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

JULY 2015

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ACKNOWLEDGEMENTS

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CDC	Centers for Disease Control and Prevention
GARPR	Global AIDS Response Progress Reporting
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
MSM	men who have sex with men
MSMGF	The Global Forum on MSM & HIV
NCPI	National Commitments and Policies Instrument (formerly the National Composite Policy Index)
NGO	nongovernmental organization
NSP	needle and syringe programme
OST	opioid substitution therapy
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
RITA	recent infection testing algorithm
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

Note on terminology: Language used in this document relating to key populations follows United Nations guidelines on preferred terminology. The use of language that relates to certain behaviours, characteristics and population groups has important implications. Members of these populations have the right to define and determine how they wish to be identified and referred to. It is also important to be aware that different terminology may be appropriate in different contexts and for different uses and that preferred language evolves over time. In this document, wherever possible, the use of abbreviations to refer to people or population groups is avoided.

PART 1

INTRODUCTION

This document is a supplement to the World Health Organization (WHO) *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (1)*. It provides technical guidance to assist countries in planning and monitoring efforts to address HIV among key populations: **men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people**.[1] Specifically this document provides guidance on monitoring and evaluating the implementation of the comprehensive package of interventions to address HIV among key populations.

The framework presented here is designed to help plan and assess progress at the macro level, in particular for national and subnational programming. This planning and assessment process should involve government agencies, nongovernmental organizations (NGOs), communities and service providers involved in developing, implementing, monitoring and evaluating HIV prevention, treatment and care programmes for these key populations. This framework builds on a similar existing framework specific to programmes for people who inject drugs: *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (2)*.

This document provides countries with:

1. **A set of harmonized indicators to examine the implementation of the package of interventions to address HIV among key populations**

   The WHO C*onsolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* recommends a comprehensive package of interventions to respond effectively to HIV among key populations; this package is summarized in Box 1. This document presents a set of meaningful and practical indicators, selected through a review of current practice and available evidence, to assess the implementation of the comprehensive package. These recommended indicators are aligned with indicators used by other United Nations (UN) and donor agencies and meet established indicator standards. The information that these indicators provide is important for policy development and effective programming to guide national responses to HIV among these key populations. The indicators also can be used to prepare proposals and report on progress to donor organizations. Only indicators that can be practically reported at the national level, and for which data are commonly available, have been included. In some countries with more sophisticated national level data collection systems it may be possible to report on additional indicators, particularly those that examine programme coverage using programmatic data.

2. **Guidance on setting targets for these indicators**

   Countries' epidemics among key populations vary. Each country will be at a different stage of progress in bringing programmes to scale. Setting clear, ambitious but achievable targets helps to plan for the scale-up of programmes with the greatest possible impact. The target-setting process is strongest when undertaken as a multisectoral process with the meaningful participation of all key populations. Indicative targets are proposed for a selected number of indicators to assist countries with calibrating their own targets and response.

The content of this document derives from existing WHO guidance. It brings together various aspects of programming the response to HIV as well as tuberculosis (TB), hepatitis B virus (HBV) and hepatitis C virus (HCV), and sexually transmitted infections (STIs) for these key populations. Related key UN documents and reporting processes are detailed in Boxes 2 and 3.

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1 Definitions for each of these key populations are provided in the WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.*

Box 1. The comprehensive package of interventions for key populations

The package has two parts:

a) **Essential health sector interventions**
    1. comprehensive condom and lubricant programming
    2. harm reduction interventions for substance use, in particular needle and syringe programmes (NSP), opioid substitution therapy (OST) and naloxone
    3. behavioural interventions
    4. HIV testing and counselling
    5. HIV treatment and care
    6. prevention and management of co-infections and other comorbidities, including viral hepatitis, TB and mental health conditions
    7. sexual and reproductive health interventions, including contraception, diagnosis and treatment of STIs, cervical screening.

b) **Essential strategies for an enabling environment**
    1. supportive legislation, policy and financial commitment, including decriminalization of behaviours of key populations
    2. addressing stigma and discrimination, including in the health sector
    3. community empowerment
    4. addressing violence against people from key populations.

The WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* provides further detail on each of the elements in this package and their implementation *(1)*.

Box 2. How does this document relate to other UN publications?

This document is a companion to other publications developed by WHO, together with the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC) and the United Nations Development Programme (UNDP), that provide evidence-based recommendations on addressing HIV among key populations. These publications include:

- *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO, 2014.*

- *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, WHO*, 2012.

