by the period of transmission (pre- or postpartum) and prevention of vertical transmission/antiretroviral therapy/infant feeding status of the mother–infant pair;
- Number of women living with HIV giving birth, by age group.

Not enough information is available about non-perinatal HIV transmission routes for children to include these cases in Spectrum. These additional modes of transmission are believed to cause only a small fraction of overall number of children acquiring HIV. The Spectrum output "New HIV infections for children 0–1 years" is not recommended for programmatic use, because some children older than one year will acquire HIV from breastfeeding.

Measurement frequency
Annually

Disaggregation
None.

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

Additional information requested
None.

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

1. Following up mother–child pairs is difficult, especially at the national level, because of the lag in reporting and the multiple health facility sites that mother–child pairs may visit for the wide range of services for preventing vertical transmission and child-care interventions delivered over a timespan.

2. Children (especially those living with HIV) may die before they are tested to determine whether transmission has occurred.

3. A directly measured indicator will not capture women and their children who do not attend programmes, possibly because of high levels of stigma.

4. Most directly measured values will not include women who seroconvert while breastfeeding.

Weaknesses. The Spectrum-estimated indicator is only as good as the assumptions and data used in the model. In countries where caesarean delivery is practised widely, the indicator may overestimate vertical transmission. Across all settings, the estimation assumes that programmatically reported provision of antiretroviral medicines could underestimate vertical transmission in cases of patient non-adherence or non-consumption.

The indicator does not capture any possible efforts to reduce vertical transmission by preventing maternal infections or by reducing the number of unintended pregnancies among women living with HIV.

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

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

3.4 Preventing vertical transmission of HIV

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

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

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

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

Numerator
Number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of vertical transmission of HIV. Global reports summarizing the coverage of antiretroviral medicine across regimens effective for preventing vertical transmission will exclude women who received single-dose nevirapine, since it is considered a suboptimal regimen. Countries should, however, report annual numbers of women who received single-dose nevirapine and any other options—even if no longer recommended—for all years applicable.

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

Denominator
Estimated number of women living with HIV who delivered within the past 12 months

Calculation
Numerator/denominator

Method of measurement
For the numerator: national programme records aggregated from programme monitoring tools, such as patient registries and summary reporting forms.

For the denominator: the Spectrum estimation model is calibrated based on national data entries for antenatal care and prevention of vertical transmission programme service delivery and uptake and related demographic parameters.

Measurement frequency
Annually.

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

Additional information requested
None.

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

1. Newly initiated on antiretroviral therapy during the current pregnancy, stratified into early start (≥4 weeks before delivery) and late start (<4 weeks before delivery).
2. Already receiving antiretroviral therapy before the current pregnancy.
3. Other (please specify regimen).

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

Disaggregation of regimen definitions

Categories	Further clarification	Common examples
The first two options include women receiving lifelong antiretroviral therapy (including Option B+): 1. Newly initiating treatment during the current pregnancy. 2. Already receiving treatment before the pregnancy.	A three-drug regimen intended to provide antiretroviral therapy for life: 1. Number of pregnant women living with HIV identified in the reporting period newly initiating lifelong antiretroviral therapy. 2. Number of pregnant women living with HIV who were already receiving antiretroviral therapy at their first antenatal clinic visit. If a woman initiates lifelong antiretroviral therapy during labour, she would be counted in Category 1.	Standard national treatment regimen, for example: ▪ TDF + 3TC + EFV.

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

Maternal triple antiretroviral medicine prophylaxis (prophylaxis component of World Health Organization (WHO) Option B during pregnancy and delivery)	A three-drug regimen provided for prophylaxis of vertical transmission started during pregnancy—or as late as during labour or delivery—with the intention of stopping at the end of the breastfeeding period (or stopping at delivery, if not breastfeeding). If a woman received Option B during the pregnancy and transitioned to triple antiretroviral medicines (Option B+) for the first time at labour or delivery, she should be counted in this Option B category if the facility is implementing Option B.	▪ TDF + 3TC + EFV. ▪ AZT + 3TC + EFV. ▪ AZT + 3TC + LPV/r.
Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)	A prophylactic regimen that uses AZT (or another nucleoside reverse- transcriptase inhibitor (NRTI)) started as early as 14 weeks—or as late as during labour or delivery—to prevent HIV transmission. If a woman received Option A during the pregnancy and transitioned to triple antiretroviral medicines (Option B+) for the first time at labour or delivery, she should be counted in the Option A category if the facility is implementing Option A.	▪ AZT at any point before labour + intrapartum NVP. ▪ AZT at any point before labour + intrapartum NVP + 7-day postpartum tail of AZT + 3TC.
Single-dose nevirapine to the mother during pregnancy or delivery	▪ Count this for years that nevirapine was the only regimen provided to pregnant women living with HIV during pregnancy, labour or delivery. Do not count as single-dose nevirapine if: ▪ Nevirapine was provided as part of Option A during pregnancy. ▪ A pregnant woman living with HIV initiated Option A, B or B+ at labour and delivery.	▪ Single-dose nevirapine for mother only at onset of labour. ▪ Single-dose nevirapine + 7-day AZT + 3TC tail only. ▪ Single-dose nevirapine for mother at onset of labour and single-dose nevirapine for baby only.

Strengths and weaknesses

Countries are encouraged to track and report numbers of women receiving treatment, stratified by the timing of initiation of antiretroviral therapy, to inform model estimates of vertical transmission of HIV and numbers of infant infections averted by the programme (see Indicator 3.3 on vertical transmission rate). The numerator should be de-duplicated to remove women attending multiple clinics over the course of the pregnancy.

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

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

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

3.5 HIV testing in pregnant women

Percentage of pregnant women with known HIV status

What it measures

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

Rationale

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

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

Numerator

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

Denominator

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

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

Calculation

Numerator/denominator

Method of measurement

Countries will report on this indicator (numerator and two alternative denominators) through Spectrum.

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

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

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

Measurement frequency

Annual

Disaggregation

HIV status/test results:

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

These three counts sum to the number of women with HIV status ascertained in their current pregnancy. The number of women known to be living with HIV at their first antenatal care entry plus the number of women who tested positive for HIV for the first time during antenatal care during their current pregnancy (whether in antenatal care or during labour and/or delivery) represents the total number of women identified as living with HIV.

If data are available, an additional disaggregation for pregnant women who inject drugs is recommended at the national level.

Additional information requested

None.

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

Strengths and weaknesses

This indicator enables a country to monitor trends in HIV testing among pregnant women. The points at which dropouts may 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 does not capture the number of women who received pre-test counselling.

Within the Spectrum platform to estimate the national epidemic and other testing- and treatment-related GAM indicators, counts of pregnant women living with HIV recorded in antenatal clinics are also used to validate and align with entries for women who received prevention for vertical transmission. Specifically, in principle, for every year with data:

- The number of women newly identified as living with HIV during their current pregnancy is expected to equal or be greater than the number of women who started lifelong antiretroviral therapy for prevention of vertical transmission (whether early or late in the current pregnancy);
- The number of women already known to be living with HIV before their current pregnancy (before their first antenatal care visit) is expected to equal or be greater than the number of women on antiretroviral therapy for prevention of vertical transmission since before their current pregnancy.

If the number of women living with HIV is greater than the respective subset of entries for antiretroviral therapy and prevention of vertical transmission, this is accepted if explained by dropout. In contrast, if the number of HIV-positive entries is below the respective subset of entries for antiretroviral therapy and prevention of vertical transmission, this indicates a problem in either set of entries and must be reconciled for Spectrum to produce a valid estimate of coverage of prevention of vertical transmission.

Criteria for assessing the quality and national adequate antenatal care attendance and HIV testing data are detailed in the Guide for Updating Spectrum HIV Estimates.

Further information

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

Guide for updating Spectrum HIV estimates. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://hivtools.unaids.org/hiv-estimates-training-material-en/).

3.6 Early infant diagnosis

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

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

Rationale
Infants acquiring HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. The World Health Organization (WHO) recommends that national programmes establish the capacity to provide early virological testing of infants for HIV at six weeks or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progresses rapidly among children; they need to start treatment as early as possible because, without early treatment, almost 50% of children would be dead by the second year.

Numerator
Number of infants who received an HIV virological test within two months of birth during the reporting period. Infants tested should only be counted once. The numerator should not include infants tested after two months.

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

Calculation
Numerator/denominator

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

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

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

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

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

Explanation of the numerator
To be collected from the databases held at early infant diagnosis testing laboratories. The numerator should represent the number of infants who received virological testing within two months of birth; it should not represent the number of samples tested at the laboratory. Data should be aggregated from the laboratory databases. Where possible, double counting should be minimized when the data are aggregated to produce national- level data.

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

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

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

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

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

Strengths and weaknesses

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

Because of the small number of testing laboratories and the electronic format of testing databases, this indicator should not have a heavy collection burden. The data quality of the laboratories is generally high, resulting in a robust indicator. The indicator does not capture the number of children with a definitive diagnosis of HIV infection or measure whether appropriate follow-up services were provided to the child based on interpretation of the test results. It also does not measure the quality of testing or the system in place for testing. A low value of the indicator could, however, signal systemic weaknesses, including poor country-level management of supplies of HIV virological test kits, poor data collection, poor follow-up and mismanagement of testing samples.

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

Countries should invest in robust logistics management information systems (LMIS) to support procurement, distribution, and inventory control at facility, district, and national levels. Proper supply chain management is vital to maintaining access to testing and ensuring the indicator reflects true program performance.

Additional information

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

Further information

MER indicator reference guide, version 2.8.2 [Internet]. Washington (DC): United States President's Emergency Plan for AIDS Relief (PEPFAR); 2025 (https://help.datim.org/hc/article_attachments/41680473566612).

Measuring the impact of national PMTCT programmes: towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. A short guide on methods. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/75478/1/9789241504362_eng.pdf).

3.7 Syphilis among pregnant women

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

What it measures

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

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

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

Rationale

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

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

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

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

Numerator

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

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

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

Denominator

A. Number of women attending antenatal care services.

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

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

Calculation

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

Method of measurement

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

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

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

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

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

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

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

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

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

Measurement frequency
Annual

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

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

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

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

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

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

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

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

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

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

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

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

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

3.8 Congenital syphilis rate (live births and stillbirth)

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

What it measures
Progress in eliminating vertical transmission[1] of syphilis

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

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

Denominator
Number of live births in the past 12 months

Calculation
Numerator/denominator

Method of measurement
Routine health information systems.

Measurement frequency
Annual

Disaggregation
None

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

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

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

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

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

3.9 Hepatitis B virus among pregnant women attending antenatal care services

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

What it measures

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

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

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

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

Rationale

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

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

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

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

Numerator

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

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

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

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

Denominator

A. Number of pregnant women attending antenatal care services.

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

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

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

Calculation

Numerator/denominator

Method of measurement

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

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

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

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

Measurement frequency

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

Disaggregation

- Age (15–24 and 25+ years)

Strengths and weaknesses

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

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

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

Specific points for the sub-indicators

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

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

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

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

Additional information requested

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

Further information

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

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

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

Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings

What it measures
Progress in reducing HIV-related discrimination experienced by people living with HIV when seeking health-care services.

Rationale
Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. In the context of HIV, discrimination refers to unfair or unjust treatment of an individual (either through actions or by failure to act) based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, thus fueling the HIV epidemic.

Stigma is the attribution of undesirable characteristics to an individual or group that reduces their status in the eyes of society. It frequently drives experiences of discrimination. The indicator measures HIV-related discrimination experienced in health-care settings. HIV is often associated with a range of behaviours that are viewed as socially deviant or immoral, such as injecting drug use and sexual promiscuity. Because of these underlying societal beliefs, people living with HIV often are viewed as shameful and are thought to be responsible for having contracted HIV. This shaming process has repercussions beyond the individual because it greatly reduces incentives to be tested for HIV or, in the event the test result is positive, to disclose HIV status to sexual partners or family members.

The health sector is one of the main settings where people living with HIV—and those perceived to be living with HIV—experience discrimination. This indicator directly measures discrimination experienced by people living with HIV when seeking services in health-care settings.

The composite indicator can be monitored as a measure of the prevalence of HIV-related discrimination experienced in the health sector by people living with HIV. This indicator could provide further understanding of HIV-related health outcomes and improve interventions to reduce and mitigate HIV-related stigma and discrimination experienced along the treatment and care cascade by (a) showing change over time in the percentage of people living with HIV who experience discrimination in health-care settings and (b) indicating priority areas for action.

Numerator
Number of respondents who respond in the affirmative ("Yes") to at least one of the seven items per question.

Denominator
Number of all respondents

Calculation
Numerator/denominator

Method of measurement
People Living with HIV Stigma Index or other survey among people living with HIV

Respondents of the study are asked if they experienced any of the following forms of HIV-related discrimination when seeking HIV and non-HIV-specific health services in the last 12 months:

- Denial of care due to HIV status.
- Advised not to have sex because of HIV status.
- Being the subject of gossip or negative talk because of HIV status.
- Verbal abuse because of HIV status.
- Physical abuse because of HIV status.
- Avoidance of physical contact because of HIV status.
- Sharing of HIV status without consent.

Measurement frequency
Every 2–3 years

Disaggregation
Responses for each question are required, as is the consolidated response for the composite indicator. The composite indicator can be disaggregated by the following:

- Type of health service (HIV, non-HIV).
- Gender (male, female, transgender, other, prefer not to say).
- Key population (gay men or other men who have sex with men, sex workers, transgender people, people who use drugs).
- Age group (18–19 years, 20–24 years, 25–49 years, 50+ years).
- Length of time knowing HIV-positive status (0–<1 years, 1–4 years, 5–9 years, 10–14 years, or 15+ years).

Strengths and weaknesses

This indicator directly measures experiences of discrimination among people living with HIV who sought health services.

The recommended questions assess whether specific forms of discrimination have been experienced in a health-care setting. During the 2016 consultation process to update the People Living with HIV Stigma Index survey, people living with HIV highlighted the importance of separately measuring discrimination experienced when seeking HIV and non-HIV care. The experience of discrimination may be dependent on whether the health-care provider is aware of the person's HIV status. Given this, disclosure of HIV status to the health-care provider should be collected whenever possible in order to help interpret the indicator.

In addition, people seeking HIV services at specialty HIV clinics may report fewer experiences of discrimination than people seeking HIV services that are integrated within general health-care services. Thus, capturing the type of clinic is recommended where possible. It also would be advisable to compare the findings from this indicator with other data available on discriminatory attitudes towards people living with HIV in the general population and among health facility staff and avoidance of healthcare among key populations for a broader understanding of the stigma environment and the discrimination that can result in a given context.

Findings from this indicator should also be analysed in conjunction with information on programmes to address stigma and discrimination in health care and their scale, as well as programs to train health-care providers on human rights and medical ethics.

The People Living with HIV Stigma Index 2.0 is a standardized tool and methodology. While they are indicative of stigma and discrimination experienced by people living with HIV in a given country or context, the data used to calculate the indicator are not generalizable beyond the people living with HIV sampled, as respondents to the People Living with HIV Stigma Index are selected using snowball sampling (versus random sampling methods).

Data from the Stigma Index 2.0 for this indicator can be complemented in years when a Stigma Index is not conducted with data from other surveys that may be conducted among and led by people living with HIV, including online surveys. Such surveys should adhere to ethical standards and good practice for surveys including ensuring ethical approval is sought in country, informed consent is requested from participants, and protections of participants' privacy and their data are in place. Complementary studies should also adhere to a key principle of the Stigma Index that people living with HIV lead and are at the center of the process, defining how the study is designed, how information is collected, analysed and used. The survey design and sampling methodology will need to be considered in data interpretation. Where people living with HIV and/or key populations are criminalized, special care to protect their safety is recommended.

Further information

Mahajan AP, Sayles JN, Patel VA, Remien RH, Sawires SR, Ortiz DJ et al. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS. 2008;22(Suppl 2):S67–79.

Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? J Int AIDS Soc. 2009;12(1):15.

Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond. Geneva: UNAIDS; 2017 (http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf).

For more on the methods and survey instrument for the People Living with HIV Stigma Index, see: https://www.stigmaindex.org/

4.2 Stigma and discrimination experienced by key populations (A–D)

Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months

This indicator is divided into four sub-indicators:

A. Experience of stigma and discrimination among sex workers

B. Experience of stigma and discrimination among gay men and other men who have sex with men

C. Experience of stigma and discrimination among people who inject drugs

D. Experience of stigma and discrimination among transgender people

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What it measures
Progress towards reducing experiences of stigma and discrimination among key populations.

Rationale
Key population stigma is a negative stereotype based on an individual belonging to a key population group. Stigma is a well-documented barrier to the HIV care continuum, creating gaps across the prevention and treatment cascades, particularly for key populations including sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people. Key population stigma results from a range of drivers and facilitators, including: negative and judgmental attitudes towards key populations; shame related to an individual's occupation, drug use, or sexual and gender identity; and social, cultural and gender norms. These manifest in a range of stigmatizing practices and experiences, including discrimination, that deny key populations full social acceptance, consequently reducing their life chances, deterring access to essential services, and fuelling social inequalities.

Reducing HIV stigma and discrimination experienced by sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people is critical for increasing HIV testing, uptake of and adherence to antiretroviral therapy, and viral suppression, all of which will improve health outcomes for key populations.

Numerator
Number of people in the key population group (sex workers, gay men and other men who have sex with men, people who inject drugs or transgender people) who report that one or more of the three experiences has happened to them in the last 6 months because of their key population status.

Denominator
Total number of respondents from the key population group

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-Lite).

This indicator is constructed from responses to the following questions among respondents who report belonging to a key population group (i.e. sex workers, gay men and other men who have sex with men, people who inject drugs, and transgender people).

- Have you ever felt excluded from family activities because you [sell sex; have sex with men; inject drugs; are transgender]? (No, Yes, in the last 6 months, Yes, but not in the last 6 months, Don't know)
- Has someone ever scolded you because you [sell sex; have sex with men; inject drugs; are transgender]? (No, Yes, in the last 6 months, Yes, but not in the last 6 months, Don't know)
- Has someone ever blackmailed you because you [sell sex; have sex with men; inject drugs; are transgender]? (No, Yes, in the last 6 months, Yes, but not in the last 6 months, Don't know)

Measurement frequency
Every two years

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

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

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

Strengths and Weaknesses
These indicators directly measure experienced stigma and discrimination among sex workers, gay men and other men who have sex with men, people who inject drugs and transgender people, important manifestations of stigma that have been demonstrated to impede HIV prevention, care and treatment services among key populations. The indicators are calculated from responses to three questions. The questions were developed by technical experts based on previously validated measures of key population stigma and discrimination used in primary research studies. Changes in the indicator should be interpreted as follows: an increase in the percentage indicates an increase in experienced stigma and discrimination among key populations and a need for mitigating action, whereas a decrease in the percentage indicates progress and a reduction in experienced stigma and discrimination among key populations.

Respondent-driven sampling (RDS) is used to implement integrated bio-behavioral surveys. This sampling methodology allows researchers to access, in a systematic way, members of typically hard-to-reach populations who may not otherwise be accessible. Because RDS is a probability sampling method, researchers are able to provide unbiased population estimates as well as measure the precision of those estimates. RDS can be especially successful at rapid recruitment in dense urban environments. However, in contexts where the hard-to-reach populations are not well-networked, or in contexts where the stigma associated with some key populations is severe, recruitment rates using RDS may be unpredictable. Other disadvantages to using RDS relate to the difficulties that may arise when analyzing collected data. For instance, since RDS must take into account weighting for network size and recruitment patterns, the statistical strength of the sample as it applies to the target population decreases if participants only recruit people who share the same characteristics as themselves.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive bio-behavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

Surveying key populations can be challenging. Consequently, the data obtained may not be based on a representative national sample of the key populations at higher risk being surveyed. If there are concerns that the data are not based on a representative sample, the interpretation of the survey data should reflect these concerns. If there are different sources of data, the best available estimate should be used.

Further information
Friedland, B, Sprague, L, Nyblade, L, Baral, S, Pulerwitz, J, Gottert, A, et al. Measuring intersecting stigma among key populations living with HIV: implementing the people living with HIV Stigma Index 2.0. J Int AIDS Soc. 2018;21(S5):e2513.1 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055043/).

Stahlman, S, Hargreaves, J, Sprague, L, Stangl, A, Baral, S. Measuring sexual behavior stigma to inform effective HIV prevention and treatment programmes for key populations. JMIR Public Health Surveill. 2017;3(2):e23. (https://publichealth.jmir.org/2017/2/e23/).

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

Joint United Nations Programme on HIV/AIDS, World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

4.3 Avoidance of health care among key populations because of stigma and discrimination (A–D)

Avoidance of health care among key populations because of stigma and discrimination

This indicator is divided into four sub-indicators:

A. Avoidance of health care by sex workers because of stigma and discrimination.

B. Avoidance of health care by gay men and other men who have sex with men because of stigma and discrimination.

C. Avoidance of health care by people who inject drugs because of stigma and discrimination.

D. Avoidance of health care by transgender people because of stigma and discrimination.

What it measures
Progress towards reducing discriminatory attitudes and support for discriminatory policies in health-care settings.

Rationale
Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. In the context of HIV, discrimination refers to unfair or unjust treatment of an individual (either through actions or by failure to act) based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, thus fueling the HIV epidemic. HIV-related stigma refers to negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g., the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, gay men and other men who have sex with men and transgender people. In addition to HIV-related stigma, people from key populations experience further discrimination because of the stigma relating to same-sex attraction and sexual behaviour, engagement in sex work, drug use and non-conforming or diverse gender expression.

This indicator is important for providing a measure of the proportion of members of key populations who have avoided accessing general health-care services, due to fear of stigma and discrimination. Related reasons for avoiding such services may include (but are not limited to) the following: a lack (or perceived lack of) confidentiality within health-care settings; negative attitudes and behaviours among health-care providers; and fears of disclosing or hinting at individual behaviours and sexual preference/orientation.

Data related to the avoidance of health-care services are important in measuring the proportion of key populations who are not fulfilling their basic health-care needs (such as routine medical check-ups) and thus may be less likely to attend health-care settings for more specialized services and care (such as HIV testing, treatment and medical care).

This indicator is important for understanding and addressing the barriers to achieving the 95–95–95 targets among members of key populations. Data from this indicator directly measure fear of stigma or discrimination. This indicator could provide further understanding and improve interventions in reducing HIV stigma and discrimination by (1) showing change over time in the percentage of people who fear experiencing stigma, (2) enabling comparisons between national, provincial, state and more local administrations, and (3) indicating priority areas for action.

Numerator
Number of respondents who reported having avoided seeking healthcare in the last 12 months.

Avoidance of services due to fear of stigma and discrimination may be asked in different ways across countries/surveys.

Denominator
Number of respondents

Calculation
Numerator/denominator

Method of measurement
Behavioural surveillance or other special surveys (e.g. BBS-Lite).

Measurement frequency
Every two years

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

Additional information requested
Please provide the questions included in the survey instruments.

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

Strengths and weaknesses
As a measure of stigma and discrimination, this indicator focuses on the outcomes of such behaviour. If perceived or experienced stigma and discrimination is sufficiently severe enough to dissuade people from seeking necessary health services, not only can it readily be identified as a problem, but it also affects critical service uptake. Some respondents, however, may experience and perceive important stigmatizing and discriminatory behaviour in their communities but, because of their own resilience or discrete or specialized services, may still seek out services. The indicator is not going to measure achieving zero discrimination but can inform on whether discrimination is reducing service uptake.

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive biobehavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

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

For further information on stigma and discrimination, and efforts to measure their prevalence, please see: Thematic segment on non-discrimination, 31st meeting of the UNAIDS Programme Coordinating Board. Background note. Geneva UNAIDS; 2012 (https://files.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121111_PCB%2031_Non%20Discrimination_final_newcoverpage_en.pdf#:~:text=the%20broad%20theme%20of%20%E2%80%9Cnon-discrimination%E2%80%9D:%20populations%20at%20higher%20risk%20with).

Confronting discrimination: Overcoming HIV-related stigma and discrimination in health-care settings and beyond. Geneva: UNAIDS; 2017 (http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf, accessed 21 November 2017).

Stangl A, Brady L, Fritz K. Technical brief: measuring HIV stigma and discrimination. Washington (DC) and London: International Center for Research on Women and London School of Tropical Medicine, STRIVE; 2012 (https://www.icrw.org/wp-content/uploads/2017/07/STRIVE_stigma-brief-A4.pdf).

Stangl A, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? J Int AIDS Soc. 2013;16(3 Suppl. 2) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833106/pdf/JIAS-16-18734.pdf).

Joint United Nations Programme on HIV/AIDS, World Health Organization. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations—implementation tool. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

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

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

This indicator is divided into four sub-indicators:

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

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

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

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

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

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

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

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

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Denominator
Total number of respondents from a key population group

Calculation
Numerator/denominator

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

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

and/or

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

Measurement frequency
Every two years

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

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

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

Strengths and weaknesses

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

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

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

BBS-Lite is less technically demanding and may be undertaken with fewer resources than larger-scale, more comprehensive biobehavioural surveys. It can also be repeated more frequently and yield results more rapidly. The results supplement data from other sources. The BBS-Lite involves non-probability sampling methods, and therefore in many cases the results are most useful for understanding the local situation for programming purposes.

Further information

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6.1 Domestic public budget for HIV

Budget for HIV and AIDS programmes from domestic public sources

What it measures

The allocated and executed government budget earmarked for HIV programmes, along with perceived near-term trends in budget (i.e., next year's budget).

The total domestic public resources allocated and executed for HIV from central and subnational levels are to be reported.

Rationale

Domestic resources have contributed significantly to the HIV funding landscape over the last decade. In recent years, domestic resources have accounted for more than half of the total financial resources for HIV in low- and middle-income countries.

The monitoring of domestic public budgets and their short-term forecasts aims to foster global efforts to mobilize resources to achieve the targets to end AIDS by 2030.

Numerator

Not applicable

Denominator

Not applicable

Data type

Currency and monetary values (nominal currency), and categorical variables indicating the magnitude of change to represent short-term forecasts of the domestic funding landscape.

Calculation

Planned and executed budgets by each fiscal year.

The relevant department of government financial statistics maintains the budgets allocated to various sectors. Many countries may have earmarked budgets for HIV and AIDS programmes, while some may have budgets for those activities under different sectors.

The indicator aims to capture the budget for HIV and AIDS activities allocated through the government's own sources of funding. Budgeted activities funded through external aid transfers from foreign entities must be excluded.

Virtually all countries have an earmarked public budget for HIV, even while not all HIV expenditures are derived from budgets. The scope of budgets may differ occasionally across countries, but trends are useful for in-country analysis.

Method of measurement

Budget analysis

Note: The short-term forecast for the approaching fiscal year must be reported based on the information obtained through the government finance statistics, the Ministry of Health or the National AIDS Commission.

Measurement frequency

Annually for fiscal year

Disaggregation

- Budgets by level of government (i.e., national/federal, provincial/state/district or municipal/city/local) as appropriate in each country.
- If segmented budgetary units exist (e.g., social security institutions or national AIDS bodies), they should be reported separately.

Strengths and weaknesses

The data quality may be robust in countries that have earmarked budgets for HIV. When there are no earmarked budgets for HIV reporting on this indicator may need coordination between government departments concerned with health and social welfare. When service provision is integrated within facilities, such expenditures will not be identified easily in earmarked budgets.

Further information

Annex 3

6.2 Antiretrovirals and other HIV-related regimens: unit prices and volume

What it measures
The average unit prices of antiretroviral regimens and other HIV-related regimens for a country's HIV programme and the associated procurement volume

Rationale
The average unit prices and procurement volume of HIV commodities help monitor the market dynamics of antiretroviral-based prevention, treatment regimens and other HIV-related regimens and support the process of triangulating with people reported to be on antiretroviral therapy and monitor the scaleup and procurement costs of PrEP regimens.

Numerator
Not applicable

Denominator
Not applicable

Data type
The average unit price per pack of regimen in current US$ or the local currency units for the reporting year, and the absolute number of packs procured within a given period.

Calculation
Not applicable

Method of measurement
Procurement and supply chain management systems

To ensure clarity in reporting, the average unit price should reflect the landing cost of the product at the central warehouse. This means:

- Include: Product cost plus freight, insurance, and any international handling charges up to the point of delivery at the central warehouse.
- Exclude: All in-country supply chain costs, such as storage, distribution to facilities, and last-mile delivery.

Data collection tools
Logistics Management Information Systems (LMIS)

Measurement frequency
Annually

Disaggregation
- By funding source (domestic, international)
- By PrEP modality (oral PrEP, long-acting Cabotegravir, long-acting Lenacapavir, and any other approved forms).
- By antiretroviral treatment regimens
- By regimens used for treatment of advanced HIV disease

Strengths and weaknesses
The procurement supply chain management systems (PSM) in countries maintain information on health commodity procurement at the central level. In some countries, there are LMIS that monitor commodities data at the level of the health facility. These information systems may be able to provide the data for reporting on this indicator.

Further information
Annex 4

6.3 HIV expenditure by origin of resources

Domestic and international HIV expenditure by programme category and financing source

What it measures

In-country expenditures of HIV programmes and services by source in a standardized and comparable manner according to mutually exclusive categories. The HIV expenditures by programme or service reported here would need to be consistent with the number of people who have received the services (as reported elsewhere in Global AIDS Monitoring).

Rationale

The indicator to be reported is total and subtotal HIV expenditures by services or programme categories and by financing sources. Countries are requested to report the spending for eight core sub-indicators (services or programme categories). These are outlined under Annex 4.

By the end of 2021, the international and domestic resource availability for the HIV response reached an estimated US$ 20.8 billion (in constant 2019 dollars) in low- and middle-income countries. Achieving country and global targets requires increased focus, resources, programme effectiveness and efficiency to provide the HIV care, treatment and prevention to reduce HIV incidence and extend life.

It is critical to identify long-term, sustainable financing sources, including domestic resource mobilization, to maintain and build upon the success achieved. However, filling the financing gap and pursuing efficient resource allocation can only be achieved by assessing and managing the resources available and their use.

The quantification of financing flows and expenditures helps to examine the questions of who benefits from HIV programmes and to determine the current state of allocations for HIV programmes and services that focus on key or other specific populations.

The vast majority of the AIDS Spending Categories (or ASCs, per National AIDS Spending Assessment [NASA] classifications) or the sub-indicators are drawn from existing frameworks and are now structured around the 2021 Political Declaration on Ending AIDS. The resource needs for low- and middle-income countries resulted in a target to mobilize at least US$ 29 billion (in constant 2019 US dollars) by 2025.