- *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*, WHO, 2013.

- *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low and middle income countries: recommendations for a public health approach*, WHO, 2012.

- *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach*, WHO, 2011.

- *Guidance on pre-exposure oral prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV*, WHO, 2012.

- *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches and collaborative interventions*, WHO, 2013.

- *HIV prevention, treatment and care in prisons: a comprehensive package of interventions*, UNODC, 2013.

- *HIV, sexually transmitted infections and other health needs among transgender people in Asia and the Pacific: joint regional technical brief*, WHO, 2013.

- *Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men and transgender people*, UNAIDS, 2015.

- *Operational guidelines for monitoring and evaluation of HIV programmes for people who inject drugs: monitoring and evaluation at the service delivery level.* UNAIDS, 2011.

- *Guidance note on HIV and sex work*, UNAIDS, 2012.

- *Universal access for men who have sex with men and transgender people: UNAIDS action framework*, UNAIDS, 2009.

- *Global HIV epidemics among people who inject drugs*, World Bank, 2013.

- *Global HIV epidemics among sex workers*, World Bank, 2013.

- *Global HIV epidemics among men who have sex with men*, World Bank, 2011.

- *Consolidated strategic information guide for HIV in the health sector*, WHO, 2015.

Box 3. How does this document relate to other international reporting mechanisms?

This document outlines a framework and indicators for evaluating the response to HIV among men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people. The indicators described in this document are intended to enable a deeper assessment of the response for these key populations in order to assist with programming and the preparation of funding proposals and monitoring the progress of national and/or donor funded programmes.

There are, however, a number of international reporting mechanisms that include indicators related to key populations. These include:

- *Monitoring progress in the health sector towards achieving universal access to HIV prevention, treatment and care, and support, 2009–2010*, WHO, 2010. http://www.who.int/hiv/universalaccess2010/hiv_me_framework_2009-10.pdf

- *Global AIDS response progress reporting (GARPR), UNAIDS, 2014 (formerly Reporting on monitoring the UNGASS Declaration of Commitment on HIV/AIDS)* http://www.unaids.org/en/media/unaids/contentassets/documents/document/2014/GARPR_2014_guidelines_en.pdf

Member States have made commitments to submit reports to these global data collection processes.

THE MONITORING AND TARGET-SETTING PROCESS

National level programme assessment

This document presents a framework for monitoring progress in implementing the evidence-based package of interventions at the *national level*.

Assessing programmes at the *service provider level* is an important component of a comprehensive monitoring and evaluation system, but this is not the focus of this document; guidance on service-level programme monitoring and evaluation is available elsewhere.[1] Monitoring certain aspects of programmes at the national level does, however, require the collection of data by service providers and that these data to be collated and analysed centrally. To allow for such data to be aggregated, data collection systems must be consistent across different service providers.

Indicators included in this document were selected because in most settings the data are readily available, can be readily collected, can be reported at the national level and can be disaggregated by key population group.

Meaningful community participation in the assessment process

Community engagement is an essential part of this assessment process. Multiple stakeholders, in particular, members of these key populations, have an invaluable contribution to make to programme design and to the evaluation of progress, highlighting strategies for improvement and developing appropriate targets. Many donor organizations and international reporting mechanisms stipulate active participation by civil society groups in this process. It is important to ensure that findings from the assessment process are fed back to communities for their use.

Indicators

The set of indicators described assesses key factors related to the enabling environment, measures the availability, coverage and quality of specific interventions, and examines the outcome and impact of these efforts. To understand where and how policy and programmes need to be developed further, it is important to consider each of the following aspects:

- programmes need to be accessible to people from key populations (measured by *availability* indicators);
- programmes need to reach those who need them (measured by *coverage* indicators);
- interventions need to be properly implemented to be effective (measured by *quality* indicators);
- it is important to determine whether or not the intended goals and objectives have been realized (measured by *outcome* and *impact* indicators);
- the successful implementation and impact of each intervention depends on supportive policy, legislation and other structural factors (measured by *enabling environment* indicators).

In addition to guiding programme development and management, the indicators can also be used for the preparation of proposals or reporting on progress to donor organizations.