Numerator

Not applicable

Denominator

Not applicable

Data type

Currency and monetary values (nominal currency)

Calculation

Social accounting and costing principles need to be applied for producing expenditure data. Rules, frameworks and principles are described in the specific manuals and guidelines (links provided below).

The calculation of each service/programme or sub-indicator may have individual characteristics to ensure proper accounting of all components (e.g., direct and shared costs of service provision) and to avoid double-counting; these calculations may be different by each financing source and service delivery modality (or even by service provider). Further guidance is available in the respective guidelines and manuals listed at the end of this section.

The quantification is limited to in-country expenditures, using international development assistance funds and the expenditures incurred using public or private funds reported in the current US$ or local currency units for the chosen reporting year.

There are certain requirements for data collection and quality to ensure the reliability and validity of the indicators to assure credibility.

The conciliation of top-down expenditures (from the financing sources) and bottom-up (from the costing of service delivery) provides the best assessment of the total HIV in-country spending.

Financial and programme records from providers or service delivery organizations are the basis for data collection.

There may be significant documented discrepancies between budgetary allocations and actual expenditures. Budget analysis is not recommended as the sole basis for reporting total in-country HIV expenditure.

It is good practice to validate expenditures funded by international sources, national financing sources and financing agents, as well as with all relevant stakeholders.

Method of measurement

Primary:

- National AIDS Spending Assessment (NASA).

Alternative:

- Budget analysis.
- System of Health Accounts 2011 (SHA-2011) with HIV module.

Note:

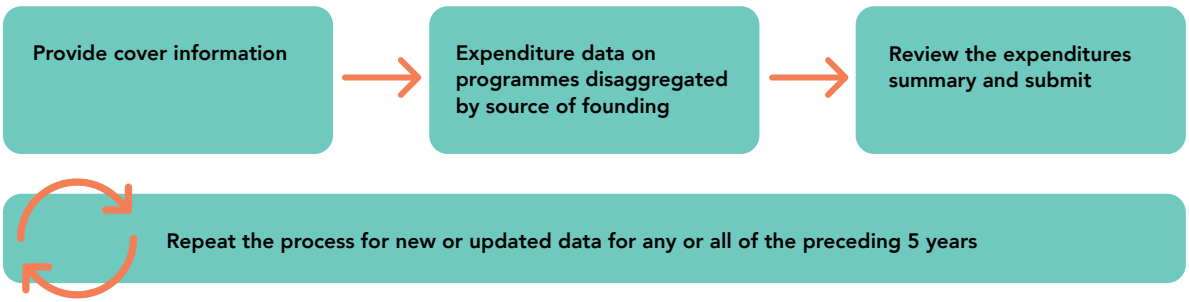
- When a NASA is not available, countries may use centrally produced results from the PEPFAR expenditure reporting system and request expenditure data from the Global Fund, that can be made available to reporting countries as a part of global coordination and resource alignment across UNAIDS, PEPFAR and the Global Fund. The reporting of expenditures for programmes funded by the Global Fund must conform to the reporting guidelines on Progress Update and Disbursement Request.[1]
- Health accounts using the SHA-2011 framework with full disease distribution attempt to capture top-level aggregated programme categories with cost item. However, depending on the objectives of a given resource-tracking exercise, SHA-2011 may or may not inform on the totality of HIV granular expenditure (disaggregated by programme) as required, and applied distribution keys must be examined and updated if necessary. The countries' health account report and data may have to be supplemented by robust costing principles to disaggregate the HIV portion of the joint costs incurred by the system.

[1] Please see Progress Update and Disbursement Request Form Instructions.

Data collection tools

Countries develop their reports on HIV expenditures by core programme/service categories and financing sources using the national funding matrix template. A full range of HIV programme categories is provided in Annex 5. If countries have developed a full and proper NASA, the filling of the funding matrix constitutes only an output template from the exercise. If countries have developed a health account using the SHA-2011 framework, the cells of the funding matrix can be filled, particularly for the international sources, and in some cases, for the domestic private and public sources of financing.

Process flow for reporting on this indicator



The amended data for previous years can be submitted if the data submitted in previous years were preliminary or were not submitted previously.

Measurement frequency

Annually for calendar or fiscal year. Since the results of any accounting exercise may take time longer than the deadline for annual reporting, countries may submit preliminary results, which will be substituted when final results are available. In this reporting cycle, we suggest that countries submit any number of annual final reports available from the last five years, indicating their status as preliminary or final and whether they substitute for previous reports. It is not required to resubmit the data that have previously been reported and that remained unchanged. The UNAIDS team can be contacted for assistance if countries would like to submit recently amended or final reports on expenditures prior to 2016.

Disaggregation

- Financing source.
- HIV and AIDS programme categories.
- For selected sub-indicators, countries are encouraged to report expenditures on the most salient commodities under each of the relevant programmes representing sub-indicators, as data allow. Reporting of total expenditures by programme is acceptable if the disaggregation is not known but there is certainty that both commodities and service delivery costs are included.

Strengths and weaknesses

Countries that have appropriately implemented a full NASA are able to fill the template with an output table from the NASA exercise. Final country estimates need to be validated with all stakeholders and triangulated to increase reliability and validity.

Countries that have implemented an SHA-2011 annual exercise may need to ensure that the allocation keys used to estimate HIV expenditures from the utilization of the health system are updated and allow the granular data for domestic sources. This process may not use certified data as some accounting principles might require. Countries that have just started the process of full distributional health accounts need to validate the results with other existing sources and all stakeholders to increase reliability and validity of the estimates, particularly the overall level, potential duplication and significant unaccounted expenditures. Countries using health accounts should add non-health-related expenditures and ensure that consistent HIV expenditure is reported, particularly for shared costs in the health system. The implementation of health accounts needs medium- to long-term planning, and it is resource-intensive and depends on coordination between health accountants and programme managers.

Countries using budget analysis need to ensure that allocated budgets were spent as planned; the estimates for any additional expenditures that are not incurred using an earmarked budget should be added to each subtotal, as appropriate.

Countries have the choice of reporting on: (a) separate costs (commodities and service delivery) if they have the data; (b) on only one cost (if that is what is available); or (c) a disaggregated total that includes both commodities and service delivery.

List of core sub-indicators and associated statistical metadata

Total HIV expenditure	Funding source or service/ programme category	Not applicable	Total expenditure from all sources spent on HIV and AIDS at the national level, including health and non-health
Sub-indicators	**Disaggregation**	**Target population**	**What it measures**
A. Expenditure on HIV testing and counselling (non- targeted; specific commodities separately)	Funding source	General population under specific indications	HIV testing and counselling is used to refer to all services involving HIV testing provided alongside counselling, including: ▪ Client-initiated HIV testing and counselling. ▪ Provider-initiated testing and counselling. ▪ HIV testing and counselling (HTC) as part of a campaign, through outreach services or through home-based/self-testing. Direct expenditures in the purchase of reagents for laboratory and rapid tests to be reported separately from other costs (as available).
B. Expenditure on antiretroviral therapy (adults and paediatric; specific commodities separately)	Funding source, adults and children (younger than 15 years old)	Persons living with HIV	Antiretroviral therapy. Direct expenditures in the purchase of antiretrovirals separately from other from other costs (as available).
C. Expenditure on HIV- specific laboratory monitoring (specific commodities separately)	Funding source	Persons living with HIV on antiretroviral therapy	Diagnostic services related to HIV clinical monitoring. Direct expenditures in the purchase of laboratory reagents for use in determining CD4+ cell counts and viral load quantification, separately from costs associated with other commodities and service delivery (as available).
D. Expenditure on tuberculosis (TB) and HIV (specific commodities separately)	Funding source	People living with HIV and people living with TB	Examinations, clinical monitoring, related laboratory services, treatment and prevention of TB (including isoniazid and drugs for treating active TB), and screening and referring clients of TB clinics for HIV testing and clinical care. Direct expenditures in the purchase of drugs for the treatment and prevention of TB (including isoniazid and drugs for treating active TB) separately from other commodities and service delivery costs (as available).

E. Expenditure on the five pillars of combination prevention (specific commodities separately)	Funding source, five pillars of combination prevention: ▪ Prevention for young women and adolescent girls (age 10–24 years, exclusively high-prevalence countries). ▪ Voluntary medical male circumcision (exclusively high-prevalence countries). ▪ Pre-exposure prophylaxis (PrEP) stratified by key population (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people, people in prisons and other closed settings, young women and adolescent girls, and serodiscordant couples). ▪ Condoms (non-targeted). ▪ Prevention among key populations (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people and people in prisons and other closed settings).	General population, key populations	This subset of prevention services is labelled and defined as combination prevention. The rest of the HIV prevention services are to be specified within the categories of the national funding matrix as part of broader prevention services. This subset includes prevention services specifically designed and delivered for each of the key populations, including prevention services for: ▪ Young women and adolescent girls (age 10–24 years) in high-prevalence countries. ▪ Gay men and other men who have sex with men. ▪ Sex workers and their clients. ▪ People who inject drugs. ▪ Voluntary medical male circumcision. ▪ PrEP, stratified by key populations. ▪ Condom promotion and provision for the general population. Direct expenditures in the purchase of condoms, needles and syringes, and drugs for substitution therapy separately from other costs (as available).
F. Expenditure on prevention of vertical transmission of HIV (specific commodities separately)	Funding source	Pregnant women and newborns	Activities aimed at elimination of new HIV infections in children, including: ▪ HIV testing for pregnant women. ▪ Antiretroviral therapy for pregnant women living with HIV. ▪ Antiretroviral medicine for newborns. ▪ Safe childbirth practices. ▪ Counselling and support for maternal nutrition and for exclusive breastfeeding. **Note**: When a woman living with HIV receives antiretroviral therapy as a part of her treatment before she knows she is pregnant, the treatment should be included under antiretroviral therapy for adults rather than for the prevention of mother-to-child transmission.
G. Expenditure on social enablers	Funding source	Not Applicable	Activities to support the implementation of basic programmes as defined in the UNAIDS Investment Framework, including: ▪ Political commitment and advocacy. ▪ Mass media. ▪ Laws, legal policies and practices. ▪ Community mobilization. ▪ Stigma reduction. ▪ Human rights programmes
H. Expenditure on cash transfers for young women and girls (age 10–24 years, high-prevalence countries)	Funding source	Young women and girls (age 10–24 years)	Total expenditure on cash transfers for young women and girls (age 10–24 years). This is defined as a development synergy with implications for HIV prevention.

Further information

To access guidelines, framework tools and classifications for NASAs, please contact AIDSspending@unaids.org

Health Accounts reports are available at the World Health Organization (WHO) Global Health Expenditure Database: http://apps.who.int/nha/database/DocumentationCentre/Index/en

Eurostat. HEDIC – Health expenditures by diseases and conditions. 2016 edition [Internet]. Luxembourg: Publications Office of the European Union; 2016 (http://ec.europa.eu/eurostat/web/products-statistical-working-papers/-/KS-TC-16-008).

Guidelines for completing the 2026 National Commitments and Policy Instrument

Introduction

Policy monitoring has been a component of global AIDS reporting since 2003, and it has been implemented every two years, most recently in 2025. The NCPI aims to measure progress in developing and implementing policies, strategies and laws related to the HIV response. It achieves this by doing the following:

- Promoting consultation and dialogue between key stakeholders at the national level, especially government and civil society and communities, in order to capture their perspectives on the AIDS response.
- Supporting countries in assessing the status of their HIV epidemic and response, and in identifying barriers, gaps and facilitators to strengthen the response.
- Collecting data on the policy and legal environment related to the AIDS response.

The responses directly monitor several targets and provide context on progress towards achieving global targets.

The full NCPI is to be completed and submitted as part of GAM reports every two years. This interval reflects the expectation that changes to laws, policies and regulations occur slowly, and that the need for more frequent monitoring may be limited.

During interim years, an interim NCPI is to be completed and submitted as part of GAM reports. The interim NCPI includes a subset of questions from the NCPI Part A that relate to policy elements that may change more frequently.

Structure of the National Commitments and Policy Instrument

The full NCPI has two parts: Part A is to be completed by national authorities, and Part B is to be completed by civil society, communities and other nongovernmental partners involved in the national AIDS response.

The questions are structured around the recommended targets for 2030 to end AIDS as a public health threat.[1]

Proposed steps for gathering and validating data

The process described below for completing the NCPI should be integrated within each country's plan and time frame for the overall GAM process. This suggested process aims to integrate consistency checks for NCPI data collected throughout the process and to promote analysis of the information that is as objective as possible.

1 Global HIV Target Setting for 2030: Global Task Team on 2030 Targets Recommendations; 2025 (https://www.unaids.org/sites/default/files/2025-05/20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf).

1. Establish a working group to accompany NCPI reporting. This could be an existing multisectoral monitoring and evaluation technical working group.
2. Identify a focal point to coordinate the completion of each part: Part A (from the national AIDS programme or equivalent) and Part B (a civil society or community representative).
3. An NCPI working group conducts a stakeholder mapping exercise to select contributors systematically for both Parts A and B.

   A mapping exercise can ensure that the most up-to-date and accurate data can be collected through the NCPI by involving relevant experts and avoiding the influence of potential biases in the reporting process. It can ensure that the reporting reflects a broad range of perspectives; involving a broad range of stakeholders can also help with interpreting qualitative or potentially ambiguous data.

   The list of all the people or entities who could provide information or insight on the questions included in the NCPI can be drawn from the knowledge of working group members, through contacts with other people knowledgeable about the national HIV response and by reviewing relevant documentation. Stakeholders can be identified from the following sectors and groups (among others):

   - Health ministry or the equivalent.
   - Education ministry or the equivalent.
   - Gender ministry or the equivalent.
   - Justice ministry or the equivalent.
   - Trade ministry or the equivalent.
   - Representatives of people living with HIV, including women and young people living with HIV.
   - Representatives of the various key population groups.
   - Bilateral and multilateral organizations engaged in the HIV response.
   - Other nongovernmental organizations or foundations engaged in the HIV response.
   - The private sector.

   Geographical diversity should be considered in identifying stakeholders to ensure representativeness.

   The following information should be recorded for all stakeholders contacted throughout the NCPI reporting process:

   - Name.
   - Contact details.
   - Organization affiliation.
   - Role in the organization.
   - Stakeholder type: health ministry, other ministry, private sector, civil society, community, international nongovernmental organization, bilateral organization, UNAIDS or other United Nations organization.

This information could be helpful for documenting the multisectoral nature of the process and supporting preparations for future rounds of NCPI reporting.

4. Collect responses to NCPI questions. To ensure accuracy and avoid respondent fatigue, it is suggested that specific questions be directed to specific respondents who are knowledgeable in that area. Focal points for Parts A and B should coordinate contact with identified stakeholders—such as through in-person interviews, by phone or email—in order to share the NCPI questions in their area of expertise and gather their responses.

   If possible, it is recommended that the same question be sent to more than one stakeholder knowledgeable in the area. If there are discrepant answers, the coordinator for that part of the NCPI could share a summary of the information received for that question with the various stakeholders who have provided it to clarify the source of the different responses and to reach a consensus (if possible). To avoid potential sources of bias, the anonymity of respondents should be maintained as much as possible during this process of data verification and follow-up.

   A PDF version of the questionnaire (Parts A and B) is available on the UNAIDS website. It can also be downloaded through the NCPI header in the indicator list in the GAM online reporting tool (https://AIDSreportingtool.unaids.org).

   Please refer to the glossary of key terms below and to additional guidance on responding to laws-related questions in the NCPI (annex 6).

5. The national GAM focal point enters responses in the online reporting tool.

6. Stakeholders view and provide comments on the draft responses. The draft of the completed NCPI can be shared with stakeholders by giving them viewing rights to the GAM online reporting tool or by sharing the NCPI questionnaire with draft responses in PDF. The PDF can be extracted from the online reporting tool by clicking Print all NCPI to PDF in the indicator list page.

7. Conduct a validation consultation:

   - To review NCPI responses for selected questions.
   - To analyse NCPI data jointly with indicator data, identifying progress, gaps, barriers and facilitators to the AIDS response.
   - To identify key points for narrative summaries for each commitment area.

   Because of the length of the questionnaire, it is suggested that responses to all questions not be reviewed during the national validation workshop, but that the workshop instead focus on: (a) specific questions identified as key for discussion during the data collection and review process before the workshop; and (b) on discussing progress and gaps for each commitment area more broadly.

8. Update the NCPI responses entered in the GAM online reporting tool based on comments received in preparation for and during the consultation, and complete the narrative summaries for each commitment area.

9. Submit the NCPI responses with other GAM components by the submission deadline.

10. Respond to queries posted through the online reporting tool during the data validation process.

Operationalizing and using the National Commitments and Policy Instrument data

Data collected through the NCPI will complement indicator and expenditure data that are also collected and reported through the GAM process. Countries are encouraged to use the NCPI data in analysing the status of the national epidemic and response, and in their national strategic planning efforts.

NCPI data will also be used: (a) to directly monitor progress globally towards the 10–10–10 targets and as proxy measures for the 30-80-60 targets; (b) to provide context to quantitative data collected through GAM indicators during the analysis of progress towards other global commitments; and (c) to inform global strategies and reports. The responses to the NCPI questions from each country will be aggregated to generate regional and global values. The NCPI data by country will be available through AIDSInfo (http://aidsinfo.unaids.org/) and Laws and Policies Analytics (http://lawsandpolicies.unaids.org/).

Loading policy data previously reported through Global AIDS Monitoring

Countries that submitted responses to questions through a previous NCPI that have remained the same from the previous reporting round can choose to load those responses into the 2026 GAM online reporting tool. Responses can then be updated or resubmitted where there has been no change.

Definitions

The following are definitions of key terms included in the NCPI questionnaire, where they are marked with an asterisk (*).

These definitions should be followed to complete the questionnaire: consistent use of these definitions over time and across countries strengthens comparability and trend analyses.

Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) flexibilities.[2] "The Agreement on Trade-related Aspects of Intellectual Property Rights (or TRIPS), supervised by the World Trade Organizations, provides certain flexibilities to low- and middle-income countries with respect to pharmaceutical patent protection. TRIPS is one of the three primary agreements of the World Trade Organization (WTO). It requires all WTO Member States to provide a minimum level of protection for various types of intellectual property, including patents on essential medicines (such as antiretroviral medicines). The TRIPS Agreement contains certain public health-related flexibilities and safeguards, such as compulsory licensing that can be used to increase access to essential medicines".[3]

Cash transfers. Programmes that give money to poor and vulnerable people. Cash transfers may be conditional, giving money in return for fulfilling specific behavioural conditions (such as school attendance among children), or unconditional (not attached to specific behavioural requirements).

Data governance framework: Creating an environment of implementing norms, infrastructure policies and technical mechanisms, laws, and regulations for data, related

2 Agreement on Trade-related Aspects of Intellectual Property Rights. Geneva: World Trade Organization; 1995 (http://www.wto.org/English/docs_e/legal_e/27-trips.pdf).

3 UNAIDS terminology guidelines. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf).

economic policies, and institutions that can effectively enable the safe, trustworthy use of public intent and private intent data to achieve development outcomes.[4]

Established on antiretroviral therapy. The World Health Organization (WHO) defines people established on antiretroviral therapy as having met all of the following criteria: they have been receiving antiretroviral therapy for at least six months; they have no current illness, which does not include well-controlled chronic health conditions; they have a good understanding of lifelong adherence: they are provided with adequate adherence counselling; and there is evidence of treatment success (at least one suppressed viral load result within the past six months; if viral load is not available at least one of the following can be considered: CD4 count >200 cells/mm^3 [CD4 count >350 cells/mm^3 for children aged 3–5 years] or weight gain, absence of symptoms and concurrent infections).[5]

Gender-based violence. Any intentional act or failure to act-whether threatened or actual-against a person on the basis of their gender that results, or is likely to result, in physical, sexual or psychological harm.[6]

Gender-transformative. Gender transformative approaches seek to actively foster critical examination of gender attitudes, norms and practices; strengthen or create systems that support gender equality; and create gender equitable attitudes, norms and dynamics.[7]

Grave or systematic human rights abuses. The qualification of "grave" indicates a serious, flagrant and egregious human rights violation. A violation of the right to life or physical integrity would constitute a grave violation of human rights. "Systematic" refers to the number of people affected and the frequency. It implies a pattern of violations and not an isolated case.

HIV case surveillance. HIV case surveillance refers to the reporting of an initial diagnosis of HIV infection and defined sentinel events from every person diagnosed with HIV to a public health agency responsible for monitoring and controlling the epidemic. Case surveillance entails individual-level, longitudinal data obtained from multiple sources that are linked by unique identifiers and maintained in a dedicated data repository at the national level.[8]

International standards for sexuality education. Standardized benchmarks for the sexuality education curriculum to ensure quality, including in the following areas: (a) generic life skills (such as decision-making, communication and negotiating skills); (b) sexual and reproductive health and sexuality education (such as human growth and development, relationships, reproductive health, sexual abuse and transmission of sexually transmitted infections); and (c) HIV transmission and prevention.[9]

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4 World Development Report 2021 - Data for Better Lives. Washington, DC: World Bank; 2021 (https://www.worldbank.org/en/publication/wdr2021).

5 Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/rest/bitstreams/1357089/retrieve).

6 UNAIDS terminology guidelines. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf).

7 Gender integration continuum. Washington, DC: Interagency Gender Working Group; 2017 (https://www.igwg.org/wp-content/uploads/2017/05/FG_GendrIntegrContinuum.pdf).

8 Consolidated guidelines on person-centred HIV patient monitoring and case surveillance. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/255702/9789241512633-eng.pdf?sequence=1).

9 Emerging evidence, lessons and practice in comprehensive sexuality education: a global review. Paris: United Nations Educational, Scientific and Cultural Organization; 2015 (https://unesdoc.unesco.org/ark:/48223/pf0000243106).

Intimate partner violence. Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.[10]

Life skills-based HIV and sexuality education. An age-appropriate, culturally sensitive approach to teaching sex and relationships by providing scientifically accurate, realistic and non-judgemental information.[11]

Participation. Participation is recognised as a human right and refers to the meaningful and formal involvement of people and communities in decision-making processes that affect their lives, across the full policy and programme cycle from design and planning through to implementation, monitoring and evaluation. In the HIV response, this is operationalised through the GIPA principle, which frames participation as a right to self-determination and to influence decisions affecting one's health and well-being. Participation is primarily reflected in governance, accountability and institutional decision making, and is also expressed through roles in service delivery. It presumes formal roles in decision-making bodies or processes, supported by an enabling civic, legal including access to relevant and timely information, freedom of expression and freedom of association. It also entails transparent representation, consultation with constituencies, and sufficient capacity to engage effectively.[12]

Social protection. Defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups."[13] Social protection is HIV-sensitive when it is inclusive of people who are either at risk of HIV infection or susceptible to the consequences of HIV.[14]

Stockout. Unplanned interruption in the stock of a health product.

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10 16 ideas for addressing violence against women in the context of HIV epidemic: a programming tool. Geneva: World Health Organization and Joint United Nations Programme on HIV/AIDS; 2013 (https://www.who.int/publications-detail-redirect/9789241506533).

11 United Nations Educational, Scientific and Cultural Organization, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, United Nations Children's Fund, World Health Organization. International technical guidance on sexuality education: Volume I—the rationale for sexuality education. Paris: United Nations Educational, Scientific and Cultural Organization; 2009 (https://unesdoc.unesco.org/ark:/48223/pf0000183281).

12 The Greater Involvement of People Living with HIV (GIPA). Geneva: Joint United Nations Programme on HIV/AIDS; 2007 (https://www.unaids.org/en/resources/documents/2007/20070410_jc1299-policybrief-gipa_en.pdf); Guidance on partnerships with civil society. Geneva: Joint United Nations Programme on HIV/AIDS; 2012 (https://data.unaids.org/pub/manual/2012/jc2236_guidance_partnership_civilsociety_en.pdf); United Nations guidance note on the protection and promotion of civic space. New York: United Nations; 2020 (https://www.ohchr.org/sites/default/files/Documents/Issues/CivicSpace/UN_Guidance_Note.pdf); Strengthening civic space and civil society engagement in the HIV response. New York: United Nations Development Programme; 2022 (https://www.undp.org/sites/g/files/zskgke326/files/2022-12/UNDP-Strengthening-Civic-Space-and-Civil-Society-Engagement-in-the-HIV-Response.pdf).

13 Sander G. HIV, HCV, TB and harm reduction in prisons: human rights, minimum standards and monitoring at the European and international levels. London: Harm Reduction International; 2016 (https://www.hri.global/files/2016/02/10/HRI_PrisonProjectReport_FINAL.pdf).

14 HIV and social protection guidance note. Geneva: Joint United Nations Programme on HIV/AIDS; 2014 (http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_HIVandsocialprotection_en.pdf).

National Commitments and Policy Instrument: Part A

* The guidelines for the NCPI define the terms marked with an asterisk (*).

1. Ensure available, accessible, acceptable and quality HIV treatment and care for people living with HIV

HIV testing

1. Which of the following HIV testing approaches are used in your country (select all that apply)?

- ☐ Client-initiated testing and counselling
- ☐ Provider-initiated testing and counselling
- ☐ Indicator condition testing
- ☐ Routine antenatal testing
- ☐ Dual HIV/syphilis rapid diagnostic testing (such as for pregnant women, partners or any population)
- ☐ Community-based testing
- ☐ Lay provider testing
- ☐ Self-testing
- ☐ Network-based testing (including partner services, social network testing, or family testing)
- ☐ Other (please specify): _____

2. Has your country adapted the recommendations from the 2024 World Health Organization (WHO) Consolidated guidelines on differentiated HIV testing services in a national process on testing guidelines?

- ☐ Yes, fully
- ☐ Yes, partially
- ☐ No
- ☐ Don't know

3. Has your country included self-testing as a national policy (either within the national testing policy/plan or as a stand-alone self-testing policy)?

3.a HIV self-testing

- ☐ Yes
- ☐ No

3.a.i If yes, is the HIV self-testing policy routinely implemented in your country?

- ☐ HIV self-testing policy is routinely implemented on a national scale
- ☐ HIV self-testing policy is routinely implemented on a subnational scale or in selected districts
- ☐ No, not implemented anywhere

3.a.ii If yes to Q3.a, has your country included HIV self-testing to support PrEP initiation or continuation (either within the national HIV testing policy or plan or as a standalone HIV self-testing policy)?

- ☐ Yes
- ☐ No

3.a.iii If yes to Q3.a.ii, is HIV self-testing to support PrEP routinely implemented in your country?

- ☐ Yes, routinely implemented on a national scale
- ☐ Yes, routinely implemented on a subnational scale or in selected districts
- ☐ No, only in pilot projects
- ☐ No, not implemented anywhere

3.a.iv **If yes to Q3.a, has your country included HIV self-testing to support PEP initiation or completion (either within the national HIV testing policy or plan or as a standalone HIV self-testing policy)?**

☐ Yes
☐ No

3.a.v **If yes to Q3.a.iv, is HIV self-testing to support PEP routinely implemented in your country?**

☐ Yes, routinely implemented on a national scale
☐ Yes, routinely implemented on a subnational scale or in selected districts
☐ No, only in pilot projects
☐ No, not implemented anywhere

3.b **Syphilis self-testing**

☐ Yes
☐ No

3.b.i **If yes, is the syphilis self-testing policy routinely implemented in your country?**

☐ Syphilis self-testing policy is routinely implemented on a national scale
☐ Syphilis self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

3.c **Hepatitis C self-testing**

☐ Yes
☐ No

3.c.i **If yes, is hepatitis C self-testing policy routinely implemented in your country?**

☐ Hepatitis C self-testing policy is routinely implemented on a national scale
☐ Hepatitis C self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

3.d **Other self-testing (please specify): _____**

☐ Yes
☐ No

3.d.i **If yes, is the other self-testing policy routinely implemented in your country?**

☐ Other self-testing policy is routinely implemented on a national scale
☐ Other self-testing policy is routinely implemented on a subnational scale or in selected districts
☐ No, not implemented anywhere

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4. **Has your country included any form of network-based testing (partner services, social network testing, family testing) in a national policy (select all that apply)?**

☐ Yes, partner services
☐ Yes, social network testing
☐ Yes, family testing
☐ No, none of the above

4.1 **If yes, which of the following network-based testing approaches are being used (select all that apply)?**

☐ Provider-assisted partner services
☐ Passive partner services
☐ Social network testing in key populations
☐ Social network testing in the general population
☐ Secondary distribution of HIVST kits to partners or network contacts
☐ Testing of biological children of people living with HIV

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5. Has your country adopted or included dual HIV/syphilis rapid diagnostic tests for pregnant women and/or key populations as a national policy or plan?

- ☐ Yes, for pregnant women only
- ☐ Yes, for key populations only
- ☐ Yes, for both pregnant women and key populations
- ☐ No

5.1 If yes, is dual HIV/syphilis rapid diagnostic testing routinely implemented in your country?

5.1.a For pregnant women:

- ☐ Yes, routinely implemented on a national scale
- ☐ Yes, routinely implemented on a subnational scale or in select districts
- ☐ No, only in pilot projects
- ☐ No, not implemented anywhere

5.1.b For people from key populations:

- ☐ Yes, routinely implemented on a national scale, including subnational
- ☐ Yes, routinely implemented on a subnational scale or in selected districts (not at a national scale)
- ☐ No, only in pilot projects
- ☐ No, not implemented anywhere

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6. Does your country use three consecutive reactive tests (3-test strategy/algorithm) for an HIV-positive diagnosis?

- ☐ Yes
- ☐ No

6.1 If yes to Q6, is the 3-test strategy routinely implemented in your country?

- ☐ Yes
- ☐ No

6.2 If no to Q6, does your country have a plan to adopt a 3-test strategy/algorithm for an HIV-positive diagnosis?

- ☐ Yes
- ☐ No

6.3 If yes to Q6.2, please indicate the year in which a national policy on 3-test strategy for an HIV-positive diagnosis is planned to be adopted.

- ☐ No planned year
- ☐ 2026
- ☐ 2027
- ☐ 2028

6.4 Does your country use the following assays in the standard/routine national testing strategy/algorithm?

- ☐ Rapid diagnostic (antibody test)
- ☐ Rapid diagnosis (antibody/antigen test)
- ☐ Immunoassay
- ☐ Western blotting
- ☐ Nucleic acid test
- ☐ Recency test

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7. Is there a law, regulation or policy specifying that HIV testing:

7.a Is mandatory before marriage?

- ☐ Yes
- ☐ No

7.b Is mandatory to obtain a work or residence permit?

- ☐ Yes
- ☐ No

7.c **Is mandatory for certain groups or professions (not including blood and/or tissue donors)?**

☐ Yes

☐ No

7.c.i **If yes, please specify which groups:** _____

Antiretroviral therapy

8. **Has your country adopted the recommendations on rapid Initiation of antiretroviral therapy in the 2021 World Health Organization (WHO) Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach?**

☐ Yes, rapid initiation within 7 days of HIV diagnosis

☐ No

☐ Other (please specify): _____

8.1 **If your country has adopted a policy on rapid initiation of antiretroviral therapy, what is the status of implementation?**

☐ Implemented in few (<50%) treatment sites

☐ Implemented in many (50–95%) treatment sites

☐ Implemented countrywide (>95% of treatment sites)

☐ Not implemented in practice

☐ Other (please specify): _____

9. **Is nurse-initiated antiretroviral therapy allowed in your country for any of the following populations (select all that apply)?**

☐ Adults, except pregnant women

☐ Pregnant women

☐ Adolescents (aged 10–19 years)

☐ Children younger than 10 years

☐ None of the above

10. **Do the country's national criteria for (or definition of) people established* on antiretroviral therapy include the following elements defined in the 2021 World Health Organization (WHO) Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach (select all that apply)?**

☐ Receiving antiretroviral therapy for at least 6 months

☐ No current Illness (does not Include well-controlled chronic health conditions)

☐ Good understanding of lifelong adherence

☐ Evidence of treatment success (i.e. at least one suppressed viral load result within the past six months)

☐ Other (please specify): _____

11. **Which of the following service provision modalities are included in the national policy on antiretroviral therapy for adults, adolescents and children (select all that apply)?**

☐ Tuberculosis (TB) service providers provide antiretroviral therapy in TB clinics for the duration of TB treatment

☐ Antiretroviral therapy providers provide TB treatment in antiretroviral therapy settings for the duration of TB treatment

☐ Maternal, newborn and child health (MNCH) service providers provide antiretroviral therapy in MNCH clinics

☐ Nutrition assessment, counselling and support provided to malnourished people living with HIV

☐ Antiretroviral therapy delivered in settings providing opioid agonist maintenance therapy

☐ Primary health-care providers deliver antiretroviral therapy in primary health care for adults and adolescents

☐ Primary health-care providers deliver antiretroviral therapy in primary health-care settings for children

☐ Psychosocial support strategies for patient-centered care (e.g. support groups, enhanced adherence counselling, support for disclosure or referral for psychological/socioeconomic services) linked to facilities

☐ Patient-centered support (e.g. counselling, enhanced adherence counselling, support for disclosure or referral for psychological/socioeconomic services) separated from facilities

☐ Facility-based key population-friendly services

☐ Community-based key population-friendly services

☐ Adolescent-friendly health services

☐ Antiretroviral therapy delivered in the community as part of a differentiated service delivery for HIV treatment

☐ Antiretroviral therapy providers carry out cardiovascular disease screening and management

☐ Antiretroviral therapy providers carry out mental health screening and treatment

☐ Other (please specify): _____

12. **Do patients pay any routine user fees or charges for services when visiting a public sector health facility?**

☐ Yes

☐ No

Antiretroviral therapy regimens

Adults and adolescents

13. **Is a TDF (or TAF) + 3TC (or FTC) + DTG regimen included in the national guidelines as an option for 1st line for adults and adolescents?**

☐ Yes, as preferred option

☐ Yes, as alternative option

☐ Not included

☐ Other (specify): _____

13.1 **If no, what is (are) the preferred option(s):**

☐ TDF + 3TC (or FTC) + EFV

☐ ABC + 3TC + DTG

☐ Other regimens (please specify): _____

13.2 **If no, is there a plan to adopt TDF (or TAF) + 3TC (or FTC) + DTG as the preferred first-line antiretroviral combination for treatment initiation in 2026?**

☐ Yes

☐ No

14. **Is a DTG-based regimen included in the national guidelines as an option for second-line antiretroviral combination for adults and adolescents with HIV?**

☐ Yes, as preferred option

☐ Yes, as alternative option

☐ No

☐ Other (please specify): _____

15. **Is atazanavir/ritonavir (ATV/r) included in national guidelines as a protease inhibitor option for second-line antiretroviral combination for adults and adolescents with HIV?**

☐ Yes, as preferred option

☐ Yes, as alternative option

☐ No

☐ Other (please specify): _____

16. **Is lopinavir/ritonavir (LPV/r) included in national guidelines as a protease inhibitor option for second-line antiretroviral combination for adults and adolescents with HIV?**

☐ Yes, as preferred option

☐ Yes, as alternative option

☐ No

☐ Other (please specify): _____

17. **Is darunavir/ritonavir (DRV/r) included in national guidelines as a protease inhibitor option for second-line antiretroviral combination for adults and adolescents with HIV?**

☐ Yes, as preferred option

☐ Yes, as alternative option

☐ No

☐ Other (please specify): _____

18. **Does your country have a current national policy on routine viral load testing for monitoring antiretroviral therapy (select all that apply)?**

- ☐ Yes, for adults
- ☐ Yes, for adolescents
- ☐ Yes, for children
- ☐ No policy on routine viral load testing

19. **Does your country have a current national policy on point-of-care viral load testing?**

- ☐ Yes
- ☐ No

19.1 **If yes, what is the status of implementation?**

- ☐ Implemented in few (95% of treatment sites)
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

Children

20. **In your country, is abacavir/lamivudine/dolutegravir (ABC/3TC/DTG) the preferred regimen for HIV treatment in infants and children living with HIV?**

20.a **For children weighing less than 30 kg:**

- ☐ Yes
- ☐ No, another regimen is preferred (please specify): _____

20.b **For neonates (from birth to age 4 weeks):**

- ☐ Yes
- ☐ No, another regimen is preferred (please specify): _____

21. **What nucleoside reverse transcriptase inhibitor (NRTI) backbone is recommended for all paediatric patients weighing less than 30 kg after failure on a regimen containing abacavir/lamivudine/dolutegravir (ABC/3TC/DTG)?**

- ☐ Abacavir/lamivudine (ABC/3TC)
- ☐ Tenofovir alafenamide/lamivudine (TAF/3TC) or tenofovir alafenamide/emtricitabine (TAF/FTC)
- ☐ Zidovudine/lamivudine (AZT/3TC)
- ☐ Abacavir/lamivudine (ABC/3TC) or tenofovir alafenamide/emtricitabine (TAF/FTC)
- ☐ Dependent on genotyping

21.1 **If tenofovir alafenamide (TAF) is recommended, for what paediatric population is it indicated (select all that apply)?**

- ☐ Children weighing ≥14 kg–25 kg
- ☐ Children weighing ≥25 kg
- ☐ Other (please specify): _____

22. **Is paediatric darunavir/ritonavir (DRV/r) available for children aged three years and over failing a dolutegravir (DTG)-containing regimen (select all that apply)?**

- ☐ Yes, through donor-funded donations or programmes
- ☐ Yes, through the national programme
- ☐ Yes, on a case-by-case basis
- ☐ No, alternative protease inhibitors are used

23. **What is the frequency of antiretroviral medicine pick-up included in the national policy for paediatric populations:**

- ☐ Once a month
- ☐ Every 2 months
- ☐ Every 3 months
- ☐ Every 6 months
- ☐ Every 12 months
- ☐ Other (please specify): _____

24. When is a child who initiated antiretroviral therapy considered lost to follow-up in your country?

- ☐ Has not been seen for HIV care or pharmacy pick-up in 1 month
- ☐ Has not been seen for HIV care or pharmacy pick-up in 2 months
- ☐ Has not been seen for HIV care or pharmacy pick-up in 3 months
- ☐ Has not been seen for HIV care or pharmacy pick-up in 6 months

25. Where are paediatric antiretroviral therapy services available?

- ☐ Available in all facilities delivering HIV care at the primary care level
- ☐ Available in some facilities delivering HIV care at the primary care level
- ☐ Not available at the primary care level, or available only at higher-level facilities

Advanced HIV disease

26. Is CD4 testing for diagnosing advanced HIV disease available?

- ☐ Yes
- ☐ No

26.1 Is yes, where is it available (select all that apply)?

- ☐ Point-of-care
- ☐ Facility laboratory
- ☐ Centralized laboratory
- ☐ Other (please specify): _____

26.2 If yes, in what percentage of sites (estimated) do clients have access to CD4 testing and return of results?

- ☐ In few (<50%) sites
- ☐ In many (50–95%) sites
- ☐ Countrywide (>95% of sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

26.3 If yes, what is the median time (in number of days) for the person to receive the CD4 result?

- ☐ Please specify: _____
- ☐ Not available

27. Has your country adopted the recommendations in the 2021 World Health Organization (WHO) Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach to offer a package of interventions to all patients presenting with advanced HIV disease (defined by WHO as CD4<200)?

- ☐ Yes, fully adopted
- ☐ Yes, partially adopted (only for specific interventions and/or populations, such as children, adolescents or adults) (please specify): _____
- ☐ No

27.1 If yes, how widely is it implemented?

- ☐ Implemented in few (<50%) treatment sites
- ☐ Implemented in many (50–95%) treatment sites
- ☐ Implemented countrywide (>95% of treatment sites)
- ☐ Not implemented in practice
- ☐ Other (please specify): _____

28. **Which of the following components of the package of advanced HIV disease interventions for tuberculosis (TB), severe bacterial infections and cryptococcal meningitis recommended in the 2021 WHO Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach are included in the national policy on antiretroviral therapy for adults, adolescents and children (select all that apply)?**

- ☐ Baseline CD4 count test to diagnose advanced HIV disease
- ☐ Molecular diagnostic tests for TB diagnosis
- ☐ Urine LF-LAM for TB diagnosis
- ☐ Cryptococcal antigen (CrAg) screening
- ☐ Co-trimoxazole prophylaxis
- ☐ TB preventive treatment
- ☐ Fluconazole empirical prophylaxis
- ☐ Fluconazole pre-emptive therapy
- ☐ Rapid antiretroviral therapy initiation
- ☐ Adapted adherence support
- ☐ Other (please specify): _____

Retention in care

29. **Does your country have a national policy promoting community delivery of antiretroviral therapy (such as outside of health facilities)?**

- ☐ Yes
- ☐ No

29.1 **If yes, where is delivery in a community setting implemented?**

- ☐ Nationally
- ☐ Regionally
- ☐ At pilot sites
- ☐ Other (please specify): _____

29.2 **If yes, which differentiated care services is your country using for the pick-up of antiretroviral medicine (select all that apply)?**

- ☐ Group models managed by health-care workers (such as adherence clubs, teen clubs)
- ☐ Group models managed by clients (such as community adherence groups, client-led ART delivery)
- ☐ Individual models based at facilities (such as multi-month ARV refills, fast track ARV pick-up)
- ☐ Individual models not based at facilities (such as community drug distribution points, ARV lockers, home ARV delivery, mobile clinics)
- ☐ Other (please specify): _____

30. **Does your country have a national policy on the frequency of clinic visits for adults who are established* on antiretroviral therapy?**

- ☐ Yes
- ☐ No

30.1 **If yes, please specify the frequency of clinic visits in the national policy.**

- ☐ Once a month
- ☐ Every 2 months
- ☐ Every 3 months
- ☐ Every 6 months
- ☐ Every 12 months

31. **Please provide the country's national criteria for (or definition of) lost to follow-up. For guidance, the World Health Organization (WHO) defines "lost to follow-up" as a patient who has not received antiretroviral medicines within 28 days of their last missed drug collection appointment.1** _____

HIV drug resistance and toxicity monitoring

1 Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022, page 127)

32. **Does your country have a national strategy to prevent, monitor and respond to HIV drug resistance?**

☐ Yes

☐ No

32.1 **If yes, please specify the years covered by the strategy:** _____

33. **In the past three years, has your country carried out HIV drug resistance (HIVDR) surveillance according to any of the following World Health Organization (WHO) protocols?**

33.a **Pre-treatment drug resistance (PDR) surveys in adults initiating ART[2]**

☐ Yes

☐ No, but there is a plan to implement the PDR survey this year

☐ No, and there is no plan to implement the PDR survey this year

33.a.i **If yes, please specify the year the last PDR survey started:** _____

33.b **HIV drug resistance survey among individuals testing positive for HIV while receiving HIV pre-exposure prophylaxis (PrEP)**

☐ Yes

☐ No, but there is a plan to implement the survey this year

☐ No, and there is no plan to implement the survey this year

33.b.i **If yes, please specify the year the last survey started:** _____

33.c **Acquired HIV drug resistance surveys among adults[3]**

☐ Yes

☐ No, but there is a plan to implement the survey this year

☐ No, and there is no plan to implement the survey this year

33.c.i **If yes, please specify the year the last survey started:** _____

33.d **Acquired HIV drug resistance surveys among children and adolescents**

☐ Yes

☐ No, but there is a plan to implement the survey this year

☐ No, and there is no plan to implement the survey this year

33.d.i **If yes, please specify the year the last survey started:** _____

33.e **HIV drug resistance among infants (<18 months) diagnosed with HIV through the early infant diagnosis programme[4]**

☐ Yes

☐ No, but there is a plan to implement the infant survey this year

☐ No, and there is no plan to implement the infant survey this year

33.e.i **If yes, please specify the year the last infant survey started:** _____

2 For more details, please see: Surveillance of HIV drug resistance in adults receiving ART. Geneva: WHO; 2014 (https://www.who.int/publications/i/item/9789241507073).

3 For more details, please see: Surveillance of HIV drug resistance in adults receiving ART. Geneva: WHO; 2014 (https://www.who.int/publications/i/item/9789241507073).

4 For more details, please see: HIV drug resistance. In: World Health Organization: Global HIV Programme: Treatment & Care. Geneva; WHO; c2018 (https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/treatment/hiv-drug-resistance).

34. Does your country have a national policy for person-centered HIV drug resistance testing for clinical management of people in whom antiretroviral therapy fails?

☐ Yes
☐ No

34.1 If yes, which of the following groups are considered in the policy (select all that apply)?

☐ Adults failing DTG-based first-line antiretroviral therapy
☐ Children and adolescents failing DTG-based first-line antiretroviral therapy
☐ Adults failing DTG-based second-line antiretroviral therapy
☐ Children and adolescents failing DTG-based second-line antiretroviral therapy
☐ Adults failing protease inhibitor-based second-line antiretroviral therapy
☐ Children and adolescents failing protease inhibitor-based second-line antiretroviral therapy
☐ Patients failing third-line antiretroviral therapy
☐ Other (please specify): _____

35. Does your country have a national policy for HIV drug resistance testing for individual patient management prior to initiation of antiretroviral therapy?

☐ Yes
☐ No

35.1 If yes, which of the following groups are considered in the policy (select all that apply)?

☐ All adults initiating first-line DTG-based first-line antiretroviral therapy
☐ People testing positive for HIV while receiving cabotegravir-based PrEP for the prevention of HIV
☐ Infants and children initiating first-line antiretroviral therapy
☐ Pregnant women initiating first-line antiretroviral therapy
☐ Other (please specify): _____

36. Excluding passive pharmacovigilance approaches, does your country make an ongoing systematic effort to monitor the toxicity of antiretroviral medicines in the country?

☐ Yes
☐ No

36.1 If yes, what approaches are used (select all that apply)?

☐ Routine toxicity monitoring as part of the national monitoring and evaluation system
☐ Active toxicity monitoring/surveillance within cohorts in adults
☐ Active toxicity monitoring/surveillance within cohorts in adolescents and children
☐ Pregnancy registry and surveillance of birth defects

37. Have toxicity monitoring approaches been introduced to monitor adverse drug reactions to DTG use?

☐ Yes
☐ No

37.1 If yes, what approaches are used (select all that apply)?

☐ Routine toxicity monitoring as part of the national monitoring and evaluation system
☐ Active toxicity monitoring/surveillance within cohorts in adults
☐ Active toxicity monitoring/surveillance within cohorts in adolescents and children
☐ Pregnancy registry and surveillance of birth defects

37.2 If yes, has training of health-care workers on the management, capture and reporting of adverse drug reactions related to DTG been implemented?

☐ Yes
☐ No

Tuberculosis/HIV

38. Are the following screening tools recommended for people living with HIV in national guidelines related to tuberculosis (TB) and/or HIV (select all that apply)?

- ☐ World Health Organization-recommended four symptom screen for adults and adolescents (>10 years)
- ☐ C-reactive protein (CRP) for adults and adolescents (>10 years)
- ☐ Chest X-ray for adults and adolescents (>10 years)
- ☐ Computer-aided detection of TB on chest x-ray
- ☐ Molecular World Health Organization-approved rapid diagnostic tests for TB (mWRD) for adults and adolescents (>10 years)
- ☐ Symptom screen, including cough, fever, poor weight gain or close contact with a TB patient for children <10 years
- ☐ None of the above

39. Has your country adopted the 2025 WHO recommendations on concurrent testing with lateral flow urine lipoarabinomannan assay (LF-LAM) and (mWRD) for diagnosis of tuberculosis disease in people living with HIV (select all age groups that apply)?

- ☐ Yes, for adults and adolescents (>10 years)
- ☐ Yes, for children (<10 years)
- ☐ No

40. Which of the following regimens are recommended for tuberculosis (TB) preventive treatment in national guidelines (select all that apply)?

40.a Adults and adolescents living with HIV

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3RH)
- ☐ 1 month of daily rifapentine plus isoniazid (1HP)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____
- ☐ None of the World Health Organization recommended TB preventive treatment regimens are recommended in national guidelines for adults and adolescents

40.a.i If more than one regimen is recommended, which is the preferred regimen?

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3RH)
- ☐ 1 month of daily rifapentine plus isoniazid (1HP)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____

40.b Children living with HIV

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3RH)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify): _____
- ☐ TB preventive treatment not recommended in national guidelines for children

40.b.i If more than one regimen is recommended, which is the preferred regimen?

- ☐ 6 months of daily isoniazid monotherapy (6H)
- ☐ 9 months of daily isoniazid monotherapy (9H)
- ☐ 4 months of daily rifampicin (4R)
- ☐ 3 months of weekly rifapentine plus isoniazid (3HP)
- ☐ 3 months of daily rifampicin plus isoniazid (3RH)
- ☐ 6 months of daily levofloxacin monotherapy (6Lfx)
- ☐ Other (please specify) :_____

41. **Are the following required in national guidelines prior to initiating tuberculosis (TB) preventive treatment in people with HIV?**

41.a **Skin tests or interferon-gamma release assay (IGRA)**

☐ Yes, for all
☐ No
☐ Only if available

41.b **X-ray**

☐ Yes, for all
☐ No
☐ Only if available

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42. **In the last reporting period, has there been a stock-out* of any of the following?**

42.a **Isoniazid**

☐ Yes, stock outs of adult formulations at the national level
☐ Yes, stock outs of pediatric formulations at the national level
☐ Yes, stock outs of adult formulations at the local level
☐ Yes, stock outs of pediatric formulations at the local level
☐ No stock outs (of adult or pediatric formulations) reported

42.b **Vitamin B6**

☐ Yes, at the national level
☐ Yes, at the local level
☐ No

42.c **Rifapentine (including fixed-dose combinations with isoniazid)**

☐ Yes, at the national level
☐ Yes, at the local level
☐ No

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43. **What is the status of integration of the following HIV and tuberculosis (TB) services?**

43.a **World Health Organization-recommended rapid molecular diagnostics (e.g. Xpert MTB/RIF) are co-located:**

☐ In few (<50%) health facilities providing HIV testing and care
☐ In many (50–95%) health facilities providing HIV testing and care
☐ Countrywide (>95% of health facilities providing HIV testing and care)
☐ Not integrated in practice
☐ Other (please specify): _____

43.b **People living with HIV who have tuberculosis (TB) received antiretroviral medicines at the same place as they receive their TB treatment:**

☐ In few (<50%) health facilities
☐ In many (50–95%) health facilities
☐ Countrywide (>95% of health facilities)
☐ Not integrated in practice
☐ Other (please specify): _____

43.c **Antiretroviral therapy is initiated by the same health-care worker providing tuberculosis (TB) treatment for people living with HIV who have TB:**

☐ In few (<50%) health facilities
☐ In many (50–95%) health facilities countrywide (>95% of health facilities) Not integrated in practice
☐ Other (please specify):

43.d **Antiretroviral therapy and tuberculosis (TB) treatment for people living with HIV who have TB are monitored by one health-care worker:**

☐ In few (<50%) health facilities
☐ In many (50–95%) health facilities
☐ Countrywide (>95%) of health facilities
☐ Not integrated in practice
☐ Other (please specify): _____

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2. Scale-up HIV prevention options that bring together biomedical, structural and behavioural interventions

HIV prevention for sex workers

44. **Does your country have a national strategy that includes actions to reduce new infections among sex workers and provide services to sex workers and their clients?**

- ☐ Yes
- ☐ No

44.1 **If yes, does the national strategy include (select all that apply):**

- ☐ Community empowerment and capacity-building for sex worker organizations
- ☐ Community-based outreach and services for sex workers and their clients
- ☐ Distribution of condoms for sex workers and their clients
- ☐ Sexually transmitted infection prevention, screening and treatment services
- ☐ Psychosocial counselling or mental health services for sex workers and their clients
- ☐ Hepatitis prevention, testing and treatment services for sex workers and their clients
- ☐ Clinical services for sex workers and their clients
- ☐ Legal support services for sex workers
- ☐ Actions to address violence, including psychological first aid
- ☐ Post-exposure prophylaxis (PEP)
- ☐ Actions to reduce stigma and discrimination

HIV prevention for gay men and other men who have sex with men

45. **Does your country have a national strategy that includes actions to reduce new infections among and provide services to gay men and other men who have sex with men?**

- ☐ Yes
- ☐ No

45.1 **If yes, does the national strategy include for gay men and other men who have sex with men (select all that apply):**

- ☐ Community empowerment and capacity-building for organizations of gay men and other men who have sex with men
- ☐ Community-based outreach and services
- ☐ Distribution of condoms and condom-compatible lubricants
- ☐ Hepatitis prevention, testing and treatment services
- ☐ Clinical services
- ☐ Sexually transmitted infection prevention, screening and treatment services
- ☐ Psychosocial counselling and/or mental health services
- ☐ Legal support services
- ☐ Actions to address violence, including psychological first aid
- ☐ Post-exposure prophylaxis (PEP)
- ☐ Actions to reduce stigma and discrimination

HIV prevention for transgender people

46. **Does your country have a national strategy that includes actions to reduce new infections among and provide services to transgender people?**

- ☐ Yes
- ☐ No

46.1 **If yes, does the national strategy include for transgender people (select all that apply):**

- ☐ Community empowerment and capacity-building for organizations of transgender people
- ☐ Community-based outreach and services
- ☐ Distribution of condoms and condom-compatible lubricants
- ☐ Sexually transmitted infection prevention, screening and treatment services
- ☐ Psychosocial counselling and/or mental health services
- ☐ Hepatitis prevention, testing and treatment services
- ☐ Clinical services
- ☐ Legal support services
- ☐ Actions to address violence, including psychological first aid
- ☐ Post-exposure prophylaxis (PEP)
- ☐ Actions to reduce stigma and discrimination
- ☐ Gender-affirming health services

HIV prevention for people who inject drugs

47. **Does your country have a national strategy that includes actions to reduce new infections among and provide services to people who inject drugs?**

- ☐ Yes
- ☐ No

47.1 **If yes, does the national strategy include for people who inject drugs (select all that apply):**

- ☐ Community empowerment and capacity-building for organizations of people who inject drugs
- ☐ Community-based outreach and services
- ☐ Distribution of condoms and condom-compatible lubricants
- ☐ Sexually transmitted infection prevention, screening and treatment services
- ☐ TB screening, treatment and prevention
- ☐ Psychosocial counselling and/or mental health services
- ☐ Hepatitis prevention, testing and treatment services
- ☐ Clinical services
- ☐ Legal support services
- ☐ Actions to address violence, including psychological first aid
- ☐ Post-exposure prophylaxis (PEP)
- ☐ Actions to reduce stigma and discrimination
- ☐ Needle and syringe programmes
- ☐ Opioid agonist maintenance therapy
- ☐ Community distribution of naloxone for overdose prevention

48. **Are needle and syringe programmes operational in your country?**

- ☐ Yes
- ☐ No, not at all
- ☐ No, but needles and syringes can be purchased legally in pharmacies without a prescription

49. **Can possession of a needle or syringe without a prescription be used as evidence of drug use or cause for arrest in your country?**

- ☐ Yes
- ☐ No

50. **Are opioid agonist maintenance therapy programmes operational in your country?**

- ☐ Yes
- ☐ No

51. **Is naloxone (used to reverse opioid overdoses) available through community distribution in your country?**

☐ Yes
☐ No

HIV prevention services for people in prisons and other closed settings

52. **Does your country have a national strategy that includes actions to reduce new infections among and provide services to people in prisons and other closed settings?**

☐ Yes
☐ No

52.1 **If yes, does the national strategy include for people in prisons and other closed settings (select all that apply):**

☐ Community empowerment and capacity-building for organizations of people formerly in prisons or other closed settings
☐ Community in-reach services
☐ Distribution of condoms and condom-compatible lubricants
☐ Sexually transmitted infection prevention, screening and treatment services
☐ TB screening, treatment and prevention
☐ Psychosocial counselling and/or mental health services
☐ Hepatitis prevention, testing and treatment services
☐ Clinical services
☐ Legal support services
☐ Actions to address violence, including psychological first aid
☐ Post-exposure prophylaxis (PEP)
☐ Actions to reduce stigma and discrimination
☐ Needle and syringe programmes
☐ Opioid agonist maintenance therapy

53. **Are needle and syringe programmes operational in prisons and other closed settings in your country?**

☐ Yes
☐ No

54. **Are opioid agonist maintenance therapy programmes operational in prisons and other closed settings in your country?**

☐ Yes
☐ No

55. **Are condoms and lubricants available to people in prisons and other closed settings in your country?**

☐ Yes
☐ No

56. **Are HIV tests in prisons and other closed settings in your country:**

56.a **Carried out only with the informed consent of people in prisons and other closed settings?**

☐ Yes
☐ No

56.b **Systematically offered at entry and/or exit?**

☐ Yes
☐ No

56.c **Free of charge?**

☐ Yes
☐ No

56.d **Confidential?**

☐ Yes
☐ No

56.e **Available at any time during detention?**

☐ Yes
☐ No

56.f **Accompanied by relevant and accessible information?**

☐ Yes
☐ No

56.g **Accompanied by confidential pre- and post-test counselling?**

☐ Yes
☐ No

56.h **Equally accessible to all people in prisons and other closed settings?**

☐ Yes
☐ No

56.h.i **If no to Q56.h, which people in prisons and other closed settings do not have equal access?** _____

57. **Is antiretroviral therapy available to people in prisons and other closed settings living with HIV in your country?**

☐ Yes
☐ No

58. **Is hepatitis C treatment (using direct-acting antiviral medicines) available in prisons and other closed settings in your country?**

☐ Yes
☐ No

59. **Are there post-release programmes to ensure continuity of care for:**

59.a **Opioid agonist maintenance therapy?**

☐ Yes
☐ No

59.b **Antiretroviral therapy?**

☐ Yes
☐ No

HIV prevention among adolescent girls, young women and their male partners in communities with high HIV incidence

60. **Does your country have a national strategy that includes actions to reduce new HIV infections among adolescent girls, young women and their male partners in communities with high HIV incidence?**

☐ Yes
☐ No
☐ Not applicable

60.1 **If yes, does the national strategy include (select all that apply):**

☐ Community-based outreach
☐ Community-based promotion and distribution of condoms specifically for these populations
☐ Youth-friendly health services
☐ School-based HIV prevention campaigns (in addition to or as part of sexuality education)
☐ New media interventions
☐ Social support/economic empowerment

Pre-exposure prophylaxis

61. Do your country's national guidelines/strategy recommend any of the following pre-exposure prophylaxis (PrEP) modalities or products (select all that apply)?

- ☐ Oral PrEP containing tenofovir (TDF)
- ☐ The dapivirine vaginal ring (DPV-VR)
- ☐ Long-acting Injectable cabotegravir (CAB-LA)
- ☐ Long-acting injectable Lenacapavir (LEN)
- ☐ No PrEP modalities/products are recommended in the national guidelines

61.1 To which populations is PrEP provided under the national guidelines/strategy (select all that apply)?

- ☐ Gay men and other men who have sex with men
- ☐ Sex workers
- ☐ People who inject drugs
- ☐ Transgender people
- ☐ Serodiscordant couples
- ☐ Young women (aged 18–24 years)
- ☐ Adolescents (aged <18 years)
- ☐ People in prisons and other closed settings
- ☐ Pregnant and breastfeeding women
- ☐ People who request PrEP
- ☐ Other (please specify): _____
- ☐ No national PrEP guidelines have been developed

61.2 Who has the authority to prescribe pre-exposure prophylaxis (PrEP) in your country (select all that apply)?

- ☐ Doctors
- ☐ Clinical officers
- ☐ Nursing cadre (e.g. midwives, nurse practitioners, registered nurses)
- ☐ Pharmacists
- ☐ Community health workers
- ☐ Other (please specify): _____
- ☐ No provider has authority to provide PrEP in the country

61.3 Is PrEP available through any of the following in your country (select all that apply)?

- ☐ Public health-care facilities
- ☐ Community-based distribution (including mobile services)
- ☐ Pharmacies (stand-alone, including online)
- ☐ Private health-care providers
- ☐ The Internet (informal purchases)
- ☐ Research sites
- ☐ Other (please specify): _____

Post-exposure prophylaxis

62. Do your country's national guidelines recommend post-exposure prophylaxis (PEP) for the following groups?

- ☐ Exposure related to health care (occupational exposure)
- ☐ Exposure related to sexual or gender-based violence
- ☐ Any other exposure

62.1 Who has the authority to provide PEP in your country (select all that apply)?

- ☐ Doctors
- ☐ Clinical officers
- ☐ Nursing cadre (e.g. midwives, nurse practitioners, registered nurses)
- ☐ Pharmacists
- ☐ Community health workers
- ☐ Other (please specify): _____

62.2 Is PEP available through any of the following in your country (select all that apply)?

- ☐ Public health-care facilities
- ☐ Community-based distribution (including mobile services)
- ☐ Pharmacies (stand-alone, including online)
- ☐ Private health-care providers
- ☐ Educational institutions
- ☐ The internet
- ☐ Research sites

Voluntary medical male circumcision

Please note that these questions are only asked of 15 countries with high HIV prevalence, low levels of male circumcision and generalized heterosexual epidemics: Botswana, Eswatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

63. What age group does your country's national strategy specify for voluntary medical male circumcision (VMMC) (select all that apply)?