Target setting

Target setting is fundamental to effective monitoring and evaluation. Targets concretely define what a successful national programme and/or projects should achieve within a specific time frame. They should be set for both cross-cutting and intervention-specific indicators. Targets should be set at the national level and for subnational areas. Modelling can help to identify how different target levels will affect the epidemic. Targets should reflect programme strategies that are tailored to the local epidemic and be based on what can realistically be achieved given available resources and any

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1 See, for example: *Operational guidelines for monitoring and evaluation of HIV programmes for people who inject drugs: monitoring and evaluation at the service delivery level*, UNAIDS, 2011 at http://www.cpc.unc.edu/measure/tools/hiv-aids and *Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men, and transgender people*, UNAIDS, 2012 at http://unaids.org.cn/pics/201210121119.pdf.

additional capacity and funding that may need to be mobilised. Part 2 of this document offers guidance on how targets might be set for the listed indicators, and proposes indicative targets for a number of indicators to assist countries in calibrating their own targets.

Target setting should be collaborative, with input from the community and other stakeholders. Ideally, targets should be set with the involvement of a national stakeholder meeting that can comment on whether the targets are realistic and determine whether they are practical for data collection in the field.

Data sources

The indicators described require data gathered from a range of different sources. Data from each of these sources provides important information, and each source has different strengths and limitations that need to be considered when reporting on and interpreting indicators.

Desk review and expert consultation

Important information can be gleaned from the review of various policy documents or legislation to identify the presence or absence of different laws or policies which may affect people from key populations.

Indicators using data gathered through desk review and expert consultation		Page
ENV–1	Audit of current legislation and policy checklist	28
ENV–2	Involvement of key population in national policy and strategy formulation	29
NSP–6	NSP-related policy and practice checklist	42
OST–4	OST-related policy and practice checklist	45
PRP-1	Oral PrEP for HIV prevention is available for men who have sex with men	52

Programmatic or administrative data

Most programmes routinely record at least some basic information when providing a service; this might include a count of the number of people who receive a service, details about the person served, or a record of the amount of materials distributed, such as condoms and lubricant.

To examine services provided to people from key populations, programme data must be disaggregated by key population group. Programmes focused on key populations may be able to provide data specific to the populations they serve. This information is not commonly available, however, from programmes that provide services to many different groups or to the general population. Service providers (for example ART programmes) may not know, or may not record, whether or not a client is a man who has sex with men, a sex worker, if they inject drugs or if they are transgender, as this information may not be relevant to the provision of services. However if programmatic data, disaggregated by key population group, are available at the national level, and are collected and recorded consistently across service providers, then these data can be used to examine programme coverage.

Furthermore, clients of these services may not wish to disclose this information. Requiring them to do so might deter people from key populations from accessing the service. In some settings disclosing one's status as a man who has sex with men, a person who uses drugs, a sex worker or a transgender person may make a person vulnerable to discrimination and even violence or prosecution. Hence, collection of such information may not be advisable. It should be noted, however, that addressing drug dependence is an important part of HIV treatment and care for people living with HIV who are drug dependent. Therefore, disclosure of drug use may be relevant in these circumstances.

In a national-level assessment it is necessary to collate data from multiple service providers. To enable aggregation of data from multiple sources, data collection methods need to be consistent across all sites. In most countries data are not collected by a single agency and may not be routinely gathered at the national level. Having a single, national-level agency responsible for regularly collating and reporting national data is highly advantageous. Web-based databases can facilitate data aggregation from different services. If Internet access is not available, offline computers or paper-based recording systems can be used.

A number of indicators in this document use programmatic data that describe certain aspects of service provision, such as the type of service provided at a particular location, the training that the staff have received or some other aspect of intervention quality. This type of programmatic data can be collected through facility-based assessments or audits.

Survey data

Behavioural and sero-surveillance surveys of key populations are an important source of prevalence data and information on experiences, risk and service utilization of people from these groups. Many countries already undertake such surveys periodically as part of the ongoing monitoring of the HIV epidemic.

It is important that all research and data collection activities adhere strictly to ethical research practices. It is also important that the community of interest has a role in the design, implementation and interpretation of these research activities.

Many countries use the 2000 Family Health International *Guidelines for repeated behavioural surveys in populations at risk of HIV (3)* as a basis for the behavioural component of these surveys among key populations. A revised version of these guidelines is due for release in 2015.

The generalizability of survey findings depends on how representative the sample is of the broader population of men who have sex with men, people in prisons and other closed settings, people who use drugs, sex workers and transgender people. It is important to consider selection bias associated with how and where participants are recruited. Significant bias may result if samples are drawn from a limited number and range of locations. Methods such as respondent-driven sampling may reduce such bias, but they require specific technical capacity and resources and take time to complete. In many cases survey results may relate only to the location from which the sample was drawn.