- ☐ Less than 10 years
- ☐ 10–14 years
- ☐ 15 years and older
- ☐ No national VMMC strategy

64. What medical male circumcision methods are recommended/approved by the national programme (select all that apply)?

- ☐ Conventional surgical methods (dorsal slit, forceps guided, sleeve resection)
- ☐ World Health Organization (WHO) prequalified device method approved for use

65. Does your country have a voluntary medical male circumcision (VMMC) sustainability strategy?

- ☐ Yes
- ☐ No

Condoms

66. Can the possession of condoms be used as sufficient evidence of arrest or to support the prosecution of a crime in your country?

- ☐ Yes
- ☐ No

67. Are there age restrictions for accessing condoms in your country?

- ☐ Yes
- ☐ No

68. **Are there restrictions on distributing condoms in public places in your country?**

☐ Yes (please specify): _____

☐ No

69. **Have there been condom stock-outs* in the past 12 months?**

69.a **National stock-outs**

☐ Yes

☐ No

69.b **Local stock-outs**

☐ Yes

☐ No

Services for people affected by humanitarian emergencies

70. **Are the following services accessible to people affected by humanitarian emergencies in your country? This includes all people affected by emergencies, including but not limited to nondisplaced people, refugees and asylum seekers, internally displaced people and migrants.**

70.a **HIV counselling and testing**

☐ Yes

☐ No

☐ Not applicable

70.b **Preventing vertical HIV transmission**[5]

☐ Yes

☐ No

☐ Not applicable

70.c **HIV treatment**

☐ Yes

☐ No

☐ Not applicable

70.d **Tuberculosis (TB) screening and treatment**

☐ Yes

☐ No

☐ Not applicable

70.e **Preventing and treating sexually transmitted infections**

☐ Yes

☐ No

☐ Not applicable

70.f **Services for key populations**

☐ Yes

☐ No

☐ Not applicable

5 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-stigmatizing alternative to "mother-to-child" transmission.

70.g **Services for survivors of sexual and gender-based violence***

☐ Yes
☐ No
☐ Not applicable

70.h **Food and nutrition support**

☐ Yes
☐ No
☐ Not applicable

71. **Does your country's national disaster or conflict preparedness plan (e.g. the national emergency or contingency plan[6]) explicitly include HIV-related actions, such as on prevention and treatment?**

☐ Yes
☐ No
☐ There is no national emergency or contingency plan

Refugees and asylum seekers

72. **Do national laws/policies enable refugees and asylum seekers to access HIV services (testing, antiretroviral medicine and care) under the same conditions as citizens?**

☐ Yes
☐ No

Migrant populations[7]

73. **Do national laws/policies enable undocumented migrants to access HIV services (testing, antiretroviral medicine and care) under the same conditions as citizens?**

☐ Yes
☐ No

Comprehensive sexuality education

74. **Does your country have education policies that guide the delivery of life skills-based HIV and sexuality education*, according to international standards*, in:**

74.a **Primary school?**

☐ Yes
☐ No

74.b **Secondary school?**

☐ Yes
☐ No

74.c **Teacher training?**

☐ Yes
☐ No

75. **Are representatives of the Ministry of Education included in the national HIV coordinating mechanism or equivalent?**

☐ There is no national HIV coordinating mechanism or equivalent
☐ There is a national HIV coordinating mechanism or equivalent, but it does not include any representatives of the Ministry of Education
☐ There is a national HIV coordinating mechanism or equivalent, and it includes representatives of the Ministry of Education

6 These will generally be developed by civil protection or disaster management authorities that may fall under the ministry of the interior, security or civil protection.

7 Migrants are defined as non-citizens who are in a country other than their country of origin for a stay of longer than six months, excluding refugees and asylum seekers.

76. **Has your country set a national target on comprehensive knowledge of HIV among adolescents and young people?**

☐ Yes
☐ No

76.1 **If yes, is there a national mechanism in place to monitor and review progress towards the target?**

☐ Yes
☐ No

77. **Is life skills-based HIV and sexuality education* part of the national curriculum or equivalent, in:**

77.a **Primary school?**

☐ Yes
☐ No

77.b **Secondary school?**

☐ Yes
☐ No

77.c **Teacher training?**

☐ Yes
☐ No

78. **Does the national Education Management Information System (EMIS) or other education sector monitoring tool include questions about delivery of the following components of life skills-based HIV and sexuality education*?**

		Questions in EMIS or equivalent	Data collected
78.a	**Generic life skills (e.g. decision-making, communication and refusal skills)**	☐ Yes ☐ No	☐ Yes ☐ No
78.b	**Sexual and reproductive health/sexuality education (e.g. teaching on human growth and development, family life, reproductive health, sexual abuse, sexually transmitted infections)**	☐ Yes ☐ No	☐ Yes ☐ No
78.c	**HIV transmission and prevention**	☐ Yes ☐ No	☐ Yes ☐ No

Eliminate vertical transmission of HIV, hepatitis B and syphilis

79. **Does your country have a national plan for the elimination of vertical transmission of the following infections (select all that apply)?**

☐ HIV
☐ Hepatitis B
☐ Syphilis
☐ For other infection or conditions (please specify):_____
☐ No national plan exists for the elimination of vertical transmission of infections

80. **Does your country have a policy for routinely testing pregnant women for the following infections (select all that apply)?**

- ☐ HIV
- ☐ Hepatitis B
- ☐ Syphilis
- ☐ No national policy exists for testing pregnant women for HIV, Hepatitis or Syphilis

80.1 **If yes for hepatitis B, do all HBeAg-positive pregnant women have access to HBeAg or HBV-DNA testing?**

- ☐ Yes for HBeAg
- ☐ Yes for HBV DNA testing
- ☐ No

81. **Does your country have a policy on retesting HIV-negative women during pregnancy, delivery and/or the post-partum/breastfeeding period?**

- ☐ Yes
- ☐ No

81.1 **If yes, when is retesting done?**

81.1.a **At third trimester visit**

- ☐ Yes
- ☐ No

81.1.b **At labour and delivery**

- ☐ Yes
- ☐ No

81.1.c **Post-partum or during breastfeeding**

- ☐ Yes
- ☐ No

81.1.c **If yes, how long after delivery (in months):** _____

Follow-up of infants exposed to HIV, hepatitis B or syphilis

82. **Do your national guidelines recommend that HIV-exposed infants be tested for HIV as follows (select all that apply)?**

- ☐ Nucleic acid testing at birth
- ☐ Nucleic acid testing at 6 weeks
- ☐ Nucleic acid testing at 9 months
- ☐ Antibody test at 18 months
- ☐ Antibody test after 3 months from cessation of breastfeeding
- ☐ Other (please specify): _____

83. **In addition to prevention of vertical transmission settings, do any of the following sites in your country carry out HIV testing of children (select all that apply)?**

- ☐ Paediatric inpatient wards
- ☐ Nutrition centres
- ☐ Immunization clinics
- ☐ Outpatient clinics
- ☐ Tuberculosis (TB) clinics
- ☐ Other (please specify): _____

84. **Does your country have a national policy on the clinical follow-up of infants born to syphilis-positive mothers?**

- ☐ Yes
- ☐ No

85. **Does your country have a policy on testing mothers of stillborn infants for syphilis?**

☐ Yes

☐ No

86. **Does your country have a policy on testing stillborn infants for syphilis?**

☐ Yes

☐ No

3. Integrate HIV services into primary health care (PHC), broader health systems and other sectors

Cervical cancer

87. **Have the recommendations in the 2021 World Health Organization (WHO) guidelines for screening of cervical pre-cancer lesions for cervical cancer prevention among women living with HIV been adopted in your country's national guidelines?**

- ☐ Yes
- ☐ No

87.1 **If yes, please indicate the WHO recommendations for women living with HIV that have been adopted (select all that apply):**

- ☐ Age to start regular cervical cancer screening is 25 years
- ☐ HPV-DNA Is used as the primary screening test as part of a screen, triage and treat approach
- ☐ VIA is used as a primary screening test as part of a screen, triage and treat approach
- ☐ Cytology Is used as a primary screening test as part of a screen and treat approach
- ☐ Cytology Is used as a primary screening test as part of a screen, triage and treat approach
- ☐ Screening interval recommended for cytology/VIA is every 3 years
- ☐ Screening interval recommended for HPV-DNA is every 3-5 years
- ☐ Other (please specify): _____

Sexually transmitted infections

88. **Does your country have a national strategy or action plan for the prevention and control of sexually transmitted infections?**

- ☐ Yes
- ☐ No

89. **Does your country have national case management guidelines for sexually transmitted infections?**

- ☐ Yes
- ☐ No

89.1 **If yes, in what year were they last updated?**

- ☐ Before 2022
- ☐ 2022
- ☐ 2023
- ☐ 2024
- ☐ 2025

Social protection

90. **Does the country have an approved social protection* strategy, policy or framework?**

- ☐ Yes, and it is being implemented
- ☐ Yes, and it is not being implemented
- ☐ No

90.1.a **If yes: Does it refer to HIV?**

- ☐ Yes
- ☐ No

90.1.b **Does it recognize people living with HIV as key beneficiaries?**

- ☐ Yes
- ☐ No

90.1.b.i **If no, please describe any conditions under which people living with HIV can access social protection benefits:** _____

90.1.c **Does it recognize any key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people or people in prisons and other closed settings) as key beneficiaries?**

☐ Yes
☐ No

90.1.c.i **If yes, which key populations are recognized as key beneficiaries (select all that apply)?**

☐ Sex workers
☐ Gay men and other men who have sex with men
☐ Transgender people
☐ People who inject drugs
☐ People in prisons and other closed settings
☐

90.1.c.ii **If no, please describe any conditions under which key populations can access social protection benefits:** _____

90.1.d **Does it recognize adolescent girls and young women as key beneficiaries?**

☐ Yes
☐ No

90.1.e **Does it recognize children affected by HIV as key beneficiaries?**

☐ Yes
☐ No

90.1.f **Does it recognize families affected by HIV as key beneficiaries?**

☐ Yes
☐ No

90.1.g **Does it address the issue of unpaid care work in the context of HIV?**

☐ Yes
☐ No

91. **Are representatives of the National AIDS Programme or equivalent included in any social protection* coordination mechanism or platform?**

☐ There is no social protection coordination mechanism or platform
☐ There is a social protection coordination mechanism or platform, but it does not include any representatives of the National AIDS Programme or equivalent
☐ There is a social protection coordination mechanism or platform, and it includes representatives of the National AIDS Programme or equivalent

92. **Are any cash transfer* programmes for young women aged 15–24 years being implemented in the country?**

☐ Yes
☐ No

Trade-related Aspects of Intellectual Property Rights

93. What public health-related Trade-related Aspects of Intellectual Property Rights (TRIPS) flexibilities* are incorporated in your country's national legislation on industrial and/or intellectual property, and which of them have been used to enhance access to HIV-related products and/or other health products?

Public health-related TRIPS flexibilities	Are they incorporated in national legislation on industrial/intellectual property?	If yes, what is the most recent year in which they were used?	If yes, for which commodity have they been used?
Exhaustion of rights (parallel importation) (Article 6)	Yes/No		
Patentable subject matter (Article 27)	Yes/No		
Research and experimental use exception (Article 30)	Yes/No		
Regulatory (Bolar) exception (Article 30)	Yes/No		
Compulsory licensing (Article 31)	Yes/No		
Public, noncommercial use (government use) (Article 31)	Yes/No		
Scope of pharmaceutical test data protection (Article 39.3)	Yes/No		
Competition law (Article 40)	Yes/No		
Transition periods (Articles 65.2, 65.4 and 66.1)	Yes/No		

Strategy

94. Does your country have a national strategy or policy that guides the AIDS response?

☐ Yes, a stand-alone AIDS strategy or policy
☐ Yes, a health strategy or policy that integrates the AIDS response
☐ No
☐ Other (please specify): _____

94.1 If yes, has the national HIV strategy or policy been reviewed in the past two years?

☐ Yes
☐ No

94.2 **If yes to Q95, does the national strategy or policy guiding the AIDS response explicitly address the following key populations or vulnerable groups (select all that apply)?**

- ☐ Adolescent key populations
- ☐ Gay men and other men who have sex with men
- ☐ People in prisons and other closed settings
- ☐ People who inject drugs
- ☐ Sex workers (male and female)
- ☐ Transgender people
- ☐ Nondisplaced people affected by emergencies
- ☐ Refugees and asylum seekers
- ☐ Internally displaced people
- ☐ Migrants

94.3 **If yes to Q94, does the national strategy or policy guiding the AIDS response do the following (select all that apply)?**

- ☐ Specifically include explicit plans or activities that address the needs of key populations
- ☐ Specifically include explicit plans or activities that address the needs of young women and girls
- ☐ Specifically include explicit plans or activities that address HIV-related stigma and discrimination
- ☐ Specifically include explicit plans or activities relating to the reform of discriminatory or punitive laws
- ☐ Draw on the most recent evidence about the national HIV epidemic and the status of the response
- ☐ Integrate inputs from a multisectoral process, including various government sectors and nongovernmental partners
- ☐ Proposes community-led delivery models for the provision of services to key and vulnerable populations
- ☐ Draw on evidence provided by community-led organizations

94.4 **If yes to Q94, does the national strategy or policy guiding the AIDS response include gender-transformative* interventions, including interventions to address the intersections of gender-based violence* and HIV?**

- ☐ Yes
- ☐ No

94.4 **If yes to 94.4, does the national strategy or policy guiding the AIDS response include a dedicated budget for implementing gender-transformative* interventions?**

- ☐ Yes
- ☐ No

Monitoring and evaluation

95. **Does your country have a national monitoring and evaluation plan or strategy for HIV?**

- ☐ Yes, a stand-alone HIV monitoring and evaluation strategy or plan
- ☐ Yes, HIV monitoring and evaluation is integrated in a broader health monitoring and evaluation strategy or plan
- ☐ No
- ☐ Other (please specify): _____

95.1 **Does your country have a data quality task team to review the subnational programme data on at least a semi-annual basis?**

- ☐ Yes
- ☐ No

Information system

96. **Are patient-level data routinely available within the health information system?**

- ☐ Yes, fully electronic
- ☐ Yes, partially electronic
- ☐ Yes, paper-based only
- ☐ No health information system exists

97. **Are data from community-led organizations on services they delivered integrated in the national health information system or equivalent?**

- ☐ Yes, community-led organizations are included as a type of provider for disaggregation of existing indicators
- ☐ Yes, specific indicators on service delivery by community-led organizations are included
- ☐ No
- ☐ Community-led organizations cannot provide services

Surveillance

98. **Does the country have a national HIV case surveillance* system?**

- ☐ Yes
- ☐ No

98.1 **If yes, does the national HIV case surveillance* system include the following (select all that apply)?**

- ☐ Individual-level data for each person diagnosed with HIV
- ☐ Collection of data from different sources (laboratories, testing and treatment records) to promote completeness of data on HIV case
- ☐ Linkage of individual-level data to remove duplicate records
- ☐ CD4 count at HIV diagnosis
- ☐ Initiation of antiretroviral therapy
- ☐ First and follow-up viral load test results
- ☐ Pregnancy in women living with HIV
- ☐ Death

Unique identification codes for patients

99. **Does the country have a method to identify and remove duplicate health information for patients within and between clinics—such as linking records using unique identifiers and/or personal identifiable information (including biometrics)—for the following services?**

	Method to identify and remove duplicate health information	If yes, please specify how data are linked
Treatment services	☐ Yes, nationally harmonized ☐ Yes, but varies by regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify): _____
Laboratory services	☐ Yes, nationally harmonized ☐ Yes, but varies by regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify): _____
HIV prevention services designed for any key population group to track combination prevention uptake		
Gay Men And Other Men Who Have Sex With Men	☐ Yes, nationally harmonized ☐ Yes, but varies by regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify): _____
Sex workers	☐ Yes, nationally harmonized ☐ Yes, but varies by regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify): _____
Transgender people	☐ Yes, nationally harmonized ☐ Yes, but varies by regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify): _____
People who inject drugs	☐ Yes, nationally harmonized ☐ Yes, but varies by regions ☐ Yes, but varies across programmes ☐ No ☐ Don't know	☐ National unique personal identifier ☐ HIV-specific unique identifier ☐ Combination of routinely collected personal identifying information ☐ Biometric ☐ Other (please specify): _____

99.1 **If yes to any of the above, does the unique identifier policy also provide for legally enforceable data privacy protections?**

☐ Yes

☐ No

Data governance

100. Does your country have a health data governance framework*?

- ☐ Yes
- ☐ In development
- ☐ No

100.1 If yes, does the framework include any of the following?

100.1.a Policies that enable the collection, exchange, storage, processing and distribution of data (infrastructure policies)

- ☐ Yes
- ☐ In development
- ☐ No

100.1.b Legal and regulatory environment

- ☐ Yes
- ☐ In development
- ☐ No

100.1.c Policies related to competition, trade and taxation that enable a country to maximize the economic and social value derived from data (economic policies)

- ☐ Yes
- ☐ In development
- ☐ No

100.1.d Institutional ecosystem (this includes the entities responsible for implementation, oversight and mechanisms)

- ☐ Yes
- ☐ In development
- ☐ No

101. Are mechanisms in place for non-governmental organizations providing health services to input data regularly into national data systems?

- ☐ Yes, and they are being implemented
- ☐ Yes, but they are not being implemented
- ☐ In development
- ☐ No

Sustainability and integration

102. Are any of the following safeguards in place for individual health data that are applicable for people living with HIV and people from key populations (select all that apply)?

- ☐ Specific clear requirements and processes for informed consent for the processing and sharing of personal data
- ☐ Transparency about data how personal data will be used in informed consent forms
- ☐ Accountability mechanisms for data users for breaches of confidentiality
- ☐ Anonymization and pseudonymization of data
- ☐ Healthcare providers are protected from the requirement to report people from criminalized populations to law enforcement
- ☐ Provisions for regular training of all staff that have access to personal data on appropriate data security and protection
- ☐ Regular reviews of data protection legislation and implementation of policies
- ☐ There is no legislation on health data protection

103. Are any mechanisms for regular quality monitoring of services operational in service delivery points where HIV services are being integrated nationally (select all that apply)?

☐ Yes, regular quality monitoring mechanisms are in place, led by clinical staff (e.g. exit or point-of-care surveys, direct observation of consultations, or real-time feedback systems)

☐ Yes, regular quality monitoring mechanisms are in place, led by non-clinical healthcare quality teams (e.g. structured surveys, analysis of secondary or routine data, or audit or feedback interventions)

☐ Yes, regular quality monitoring mechanisms are in place, led by community members (e.g. community-led monitoring)

☐ No, regular quality monitoring mechanisms are not in place, but sporadic monitoring is carried out by external academic researchers

☐ None of the above

103.1 If any regular quality monitoring mechanisms are operational, what is the coverage of these mechanisms?

☐ Implemented in few (<50%) facilities providing integrated services

☐ Implemented in many (50–95%) facilities providing integrated services

☐ Implemented countrywide (>95% of facilities providing integrated services)

☐ Not implemented in practice

☐ Other (please specify): _____

4. End stigma and discrimination and uphold human rights and gender equality in the HIV response

Violence

104. **Does your country have a national gender equality plan or strategy?**

- ☐ Yes
- ☐ No

104.1 **If yes, is there a national mechanism with a mandate to monitor and review implementation?**

- ☐ Yes
- ☐ No

104.2 **If yes, identify the national mechanism that has a mandate to monitor and review implementation (select all that apply)?**

- ☐ Parliamentary
- ☐ Interministerial
- ☐ Includes participation of women's groups
- ☐ Includes participation of violence against women groups

104.3 **If yes, do government entities provide budgetary commitments for the implementation of the gender equality plan or strategy?**

- ☐ Yes
- ☐ No

105. **Does your country have a national plan or strategy to address gender-based violence* and violence against women that includes HIV?**

- ☐ Yes
- ☐ No

105.1 **If yes, is there a national mechanism with a mandate to monitor and review implementation?**

- ☐ Yes
- ☐ No

105.2 **If yes, identify the national mechanism that has a mandate to monitor and review implementation (select all that apply)?**

- ☐ Parliamentary
- ☐ Interministerial
- ☐ Includes participation of women's groups
- ☐ Includes participation of violence against women groups

106. **If legislation on domestic violence exists, is it (select those that apply):**

- ☐ Specific to violence against women and girls
- ☐ Inclusive of all forms of familiar and intimate partner violence
- ☐ Country does not have legislation on domestic violence

106.1 **If legislation includes explicit criminalization of marital rape, are laws based on lack of consent, without requiring proof of physical force, coercion or resistance?**

- ☐ Yes, based on lack of consent
- ☐ No, require evidence of force, coercion or resistance
- ☐ Legislation does not explicitly criminalize marital rape

106.2 **If legislation on domestic violence exists, have there been any successful criminal prosecutions for domestic violence in the past two years?**

- ☐ Yes
- ☐ No

107. **Do government entities provide budgetary commitments for the implementation of legislation and national plans addressing violence against women through any of the following?**

107.a **Legally-mandated annual appropriations**

☐ Yes
☐ No

107.b **Annual sectoral allocations (e.g. health, education, justice)**

☐ Yes
☐ No

107.c **Allocating funding and/or incentives to women's or other nongovernmental organizations for relevant activities**

☐ Yes
☐ No

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108. **Does legislation include any of the following provisions related to violence against women in your country (select all that apply)?**

☐ Court injunctions for the safety and security of survivors
☐ Special prosecution units in law enforcement
☐ Free legal services or assistance
☐ Access to shelters or other safe housing
☐ Financial support to survivors
☐ Specialized police staff or unit to deal with violence against women
☐ Services for the person perpetrating violence
☐ Other (please specify): _____

108.1 **If any of the above provisions are included in legislation, are they inclusive of trans women?**

☐ Yes
☐ No

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109. **Are there national protocols for:**

109.a **Health professionals dealing with cases of violence against women?**

☐ Yes
☐ No

109.b **Law enforcement personnel dealing with cases of violence against women?**

☐ Yes
☐ No

109.c **Education personnel dealing with cases of sexual abuse against children and other forms of gender-based violence* against girls in school environments (select all that apply)?**

☐ Yes, for violence against girls
☐ Yes, for violence against boys
☐ Yes, for violence against gender-diverse children
☐ No

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110. **Does your country have any of the following to protect people living with HIV from violence (select all that apply)?**

☐ General criminal laws prohibiting violence
☐ Specific legal provisions prohibiting violence against people based on their HIV status
☐ Programmes to address intimate partner violence*
☐ Programmes to address workplace violence Interventions to address police abuse
☐ Interventions to address torture and ill treatment in prisons and other closed settings

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111. Does your country have any of the following to protect key populations from violence (select all that apply)?

☐ General criminal laws prohibiting violence
☐ Specific legal provisions prohibiting violence against people based on belonging to a key population
☐ Programmes to address intimate partner violence*
☐ Programmes to address workplace violence
☐ Interventions to address police abuse
☐ Interventions to address torture and ill treatment in prisons and other closed settings

112. Does your country have at least one service delivery point that provides elements of comprehensive post-rape care as per World Health Organization (WHO) guidelines? The elements are: (1) first-line support, psychological first aid and psychosocial support; (2) emergency contraception; (3) sexually transmitted infection prophylaxis or treatment; (4) HIV post-exposure prophylaxis (PEP); and (5) safe abortion to the full extent of the law.

☐ Yes, provides all 5 elements
☐ Yes, provides 4 out of 5 elements
☐ Yes, provides 1 to 3 elements
☐ No services delivery point provides any of these elements

112.1 If yes, what proportion of health facilities provides each of the following elements of comprehensive post-rape care as per World Health Organization (WHO) guidelines:

112.1.a First-line support, psychological first aid and psychosocial support

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

112.1.b Emergency contraception

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

112.1.c Sexually transmitted infection treatment or prophylaxis

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

112.1.d HIV post-exposure prophylaxis (PEP)

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

112.1.e Safe abortion to the full extent of the law

☐ <50% of health facilities
☐ 50–80% of health facilities
☐ >80% of health facilities
☐ Not provided in any health facility
☐ Don't know

Punitive laws

113. Does your country have laws at national or sub-national level criminalizing HIV nondisclosure, exposure or transmission?

- ☐ Yes, HIV nondisclosure, exposure or transmission is a specific crime
- ☐ Yes, HIV nondisclosure, exposure or transmission is a crime under a law that covers a broader range of communicable diseases and mentions HIV
- ☐ Yes, HIV nondisclosure, exposure or transmission is a crime under a law that covers a broader range of communicable disease but does not specifically mention HIV
- ☐ No, but the general law has been used to prosecute cases in the past 10 years
- ☐ No

113.1 If HIV non-disclosure, exposure or transmission are criminalized, either under a specific law or general law, is it limited to cases where the individual knows they have HIV, intends to transmit HIV and actually transmits it as per the 2013 recommendations on Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Critical scientific, medical and legal considerations8?

- ☐ Yes, the criminal law is written to restrict it to these cases
- ☐ No, but prosecutorial guidelines, judicial practices or equivalent restrict it to these cases
- ☐ No

113.2 If HIV nondisclosure, exposure or transmission are criminalized, has there been a moratorium on these laws in the last two years?

- ☐ Yes
- ☐ No

113.3 If HIV nondisclosure, exposure or transmission are criminalized, have any legal actions to decriminalize HIV nondisclosure, exposure or transmission either started or been in process in the last two years (select all that apply)?

- ☐ Strategic litigation
- ☐ Proposal put before parliament
- ☐ Other (please specify): _____

113.4 If HIV nondisclosure, exposure or transmission are criminalized, does that include vertical transmission (parent to a child during pregnancy, childbirth or breastfeeding)?

- ☐ Yes
- ☐ No

114. Does the law list HIV status as an aggravating circumstance in any offence?

- ☐ Yes
- ☐ No

115. Are there any laws at national or sub-national level that criminalize transgender people based on gender identity or gender expression (e.g. for impersonating the opposite sex or cross-dressing)?

- ☐ Yes
- ☐ No

115.1 If transgender people are criminalized, have authorities issued a moratorium, suspension, or directive limiting arrests or prosecutions under these laws in the last two years?

- ☐ Yes
- ☐ No

115.2 If transgender people are criminalized, have any legal actions to repeal, amend or challenge these laws either started or been in process in the last two years (select all that apply)?

- ☐ Strategic litigation
- ☐ Proposal put before parliament
- ☐ Policy directive by local or national authorities
- ☐ Other (please specify): _____
- ☐ No reform effort identified

8 Ending Overly Broad Criminalization Of Hiv Non-Disclosure, Exposure And Transmission: Critical Scientific, Medical And Legal Considerations. Geneva: Unaids; 2013 (Https://Www.unaids.org/Sites/Default/Files/Media_asset/20130530_guidance_ending_criminalisation_0.Pdf).

116. Are other laws used in practice to criminalize or penalize people based on real or perceived gender identity, even when not explicitly criminalized (select all that apply)?

- ☐ "Debauchery" or "habitual debauchery" laws
- ☐ "Sodomy" or "unnatural carnal knowledge" laws
- ☐ Public morality or public decency laws
- ☐ Vagrancy or public nuisance laws
- ☐ Laws against "promotion" or "propaganda" of homosexuality
- ☐ Anti-"prostitution" or sex work laws
- ☐ Other (please specify): _____
- ☐ No such laws are used in this way

117. Is sex work criminalized or otherwise subject to punitive regulations in your country at national or sub-national level (select all that apply)?

- ☐ Yes, selling sexual services is criminalized
- ☐ Yes, buying sexual services is criminalized
- ☐ Yes, ancillary activities associated with selling sexual services are criminalized
- ☐ Yes, ancillary activities associated with buying sexual services are criminalized
- ☐ Yes, profiting from organizing and/or managing sexual services is criminalized
- ☐ Yes, other punitive regulation of sex work
- ☐ Sex work is not subject to punitive regulations and is not criminalized anywhere in the country

117.1 If there are laws criminalizing any aspect of sex work, have authorities issued a moratorium, suspension or directive limiting arrests or prosecutions under these laws in the last two years?

- ☐ Yes
- ☐ No

117.2 If sex work is criminalized, have any legal actions to repeal, amend or challenge these laws either started or been in process in the last two years (select all that apply)?

- ☐ Strategic litigation
- ☐ Proposal put before parliament
- ☐ Policy directive by local or national authorities
- ☐ Other (please specify): _____
- ☐ No reform effort identified

118. Are other laws used in practice to criminalize or penalize sex workers based on real or perceived occupation, even when not explicitly criminalized (select all that apply)?

- ☐ "Debauchery" or "habitual debauchery" laws
- ☐ "Sodomy" or "unnatural carnal knowledge" laws
- ☐ Public morality or public decency laws
- ☐ Vagrancy or public nuisance laws
- ☐ Anti-"prostitution" or sex work laws
- ☐ Other (please specify): _____
- ☐ No such laws are used in this way

119. Does your country have laws at national or subnational level criminalizing consensual same-sex sexual acts in private?

- ☐ Yes, death penalty
- ☐ Yes, imprisonment (14 years–life)
- ☐ Yes, imprisonment (up to 14 years)
- ☐ Yes, penalty not specified
- ☐ No, laws penalizing consensual same-sex sexual acts have been decriminalized or have never existed anywhere in the country

119.1 If there are laws criminalizing same-sex sexual acts, have authorities issued a moratorium, suspension or directive limiting arrests or prosecutions under these laws in the last two years?

- ☐ Yes
- ☐ No

119.2 If same-sex sexual acts are criminalized, have any legal actions to repeal, amend or or challenge these laws either started or been in process in the last two years (select all that apply)?

- ☐ Strategic litigation
- ☐ Proposal put before parliament
- ☐ Policy directive by local or national authorities
- ☐ Other (please specify): _____
- ☐ No reform efforts identified

120. Are other laws used in practice to criminalize or penalize people based on real or perceived sexual orientation or consensual same-sex behavior, even when same-sex sexual acts themselves are not explicitly criminalized? (select all that apply)

- ☐ "Debauchery" or "habitual debauchery" laws
- ☐ "Sodomy" or "unnatural carnal knowledge" laws
- ☐ Public morality or public decency laws
- ☐ Vagrancy or public nuisance laws
- ☐ Laws against "promotion" or "propaganda" of homosexuality
- ☐ Anti-"prostitution" or sex work laws
- ☐ Other (please specify): _____
- ☐ No such laws are used in this way

121. Are drug use and/or possession for personal use an offence in your country at the national or sub-national level?

- ☐ Yes, a criminal offence for all drugs
- ☐ Yes, a criminal offence for all drugs except cannabis
- ☐ Yes, an administrative/non-criminal offence for all drugs
- ☐ No, not an offence anywhere in the country

121.1 If drug use and/or possession for personal use are a criminal offence, does your country apply compulsory detention or compulsory rehabilitation in a closed facility for people who use drugs (including specialized hospitals and rehabilitation centers)?

- ☐ Yes
- ☐ No

121.2 If drug use and/or possession for personal use are criminal offences, have authorities issued a moratorium, suspension or directive limiting arrests or prosecutions under these laws in the last two years?

- ☐ Yes
- ☐ No

121.3 If drug use and/or possession for personal use are criminal offences, have any legal actions to decriminalize drug use or possession for personal use either started or been in process in the last two years (select all that apply)?

- ☐ Strategic litigation
- ☐ Proposal put before parliament
- ☐ Policy directive by local or national authorities
- ☐ Other (please specify): _____
- ☐ No reform efforts identified

121.4 **If drug use and/or possession are administrative or non-criminal offences, are any of the following applied in your country for people who use drugs (select all that apply)?**

- ☐ Compulsory detention or compulsory rehabilitation in a closed facility
- ☐ Compulsory detention or rehabilitation outside of a facility
- ☐ Restrictions on movement, including suspension of passport or driving license
- ☐ Mandatory counselling
- ☐ Fines
- ☐ Drug registers
- ☐ Other administrative penalties (please specify): _____

122. **Apart from criminalization, does your country have other punitive laws affecting people who use drugs (select all that apply)?**

- ☐ Public morality or public decency laws
- ☐ Vagrancy or public nuisance laws
- ☐ Other (please specify): _____

123. **Does the law use quantity thresholds to estimate when drugs are possessed for personal use?**

- ☐ Yes, for all drugs
- ☐ Yes, only for cannabis
- ☐ No

123.1 **If yes, does the law specify the amount of drugs considered to be for personal use?**

- ☐ Yes
- ☐ No

123.2 **If yes, is this amount:**

- ☐ Indicative
- ☐ Determinative

Legal protections

124. **Does your country have laws protecting against discrimination on the basis of HIV status?**

- ☐ Yes, constitutional or legislative protections that specify HIV status as a protected attribute
- ☐ Yes, constitutional or legislative protections that protect against discrimination on the basis of HIV status under another status (such as health, disability or "other status")
- ☐ No

124.1 **If yes, do constitutional or legislative protections apply to any of the following (select all that apply)?**

- ☐ Employment
- ☐ Education
- ☐ Health care
- ☐ Provision of other goods and services
- ☐ Other (please specify): _____

125. **Does your country have constitutional or legislative protections against discrimination on the basis of gender identity?**

- ☐ Yes, gender identity is specified as a protected attribute
- ☐ Yes, courts or government have legally recognized that gender identity is protected under another attribute (e.g. gender, sex, other status) (please specify): _____
- ☐ Yes, other (please specify): _____
- ☐ No

126. **Does your country have hate crime or bias-motivated violence laws that explicitly include sexual orientation or gender identity or gender expression as protected characteristics (select all that apply)?**

- ☐ Yes, explicitly include sexual orientation as a protected attribute
- ☐ Yes, explicitly include gender identity or gender expression as a protected attribute
- ☐ Yes, include sexual orientation as a protected attribute under another attribute (e.g. other status)
- ☐ Yes, include gender identity or gender expression as a protected attribute under another attribute (e.g. other status)
- ☐ No

127. **Does your country have legal gender recognition laws or policies that enable the legal change of gender?**

☐ Yes

☐ No

127.1 **If yes, are any of the following required in order to change gender (select all that apply)?**

Self-declaration (no medical evidence required)

☐ Gender reassignment surgery

☐ Sterilization

☐ Certificate of psychological assessment

☐ Other (please specify): _____

127.2 **If yes, is it legally possible to change one's gender marker on the following (select all that apply)?**

☐ Passport or other national ID

☐ Own birth certificate

☐ Marriage/divorce certificate

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128. **Is it legally possible to change one's name to that of another gender on any of the following (select all that apply)?**

☐ Passport or other national ID

☐ Own birth certificate

☐ Marriage/divorce certificate

☐ No

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129. **Does your country have constitutional or legislative protections against discrimination based on the Involvement in sex work (e.g. occupation or profession)?**

☐ Yes, courts or government have legally recognized that sex work is protected under another attribute (please specify): _____

☐ Yes, other (please specify): _____

☐ No

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130. **Does your country have constitutional or legislative protections against discrimination on the basis of sexual orientation?**

☐ Yes, sexual orientation is specified as a protected attribute

☐ Yes, courts or government have legally recognized that sexual orientation is protected under another attribute (e.g. gender, sex, other status) (please specify): _____

☐ Yes, other (please specify): _____

☐ No

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131. **Does your country have constitutional or legislative protections against discrimination based on the involvement in drug use or possession?**

☐ Yes, courts or government have legally recognized that drug use or possession is protected under another attribute (please specify): _____

☐ Yes, other (please specify): _____

☐ No

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132. **Is there explicit supportive reference to harm reduction in national policies?**

☐ Yes

☐ No

132.1 **If yes, do policies address the specific needs of women who inject drugs?**

☐ Yes

☐ No

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133. **Is drug use and/or possession a legal basis for removing children from parental custody?**

☐ Yes

☐ No

Parental/guardian and spousal consent for accessing services

134. Does your country have laws and/or policies requiring parental/guardian consent for adolescents (under age 18) to access hormonal or long-lasting contraceptives?

- ☐ Yes, for adolescents aged 17–18 years
- ☐ Yes, for adolescents aged 15–16 years
- ☐ Yes, for adolescents aged 13–14 years
- ☐ Yes, for adolescents aged 12 years or younger
- ☐ No age specified—ability to consent is based on an assessment of maturity
- ☐ Other (please specify): _____
- ☐ Not addressed in law/policy

134.1. If yes, are there exceptions for adolescents below the age of legal consent to be able to access hormonal or long-lasting contraceptives without parental/guardian consent (select all that apply)?

- ☐ Yes, demonstrated maturity
- ☐ Yes, emancipated minors
- ☐ Yes, pregnant adolescents
- ☐ Yes, other (please specify): _____
- ☐ No

135. Does your country have laws and/or policies requiring parental/guardian consent for adolescents (under age 18) to access HIV testing and receive the results?

- ☐ Yes, for adolescents aged 17–18 years
- ☐ Yes, for adolescents aged 15–16 years
- ☐ Yes, for adolescents aged 13–14 years
- ☐ Yes, for adolescents aged 12 years or younger
- ☐ No age specified—ability to consent is based on an assessment of maturity
- ☐ Other (please specify): _____
- ☐ Not addressed in law/policy

135.1 If yes, are there exceptions for adolescents below the age of legal consent to be able to access HIV testing and receive the results without parental/guardian consent (select all that apply)?

- ☐ Yes, demonstrated maturity
- ☐ Yes, emancipated minors
- ☐ Yes, pregnant adolescents
- ☐ Yes, other (please specify):
- ☐ No

136. Does your country have laws and/or policies requiring parental/guardian consent for adolescents (under age 18) to access HIV self-testing and receive the results?

- ☐ Yes, for adolescents aged 17–18 years
- ☐ Yes, for adolescents aged 15–16 years
- ☐ Yes, for adolescents aged 13–14 years
- ☐ Yes, for adolescents aged 12 years or younger
- ☐ No age specified—ability to consent is based on an assessment of maturity
- ☐ Other (please specify): _____
- ☐ Not addressed in law/policy

136.1 If yes, are there exceptions for adolescents below the age of legal consent to be able to access HIV self-testing and receive the results without parental/guardian consent (select all that apply)?

- ☐ Yes, demonstrated maturity
- ☐ Yes, emancipated minors
- ☐ Yes, pregnant adolescents
- ☐ Yes, other (please specify): _____
- ☐ No

137. **Does your country have laws and/or policies requiring parental/guardian consent for adolescents (under age 18) to access HIV treatment?**

- ☐ Yes, for adolescents aged 17–18 years
- ☐ Yes, for adolescents aged 15–16 years
- ☐ Yes, for adolescents aged 13–14 years
- ☐ Yes, for adolescents aged 12 years or younger
- ☐ No age specified—ability to consent is based on an assessment of maturity
- ☐ Other (please specify): _____
- ☐ Not addressed in law/policy

137.1 **If yes, are there exceptions for adolescents below the age of legal consent to be able to access HIV treatment without parental/guardian consent (select all that apply)?**

- ☐ Yes, demonstrated maturity
- ☐ Yes, emancipated minors
- ☐ Yes, pregnant adolescents
- ☐ Yes, other (please specify): _____
- ☐ No

138. **Does the law allow adolescents (under age 18) to access the following services:**

138.a **Opioid agonist maintenance therapy**

- ☐ Yes
- ☐ No

138.a.i **If yes, is parental/guardian consent required to access?**

- ☐ Yes
- ☐ No

138.a.ii **If yes, please specify until what age parental/guardian consent is required to access:** _____

138.b **Needle and syringe programmes**

- ☐ Yes
- ☐ No

138.b.i **If yes, is parental/guardian consent required to access?**

- ☐ Yes
- ☐ No

138.b.ii **If yes, please specify until what age parental/guardian consent is required to access:** _____

138.c **Naloxone**

- ☐ Yes
- ☐ No

138.c.i **If yes, is parental/guardian consent required to access?**

- ☐ Yes
- ☐ No

138.c.ii **If yes, please specify until what age parental/guardian consent is required to access:** _____

139. **Does your country have laws or policies requiring parental or guardian consent for adolescents aged under 18 years to access pre-exposure prophylaxis (PrEP)?**

- ☐ Yes, for adolescents aged 17–18 years
- ☐ Yes, for adolescents aged 15–16 years
- ☐ Yes, for adolescents aged 13–14 years
- ☐ Yes, for adolescents aged 12 years or younger
- ☐ No age specified—ability to consent is based on an assessment of maturity
- ☐ Other (please specify): _____
- ☐ Not addressed in law/policy

139.1 **If yes, are there exceptions for adolescents under the age of legal consent to access HIV treatment without parental or guardian consent (select all that apply)?**

- ☐ Yes, demonstrated maturity
- ☐ Yes, emancipated minors
- ☐ Yes, pregnant adolescents
- ☐ Yes, other (please specify): _____
- ☐ No

140. **Does your country have laws requiring spousal consent for married women to access any sexual or reproductive health services?**

- ☐ Yes
- ☐ No

141. **Does your country have laws requiring spousal consent for married women to access HIV testing?**

- ☐ Yes
- ☐ No

Stigma and discrimination

142. **Does your country have training programmes for the following groups on human rights and non-discrimination legal frameworks as applicable to HIV?**

142.a **For police and other law enforcement personnel**

- ☐ Yes, as part of formative training curricula at the national level
- ☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
- ☐ Yes, as a recurrent part of on-the-job training at the national level
- ☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
- ☐ Yes, as one-off or ad hoc activities
- ☐ No

142.b **For members of the judiciary**

- ☐ Yes, as part of formative training curricula at the national level
- ☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
- ☐ Yes, as a recurrent part of on-the-job training at the national level
- ☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
- ☐ Yes, as one-off or ad hoc activities
- ☐ No

142.c **For elected officials (lawmakers/parliamentarians)**

- ☐ Yes, as part of formative training curricula at the national level
- ☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
- ☐ Yes, as a recurrent part of on-the-job training at the national level
- ☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
- ☐ Yes, as one-off or ad hoc activities
- ☐ No

142.d **For health-care workers**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

142.e **For educators**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

143. **In the past two years, has the government provided and/or funded training for the following groups on human rights and nondiscrimination relating to key populations in at least 25% of provinces/regions/districts (select all that apply)?**

143.a **For police and other law enforcement personnel**

☐ Sex workers
☐ Gay men and other men who have sex with men
☐ Transgender people
☐ People who inject drugs
☐ People in prisons and other closed settings

143.b **For members of the judiciary**

☐ Sex workers
☐ Gay men and other men who have sex with men
☐ Transgender people
☐ People who inject drugs
☐ People in prisons and other closed settings

143.c **For elected officials (lawmakers/parliamentarians)**

☐ Sex workers
☐ Gay men and other men who have sex with men
☐ Transgender people
☐ People who inject drugs
☐ People in prisons and other closed settings

143.d **For health-care workers**

☐ Sex workers
☐ Gay men and other men who have sex with men
☐ Transgender people
☐ People who inject drugs
☐ People in prisons and other closed settings

143.e **For educators**

☐ Sex workers
☐ Gay men and other men who have sex with men
☐ Transgender people
☐ People who inject drugs
☐ People in prisons and other closed settings

144. **Does your country have training programmes on the prevention of violence against women and gender-based violence for the following groups?**

144.a **For police and other law enforcement personnel**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

144.b **For members of the judiciary**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

144.c **For elected officials (lawmakers/parliamentarians)**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

144.d **For health-care workers**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

144.e **For educators**

☐ Yes, as part of formative training curricula at the national level
☐ Yes, as part of formative training curricula at the subnational level (in at least one province/region/district)
☐ Yes, as a recurrent part of on-the-job training at the national level
☐ Yes, as a recurrent part of on-the-job training at the subnational level (in at least one province/region/district)
☐ Yes, as one-off or ad hoc activities
☐ No

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145. **Are there public accountability mechanisms established by the government through which people can make complaints and seek redress for cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population)? Examples include (but are not limited to) a national human rights institution, ombudsperson, tribunal or commission.**

☐ Yes (please describe): _____
☐ No

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146. **Does your country have any of the following human rights monitoring and enforcement mechanisms?**

146.a **Existence of independent functional national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs and ombudspersons that consider HIV-related issues within their work**

☐ Yes
☐ No

146.b **Oversight for implementation of concluding observations and recommendations from treaty monitoring bodies and Universal Periodic Review (UPR)**

☐ Yes
☐ No

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147. Does your country have mechanisms in place for accessing affordable legal services (select all that apply)?

☐ Yes, publicly-funded legal aid systems applicable to HIV casework
☐ Yes, pro bono legal services provided by private law firms
☐ Yes, legal services provided by (university-based) legal clinics
☐ Yes, community paralegals
☐ Yes, other (please describe): _____
☐ No

5. Ensure community leadership in the HIV response

Community leadership

148. **Does your country differentiate between community-led organizations and other types of civil society organizations in the national HIV strategic plan, community health strategies or other documents guiding the HIV response?**

- ☐ Yes
- ☐ No

148.1 **If yes, are the specific roles of community-led organizations articulated in the(se) documents?**

- ☐ Yes
- ☐ No

149. **Are there any laws, regulations or policies that provide for the registration of community-led organizations in your country (select all that apply)?**

- ☐ Registration of organizations led by people living with HIV is possible
- ☐ Registration of organizations led by sex workers is possible
- ☐ Registration of organizations led by gay men and other men who have sex with men is possible
- ☐ Registration of organizations led by transgender people is possible
- ☐ Registration of organizations led by people who inject drugs is possible
- ☐ There are no laws, regulations or policies that provide for the registration of community-led organizations in the country
- ☐ Other (please specify): _____

150. **Are there laws, policies or regulations that enable access to funding for community-led organizations (select all that apply)?**

- ☐ Social contracting allowing for funding of service delivery by communities from domestic funding
- ☐ From international donors
- ☐ Require a certain percentage of government funding for community-led organizations to be allowed to operate
- ☐ No laws enabling access to funding, but community-led organizations are able to access funding under general laws, policies or regulations
- ☐ There are no laws, policies or regulations enabling access to funding for community-led organizations
- ☐ Other (please specify): _____

151. **Are representatives of community-led organizations included in the national HIV coordinating mechanism or equivalent?**

- ☐ There is no national HIV coordinating mechanism or equivalent
- ☐ There is a national HIV coordinating mechanism or equivalent, but it does not include any representatives of community-led organizations
- ☐ There is a national HIV coordinating mechanism or equivalent, and it includes representatives of community-led organizations

151.1 **If yes, please specify from which of the following community-led organizations (including youth-led and women-led) are representatives included (select all that apply):**

- ☐ Representatives of organizations led by people living with HIV
- ☐ Representatives of sex worker-led organizations
- ☐ Representatives of organizations led by gay men and other men who have sex with men
- ☐ Representatives of transgender-led organizations
- ☐ Representatives of organizations led by people who inject drugs

152. **Can community-led organizations legally provide any of the following services (select all that apply)?**

- ☐ Linkage to HIV treatment
- ☐ Adherence and retention support
- ☐ Treatment literacy
- ☐ Distribution of antiretroviral medicines
- ☐ Distribution of condoms and lubricants
- ☐ HIV testing
- ☐ Needle–syringe distribution
- ☐ Naloxone distribution
- ☐ Legal literacy
- ☐ Legal services
- ☐ Information on life skills-based HIV and sexuality education*
- ☐ Sexual and gender-based violence prevention, psychosocial and medical support and referrals
- ☐ Information on sexual and reproductive health
- ☐ Trainings for healthcare workers

153. **Is there a process specified in policy on accreditation of community-led organizations to deliver clinical services (e.g. testing)?**

- ☐ Yes
- ☐ No

Participation

154. **Do people living with HIV participate* in developing national policies, guidelines and/or strategies relating to their health in your country?**

- ☐ Yes
- ☐ No

155. **Do women living with HIV participate* in developing national policies, guidelines and strategies relating to prevention of vertical transmission?**

- ☐ Yes
- ☐ No

156. **Do gay men and other men who have sex with men participate* in developing national policies, guidelines and/or strategies relating to their health in your country?**

- ☐ Yes
- ☐ No

157. **Do sex workers participate* in developing national policies, guidelines and strategies relating to their health in your country?**

- ☐ Yes
- ☐ No

158. **Do people who inject drugs participate* in developing national policies, guidelines and strategies relating to their health in your country?**

- ☐ Yes
- ☐ No

159. **Do transgender people participate* in developing national policies, guidelines and strategies relating to their health in your country?**

- ☐ Yes
- ☐ No

160. **Do former or current people in prisons and other closed settings participate* in developing national policies, guidelines and strategies relating to their health in your country?**

- ☐ Yes
- ☐ No

161. Do young people (aged 15–24 years) participate* in developing national policies, guidelines and strategies relating to their health in your country?

☐ Yes
☐ No

162. Do people living with HIV and people from key populations participate* in the following decision-making spaces:

162.a Technical teams for the development, review and update of national AIDS strategies and plan (select all that apply):

☐ People living with HIV
☐ Women living with HIV
☐ Gay men and other men who have sex with men
☐ Sex workers
☐ People who inject drugs
☐ Transgender people
☐ People formerly or currently in prisons and other closed settings
☐ Young people
☐ None of the above participate in this decision-making space

162.b Technical teams for the development or review of policies and programmes that relate to access to HIV prevention, treatment, care and support services and integration (select all that apply):

☐ People living with HIV
☐ Women living with HIV
☐ Gay men and other men who have sex with men
☐ Sex workers
☐ People who inject drugs
☐ Transgender people
☐ People formerly or currently in prisons and other closed settings
☐ Young people
☐ None of the above participate in this decision-making space

162.c National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate (select all that apply):

☐ People living with HIV
☐ Women living with HIV
☐ Gay men and other men who have sex with men
☐ Sex workers
☐ People who inject drugs
☐ Transgender people
☐ People formerly or currently in prisons and other closed settings
☐ Young people
☐ None of the above participate in this decision-making space

162d. Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism (select all that apply):

☐ People living with HIV
☐ Women living with HIV
☐ Gay men and other men who have sex with men
☐ Sex workers
☐ People who inject drugs
☐ Transgender people
☐ People formerly or currently in prisons and other closed settings
☐ Young people
☐ None of the above participate in this decision-making space

163. Do government entities allocate domestic public funds to community engagement in the HIV response?

163.a Participation in decision-making mechanisms (select all that apply):

☐ Legally-mandated annual appropriations
☐ Allocating funding to community-led organizations for relevant activities
☐ Other (please specify): _____
☐ No budgetary commitments

163.b Service delivery (e.g. clinical services, education and information) (select all that apply):

☐ Legally-mandated annual appropriations
☐ Allocating funding to community-led organizations for relevant activities
☐ Other (please specify): _____
☐ No budgetary commitments

163.c Monitoring (select all that apply):

☐ Legally-mandated annual appropriations
☐ Allocating funding to community-led organizations for relevant activities
☐ Other (please specify): _____
☐ No budgetary commitments

163.d Advocacy (select all that apply):

☐ Legally-mandated annual appropriations
☐ Allocating funding to community-led organizations for relevant activities
☐ Other (please specify): _____
☐ No budgetary commitments

National Commitments and Policy Instrument: Part B

* The guidelines for the NCPI define the terms marked with an asterisk (*).

1. Ensure available, accessible, acceptable and quality HIV treatment and care for people living with HIV

1. Does your country have any forms of mandatory (or compulsory) HIV testing that are provided for or carried out?

☐ No

☐ Yes (please briefly explain when mandatory testing is carried out and the groups that are affected): _____

2. Where is viral load testing available in your country?

☐ Available at specialized centres only

☐ Available at antiretroviral therapy facilities, either on-site or by referral

☐ Other (please specify): _____

3. Are any of the following retention support services available in your country (select all that apply)?

☐ Community-based interventions (e.g. patient advocates, treatment and peer support interventions providing adherence and psychosocial support in the community)

☐ Adherence clubs and peer support (e.g. peer support, distribution of antiretroviral medicines and assessment by nonclinical or lay providers)

☐ Other (please specify): _____

4. Are any of the following adherence support services available in your country (select all that apply)?

☐ Peer counsellors

☐ Text messages

☐ Use of reminder devices

☐ Patient reintegration follow-up (telephone calls/home visits)

☐ Enhanced adherence counselling

☐ Referral to psychological/socioeconomic support

☐ Cognitive behavioural therapy

☐ Behavioural skills training/medication adherence training

☐ Fixed-dose combinations and once-daily regimens

☐ Case management

☐ Peer navigation

☐ Other (please specify): _____

5. Are migrants[9] able to access HIV services (testing, antiretroviral medicines and care)?

☐ Yes

☐ No

9 Migrants are defined as non-citizens who are in a country other than their country of origin for a stay of longer than six months, excluding refugees and asylum seekers.

6. **In the context of prevention of vertical HIV transmission programmes in your country, are there reports on (or documentation of) any of the following (select all that apply)?**

- ☐ Mandatory or coerced testing and/or treatment for HIV
- ☐ Lack of informed, voluntary and prior obtained consent
- ☐ Forced and coerced abortion, contraception and/or sterilization
- ☐ Lack of confidentiality and privacy
- ☐ Other grave or systematic human rights abuses* (please describe): _____

6.1 **If there are reports of any of these situations in your country, is the government carrying out due diligence in responding to them?**

- ☐ Yes
- ☐ No
- ☐ Don't know

2.Scale-up HIV prevention options that bring together biomedical, structural, and behavioural interventions

HIV prevention services for people who inject drugs

7. **Are needle–syringe programmes operational in your country?**

- ☐ Yes
- ☐ No, not at all
- ☐ No, but needles and syringes can be legally purchased in pharmacies without a prescription

8. **Is naloxone (used to reverse opioid overdoses) available through community distribution in your country?**

- ☐ Yes
- ☐ No

9. **Are opioid agonist maintenance therapy programmes operational in your country?**

- ☐ Yes
- ☐ No

HIV prevention services in prisons and other closed settings

10. **Are needle–syringe programmes operational in prisons and other closed settings in your country?**

- ☐ Yes
- ☐ No

11. **Are opioid agonist maintenance therapy programmes operational in prisons and other closed settings in your country?**

- ☐ Yes
- ☐ No

12. **Are condoms and lubricants available to people in prisons and other closed settings in your country?**

- ☐ Yes
- ☐ No

13. **Is antiretroviral therapy available to all people in prisons and other closed settings living with HIV in your country?**

- ☐ Yes
- ☐ No

14. **Are HIV tests in prisons and other closed settings in your country:**

14.a **Carried out only with the informed consent of people in prisons and other closed settings?**

☐ Yes
☐ No

14.b **Systematically offered at entry and/or exit?**

☐ Yes
☐ No

14.c **Free of charge?**

☐ Yes
☐ No

14.d **Confidential?**

☐ Yes
☐ No

14.e **Available at any time during detention?**

☐ Yes
☐ No

14.f **Accompanied by relevant and accessible information?**

☐ Yes
☐ No

14.g **Accompanied by confidential pre- and post-test counselling?**

☐ Yes
☐ No

14.h **Equality accessible to all people in prisons and other closed setting?**

☐ Yes
☐ No

14.h.i **If no, which people in prisons and other closed settings do not have equal access (please specify):** _____

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15. **Is hepatitis C treatment (using direct-acting antiviral medicines) available in prisons and other closed settings in your country?**

☐ Yes
☐ No

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16. **Is pre-exposure prophylaxis (PrEP) available through any of the following in your country (select all that apply)?**

☐ Public health-care facilities
☐ Community-based distribution (including mobile services)
☐ Pharmacies (stand-alone, including online)
☐ Private health-care providers
☐ The Internet (informal purchases)
☐ Educational institutions (e.g. schools, universities)
☐ Research sites
☐ Other (please specify):

---

17. Do any of the following barriers limit access to pre-exposure prophylaxis (PrEP) in your country (select all that apply)?

- ☐ Possession of PrEP used as evidence of sex work or other criminalized sexual activity
- ☐ PrEP is associated with stigmatized sexual behaviour
- ☐ PrEP is only provided in specific geographic locations
- ☐ PrEP is only provided in specialized HIV treatment locations
- ☐ High out-of-pocket cost of PrEP services
- ☐ Eligibility criteria (e.g. PrEP is limited to certain populations)
- ☐ Negative attitudes of PrEP providers Inconvenient service provision (e.g. opening hours)
- ☐ PrEP is not available in the country

3.Integrate HIV services into primary health care (PHC), broader health systems and other sectors

18. Do any of the following barriers limit access to social protection* programmes in your country (select all that apply)?

- ☐ Lack of information available on the programmes
- ☐ Complicated procedures
- ☐ Fear of stigma and discrimination
- ☐ Lack of documentation that confers eligibility, such as national identity cards
- ☐ Laws or policies that present obstacles to access
- ☐ High out-of-pocket expenses (e.g. transport, time to receive transfers)
- ☐ Limited access to bank accounts where they are used for delivery of social protection programmes
- ☐ Limited access to mobile phones where they are used for delivery of social protection programmes
- ☐ People living with HIV, key populations and/or people affected by HIV are covered by another programme
- ☐ Other (please specify): _____

4.End stigma and discrimination and uphold human rights and gender equality in the HIV response

Violence

19. Does legislation include any of the following provisions related to violence against women in your country (select all that apply)?

- ☐ Court injunctions to ensure the safety and security of survivors
- ☐ Special prosecutions unit in law enforcement
- ☐ Free legal services or assistance
- ☐ Financial support to survivors
- ☐ Specialized police staff or unit to deal with violence against women
- ☐ Services for the person perpetrating violence
- ☐ Other (please specify): _____

20. Does your country have any of the following to protect key populations and people living with HIV from violence (select all that apply)?

- ☐ General criminal laws prohibiting violence
- ☐ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population
- ☐ Programmes to address intimate partner violence*
- ☐ Programmes to address workplace violence
- ☐ Interventions to address police abuse
- ☐ Interventions to address torture and ill treatment in prisons and other closed settings

Law enforcement

21. Have people living with HIV in your country been arrested or prosecuted for nondisclosure, exposure or transmission in the last two years?

- ☐ Yes
- ☐ No

22. Have people living with HIV in your country been arrested or prosecuted for vertical exposure or transmission in the last two years?

- ☐ Yes
- ☐ No

23. Can possession of a needle or syringe without a prescription be used as evidence of drug use or cause for arrest in your country?

- ☐ Yes
- ☐ No

24. Have trans people in your country been arrested or prosecuted for expressions of their gender identity in the past two years?

- ☐ Yes
- ☐ No

25. Have sex workers in your country been arrested or prosecuted in relation to selling sex in the past two years?

- ☐ Yes
- ☐ No

26. Have people in your country been arrested or prosecuted for consensual same-sex sexual acts in the past two years?

- ☐ Yes
- ☐ No

27. Have people in your country been arrested or prosecuted for using or being in possession of any drugs in the past two years?

- ☐ Yes
- ☐ No

28. If possession of any drug for personal use is not a criminal offence in your country, are there legal or administrative provisions for drug use and/or possession for personal use that amount to a form of punishment (select all that apply)?

- ☐ Fines
- ☐ Loss of identity documents, including passport
- ☐ Loss or suspension of driving license
- ☐ Quantity thresholds for drug possession do not reflect use
- ☐ Lack of enforcement of quantity thresholds defined in laws or policies
- ☐ Lack or limited understanding by law enforcement officials of quantity thresholds or other legal provisions that allow possession and/or use of limited amount of drugs, where these exist
- ☐ Compulsory treatment in a detention facility
- ☐ Compulsory treatment in the community
- ☐ Drug registers
- ☐ Other (please specify): _____

29. Have constitutional or legislative prohibitions of discrimination been successfully used to protect or advocate for transgender people's rights in the last two years in any of the following (select all that apply)?

- ☐ Courts
- ☐ Advocacy with government for law or policy reform
- ☐ Advocacy with government for implementation or enforcement of the constitutional or legislative prohibitions of discrimination
- ☐ Other (please specify): _____

30. **If a change of gender marker is legally recognized, do any of the following barriers limit its application (select all that apply)?**

- ☐ Unclear or vague regulations or application processes
- ☐ High cost
- ☐ Gender reassignment surgery a requirement for change
- ☐ Other (please specify): _____
- ☐ Gender marker change not legally recognized

31. **Have constitutional or legislative prohibitions of discrimination been successfully used to protect or advocate for sex workers' rights in the last two years in any of the following (select all that apply)?**

- ☐ Courts
- ☐ Advocacy with government for law or policy reform
- ☐ Advocacy with government for implementation or enforcement of the constitutional or legislative prohibitions of discrimination
- ☐ Other (please specify): _____

32. **Have constitutional or legislative prohibitions of discrimination been successfully used to protect or advocate for the rights of people on the basis of their sexual orientation in the last two years in any of the following (select all that apply)?**

- ☐ Courts
- ☐ Advocacy with government for law or policy reform
- ☐ Advocacy with government for implementation or enforcement of the constitutional or legislative prohibitions of discrimination
- ☐ Other (please specify): _____

33. **Have protective provisions been successfully used to protect or advocate for the rights of people who use drugs in the last two years in any of the following (select all that apply)?**

- ☐ Courts
- ☐ Advocacy with government for law or policy reform
- ☐ Advocacy with government for implementation or enforcement of the constitutional or legislative prohibitions of discrimination
- ☐ Other (please specify): _____

34. **Do any of the following act as barriers to making use of constitutional or other legislative protections in your country (select all that apply)?**

- ☐ Unclear or lengthy administrative processes
- ☐ High cost
- ☐ Difficulties in accessing the judicial system
- ☐ Lack of legal support
- ☐ Other (please specify): _____

35. **Can people from key populations (gay men and other men who have sex with men, sex workers, people who inject drugs, transgender people, people formerly or currently in prisons or other closed settings) safely report violence or discrimination to law enforcement without risk of violence, punishment, outing, ridicule, or arrest?**

- ☐ Yes, generally safe
- ☐ Reporting is possible but risks vary
- ☐ Reporting is unsafe for most people from key populations

Rights Literacy

36. In the past two years, have there been training and/or capacity-building programmes for people living with HIV and key populations to raise awareness about their rights in the context of HIV in your country?