Behavioural surveys are susceptible to a number of sources of bias. Social desirability bias may occur when respondents who have been in contact with a programme give answers about their behaviour that they know are more "acceptable". Recall bias occurs when respondents are required to recollect experiences. Questions should be appropriately worded and use local language to ensure they can be understood by respondents. Assuring anonymity, maintaining privacy, and using self-interviewing techniques may reduce such biases.

TYPES OF INDICTORS

1. Assessing key factors associated with the enabling environment

Existing assessment tools, such as the UNAIDS National Commitments and Policy Instrument (NCPI), can be used to identify whether or not key factors necessary for an enabling environment are present in a particular setting.

In this document additional indicators are described that look at important structural factors affecting men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people. Part of this assessment involves undertaking a legal audit to examine the impact of existing legislation and law enforcement upon members of these key populations and how accessible the legal system is to them *(4)*.

In addition, included indicators look at levels of community empowerment, leadership and participation in policy and strategy formulation; the existence of support services for victims of violence; and stigma and sensitization training for service providers and law enforcement officers.

Indicators assessing key factors associated with the enabling environment	Page
ENV–1 Audit of current legislation and policy checklist	28
ENV–2 Involvement of key population in national policy and strategy formulation	29
ENV–3 Legal support services for key population	29
ENV–4 Support services for people from key populations who experience violence	30
ENV–5 Sensitization training on key populations for law enforcement officers	30

> **Further reading on assessment of legislation**
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> ■ *Legal environment assessment for HIV: an operational guide to conducting national legal, regulatory and policy assessments for HIV*, UNDP, 2014.
> http://www.undp.org/content/dam/undp/library/HIV-AIDS/Governance%20of%20HIV%20Responses/UNDP%20
> Practical%20Manual%20LEA%20FINAL%20web.pdf

2. Measuring the availability of health sector interventions

Number of sites where an intervention is available

Counting the number of sites or locations where an intervention is available gives a gross indication of the scale of roll-out of the intervention.

Site definitions

For purpose of such an assessment, it is important to define what constitutes an intervention "*site*" as definitions may differ for different interventions.

In the case of outreach or mobile services, a single service provider may deliver an intervention at multiple locations. It is suggested that each of these sites are counted but that the timing and frequency of service provision is also reported.

Mainstream programmes versus key population-focused programmes

When assessing where interventions are provided, it is useful to distinguish between programmes that are specifically designed to serve members of key populations – which are referred to in this document as "***key population-focused***

programmes" – and programmes that are not specifically focused on key populations but which provide an intervention for the general population – so called "*mainstream programmes*".

Key population-focused programmes might include services such as stand-alone needle and syringe programmes or drug dependence treatment services for people who use and inject drugs, or drop-in centres, outreach or health-care services that are established to cater specifically to key populations.

Some *mainstream programmes* may have only limited experience with providing services to people from key populations and may have difficulty responding to their needs. In some cases staff may hold negative attitudes towards people from these key populations, which may result in discriminatory practices. People from key populations are less likely to access programmes that are not equipped to meet their needs and where they might face discrimination.

Service providers can take a number of steps to address stigma and discrimination. These include implementing codes of conduct that aim to guard against stigma and discrimination and providing staff with appropriate sensitization training and support to ensure that they have the skills and understanding to ensure patients' rights to health, confidentiality and non-discrimination. Accordingly, when measuring intervention availability for key populations, it is useful to differentiate between sites that have taken such steps and those that have not. It may also be appropriate for services to employ staff who are members of key populations.

As described in the section *Measuring intervention quality* (page 18), a checklist examining programme policy and practice can help assess whether or not a site meets sensitization standards for service provision (see *Indicator Q–1 Programme quality checklist*, page 31). In addition, an indicator monitoring the number of health-care workers who have received appropriate sensitization training on key populations can also be used (see *Indicator Q–2 Sensitization training on key populations for service providers*, page 32).