- ☐ Yes, at scale at the national level
- ☐ Yes, at scale at the subnational level (in at least one province/region/district)
- ☐ Yes, one-off activities
- ☐ Yes, at a small scale
- ☐ No

36.1 If yes:

36.1.a Was any public funding provided to support trainings?

- ☐ Yes
- ☐ No
- ☐ Don't know

36.2 Who delivered the trainings (select all that apply)?

- ☐ Community-led organizations
- ☐ Government
- ☐ Other (please specify): _____

37. Are there any of the following barriers to providing training and/or capacity-building for people living with HIV and key populations to educate them and raise their awareness about their rights (select all that apply)?

- ☐ Lack of political will
- ☐ Lack of funding
- ☐ Lack of capacity for delivery of trainings
- ☐ Barriers that hinder the target audience in accessing such trainings or capacity-building
- ☐ Others (please describe): _____

Accountability mechanisms

38. Are there mechanisms established by the community and/or nongovernmental organizations to record and address individual complaints of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population)? Examples of such mechanisms include traditional cultural structures or non-governmental organizations trained to address claims through mediation.

- ☐ Yes (please describe): _____
- ☐ No

39. Does your country have mechanisms in place for accessing affordable legal services (select all that apply)?

- ☐ Yes, publicly-funded legal aid systems applicable to HIV casework
- ☐ Yes, pro bono legal services provided by private law firms or individual lawyers
- ☐ Yes, legal services provided by (university-based) legal clinics
- ☐ Yes, community paralegals
- ☐ Yes, other (please describe): _____
- ☐ No

40. Does your country have any of the following barriers to accessing justice, including through formal and informal mechanisms (select all that apply)?

- ☐ Mechanisms do not function
- ☐ Mechanisms are not sensitive to HIV
- ☐ Affordability constraints for people from marginalized and affected groups
- ☐ Awareness or knowledge of how to use such mechanisms is limited
- ☐ Other (please specify): _____

41. Do key populations or people living with or affected by HIV face particular barriers in accessing justice in your country?

- ☐ No
- ☐ Yes—please describe and provide details on the scale (i.e., nationally): _____

5.Ensure community leadership in the HIV response

Community leadership

42. Does your country have restrictions for the registration and operation of community-led organizations that affect HIV service delivery (select all that apply)?

- ☐ Restrictions on registration
- ☐ Territorial restrictions on operations, such as zoning
- ☐ Restrictions on providing services to key populations
- ☐ Cumbersome reporting and other restrictions on operations
- ☐ High cost of registration
- ☐ Other (please specify): _____
- ☐ No

43. Does your country have laws, policies or regulations that hinder access to funding for HIV-related work by community-led organizations (select all that apply)?

- ☐ Lack of social contracting or other mechanisms allowing community-led service delivery to be funded from domestic funding
- ☐ Restrictions on accessing funding from "foreign agents" or international donors
- ☐ Regulations governing how organizations can conduct fundraising activities
- ☐ Time-consuming procedures and documentation
- ☐ Eligibility requirements impeding small or recently established organizations to access funding
- ☐ Administrative requirements limiting the capacity of organizations to transfer and implement funds
- ☐ Other (please describe): _____
- ☐ No

44. Do people living with HIV participate* in developing national policies, guidelines and/or strategies relating to their health in your country?

- ☐ Yes
- ☐ No

45. Do women living with HIV participate* in developing national policies, guidelines and strategies relating to prevention of vertical transmission?

- ☐ Yes
- ☐ No

46. Do gay men and other men who have sex with men participate* in developing national policies, guidelines and/or strategies relating to their health in your country?

- ☐ Yes
- ☐ No

47. Do sex workers participate* in developing national policies, guidelines and strategies relating to their health in your country?

- ☐ Yes
- ☐ No

48. Do people who inject drugs participate* in developing national policies, guidelines and strategies relating to their health in your country?

- ☐ Yes
- ☐ No

49. Do transgender people participate* in developing national policies, guidelines and strategies relating to their health in your country?

- ☐ Yes
- ☐ No

50. Do former or current people in prisons and other closed settings participate* in developing national policies, guidelines and strategies relating to their health in your country?

- ☐ Yes
- ☐ No

51. Do young people (aged 15–24 years) participate* in developing national policies, guidelines and strategies relating to their health in your country?

- ☐ Yes
- ☐ No

52. Do people living with HIV participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of policies and programmes that relate to HIV prevention, treatment, care and support services, and integration.
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ People living with HIV do not participate in any decision-making spaces in the national HIV response

53. Do women living with HIV participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ Women living with HIV do not participate in any decision-making spaces in the national HIV response

54. Do gay men and other men who have sex with men participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ Gay men and other men who have sex with men do not participate in any decision-making spaces in the national HIV response

55. Do sex workers participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ Sex workers do not participate in any decision-making spaces in the national HIV response

56. Do people who inject drugs participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ People who inject drugs do not participate in any decision-making spaces in the national HIV response

57. Do transgender people participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ Transgender people do not participate in any decision-making spaces in the national HIV response

58. Do people formerly or currently in prisons and other closed settings participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ People formerly or currently in prisons and other closed settings do not participate in any decision-making spaces in the national HIV response

59. Do young people participate* in any of the following decision-making spaces in the national HIV response (select all that apply)?

- ☐ Technical teams for the development, review and update of national HIV strategies and plans
- ☐ Technical teams for the development or review of programmes that relate to access to HIV treatment, care and support services
- ☐ National AIDS Coordinating authority or equivalent, with a broad-based multisectoral mandate
- ☐ Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism
- ☐ Community advisory body for hospitals, clinics or research projects
- ☐ Other (please specify): _____
- ☐ Young people do not participate in any decision-making spaces in the national HIV response

WHO AIDS medicines and diagnostics survey on the use of antiretroviral medicines and laboratory technologies and implementation of WHO related guidelines

Survey to document the data situation in 2025

The WHO AIDS Medicine and Diagnostics Services of the Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes is conducting the nineteenth annual survey on antiretroviral therapy regimens used in low- and middle-income countries. The 2026 questionnaire covers the use of antiretroviral medicines in adults and children for antiretroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT); use of laboratory tests for ART initiation and monitoring; 2025 procurement data; and national 3-year *(2026–2028)* forecasts by regimen.

To complete the questionnaire, please ask relevant ART, PMTCT, national laboratory and procurement programme officers to gather the requested information for the period 1 January–31 December 2025. Professional officers submitting the data should check the questionnaire's completeness, quality, accuracy and validity.

The results of this survey will be used to analyse regional and global trends of antiretroviral medicine use and produce global demand forecasts for antiretroviral medicines. These analyses and forecasts will be discussed with medicines and diagnostics manufacturers and donors to prevent global shortages.

WHO will analyse the responses of each country to produce country Procurement and Supply Management profiles that present country-specific strategic information and provide feedback to assist national programme managers to develop more cost-effective interventions.

For any queries concerning the questionnaire, please contact Mr Boniface Dongmo Nguimfack (dongmonguimfackb@who.int), Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes, WHO, Geneva.

Section 1A. Overview of treatment with antiretroviral medicines

Question 1. Total number of adults and children on ART at the end of 2025: _____

Section 1B. Treatment of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women

Question 2. Number of adults and adolescents (aged ≥10 years) living with HIV and on ART by treatment line at the end of 2025:

Treatment line	**Number of adults and adolescents (aged ≥10 years) living with HIV by treatment line at the end of 2025**
Dolutegravir (DTG) based regimens	
Protease inhibitor (PI) based regimens	
Other treatment regimens	
Total	

Question 3. Number of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women living with HIV, per dolutegravir (DTG) based regimens at the end of 2025 (start with regimens with higher numbers):

Dolutegravir (DTG) based regimens (e.g. TDF+3TC+DTG, ABC+3TC+DTG, TAF+FTC+DTG.....)	**Number of adults and adolescents (aged ≥10 years) living with HIV receiving this ART regimen at the end of 2025** (start with regimens with higher numbers)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
Total	

Question 4. Number of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women living with HIV, on protease inhibitor (PI) based regimens at the end of 2025 (start with regimens with higher numbers):

Protease inhibitor (PI) based regimens (e.g. TAF+FTC+DRV/r, TDF+3TC+LPV/r ….)	**Number of adults and adolescents (aged ≥10 years) living with HIV receiving this ART regimen at the end of 2025** (start with regimens with higher numbers)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
Total	

Question 5. Number of adults and adolescents (aged ≥10 years) living with HIV, including pregnant women living with HIV, on other treatment regimens at the end of 2025 (start with regimens with higher numbers):

Other treatment regimens (not reported above)	**Number of adults and adolescents (aged ≥10 years) living with HIV receiving this ART regimen at the end of 2025** (start with regimens with higher numbers)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
Total	

Section 2. Treatment of children (aged <10 years) living with HIV

Question 6. Number of children (aged <10 years) living with HIV by treatment line at the end of 2025:

Treatment line	**Total number of children (aged <10 years) living with HIV by treatment line at the end of 2025**
Dolutegravir (DTG) based regimens	
Protease inhibitor (PI) based regimens	
Other treatment regimens	
Total	

Question 7. Number of infants and children (aged <10 years) living with HIV on dolutegravir (DTG) based regimens at the end of 2025 (start with regimens with higher numbers):

Dolutegravir (DTG) based regimens (e.g. TDF+3TC+DTG, ABC+3TC+DTG, TAF+FTC+DTG.....)	Number of infants and children (aged <10 years) receiving this regimen at the end of 2025		
	<3 years (A)	≥3 to <10 years (B)	All children aged <10 years (A) + (B)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
Total			

Question 8. Number of children (aged <10 years) living with HIV on protease inhibitor (PI) based regimens at the end of 2025 (start with regimens with higher numbers)

Protease inhibitor (PI) based regimens (e.g. TAF+FTC+DRV/r, TDF+3TC+LPV/r ....)	Number of children (aged <10 years) living with HIV receiving this regimen at the end of 2025
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
Total	

Question 9. Number of children (aged <10 years) living with HIV on other treatment regimens at the end of 2025 (start with regimens with higher numbers)

Other treatment regimens (not reported above)	Number of children (aged <10 years) living with HIV receiving this regimen at the end of 2025
1.	
2.	
3.	
4.	
5.	
6.	
Total	

Section 3. Prevention of mother to child transmission

Question 10. Number of pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission and various PMTCT options during 2025:_____

Question 11. Number of neonates per antiretroviral medicine used for HIV prophylaxis in neonates born to women living with HIV in 2025:

Antiretroviral medicine	Number of neonates starting this regimen in 2025
Total	

Section 4. Laboratory services

HIV testing

Question 12. Total number of HIV rapid diagnostic tests done between January and December 2025: ___

Question 13. Total number of HIV enzyme-linked immunosorbent assay (ELISA) tests done between January and December 2025: ___

Question 14. Total number of HIV serology antibody tests, including rapid diagnostic tests and ELISA tests, done between January and December 2025:___

CD4 testing

Question 15. Total number of CD4 tests done between January and December 2025:___

Question 16. Total number of people on ART who had at least one CD4 test between January and December 2025: ___

Question 17. Total number of pregnant women living with HIV who had at least one CD4 test between January and December 2025: ____

Viral load (VL) testing

Question 18. Total number of VL tests done between January and December 2025: ____

Question 19. Total number of people on ART who had at least one VL test between January and December 2025: ____

Question 20. Total number of pregnant women living with HIV who had at least one VL test between January and December 2025: ____

Infant diagnosis

Question 21. Total number of infant diagnosis tests done between January and December 2025: ___

Question 22. Total number of infants (aged <12 months) born to women living with HIV who had at least one infant diagnosis test between January and December 2025: ____

Testing and screening for sexually transmitted infections, advanced HIV and hepatitis

Question 23. Total number of sexually transmitted infection diagnostic tests done between January and December 2025: ___

Question 24. Total number of CrAg tests done between January and December 2025: ___

Question 25. Total number of TB LAM tests done between January and December 2025:___

Question 26. Total number of hepatitis B screening tests done between January and December 2025: ___

Question 27. Total number of hepatitis C (rapid diagnostic) tests done between January and December 2025: ___

Question 28. Total number of laboratories or sites by types of test in your country in 2025:

Type of test	Number of laboratories or sites where samples are collected (sites with testing and sites without testing)	Number of laboratories or sites where testing is performed	Number of laboratories or sites where testing is performed and that participate in an external quality assessment (EQA) scheme	Number of laboratories or sites that need quality improvement activities based on most recent EQA exercise	Main activities required for quality improvement
HIV serology antibody testing, including rapid test and ELISA					
Infant diagnosis					
CD4 testing					
Viral load testing					
HIV drug resistance genotype testing					
GeneXpert (tuberculosis test)					
AHD testing services CrAg					
AHD testing services TB LAM					
Sexually transmitted infection testing services					
HCV PCR testing services					
HBV PCR testing services					

Section 5. Country targets

Question 29. National targets for ART, PMTCT and laboratory tests in the next 5 years:

Target	End of 2026	End of 2027	End of 2028	End of 2029	End of 2030
1. Number of adults and children on ART					
1.1 Number of adults and adolescents (aged ≥10 years) on ART					
1.2 Number of children (aged <10 years) on ART					
1.2.1 Number of children (aged <3 years) on ART					
1.2.2 Number of children (aged ≥3 to <10 years) on ART					
2. Number of pregnant women on ART					
3. Number of people tested for HIV					
4. Number of people taking a CD4 test					
5. Number of people taking a VL test					
6. Number of children born to women living with HIV having an infant diagnosis test					
7. Number of HIV serology tests					
8. Number of CD4 tests					
9. Number of VL tests					
10. Number of early infant diagnosis tests					
11. Number of HIV AHD tests CrAg					
12. Number of HIV AHD tests TB LAM					
13. Number of sexually transmitted infection tests					

Question 30. National 3-year forecasts by antiretroviral medicine regimen for adults:

First-line antiretroviral medicine regimen	Number of people on regimen			Second-line antiretroviral medicine regimen	Number of people on regimen			Third-line antiretroviral medicine regimen	Number of people on regimen		
	2026	2027	2028		2026	2027	2028		2026	2027	2028
1.											
2.											
3.											
4.											
5.											
Etc…											
Subtotal											

Question 31. National 3-year forecasts by antiretroviral medicine regimen for children:

First-line antiretroviral medicine regimen	Number of people on regimen			Second-line antiretroviral medicine regimen	Number of people on regimen			Third-line antiretroviral medicine regimen	Number of people on regimen		
	2026	2027	2028		2026	2027	2028		2026	2027	2028
1.											
2.											
3.											
4.											
Etc…											
Subtotal											

Question 32. National 3-year forecasts of HIV tests, CD4 tests, VL tests and early infant diagnostic tests:

Type of test	Number of tests procured in 2024 and planned for the next three years			
	Procured for 2025	Planned for 2026	Planned for 2027	Planned for 2028
HIV diagnosis test (rapid diagnostic tests, self-tests)				
CD4 tests				
Viral Load tests				
Early infant HIV diagnosis tests				

Annex 1. Selected bibliography

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2. 12 components monitoring and evaluation system strengthening tool. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/sub_landing/files/2_MERG_Strengthening_Tool_12_Components_ME_System.pdf)

3. Glossary: monitoring and evaluation terms. Geneva: UNAIDS; 2011 (https://www.unaids.org/sites/default/files/sub_landing/files/11_ME_Glossary_FinalWorkingDraft.pdf)

4. Guidance on capacity building for HIV monitoring and evaluation. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/sub_landing/files/5_4_MERG_Guidance_HIV_ME_Capacity_Buidling.pdf)

5. Indicator standards: operational guidelines for selecting indicators for the HIV response. Geneva: UNAIDS; 2015 (https://www.unaids.org/sites/default/files/media_asset/JC2742_operational_guidelines_for_selecting_indicators_for_the_HIV_response_en.pdf)

6. A national evaluation agenda for HIV. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/sub_landing/files/9_3-National-Eval-Agenda-MEF.pdf)

7. An introduction to triangulation. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/sub_landing/files/10_4-Intro-to-triangulation-MEF.pdf)

8. An introduction to indicators. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/sub_landing/files/8_2-Intro-to-IndicatorsFMEF.pdf)

9. Basic terminology and frameworks for monitoring and evaluation. Geneva: UNAIDS; 2010 (https://www.unaids.org/sites/default/files/sub_landing/files/7_1-Basic-Terminology-and-Frameworks-MEF.pdf)

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11. Global HIV target setting for 2030: Global Task Team on 2030 targets recommendations. Geneva: UNAIDS; 2025 (https://www.unaids.org/sites/default/files/2025-05/20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf).

12. Global AIDS Update 2025: AIDS, crisis and the power to transform. Geneva: UNAIDS; 2025 (https://www.unaids.org/sites/default/files/2025-05/20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf).

13. The state of the world's children 2025. New York: UNICEF; 2025 (https://www.unicef.org/reports/state-of-worlds-children/2025?brid=u6MbEuX_KkgBQuLYgK5U0A).

14. Segone M, ed. Country-led monitoring and evaluation systems: better evidence, better policies, better development results. New York: UNICEF; 2009 (https://mics.unicef.org/sites/mics/files/2024-05/Country_led_ME_systems.pdf).

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

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

Annex 2.
Indicators and data collection tools for monitoring the recommended 2030 targets

The table below reflects indicators and data collection tools for monitoring the recommended 2030 targets. The 16 top-line targets are in bold. Corresponding indicators included in GAM are also in bold. the 50 additional second-line targets are recommended for national monitoring if the topline targets are not met.

For more information on the 2030 recommended targets, please see: Global HIV target setting for 2030: Global Task Team on 2030 targets recommendations. Geneva: United Nations Joint Programme on HIV/AIDS; 2025 (https://www.unaids.org/sites/default/files/2025-05/20250328_recommended_2030_HIV_targets_livedocument_en_13_May_2025.pdf).

2030 Target	Indicators	Method of measurement	Links
Overarching targets			
A 90% reduction in new HIV infections between 2010 and 2030 and a continued reduction of 5% per year post-2030.	**HIV incidence: Number of people newly infected with HIV in the reporting period per 1000 uninfected population**	Epidemiological estimates	https://indicatorregistry.unaids.org/indicator/hiv-incidence-rate
A 90% reduction in AIDS-related deaths since 2010	**AIDS mortality: Total number of people who have died from AIDS-related causes per 100 000 population**	Epidemiological estimates	https://indicatorregistry.unaids.org/indicator/aids-mortality
Area 1: Ensure available, accessible, acceptable and quality HIV treatment and care for people living with HIV			
95% of people who are living with HIV know their HIV status.	**People living with HIV who know their HIV status: Percentage of people living with HIV who know their HIV status at the end of the reporting period**	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/people-living-hiv-who-know-their-status
	HIV testing and status awareness among key populations (A–D): Percentage of people from key populations who report having tested negative for HIV in the past 12 months, or who know that they are living with HIV	Integrated biobehavioural surveillance surveys or other special survey	https://indicatorregistry.unaids.org/indicator/knowledge-hiv-status-among-key-populations-d
	HIV testing volume and positivity: The number of HIV tests conducted (testing volume) and the percentage of HIV-positive results returned to people (positivity) in the calendar year	Programme data	https://indicatorregistry.unaids.org/indicator/hiv-testing-volume-and-positivity-0

2030 Target	Indicators	Method of measurement	Links
95% of people living with HIV who know their status are on treatment.	**People living with HIV on ART: Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period**	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/people-living-hiv-antiretroviral-therapy
	ART coverage among people living with HIV in key populations: Percentage of the people living with HIV in a key population receiving antiretroviral therapy in the past 12 months	Integrated biobehavioural surveillance surveys or other special survey	https://indicatorregistry.unaids.org/indicator/antiretroviral-therapy-coverage-among-people-living-hiv-key-populations-e
	People living with HIV receiving multi-month dispensing of antiretroviral medicine: Proportion of people living with HIV and currently on antiretroviral therapy who are receiving multimonth dispensing of antiretroviral medicine	Programme data	https://indicatorregistry.unaids.org/indicator/people-living-hiv-receiving-multimonth-dispensing-antiretroviral-medicine
	Estimates of the size of key populations (A–E)	Population size estimates	https://indicatorregistry.unaids.org/indicator/size-estimations-key-populations
	HIV prevalence among key populations (A–E): Percentage of specific key populations living with HIV	Integrated biobehavioural surveillance surveys or other special survey	https://indicatorregistry.unaids.org/indicator/hiv-prevalence-among-key-populations-e
95% of people living with HIV on treatment have a suppressed viral load.	**People living with HIV who have suppressed viral loads: Percentage and number of adults and children living with HIV who have suppressed viral loads at the end of the reporting period**	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/people-living-hiv-who-have-suppressed-viral-loads
	Advanced HIV disease and late HIV diagnosis: Percentage and number of adults and children with CD4 cell count <200 cells/mm3 (or <15%) at initial diagnosis or initiation/reinitiation of antiretroviral therapy during the reporting period	Programme data	https://indicatorregistry.unaids.org/indicator/late-hiv-diagnosis
	Management of cryptococcal infection: Percentage of people living with HIV with a CD4 count below 200 cells/mm3 who were screened for, diagnosed with and treated for cryptococcal infection	Programme data	https://indicatorregistry.unaids.org/indicator/management-cryptococcal-infection
95% of people newly diagnosed with HIV and people reinitiating antiretroviral therapy (ART) are screened for advanced HIV disease (AHD) as measured by CD4 count or WHO staging when CD4 is not available.	**Advanced HIV disease and late HIV diagnosis: Percentage and number of adults and children with CD4 cell count <200 cells/mm3 (or <15%) at initial diagnosis or initiation/reinitiation of antiretroviral therapy during the reporting period**	Programme data	https://indicatorregistry.unaids.org/indicator/late-hiv-diagnosis
30% of HIV testing and supportive services related to care and treatment are delivered by community-led organizations, including key population led and women-led organizations.	No standard indicator available		

2030 Target	Indicators	Method of measurement	Links
95% of HIV-exposed children are tested by two months of age	**Early infant diagnosis: Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth**	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/early-infant-diagnosis
95% of HIV-exposed infants and children are tested after cessation of breastfeeding	No standard indicator available		
95% of pregnant women receive antenatal care and know their HIV status	**HIV testing in pregnant women: Percentage of pregnant women with known HIV status**	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/hiv-testing-pregnant-women-0
90% of people living with HIV entering care through either HIV or TB services receive testing (and treatment if needed) for the other disease	TB screening coverage among new ART patients: % of people living with HIV newly initiated on ART who were screened for TB	Programme data	https://www.who.int/publications/i/item/9789240055315
	Proportion of registered new and relapse TB patients with documented HIV status: Number of new and relapse TB patients who had an HIV test result recorded in the TB register expressed as a percentage of the number registered during the reporting period	Programme data	https://iris.who.int/server/api/core/bitstreams/616eddc1-33bb-461a-92db-512abbe371be/content
95% of people living with HIV have received preventive therapy for TB	**People living with HIV on antiretroviral therapy who started tuberculosis preventive treatment: Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment during the reporting period**	Programme data	https://indicatorregistry.unaids.org/indicator/people-living-hiv-who-started-tuberculosis-preventive-treatment
	Percentage of people living with HIV on antiretroviral therapy who completed a course of tuberculosis preventive treatment among those who initiated tuberculosis preventive treatment	Programme data	https://indicatorregistry.unaids.org/indicator/percentage-people-living-hiv-antiretroviral-therapy-who-completed-course-tb-preventive
90% reduction in TB-related deaths among people living with HIV (compared to 2010)	Number of TB-related deaths among people living with HIV	World Health Organization estimates	https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/data

2030 Target	Indicators	Method of measurement	Links
Area 2: Scale-up HIV prevention options that bring together biomedical, structural and behavioural interventions			
90% of people in need of prevention use appropriate, prioritized, person-centred and effective prevention options (pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), condoms, needle/syringe programmes (NSPs), opioid agonist therapy (OAT) (topline).	**Condom need met: Percentage of the estimated number of condoms needed that were distributed during the past 12 months**	Programme data and condom needs estimate	
	PrEP need met: Ratio of the estimated number of people in need of pre-exposure prophylaxis (PrEP) per 1000 people per year who received it at least once during the reporting period	Programme data and estimated need for PrEP	
	Needles and syringes distributed per person who injects drugs: Number of needles and syringes distributed per person who injects drugs per year by needle–syringe programmes	Programme data	https://indicatorregistry.unaids.org/indicator/people-who-inject-drugs-prevention-programmes
	Coverage of opioid agonist maintenance therapy: Percentage of people who inject drugs receiving opioid agonist maintenance therapy	Programme data and population size estimate	https://indicatorregistry.unaids.org/indicator/coverage-opioid-substitution-therapy
	Syphilis prevalence among key populations (A, B, D)	Integrated biobehavioural surveillance surveys or programme data	https://indicatorregistry.unaids.org/indicator/syphilis-prevalence-among-key-populations-b-d
	Annual number of males voluntarily circumcised	Programme data	https://indicatorregistry.unaids.org/indicator/annual-number-men-voluntarily-circumcised
80% of people use a condom at last sex with a non-regular partner	Condom use at last high-risk sex: The percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Population-based surveys	https://indicatorregistry.unaids.org/indicator/condom-use-last-high-risk-sex
50% of people at high risk of acquiring HIV (including key populations) use effective, ARV-based, prevention options: oral PrEP, long acting PrEP, PEP (target levels in line with epidemiology and people's choices)	No standard indicator available		
95% of sex workers and their clients used a condom at last paid sex.	**Condom use among sex workers: Percentage of sex workers reporting using a condom with their most recent clien**	Integrated biobehavioural surveillance surveys or other special survey	https://indicatorregistry.unaids.org/indicator/sex-workers-condom-use
95% of people who inject drugs used safe injecting equipment during their last injection	**Safe injecting practices among people who inject drugs: Percentage of people who inject drugs reporting using sterile injecting equipment the last time they injected**	Integrated biobehavioural surveillance surveys or other special survey	https://indicatorregistry.unaids.org/indicator/people-who-inject-drugs-safe-injecting-practices
50% use of opioid agonist maintenance treatment among people who inject opioids	**Coverage of opioid agonist maintenance therapy: Percentage of people who inject drugs receiving opioid agonist maintenance therapy**	Programme data and population size estimate	https://indicatorregistry.unaids.org/indicator/coverage-opioid-substitution-therapy

2030 Target	Indicators	Method of measurement	Links
95% of adolescent girls and young women, adult women, pregnant and breastfeeding women, and adolescent boys and men, effectively reached with people-centred HIV prevention programmes (HIV prevention related contact with health services, (including SRH quality services), community outreach, virtual interventions, schools or other providers	No standard indicator available		
90% of schools provide life skills-based HIV and sexuality education	SDG thematic indicator 4.7.2: Percentage of schools that provided life skills-based HIV and sexuality education within the previous academic year	Annual School Census questionnaire or the UNESCO Institute for Statistics (UIS) Annual Survey of Formal Education questionnaire	https://iris.who.int/server/api/core/bitstreams/83f3a1f4-13fc-46f3-9397-26ad6e5acd46/content
95% of key populations effectively reached with people-centred HIV prevention programmes	Coverage of HIV prevention programmes among key populations (A–D): Coverage of HIV prevention programmes: percentage of people in a key population reporting having received a combined set of HIV prevention interventions	Integrated biobehavioural surveillance survey or other special survey or programme data	https://indicatorregistry.unaids.org/indicator/coverage-hiv-prevention-programmes-among-key-populations-d
	HIV prevention programmes in prisons: HIV prevention and treatment programmes offered to people in prisons and other closed settings while detained	Programme data	https://indicatorregistry.unaids.org/indicator/hiv-prevention-programmes-prisons
95% of the estimated need for condoms is available and distributed	**Condom need met: Percentage of the estimated number of condoms needed that were distributed during the past 12 months**	Programme data and condom needs estimate	
95% of the estimated need for PrEP is available and distributed	**PrEP need met: Ratio of the estimated number of people in need of pre-exposure prophylaxis (PrEP) per 1000 people per year who received it at least once during the reporting period**	Programme data and estimated need for PrEP	
95% of the estimated need for PEP is available and distributed	PRV.5 Number of PEP recipients: Number of people prescribed PEP during the reporting period	Programme data	https://www.who.int/publications/i/item/9789240055315
95% of the estimated need for sterile syringes is available and distributed.	**Needles and syringes distributed per person who injects drugs: Number of needles and syringes distributed per person who injects drugs per year by needle–syringe programmes**	Programme data	https://indicatorregistry.unaids.org/indicator/people-who-inject-drugs-prevention-programmes
80% of people-centred HIV prevention programmes for key populations to be delivered by community-led organizations.	**Disaggregation by type of service provider of indicators HIV testing volume and positivity, Needles and syringes distributed per person who injects drugs, Coverage of opioid agonist maintenance therapy**	Programme data	
90% of all people living with HIV are virally suppressed by 2030, increasing to 95% by 2040	**People living with HIV who have suppressed viral loads: Percentage and number of adults and children living with HIV who have suppressed viral loads at the end of the reporting period**	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/people-living-hiv-who-have-suppressed-viral-loads

2030 Target	Indicators	Method of measurement	Links
Area 3: Integrate HIV services into primary health care (PHC), broader health systems and other sectors			
95% of people who are receiving HIV prevention or treatment services also receive sexual and reproductive health services they need (including for STIs).	**Number of women living with HIV who were screened for cervical cancer using any screening test: The number of women living with HIV who were screened for cervical cancer in the last 12 months using any screening test**	Programme data	https://indicatorregistry.unaids.org/indicator/cervical-cancer-screening-among-women-living-hiv
	Cervical precancer treatment in women living with HIV: Percentage of women living with HIV who screened positive for cervical precancer who received treatment for precancerous lesions in the last 12 months	Programme data	https://indicatorregistry.unaids.org/indicator/cervical-precancer-treatment-women-living-hiv
95% of pregnant women living with HIV and their newborns receive maternal and newborn care that integrates or links to comprehensive HIV services, including for prevention of the triple vertical transmission of HIV and hepatitis B virus and treatment of syphilis.	**Vertical transmission of HIV: Estimated percentage of children newly infected with HIV in the past 12 months due to vertical transmission**	Epidemiological estimates	https://indicatorregistry.unaids.org/indicator/mother-child-transmission-hiv
	Prevention of vertical transmission of HIV: Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of vertical transmission of HIV	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/preventing-mother-child-transmission-hiv
	HIV testing in pregnant women: Percentage of pregnant women with known HIV status	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/hiv-testing-pregnant-women-0
	Early infant diagnosis: Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	Programme data and epidemiological estimates	https://indicatorregistry.unaids.org/indicator/early-infant-diagnosis
	Syphilis among pregnant women: Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and were treated	Programme data	https://indicatorregistry.unaids.org/indicator/syphilis-among-pregnant-women
	Congenital syphilis rate: Reported congenital syphilis cases per 100 000 live births in the 12-month reporting period	Programme data	https://indicatorregistry.unaids.org/indicator/congenital-syphilis-rate-live-births-and-stillbirth
	Hepatitis B virus among pregnant women attending antenatal care services	Programme data	
90% of women living with HIV screened for cervical cancer at least once in the last five years	**Number of women living with HIV who were screened for cervical cancer using any screening test: The number of women living with HIV who were screened for cervical cancer in the last 12 months using any screening test**	Programme data	https://indicatorregistry.unaids.org/indicator/cervical-cancer-screening-among-women-living-hiv

2030 Target	Indicators	Method of measurement	Links
90% of women living with HIV identified with cervical disease are treated and 90% of women with precancer are treated	**Cervical precancer treatment in women living with HIV: Percentage of women living with HIV, who screened positive for cervical precancer who received treatment for precancerous lesions in the last 12 months**	Programme data	https://indicatorregistry.unaids.org/indicator/cervical-precancer-treatment-women-living-hiv
	Treatment of invasive cervical cancer in women living with HIV: The percentage of women living with HIV with suspected invasive cervical cancer who were treated within the last 12 months	Programme data	https://indicatorregistry.unaids.org/indicator/treatment-invasive-cervical-cancer-women-living-hiv
80% of people living with HIV in need receive screening for hypertension and diabetes	No standard indicator available		
90% of people living with HIV in HIV care receive screening for depression	No standard indicator available		
90% of gay men and other men who have sex with men and sex workers are screened for syphilis	**Syphilis prevalence among gay men and other men who have sex with men**	Programme data	https://indicatorregistry.unaids.org/indicator/syphilis-prevalence-among-key-populations-b-d
90% of people living with HIV tested for hepatitis C	Management of viral hepatitis C: Percentage of people living with HIV on antiretroviral therapy who were tested for, diagnosed with and treated for chronic hepatitis C virus (HCV) infection	Programme data	https://indicatorregistry.unaids.org/indicator/management-viral-hepatitis-c
90% of people living with hepatitis B diagnosed	Viral hepatitis among key populations: Prevalence of hepatitis and coinfection with HIV among key populations	Programme data	https://indicatorregistry.unaids.org/indicator/viral-hepatitis-among-key-populations
Area 4: End stigma and discrimination and uphold human rights and gender equality in the HIV response			
Less than 10% of countries have punitive legal and policy environments that deny or limit access to services (topline target).	**Countries with accountability mechanisms established by the government or community and non-governmental organizations to record and address complaints of HIV-related discrimination and seek redress**	National Commitments and Policy Instrument (NCPI) and national legal document reviews	
Less than 10% of people living with HIV and people from key populations lack access to legal services	**Countries with mechanisms in place for accessing affordable legal services**	National Commitments and Policy Instrument (NCPI)	
Less than 10% of countries criminalize sex work, possession of small amounts of drugs, same sex sexual behaviour and HIV non-disclosure, exposure or transmission	**Countries with laws criminalizing sex work, possession of small amounts of drugs, same-sex sexual behaviour and HIV non-disclosure, exposure or transmission**	National Commitments and Policy Instrument (NCPI) and national legal document reviews	
Less than 10% of countries lack mechanisms for people living with HIV and people from key populations to report abuse and discrimination and seek redress	**Countries with accountability mechanisms established by the government or community and non-governmental organizations to record and address complaints of HIV-related discrimination and seek redress**	National Commitments and Policy Instrument (NCPI)	

2030 Target	Indicators	Method of measurement	Links
Over 90% of people living with HIV who experienced rights abuses have sought redress	People living with HIV seeking redress for violation of their rights: Proportion of people living with HIV who have experienced rights abuses in the last 12 months and have sought redress	People living with HIV Stigma Index 2.0	https://indicatorregistry.unaids.org/indicator/people-living-hiv-seeking-redress-violation-their-rights
Less than 10% of key populations experienced harassment, arrest, detention, or incarceration in the past year at the individual level	No standard indicator available	Integrated biobehavioural surveillance survey	https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/who_blue-book-questionnaire_final.pdf?sfvrsn=e49ece88_5&ua=1
Less than 10% of people living with HIV and key populations (gay men and other men who have sex with men, sex workers, transgender and people who inject drugs) experience stigma and discrimination (topline target).	**Experience of HIV-related discrimination in health-care settings: Percentage of people living with HIV who report experiences of HIV-related discrimination in health care settings**	People living with HIV Stigma Index 2.0	https://indicatorregistry.unaids.org/indicator/experience-hiv-related-discrimination-health-care-settings-0
	Stigma and discrimination experienced by key populations (A–D): Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months	Integrated biobehavioural surveillance survey or other special survey	https://indicatorregistry.unaids.org/indicator/stigma-and-discrimination-experienced-key-populations
	Avoidance of health care among key populations because of stigma and discrimination (A–D): Avoidance of health care among key populations because of stigma and discrimination	Integrated biobehavioural surveillance survey or other special survey	https://indicatorregistry.unaids.org/indicator/avoidance-hiv-services-because-stigma-and-discrimination-among-key-populations-d
Less than 10% of the general population reports discriminatory attitudes towards people living with HIV.	Discriminatory attitudes towards people living with HIV: Percentage of women and men 15–49 years old who report discriminatory attitudes towards people living with HIV	Population-based survey	https://indicatorregistry.unaids.org/indicator/discriminatory-attitudes-towards-people-living-hiv
Less than 10% of health workers report negative attitudes towards people living with HIV	Discriminatory attitudes towards people living with HIV among health facility staff: Percentage of health facility staff who report discriminatory attitudes towards people living with HIV	Health facility survey measuring HIV stigma and discrimination among health facility staff	https://indicatorregistry.unaids.org/indicator/discriminatory-attitudes-towards-people-living-hiv-among-health-facility-staff
Less than 10% of health workers report negative attitudes towards key populations	Discriminatory attitudes towards people from key populations among health facility staff (A–D): Percentage of health facility staff who report discriminatory attitudes towards people from key populations	Health facility survey measuring HIV stigma and discrimination among health facility staff	https://indicatorregistry.unaids.org/indicator/discriminatory-attitudes-towards-people-key-populations-among-health-facility-staff
Less than 10% of law enforcement officers report negative attitudes towards key populations.	Discriminatory attitudes towards people from key populations among police (A–D): Percentage of police who report discriminatory attitudes towards people from key populations	Survey among police officers	https://indicatorregistry.unaids.org/indicator/discriminatory-attitudes-towards-people-key-populations-among-police https://www.unaids.org/sites/default/files/2025-05/JC3143_stigma-discrimination_en.pdf

2030 Target	Indicators	Method of measurement	Links
Less than 10% of people from key populations experience stigma and discrimination	**Stigma and discrimination experienced by key populations (A–D): Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months**	Integrated biobehavioural surveillance survey or other special survey	https://indicatorregistry.unaids.org/indicator/stigma-and-discrimination-experienced-key-populations
Less than 10% of people living with HIV experience stigma and discrimination in healthcare and community settings	Stigma and discrimination experienced by people living with HIV in community settings: Percentage of people living with HIV who report experienced stigma and discrimination in the general community in the last 12 months	People living with HIV Stigma Index 2.0	https://indicatorregistry.unaids.org/indicator/stigma-and-discrimination-experienced-people-living-hiv-community-settings
	Experience of HIV-related discrimination in health-care settings: Percentage of people living with HIV who report experiences of HIV-related discrimination in health care settings	People living with HIV Stigma Index 2.0	https://indicatorregistry.unaids.org/indicator/experience-hiv-related-discrimination-health-care-settings-0
Less than 10% of people living with HIV report internalized stigma	Internalized stigma reported by people living with HIV: Percentage of people living with HIV who report internalized stigma	People living with HIV Stigma Index 2.0	https://indicatorregistry.unaids.org/indicator/internalized-stigma-reported-people-living-hiv
Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence (topline target).	SDG indicator Indicator 5.2.1: Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Population-based survey	https://unstats.un.org/sdgs/metadata/files/Metadata-05-02-01.pdf https://dhsprogram.com/pubs/pdf/DHSQM/DHS8-Module-DomViol-Qnnaire-EN-12Nov2021-DHSQM.pdf
	Physical and/or sexual violence experienced by key populations (A–D): Percentage of people in a key population who report having experienced physical and/or sexual violence in the last 12 months	Integrated biobehavioural surveillance survey or other special survey	https://indicatorregistry.unaids.org/indicator/experience-physical-andor-sexual-violence-among-key-populations
Less than 10% of women and girls experience psychological, physical, or sexual violence from an intimate partner	SDG indicator Indicator 5.2.1: Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Population-based survey	https://unstats.un.org/sdgs/metadata/files/Metadata-05-02-01.pdf https://dhsprogram.com/pubs/pdf/DHSQM/DHS8-Module-DomViol-Qnnaire-EN-12Nov2021-DHSQM.pdf
Less than 10% of people from key populations (gay men and other men who have sex with men, sex workers, transgender and people who inject drugs) experience physical or sexual violence	**Physical and/or sexual violence experienced by key populations (A–D): Percentage of people in a key population who report having experienced physical and/or sexual violence in the last 12 months**	Integrated biobehavioural surveillance survey or other special survey	https://indicatorregistry.unaids.org/indicator/experience-physical-andor-sexual-violence-among-key-populations
Less than 10% of people support inequitable gender norms	Attitudes towards violence against women: The percentage of women and men aged 15 to 49 years who agree that a husband is justified in hitting or beating his wife for specific reasons	Population-based survey	https://indicatorregistry.unaids.org/indicator/attitudes-towards-violence-against-women

2030 Target	Indicators	Method of measurement	Links
More than 90% of HIV services are gender responsive	Gender-responsiveness of HIV services: Percentage of health facilities providing gender-responsive HIV services	Health facility checklist https://www.unaids.org/sites/default/files/2025-05/JC3142_gender-responsiveness-HIV_en.pdf	https://indicatorregistry.unaids.org/indicator/gender-responsiveness-hiv-services
Less than 10% of people living with HIV experience physical or sexual violence	No standard indicator available		
Less than 10% of women living with HIV experience coercion, mistreatment, or abuse in sexual and reproductive health services	No standard indicator available	People living with HIV Stigma Index 2.0	https://development.stigmaindex.org/ https://www.wlhiv.org/_files/ugd/682db7_2fe9a24ef-9454c6691e1cc06bee58165.pdf
Area 5: Ensure community leadership in the HIV response [to be read in conjunction with areas 1 and 2]			
60% of programmes that support achievement of the societal enablers to be delivered by community-led organizations, including key population-led and women-led organizations.	No standard indicator available		
90% of countries remove regulatory barriers for HIV-related community-led organizations (registration, eligibility, etc.).	**Countries with laws, regulations or policies that provide for the registration of community-led organizations**	National Commitments and Policy Instrument (NCPI)	
	Countries with laws, regulations or policies that enable access to funding for community-led organizations	National Commitments and Policy Instrument (NCPI)	
90% of countries incorporate community-led monitoring data into national decision-making processes to strengthen accountability in HIV and TB programmes.	No standard indicator available		
Area 6: Ensure sustainable financing for a people-centered national and global HIV response			
Countries commit to sustaining the HIV response by progressively increasing domestic funding; low-income countries reach 30%, low and middle-income countries reach 50%, and upper and middle-income countries reach 95% of their total funding for HIV.	**Domestic public budget for HIV: Budget for HIV and AIDS programmes from domestic public sources**	Budget analysis	https://indicatorregistry.unaids.org/indicator/domestic-public-budget-hiv
	HIV expenditure by origin of resources: Domestic and international HIV expenditure by programme category and financing source	National AIDS Spending Assessment (NASA)	https://indicatorregistry.unaids.org/indicator/aids-spending
Countries monitor and report on resources allocated to community-led and other civil society organizations to deliver: community-led monitoring (CLM); programmes addressing societal enablers; and HIV prevention, testing and supportive services to treatment and care from both national governments and international sources	**HIV expenditure by origin of resources: Domestic and international HIV expenditure by programme category and financing source**	National AIDS Spending Assessment (NASA)	https://indicatorregistry.unaids.org/indicator/aids-spending

2030 Target	Indicators	Method of measurement	Links
A reduction in out-of-pocket expenditures (OOPEs), through national policy instruments, in accordance with WHO Universal Health Coverage guidelines.	**HIV expenditure by origin of resources: Domestic and international HIV expenditure by programme category and financing source**	National AIDS Spending Assessment (NASA)	https://indicatorregistry.unaids.org/indicator/aids-spending
Mobilize HIV Investments of US$21.9 billion annually in LMICs by 2030.	**HIV expenditure by origin of resources: Domestic and international HIV expenditure by programme category and financing source**	National AIDS Spending Assessment (NASA)	https://indicatorregistry.unaids.org/indicator/aids-spending
Mobilize an average of 25% of the required resources for HIV prevention in low- and middle-income countries tailored to the unique needs of each country	**HIV expenditure by origin of resources: Domestic and international HIV expenditure by programme category and financing source**	National AIDS Spending Assessment (NASA)	https://indicatorregistry.unaids.org/indicator/aids-spending
Mobilize an average of 10% of the required resources for societal enablers in low- and middle-income countries, tailored to the specific needs of each country and leveraging the latest opportunities.	**HIV expenditure by origin of resources: Domestic and international HIV expenditure by programme category and financing source**	National AIDS Spending Assessment (NASA)	https://indicatorregistry.unaids.org/indicator/aids-spending

Annex 3.
Expected levels of earmarked domestic public budget for HIV

To fill in the form, please consider the following:

1. Indication of a fiscal year is required. A fiscal year may or may not align with the calendar year (use the fiscal year that starts on the calendar year specified in the field).
2. Choose the reporting currency. This could be filled in local currency or converted into US dollars when an official exchange rate is specified.
3. It is required to express the amounts in currency units in thousands or millions.
4. Fill the approved and executed budget in the corresponding fiscal year. The approved budget includes the domestic budget that is approved by the government. Budget allocations using government loans (non-official development assistance loans) are also considered to be part of the domestic budget. The executed budget is the spending of the approved budget; it should not be more than the approved budget unless there were additional funds provided (if so, please specify). The totality of the expenditures can exceed the approved budget because some incurred expenditures were not funded by HIV-specific earmarked budgets.
5. Indicate the perception of a budget increase, maintenance at the same level or a budget decrease for the next fiscal year.
6. It is necessary to provide the aggregate subtotals for budgets at each level
7. of government, and for under-segmented and independent budget structures. For the levels of government, report the subtotals for the national/central/ federal, provincial/state/district and municipal/city/local levels in each country (as appropriate). Separately report the public budgets for institutions that pertain to different systems—such as security institutions or other national bodies
8. (e.g., the national AIDS commission)—if those systems are independent from the government levels mentioned above.

Annex 4. Volume and unit prices of antiretrovirals medicines and other HIV-related regimens procured and distributed

As part of Indicator 6.2, it is mandatory to complete the information on the volume and unit prices of antiretroviral medicines and other HIV-related regimens procured and distributed.

Antiretroviral regimen/formulation	Posology	Pills or smallest dose per pack	Total number of packs procured in the fiscal year	Average price per pack (in US$) (exclude freight and other administrative costs)	Total number of packs picked up by beneficiaries in the fiscal year
Tenofovir + Emtricitabine + Efavirenz [TDF + FTC + EFV]	300 mg + 200 mg + 600 mg				
Tenofovir + Lamivudine + Efavirenz [TDF + 3TC + EFV]	300 mg + 300 mg + 600 mg				
Tenofovir + Lamivudine + Nevirapine [TDF + 3TC] + NVP	300 mg + 300 mg + 200 mg				
Zidovudine + Lamivudine + Efavirenz [ZVD + 3TC] + EFV	300 mg + 150 mg + 200 mg				
Abacavir + Lamivudine + Zidovudine [ABC + 3TC + ZDV]	300 mg + 150 mg + 300 mg				
Zidovudine + Lamivudine + Nevirapine [ZVD + 3TC + NVP]	300 mg + 150 mg + 200 mg				
Zidovudine + Lamivudine + Nevirapine [ZVD + 3TC + NVP]	60 mg + 30 mg + 50 mg				
Tenofovir + Emtricitabine [TDF + FTC]	300 mg + 200 mg				
Zidovudine + Lamivudine [ZDV + 3TC]	300 mg + 150 mg				
Lopinavir + Ritonavir [LPV + RTV]	200 mg + 50 mg				
Lopinavir + Ritonavir [LPV + RTV]	80 mg + 20 mg/ml				
Abacavir + Lamivudine [ABC + 3TC]	860 mg + 30 mg				
Tenofovir + Lamivudine [TDF + 3TC]	300 mg + 300 mg				
Darunavir [DRV]	300 mg				
Dolutegravir [DTG]	50 mg				
Others (please specify):					

Regimen/formulation related to the management of advanced HIV disease	Posology	Pills or smallest dose per pack	Total number of packs procured in the fiscal year	Average price per pack (in US$) (exclude freight and other administrative costs)	Total number of packs picked up by beneficiaries in the fiscal year
Ambisome (high dose liposomal amphotericin B) injection	50 mg/vial	1 vial			
Conventional liposomal amphotericin	50 mg/ml				
Amphotericin B deoxycholate injection	5 mg/ml	1 vial			
Flucytosine tablet (5FC)	500 mg				
Flucytosine injection	10 mg/ml	5 bottles			
Fluconazole capsule	50 mg				
Fluconazole capsule	200 mg	100			
Fluconazole solution for parentral injection	2 mg/ml	100 ml bag			
Itraconazole Capsule	200 mg				
Cotrimoxazole (Sulfamethoxazole and Trimethoprim) tablet	800 mg/160mg				
Isoniazid/cotrimoxazole/vitamin B6 tablet	300/960/25 mg	30			

Regimen / formulation related to pre-exposure prophylaxis (PrEP)	Posology	Smallest dose per pack	Total number of packs procured in the fiscal year	Average price per pack (in US$)
Oral PrEP (TDF/FTC or equivalent)	Tablet	30 tablets		
Long-acting Cabotegravir (CAB-LA)	Injection (every 2 months)	1 vial		
Long-acting Lenacapavir (LEN)	Injection (every 6 months)	1 vial		

Notes:

1. Please express volume in the number of packs procured and unit prices in local currency units or current US$ for the reporting year.
2. The data on the number of packages picked up by beneficiaries correspond to the regimen/formulations without need to disaggregate by procurement process.
3. By choosing the "Other" option, the rapporteur will be able to provide custom data on the regimen and posology combination in case the regimen information is not found in the standard list shown above.
4. Information on patients per regimen will be captured as part of the WHO/AIDS Medicines and Diagnostics Service Survey on the Use of ARV Medicines and Laboratory Technologies and in the implementation of the WHO Related guidelines, hosted on the Global AIDS Monitoring online tool.

Annex 5.
The national funding matrix for Indicator 6.3: HIV expenditure by origin of the resources

As in previous reporting cycles, the national funding matrix suggested for the Global AIDS Monitoring 2025 cycle contains a set of key core programmes and services by financing source. Each of the programme categories are divided into sets of sub-indicators. The set of the core sub-indicators comprise the following key programmes or services:

- Combination prevention, including condoms, PrEP, voluntary medical male circumcision, harm reduction services, empowering young women and girls, and providing essential service packages for key populations.
- Prevention of mother-to-child transmission of HIV.
- HIV testing and counselling.
- HIV-specific laboratory monitoring.
- Antiretroviral therapy.
- HIV and tuberculosis (TB).
- Social enablers, including reducing stigma and discrimination.
- Instituting human rights programmes.

The reporting framework of Indicator 6.3—"Total HIV expenditure by origin of the resources"—is organized around a two-dimensional system for recording HIV

expenditure by programme and financing source. The form of reporting therefore has the format of a matrix.

The table below (Table 1) provides a complete set of programmes or services and a residual category that account for the totality of possible use of resources in countries, including financing sources. Countries are requested to report on the applicable programmes or services as appropriate (i.e., countries should only report on the relevant rows of the matrix, not on each one). The same is true for the financing sources: they need to be completed as they exist in each country. It is important to differentiate when the expenditure is non-existent (i.e., it has a value of "0"), unavailable or not applicable.

The total HIV expenditure is the sum of the core programmes and services from reported figures from Commitments 1 to 10 Table 1, plus the residual category of "Other essential programmes outside of the suggested framework" to account for total HIV expenditure and not just for the expenditures derived from earmarked budgets.

Further guidance will be provided in the Global AIDS Monitoring online reporting tool on how to complete the reporting forms and submit expenditure indicators to UNAIDS. The total amount of resources should include the totality of financing flows and expenditures by all programmes or services and by all sources. The sub-indicators would represent only a subset of the total that corresponds to parts of the specific commitments. The amounts reported will be compared to the number of people receiving the same services reported in Global AIDS Monitoring or elsewhere.

The National AIDS Spending Assessment (NASA) guidelines are being updated. A crosswalk on the new AIDS Spending Categories (ASCs) and the Global AIDS Monitoring funding matrix requested for Indicator 6.3 will be made available in time for Global AIDS Monitoring reporting. When a NASA—an in-depth HIV resource tracking exercise—is performed in countries, one can extract a Excel report from the resource tracking tool (RTT) and upload it into the Global AIDS Monitoring AIDS spending module.

Table 1

List of HIV programmes or services in the national funding matrix

Codes in the Global AIDS Monitoring national funding matrix	Global AIDS Monitoring programme categories: complete set of interventions	Global AIDS Monitoring programme categories: core sub-indicators
1 Treatment, care and support (subtotal)		
1.1	HIV testing and counselling (HTC) for populations other than key populations	Expenditure on HTC (non-targeted), disaggregated by commodities and other direct/indirect costs. Including: vulnerable and accessible populations, general population, provider-initiated testing and counseling, testing in blood centers, etc.
1.2	Antiretroviral treatment (subtotal)	Expenditure on antiretroviral therapy (adults and paediatric).
1.2.1.	Adult antiretroviral treatment	Expenditure on antiretroviral therapy for adults disaggregated by commodities and other direct/indirect costs.
1.2.2.	Paediatric antiretroviral treatment	Expenditure on antiretroviral therapy for paediatric use, disaggregated by commodities and other direct/indirect costs.
1.2.3.	Antiretroviral therapy not broken down by either age or line of treatment	Expenditure on antiretroviral therapy not broken down by either age or line of treatment, disaggregated by commodities and other direct/indirect costs.
1.3	Specific HIV-related laboratory monitoring (CD4, viral load)	Expenditure on HIV-specific laboratory monitoring (CD4 cell count, viral load and other lab/tests) disaggregated by commodities and other direct/indirect costs.
1.4	Opportunistic infections (OI) prophylaxis and treatment, excluding treatment and prevention of TB for people living with HIV	
1.5	Palliative care	
1.6	Support and retention	
1.98	Programmatic activities for treatment, care and support not disaggregated by type	
2 Prevention of vertical transmission of HIV (subtotal)		
2.1	HIV testing and counselling (HTC) for pregnant women	Expenditure on prevention of vertical transmission of HIV disaggregated by commodities and other direct/indirect costs.
2.2	Early infant diagnosis	Expenditure on prevention of vertical transmission of HIV disaggregated by commodities and other direct/indirect costs.
2.3	Antiretroviral treatment to reduce vertical transmission of HIV	Expenditure on prevention of vertical transmission of HIV disaggregated by commodities and other direct/indirect costs.
2.4	Non-ARV antiretroviral medicine-related component of prevention of mother-to-child transmission	Expenditure on prevention of vertical transmission of HIV other than the expenditures on the antiretroviral treatment provided to the pregnant women if a regimen as an adult living with HIV is provided.
2.98	Prevention of vertical transmission of HIV not disaggregated	

3 Prevention (subtotal)		
3.1	Social and behaviour change (SBC) programmes for populations other than key populations	Non-targeted.
3.2	Condoms (for HIV prevention) for the general population	Condoms (non-targeted) disaggregated by commodities and other direct/indirect costs.
3.3	Pre-exposure exposure prophylaxis (PrEP) disaggregated by key populations (subtotal)	PrEP stratified by key population.
3.3.1.	PrEP for gay men and other men who have sex with men (MSM)	PrEP stratified by key population.
3.2.2.	PrEP for sex workers	PrEP stratified by key population.
3.3.3.	PrEP for persons who inject drugs (PWID)	PrEP stratified by key population.
3.3.4.	PrEP for transgender persons	PrEP stratified by key population.
3.3.5.	PrEP for key populations	PrEP stratified by key population.
3.3.6.	PrEP for young women and adolescent girls in high-prevalence countries	PrEP stratified by key population.
3.3.7	PrEP for serodiscordant couples	Pre-exposure prophylaxis(PrEP)
3.3.98	Pre-exposure prophylaxis PrEP not disaggregated by population type	
3.4	Voluntary medical male circumcision (VMMC) in high-prevalence countries	Voluntary medical male circumcision (VMMC).
3.5	Prevention, promotion of testing and linkage to care programmes for gay men and other men who have sex with men (MSM)	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.6	Prevention, promotion of testing and linkage to care programmes for sex workers and their clients	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.7	Prevention, promotion of testing and linkage to care programmes for persons who inject drugs (subtotal)	Prevention among people who inject drugs
3.7.1.	Needle–syringe exchange, and prevention and promotion of testing, and linkage to care programmes for people who inject drugs	Prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.7.2.	Substitution therapy	Prevention among key populations disaggregated by commodities and other direct/indirect costs.

3.7.3	HIV testing and counseling (HTC) for people who inject drugs	HIV testing and counseling activities disaggregated by commodities and other direct/indirect costs.
3.8	Prevention and promotion of testing and linkage to care programmes for transgender persons	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.9	Prevention and promotion of testing and linkage to care programmes for prisoners	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs.
3.10	Prevention and promotion of testing and linkage to care programmes for young women and adolescent girls (high-prevalence countries)	This category includes preventive activities and HIV testing and counseling sub-activities. All prevention among key populations disaggregated by commodities and other direct/indirect costs. This category also includes expenditures on cash transfers for young women and girls (age 10–24 years in high-prevalence countries) from HIV earmarked budgets.
3.11	Prevention programmes for vulnerable and accessible populations	
3.12	Post-exposure prophylaxis (PEP)	
3.13	Workplace	
3.14	Synergies with health sector	
3.15	Prevention of HIV transmission aimed at people living with HIV (PLHIV) not disaggregated	
3.98	Prevention (five pillars) not disaggregated	
3.99	Prevention of HIV transmission not disaggregated	Do not include other activities in this code if not explicitly listed. If there are additional activities, list them individually in mutually exclusive categories (ensuring no double-counting); avoid using a category already included above.
4 Gender programmes		
5 Programmes for children and adolescents		
6 Social protection and economic support		
7 Community mobilization and system strengthening		Expenditures on strengthening community organizations through education, training, and support for workers. It includes resource mobilization, financial sustainability activities, volunteer recruitment and retention, and community-led monitoring to ensure effective service delivery and long-term growth.

8 Governance and sustainability (subtotal)		
8.1	Programme administration and management	
8.2	Strategic information	
8.3	Planning and coordination	
8.4	Procurement and logistics (procurement and supply chain)	
8.5	Health systems strengthening	
8.6	Education	
8.7	HIV- and AIDS-related research	
8.98	Governance and sustainability not disaggregated	
9 Critical social enablers (subtotal)		
9.1	Policy dialogue	
9.2	Key human rights programmes and advocacy activities	
9.3	AIDS-specific institutional development	
9.98	Critical social enablers not disaggregated	
10 TB–HIV coinfection, diagnosis and treatment (subtotal)		
10.1	TB screening and diagnosis among people living with HIV (PLHIV)	Expenditure on TB and HIV.
10.2	TB prevention and treatment for people living with HIV (PLHIV)	Expenditure on TB and HIV.
10.98	TB–HIV coinfection, diagnosis and treatment not disaggregated	
11.99	Other essential programmes outside the suggested framework of core HIV and AIDS programmes (please list below and specify)	All other HIV expenditure not elsewhere classified in any of the above categories (codes 1 through 10). Please ensure that none of the programmes or activities listed here are duplicated with any of the previous categories. Any programme or service listed below should be mutually exclusive with any of the codes listed above (codes 1 through 10).

Annex 6.
Global AIDS Monitoring 2026 National Commitments and Policy Instruments (NCPI) Guidance on law-related questions

The NCPI asks a number of questions regarding laws and regulations relating to HIV, key populations and vulnerable groups. The way in which various aspects of public and private life are regulated or criminalized differs widely between and within countries.

This document provides further guidance and some examples to assist countries in answering those questions. Examples given are illustrative only and should not be seen as exhaustive—they may not necessarily reflect the reality in your country.

This guidance covers the following questions from Parts A and B:

Part A	Part B
7	1
	6, 6.1
49	23
66	
74	
107, 107.1, 107.2	
111, 112	20
114, 114.1	21
115	
114.2, 116.1, 118.1, 120.1, 120.2	
114.3, 116.2, 118.2, 120.2, 120.3	
114.4	22
116	24
118	25
120	26
122	27
124, 124.1, 124.2	
122.1, 122.4	
117, 119, 121, 123	
126	29
128, 128.1, 128.2	30
129	
130	31
131	32
132	33
134	
135, 136, 136, 138, 140	
135.1, 136.1, 137.1	
138.1, 140.1	
141, 142	
	38
150	

Explanations of law-related questions in the NCPI

The following explanations are numbered according to the questions in Part A. Corresponding and identical questions in Part B are denoted in italics.

Sections A1 and B1

A7. Is there a law, regulation or policy specifying that HIV testing:
Is mandatory before marriage?
Is mandatory to obtain a work or residence permit?
Is mandatory for certain groups or professions (not including blood and/ or tissue donors)? If yes, please specify which groups.

Part B—related to Q1

Some countries require HIV testing as a prerequisite for certain life events or for specific communities. This type of mandatory screening may be found in the legal code (law), or it may be a rule or directive from a government body (regulation).

A7a. Before marriage

Some countries have laws, regulations or policies that require people to undergo HIV screening before they may be married. This requirement may explicitly require testing for HIV status or may be a part of a broader health check (e.g. health certificate). This law, policy or regulation can apply to women, men or both.

If your country has such a law, regulation or policy, select "Yes".

A7b. Work or residence permit

Some countries have laws, regulations or policies that require people to undergo HIV testing to qualify for a work or residency permit. This requirement may be for all work permits or may apply only to specific types of work (e.g. foreign language teachers) or to temporary residency or permanent residency applications. Sometimes, this requirement is part of a broader health check.

If your country has such a law, regulation or policy, select "Yes".

A7c. Mandatory for certain groups or professions (not including blood or tissue donors)

Some countries have laws, regulations or policies that require people belonging to specific groups to undergo HIV screening. This requirement may be freestanding (e.g. all sex workers must undergo screening), or it may be a prerequisite to obtaining specific services (e.g. HIV screening requirement to obtain harm reduction services). The groups of people required to undergo testing may be defined by physical characteristics (e.g. pregnant women, people of African descent) or behaviours (e.g. people who use drugs, sex workers, immigrants). Such testing requirements may only apply to specific forms of work (e.g. teaching, health care, military).

If your country has such a law, regulation or policy, select "Yes" and provide the details of the specific groups of people that must undergo mandatory HIV screening.

This question does not apply to HIV testing when a person donates blood or tissue if the testing is done on all people who donate blood or tissue without discrimination. If this is the only situation in which your country has mandatory testing, select "No".

B6. In the context of prevention of vertical HIV transmission programmes in your country, are there reports or is there documentation of any of the following (select all that apply):

B6.1 If there are reports of any of these situations in your country, is the government carrying out due diligence in responding to them?

"Due diligence" generally refers to reasonable care and caution to avoid harm. As such, Q6.1 is not simply asking whether the government is taking any action, but whether it is taking sufficient reasonable action to ensure people who are arrested or prosecuted receive adequate redress and address the systemic issues that have led to the rights violations and abuses.

Sections A2 and B2

A49. Can possession of a needle or syringe without a prescription be used as evidence of drug use or cause for arrest in your country?

Part B—related to Q23

In some countries, law enforcement uses possession of a needle or syringe without a prescription as evidence of drug use or as grounds for arrest. This practice can be enshrined in laws, policies or regulations related to drug offences and/or law enforcement and may be criminal or civil (e.g. regulatory, administrative) in nature. For instance, countries may have paraphernalia laws that criminalize possession of needles and syringes.

If your country has laws, policies or practices to use needle and syringes as grounds for arrest or evidence of drug use, select "Yes".

A66. Can the possession of condoms be used as sufficient evidence of arrest or to support the prosecution of a crime in your country?

Law enforcement in some countries may have a practice of using possession of condoms as evidence of involvement in sex work or same-sex sexual activity.

If your country has a practice of using condoms as evidence for prosecutions or arrests, select "Yes".

A74. Does your country have education policies that guide the delivery of life skills-based HIV and sexuality education, according to international standards?

Sexuality education is defined in international standards developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) International Technical Guidance on Sexuality Education, published in 2009 and revised in 2018.

Select "Yes" only if your country's education policies are in line with these international standards.

Sections A4 and B4

A106. If legislation on domestic violence exists, is it (select all that apply):

Domestic violence occurs between partners, within the family, between members of the same household and in interpersonal relationships. It includes intimate partner violence. In addition to general anti-violence laws (e.g. assault, battery, harassment), countries may have explicit laws or legal provisions that protect against domestic violence. This question is only about explicit laws or legal provisions designed to cover this type of violence. They may be referred to as domestic violence, gender-based violence, family violence or intimate partner violence laws, to name a few. They may be freestanding pieces of legislation against domestic violence, or they may be specific provisions found in legal codes. These laws can be found in criminal and civil codes.

Countries have defined domestic violence in different ways. In some cases, the laws may protect only against violence against women and girls (e.g. by restricting it to a husband against a wife or by using gendered language when talking about survivors and perpetrators). Other legislation may be broader and survivors may be of any gender (e.g. violence against children or elderly parents, committed by extended family members, or in same-sex relationships).

Based on the legal provisions that exist in your country, select all the provisions that your laws cover.

A106.1 If legislation includes explicit criminalization of marital rape, are laws based on lack of consent, without requiring proof of physical force, coercion or resistance?

In many countries, rape within a marriage is covered under general rape or sexual assault legislation. Other countries have separate legislation on marital rape, or make it explicit in their general legislation that the law also applies within a marriage.

If your country does not explicitly mention marital rape in law, select "Legislation does not explicitly criminalize marital rape".

The definition of rape varies between countries. In some cases, evidence of coercion of physical force, or that the survivor attempted to resist or fight back, is required. Other laws define rape as being any sexual penetration that occurs without the consent of the victim. This may be defined in the legislation itself or in the court's interpretation of the legislation.

If the law in your country requires any evidence of force, coercion or resistance, select "Require evidence of force, coercion or resistance".

A106.2 If legislation on domestic violence exists, have there been any successful criminal prosecutions for domestic violence in the past 2 years?

Even if your country criminalizes domestic violence, it may or may not be implemented. Please review the cases of prosecutions under this law within your country to see whether there have been successful prosecutions within the past 2 years. A successful prosecution is where it results in a conviction.

If there have been successful prosecutions in your country, select "Yes".

If the law exists but there have been no successful prosecutions in your country, select "No".

A110. Does your country have any of the following to protect people living with HIV from violence (select all that apply)?

A111. Does your country have any of the following to protect key populations from violence (select all that apply)?

Part B—related to Q20

This question looks specifically at laws and programmes that address violence based on HIV status or affiliation to key populations within a country. Countries may have multiple and concurrent approaches to violence.

General criminal laws prohibiting violence: Countries may have general criminal laws that prohibit violence in general (e.g. assault, battery, intimidation).

If these laws have been used to protect people from key populations and people living with HIV from violence, and to prosecute perpetrators of violence against people from key populations and people living with HIV in your country, select this.

Specific legal provisions prohibiting violence based on belonging to a key population: Countries may have specific laws that address violence against people based on their HIV status or based on their gender identity, sexual orientation, involvement in sex work or drug use. Some laws explicitly prohibit violence against one or more of these groups by, for example, enactment of a hate crimes law. Other countries have laws that provide for stricter sentencing or aggravated offences in cases where a person is targeted based on their HIV status or belonging to a key population (e.g. a hate crimes law that covers HIV status or one or more key populations such as LGBTQI people or sex workers).

If your country has such a law or laws, select this. For Q112, select this if a law in your country covers at least one or more key populations.

Programmes and interventions: In addition to (or despite the lack of) any anti-violence legal provisions that exist, countries may run programmes or interventions that address violence. These programmes may address environments where violence may occur (e.g. in intimate partnerships or in workplaces), or they may address the behaviour of law enforcement (e.g. to address police abuse or abuse in prisons or other closed settings), or they may aim to remove elements that fuel or exacerbate violence, such as harmful gender norms or punitive legal environments. In terms of scope, they can be one-off programmes or may be long-term. The programmes may be specifically targeted to violence against people living with HIV or people from key populations, or they may be more general in nature but include specific sections concerning people living with HIV or people from key populations.

If your country has any such programmes or interventions, select the relevant responses.

A113. Does your country have laws at national or subnational level criminalizing HIV nondisclosure, exposure or transmission?

Part B—related to Q21

In 2013, UNAIDS developed guidance on ending overly broad criminalization of HIV nondisclosure, exposure and transmission and set out the UNAIDS policy on HIV criminalization. Countries continue to criminalize people living

with HIV if they are accused of not disclosing their HIV status in certain circumstances (e.g. with a new sexual partner), exposing other people to HIV or transmitting HIV.

HIV criminalization may be reflected in law in a variety of ways. Countries may have specific HIV criminal laws or broader laws on sexually transmitted infections, or may rely on general criminal laws relating to harm. These questions are intended to capture the variety of ways in which a country criminalizes HIV nondisclosure, exposure or transmission.

Even if the law in your country criminalizes one of the three (nondisclosure, exposure or transmission), select "Yes".

Yes, HIV nondisclosure, exposure or transmission is a specific crime: Select this response if your country has a specific crime of HIV nondisclosure, exposure or transmission. This may be in a penal or criminal code or act, or in legislation relating to public health or to HIV.

Yes, HIV nondisclosure, exposure or transmission is a crime under a law that covers a broader range of communicable diseases and mentions HIV: Select this option if your country has a specific crime relating to the spread of communicable diseases or sexually transmitted infections and HIV is specifically mentioned in the text of the law.

Yes, HIV nondisclosure, exposure or transmission is a crime under a law that covers a broader range of communicable disease but does not specifically mention HIV: Select this option if your country has a specific crime relating to the spread of communicable diseases or sexually transmitted infections that covers HIV, but HIV is not specifically mentioned in the text of the law.

No, but the general law has been used to prosecute cases in the past 10 years: Even without a specific law, some countries may have applied general criminal laws relating to harm to prosecute cases of HIV nondisclosure, exposure or transmission, such as bodily harm or grievous bodily harm. If there have been prosecutions (even if unsuccessful) since 2013 using more general criminal laws in your country, select this option.

No: If your country does not have specific HIV nondisclosure, exposure or transmission laws, and general criminal laws have not been used to prosecute HIV nondisclosure, exposure or transmission in the past 10 years, select "No".

A113.1 If HIV nondisclosure, exposure or transmission are criminalized, either under a specific law or general law, is it limited to cases where the knows they have HIV, intends to transmit HIV and actually transmits it as per the 2013 recommendations on Ending Overly Broad Criminalization of HIV Non-disclosure, Exposure and Transmission: Critical scientific, medical and legal considerations?[1]

UNAIDS recommends that the use of criminal law in relation to HIV should be limited to cases where the accused person knows they are living with HIV, intends to transmit HIV to another person and actually does transmit it. Any prosecutions should be under the general law, and all HIV-specific criminal laws should be removed.

1 Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (https://www.unaids.org/sites/default/files/media_asset/20130530_Guidance_ Ending_Criminalisation_0.pdf, accessed 17 November 2023).

Yes, the criminal law is written to restrict it to these cases: If the law in your country is drafted in such a way that only cases where a person knows they are living with HIV intentionally transmits HIV to another person, select this response. This may be under an HIV-specific law, a sexually transmitted infections law or the general law.

No, but prosecutorial guidelines, judicial practices or equivalent restrict it to these cases: If the law in your country is broader than that recommended by UNAIDS, but prosecutorial guidelines exist that restrict the application of the law to cases where the person knows they are living with HIV and intentionally transmits it to another person, select this response.

A114. Does the law list HIV status as an aggravating circumstance in any offence?

In some countries, if a person is accused of a crime (other than HIV nondisclosure, exposure or transmission), the fact that the accused is living with HIV or has allegedly transmitted HIV to another person may be listed as a factor that increases the possible punishment for the accused person. This may be set out in the criminal law itself or in sentencing guidelines.

If this is the case in your country, select "Yes".

A113.2, A115.1, A117.1, A119.1, A121.2.

Have authorities issued a moratorium, suspension or directive limiting arrests or prosecutions under these laws in the last two years?

A moratorium is a delay or suspension of the implementation of a law. Often it is used when a particular law is being reviewed or under legal challenge. A moratorium is usually formalized by a government statement, decree, new policy, government order, or a regulation or other law. These questions relate to an official moratorium rather than situations where the law is unofficially not enforced.

A113.3, A115.2, A117.2, A119.2, A121.3.

Have any legal actions to repeal, amend or challenge these laws either started or been in process in the last two years?

Although law reform can take a long time, there are some specific concrete actions that can be taken as steps towards law reform. This question is aimed at capturing substantial concrete actions that lead to, or could lead to, decriminalization. Although strategic litigation, proposals discussed by parliament and policy directives by local or national authorities are three main forms, there may be others in your country, such as a national consultation on a proposed bill, a draft decree being discussed, or a referendum proposed. The action must be legal in nature—that is, it must involve parliamentary, governmental or judicial processes. It excludes practices that, although important, are not legal steps towards change—for example, it would not include sensitization or training activities.

A113.4 If HIV nondisclosure, exposure or transmission are criminalized, does that include vertical transmission?

Part B—related to Q22

Some countries criminalize vertical transmission, (transmission of HIV from parent to child during pregnancy, birth or breastfeeding). This criminalization can include exposure, imposing criminal liability on a parent who is giving birth or breastfeeding a child. Vertical transmission may be explicitly criminalized, which is where the law specifically mentions vertical transmission or mother-to-child transmission. It may also be criminalized under more general laws, where laws that broadly criminalize nondisclosure, exposure or transmission of HIV

or sexually transmitted infections have been, or could be, applied to vertical transmission. It also includes situations where general bodily harm or assault laws have been used to prosecute vertical transmission.

If your country has explicit or implicit laws that can apply to vertical transmission, select "Yes", even if there have been no prosecutions.

If your country's legislation is specifically worded in a way that excludes vertical transmission, or the courts have interpreted the law as not applying to vertical transmission, select "No".

A115. Are there any laws at national or subnational level that criminalize transgender people based on gender identity or gender expression (e.g. for impersonating the opposite sex or cross-dressing)?

Part B—related to Q24

Transgender and gender diverse are terms used to describe a wide range of gender identities for people whose gender identity is different from the sex they were assigned at birth. Gender identity exists on a spectrum: people may not identify as completely male or completely female, and some people may identify as nonbinary. Across cultures, many other terms are used to describe gender identities and expressions that differ from the sex assigned at birth, in addition to nonbinary gender expressions and identities.

This question asks about laws that target people based on their gender identity or expression. Although it is rare to have a law that criminalizes being transgender, there are laws that criminalize the gender expression of transgender and gender diverse people. These primarily are expressed as laws against cross-dressing or criminalizing the opposite sex. Relevant laws may be found in legislation or personal or religious laws.

If your country (or a state or province within your country) has any of these laws or something similar, select "Yes".

This question does not cover broader laws, such as morality or vagrancy laws, that may be used in a discriminatory manner against transgender people.

There is a separate question on this in the NCPI. If only those laws exist, select "No".

A117. Is sex work criminalized or otherwise subject to punitive regulations in your country at the national or subnational level?

Part B—related to Q25

There are multiple ways that countries have criminalized sex work and/or activities related to sex work. To facilitate a better understanding of sex work-related laws, this question is split into several sections. Please note this question focuses only on criminalization related to adult sex work—that is, the consensual selling of sexual services. It does not ask about sex trafficking, sexual exploitation or child exploitation.

Select all responses that apply.

Yes, selling sexual services is criminalized: Countries may specifically criminalize the provision of sexual services, where the person personally providing such services (the sex worker) is criminalized (i.e. the sex worker is criminally liable).

If your country has such a law, select this response.

Yes, buying sexual services is criminalized: Another form of criminalization is where it is illegal to purchase the services of a sex worker (i.e. the client is liable). (Note this is different from buying the services for a third person, which is included under "profiting from").

If your country criminalizes people who buy sexual services, select this response.

Yes, ancillary activities associated with selling sexual services are criminalized: These laws target activities directly related to selling sex but do not cover the act of selling sex itself. Such laws may include sex work-related advertising and solicitation (offering sexual services). These laws also cover, for example, sex workers congregating in one place, sex workers living with each other, or sex workers working too close to a school or place of worship.

If your country criminalizes sex workers for activities related to selling sex, select this response.

Yes, ancillary activities associated with buying sexual services are criminalized: Countries may criminalize activities related to buying sexual services, such as solicitation (looking for sexual services) and curb-crawling. It does not include the act of buying sex itself.

If your country has any laws that criminalize buyers that are related to the buying of sex, select this response.

Yes, profiting from organizing or managing sexual services is criminalized: Countries may criminalize third parties that profit from the proceeds of sex work. Many of these laws were written to criminalize "pimping" or managing sex workers, but some countries have applied them to a broader spectrum of activities, such as running a website that allows people to "order" sexual services, acting as a security guard for sex workers, or providing beauty services for sex workers.

If your country has similar laws that criminalize living off the profits of sex workers, select this response.

Yes, other punitive regulation of sex work: Even if countries decriminalize sex work (i.e. remove all criminal liability related to sex work), they may still regulate it in a way that imposes punitive administrative or civil penalties.

For instance, countries may require burdensome mandatory HIV testing of sex workers or may allow sex workers to be held in administrative detention. Alternatively, trafficking laws may be overly broad and applied in a way that makes it difficult for sex workers to work.

If your country has any similar types of law, and they are applied to sex workers in practice, select this response.

Sex work is not subject to punitive regulations and is not criminalized anywhere in the country: Some countries fully decriminalize sex work and regulate it in a way that is not punitive. For instance, a country may require sex workers to apply for a business license or provide health benefits to employees.

If your country has such laws, select this response.

A119. Does your country have laws at national or subnational level criminalizing consensual same-sex sexual acts in private?

Part B—related to Q26

Countries may criminalize consensual same-sex sexual acts between adults. If such provisions exist, they are generally found in criminal codes and penal codes. They may also exist in military codes, even if they do not exist in general national law. The precise crimes may be known as "sodomy", "buggery" or "sexual acts against the order of nature", or the law may simply say that sexual acts between two adults of the same sex are illegal. Where the law mandates a particular sentence or length of imprisonment, this may vary from a fine, to a few months, to life imprisonment or the death penalty. In other cases, the law may not prescribe a sentence but may leave it to the courts to determine.

Yes, death penalty: If your country criminalizes consensual same-sex sexual acts and the law imposes the death penalty for such behaviour—even if the death penalty is not implemented in practice—select this response.

Yes, imprisonment for 14 years to life: If your country criminalizes same-sex sexual acts and allows for a maximum sentence over 14 years and up to life imprisonment—even if the practice is to sentence people to lower than the maximum—select this option. (For example, if the law provides for a maximum sentence of 15 years but the courts generally impose a sentence of 2–3 years, select this option because the maximum allowable sentence is over 14 years.)

Yes, imprisonment up to 14 years: If your country's laws allow courts to impose a maximum sentence of up to 14 years for consensual same-sex sexual acts, select this option.

Yes, penalty not specified: A criminal law on consensual same-sex sexual acts may exist but the penalty may not be specified. For example, a country may have a sodomy law, but the courts may have discretion to order any punishment they see fit for the crime.

If this is the case in your country, select this option.

No, laws penalizing same-sex sexual acts have been decriminalized or have never existed anywhere in the country: If your country does not criminalize consensual same-sex relations in any way, select this option.

A121. Are drug use and/or possession for personal use an offence in your country at the national or subnational level (select all that apply)?

Part B—related to Q27

This question applies to illegal drug use only (i.e. it does not apply to legal narcotics prescribed for medical purposes). Countries have a range of laws that apply to personal drug use and/or possession.

Countries may still consider use or possession of illicit drugs for personal use as a criminal offence for all drugs. If this applies in your country, select "Yes, a criminal offence for all drugs", regardless of whether the punishment is custodial or noncustodial.

A number of countries have decriminalized or legalized some drugs, but this is often limited to cannabis. If this applies in your country, select "Yes, a criminal offence for all drugs except cannabis".

Some countries have decriminalized drug use and possession for personal use, often by allowing possession of a small amount of drugs—meaning it is illegal but not considered a crime or does not lead to arrest and prosecution.

In these cases, countries may replace criminal penalties with, for example, an administrative fine or referral to treatment and counselling or a harm reduction clinic. Select "Yes, an administrative or noncriminal offence for all drugs" only if it applies to all illicit drugs.

A123. Does the law use quantity thresholds to estimate when drugs are possessed for personal use?

A123.1 If yes, does the law specify the amount of drugs considered to be for personal use?

A123.2 If yes, is this amount indicative or determinative?

Where the law has decriminalized possession of drugs for personal use, the law may specify the amounts they consider are for personal use—a threshold. If a person possesses less than the threshold amount, it is considered personal use. If a person possesses more than the threshold amount, they may be considered to be involved in the sale or trafficking of drugs, and thus it becomes a criminal offence. The threshold may be written in the law or in subordinate legislation such as regulation.

If your country states threshold limits for all drugs, select "Yes, for all drugs".

If the thresholds in your country are only for cannabis, select "Yes, only for cannabis".

The way in which thresholds are used can also differ. A threshold is indicative if the police, prosecutor or judge can take it into account when considering whether the amount a person possessed was for personal use, but they can also take other elements into account—that is, it is only of a number of elements that law enforcement and the judiciary consider when deciding whether the amount of drugs possessed was for personal use. The threshold is determinative if, when a person is found to possess less than this amount, it is automatically considered to be for personal use—and if they have more, it is automatically considered to be not for personal use only.

A121.1, A121.4.

Does your country apply compulsory detention or compulsory rehabilitation in a closed facility for people who use drugs?

Compulsory facilities for people who use drugs are a form of custodial confinement in which people perceived or known to use drugs are placed to undergo abstinence and "treatment" for a predetermined period of time.

This duration depends on the country and can vary significantly. Administered through criminal law, administrative law or government policy, these centres are operated by various government agencies, including the military, the police, national drug control authorities, and in some places ministries of health or social affairs.

If your country has a system of compulsory treatment in a facility, select "Yes".

A116, A118, A120.

Are other laws used in practice to criminalize or penalize people based on real or perceived gender identity/sex workers based on real or perceived occupation/ based on real or perceived sexual orientation or consensual same-sex behaviour, even when not explicitly criminalized?

A122. Apart from criminalization, does your country have other punitive laws affecting people who use drugs?

Outside of the more explicit laws mentioned above, countries may have more general laws that may be used to target or that disproportionately affect people from key populations (e.g. vagrancy and petty offence laws, propaganda law, morality laws).

Public morality laws or religious laws that limit lesbian, gay, bisexual, transgender and intersex freedom of expression and association: Countries may have laws that aim to curb LGBTQI-related freedom of expression and association on the basis of morality (e.g. acting against public morals, public indecency, prohibition of public protests, demonstrations, marches on grounds of morality). These may be in the legal code or may be found in customary or religious laws, even if they are applicable in only some parts of the country and impose sanctions if such prohibitions are violated. They may also be used to limit expression and association for sex workers and people who use drugs.

If such laws exist in your country, select this option.

Vagrancy or public nuisance laws: Vagrancy laws are usually very broadly worded laws that can be interpreted to include a variety of actions or behaviours. Vagrancy laws usually refer to people being in public or "loitering" on public streets, but they are often used to target people who are homeless, under the influence of drugs or alcohol, engaging in sex work, or seen to be a public nuisance.

If such laws exist in your country, even if not used regularly, select "Yes". Also select "Yes" if laws exist relating to public nuisance or loitering.

Promotion ("propaganda") laws: Countries may have laws that prohibit the "promotion" of information, education or awareness about LGBTQI people or illicit drugs.

If your country has such a law, select this option.

Others: Countries may have other types of punitive law affecting people from key populations. For example, a country may criminalize same-sex marriage separately from any laws around same-sex sexual acts.

If your country has such laws, select this option and specify what those laws are and what they criminalize.

No: Select this option if your country has no other punitive laws affecting people from key populations.

A125. Does your country have constitutional or legislative protections against discrimination on the basis of gender identity?

Part B—related to Q29

Yes, constitutional or legislative protections that specify HIV status as a protected attribute: Countries may have provisions in their constitutions or other legislation that prohibit discrimination based on listed grounds such as gender diversity or gender identity, or that identify transgender people as a protected group. If this is the case in your country, select this option.

Yes, constitutional or legislative protections that protect against discrimination on the basis of HIV status under another status: In some countries, the law may not specifically mention gender identity, gender diversity or transgender people, but other protected attributes such as "sex", "gender" or "other status" may have been interpreted by the courts or government as including gender identity and expression or transgender people.

If other attributes have been interpreted by the courts or government to include gender identity or expression or transgender people as a group in your country, select this option" and indicate which attribute has been used (e.g. sexual orientation, gender identity, sex).

No: If your country has antidiscrimination provisions within the constitution, but they have not been interpreted to include discrimination against transgender people, select this option.

A127. Does your country have legal gender recognition laws or policies that enable the legal change of gender?

A127.1 If yes, are any of the following required in order to change gender (select all that apply)?

A127.2.f yes, is it legally possible to change one's gender marker on the following (select all that apply)?

Part B—related to Q30

If the laws or policies in your country permit a person to be identified, legally and administratively, by a sex or gender that is different from their assigned sex at birth, select "Yes".

If you selected "Yes" to Q128, select any and all the conditions that must be met before a person can obtain legal recognition of their gender, whether a simple self-declaration by the person is sufficient, or whether proof of gender reassignment surgery or proof of sterilization or a certificate of psychological assessment or other conditions are required.

Change of gender marker on official documents: select the official documents (e.g. passport, other national identity document, birth certificate, marriage or divorce certificate) on which laws or policies permit a person to change their gender marker, from male to female, or from female to male, or, where permitted, to another nonbinary gender marker.

Select only those options where it is possible to change the gender on the document in a manner that does not reveal the gender has been changed or the person is transgender.

A128. Is it legally possible to change one's name to that of another gender on any of the following (official documents)?

Select the official documents (e.g. passport, other national identity document, birth certificate, marriage or divorce certificate) on which laws or policies permit a person to change their name to a name that may not be associated with their gender marker at birth.

A129. Does your country have constitutional or legislative protections against discrimination based on the involvement in sex work?

Part B—related to Q31

Although sex work is not usually mentioned as grounds or an attribute for which there is constitutional protection against discrimination, in some countries other characteristics have been interpreted to include sex work, for example on the basis of occupation or the catch-all phrase "any other status".

If your country has made such interpretation by decision of a court of law or by government policy, select the relevant option.

Separately from constitutional protections, there may be legislation that explicitly specifies sex workers as a group protected from discrimination—for example, in legislation on employment discrimination.

A130. Does your country have constitutional or legislative protections against discrimination on the basis of sexual orientation?

Part B—related to Q32

Yes, sexual orientation is specified as a protected attribute: Countries may have provisions in their constitutions or other legislation that explicitly prohibit discrimination based on a person's sexuality or sexual orientation, where "sexuality" or "sexual orientation" are mentioned in the legislation as protected attributes. If this is the case in your country, select this option.

Yes, courts or government have legally recognized that sexual orientation is protected under another attribute: Where legislation does not specifically mention "sexuality" or "sexual orientation", the courts or government may have interpreted other attributes as including sexual orientation, such as "sex", "gender" or "other status". If this is the case in your country, select this option and specify which attribute has been interpreted to include sexual orientation.

Yes, other: If there are legal protections against discrimination but the above two scenarios do not apply in your country, select "Other".

A131. Does your country have constitutional or legislative protections against discrimination based on the involvement in drug use or possession?

Part B—related to Q 33

Although constitutional protections on discrimination may not specifically mention people who use drugs or drug dependency, other protected attributes may have been interpreted by the courts or government to protect people who use drugs or have drug dependency, against discrimination on the basis of their drug use or drug dependency. For example, the courts or government may have interpreted health status or other status as including drug use or drug dependency.

A133. Is drug use and/or possession a legal basis for removing children from parental custody?

Laws and regulations relating to child custody and child protection may have a list of criteria by which courts and child protection specialists determine whether a child should be removed from their parents.

Indicate whether drug use or drug possession is considered a legal basis for removing children from parental custody in your country.

A134, A135, A136, A137, A139.

Does your country have laws and//or policies requiring parental/guardian consent for adolescents (under age 18) to access hormonal or long-lasting contraceptives, HIV testing, HIV self-testing, pre-exposure prophylaxis (PrEP) or HIV treatment?

Some countries have laws that require parental consent for children (generally people aged under 18 years) to access hormonal or long-lasting contraceptives, HIV testing, HIV self-testing, PrEP or HIV treatment without parental or guardian consent. The age at which parental consent is not required varies from country to country, as does the way in which it is legislated. It may be covered by common law concepts of capacity to consent and evolving capacities of the child, or it may be in legislation generally covering a child's age of majority and legal capacity or health law. There may also be legislation specifically on HIV and children, as a country may have passed legislation or policies specific to HIV.

If your country does not have a law that determines age of consent to hormonal or long-lasting contraceptives, HIV testing, self-testing, PrEP or HIV treatment, either through common law or specific legislation, select "Not addressed in law/policy".

Access to testing and receiving the results and access to treatment: This includes being able to receive the results, undertake counselling, or receive a prescription for and access antiretroviral medicines without the parents or guardians being informed of the HIV status of the child.

A134.1, A135.1, A136.1, A137.1, A139.1

If yes, are there exceptions for adolescents below the age of legal consent to access hormonal or long-lasting contraceptives, HIV testing, HIV self-testing, PrEP or HIV treatment without parental/guardian consent, e.g. through demonstrated maturity, declarations of emancipation, pregnancy or sexual activity?

Even in jurisdictions where there is an age of consent for access to hormonal or long-lasting contraceptives, HIV testing, HIV self-testing, PrEP and HIV treatment, there may be bypass mechanisms. For instance, in some countries, a doctor has the authority to decide whether a child is mature enough

to independently access health services, or a child may be able to petition a court for an order that allows them to be considered emancipated.

If this is the case in your country, select the corresponding "Yes" option.

If parental or guardian consent is mandatory without any exceptions in your country, select "No".

A140 and A141.

Does your country have laws requiring spousal consent for married women to access any sexual or reproductive health services and/or HIV testing?

Some countries mandate that married women can access sexual and reproductive health services and/or HIV testing only if they have consent from their spouses. In addition to HIV testing, other services that may require spousal authorization include access to contraceptives and voluntary sterilization.

If your country has such spousal laws, select "Yes".

B38. Are there mechanisms established by the community and/or nongovernmental organizations to record and address individual complaints of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population). Examples of such mechanisms include traditional cultural structures or nongovernmental organizations trained to address claims through mediation.

In some countries, communities and/or nongovernmental organizations have set up a (sometimes informal) structure for receiving and solving individual claims of discrimination based on real or perceived HIV status, or for belonging to a key population.

If such a structure exists in your country, select "Yes" and provide a brief description.

Section A5

A149. Are there any laws, regulations or policies that provide for the registration of community-led organizations in your country (select all that apply)?

Community-led organizations are organizations where the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies. Laws and regulations may influence whether or not different groups can form legal associations and the ease with which these associations can operate, provide health-services, meet reporting requirements, and so forth.

The response options in Q150 relate to laws and policies that determine what types of entities can register an association. The laws and regulations may not specifically mention community-led organisations, but may, by interpretation, include them, for example under not-for-profit laws.

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