The following site counts are suggested to measure the availability of each intervention:

a	The number of sites where **key population-focused programmes** currently provide the intervention
b	The number of sites where **mainstream programmes meeting key population sensitization standards** currently provide the intervention
c	The total number of all sites where **any key population-focused programmes** are currently offered
d	The total number of sites where **mainstream programmes** currently provide the intervention

It is then possible to use these counts to calculate the following indicators:

e	The percentage of **key population-focused programmes** currently providing the intervention $= \dfrac{[a]}{[c]} \times 100$ Depending on the intervention in question, this indicator can help to identify which key population-focused programme sites may be appropriate places to provide the intervention.
f	The percentage of mainstream programme sites where the intervention is provided that **meet key population sensitization standards** $= \dfrac{[b]}{[d]} \times 100$ This indicator is helpful in identifying mainstream sites offering the intervention but which do not currently meet key population sensitization standards.
g	The percentage of **all sites where the intervention is currently provided that meet key population sensitization standards** – that is, *mainstream programmes meeting key population sensitization standards and sites of key population-focused programmes* $= \dfrac{[a]+[b]}{[a]+[d]} \times 100$ This indicator identifies which sites currently provide the intervention but which might not be sensitized or focused on the needs of people from key populations.

The following indicators use this formulation to measure intervention availability for key populations:

There can be considerable benefit gained from providing multiple interventions at a single location. Such integrated service delivery can increase access to important interventions for people from key populations and can facilitate coordinated, multidisciplinary case management. Therefore, a site providing multiple interventions will be counted in more than one of these indicators that look at a specific intervention. In addition, an indicator can be used to identify sites where multiple interventions are provided. The indicator could be defined to identify sites providing all, or a subset of, the essential health sector interventions of the recommended package.

Knowing the number of sites alone does not indicate how accessible an intervention is to the population it is intended to reach. The following two methods can provide some additional information to better understand the accessibility of an intervention.

Accessibility of an intervention as reported by people from key populations

Access to interventions is not determined by location alone, but also by many different factors such as hours of operation, the cost of using the intervention and an individual's ability and willingness to pay, the presence of deterrents such as police activity, and the acceptability of the programme to those it is intended to reach. An important method of evaluating whether or not an intervention is accessible is to ask people from key populations about their experiences. Relevant questions can be included in key population surveys.

Mapping of key populations and services

Geographic mapping exercises identify where people from specific populations live and congregate in relation to where interventions are provided. This information can be used to inform where services should be located so that they are accessible to the greatest number of people or to those most at risk. Mapping also can provide information on patterns of social interaction and spatial factors that may be relevant to disease transmission patterns. Mapping is most relevant when key populations are concentrated in an area. For example, in many countries sex work may most often take place in specific areas such as along trade routes, in large urban settings or in designated areas; this may vary seasonally (e.g. trading seasons) or be linked to migratory trends.

It is also important to consider "virtual" spaces and online communities in which members of key populations may participate. These online spaces may be important points of access for these communities and may be used to deliver information and some behavioural interventions; virtual spaces can also be used for conducting surveys in a manner that is safe and confidential.

In some circumstances mapping of key populations can have the unintended negative consequence of putting community members in danger of violence and stigma by identifying these populations and where they are located. When undertaking such exercises, it is important to ensure the safety and security of community members by strictly maintaining privacy, confidentiality and the security of information collected *(5, 6)*. Detailed mapping at the national level can be a technically challenging and expensive undertaking. Mapping is more commonly done for smaller catchment areas such as at district, neighbourhood, street and venue levels.

Further reading on mapping methods

- *An overview to spatial data protocols for HIV/AIDS activities: why and how to include the "where" in your data,* The MEASURE Evaluation Project, 2011.
  http://www.cpc.unc.edu/measure/publications/ms-11-41a

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3. Measuring intervention coverage

In this document the term "*coverage*" is used to describe the extent to which an intervention is delivered to a key population.

Indicators that measure the extent of coverage *relative* to need or to the size of the population of interest are particularly useful for assessing programme implementation.

The coverage indicators listed in this document utilize information gathered from:

A. Programmatic or administrative data

B. Key population surveys

As discussed on page 8, each method of estimating intervention coverage has limitations that are important to consider when interpreting results. If data are available from more than one source, these can be used in a process of triangulation to better understand levels of coverage.

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1 **Note**: While these interventions can be provided on a single occasion, it does not mean that they need to be provided to an individual only once. For example, condoms should be distributed on multiple occasions, and made continuously available to those who require them.

Using programme or administrative data to assess coverage

Data collected by service providers are an important source of information for assessing intervention coverage. The *programmatic* or *administrative* data of most interest include:

- **The number of people who received the intervention**

  If interventions that can be provided on a single occasion (e.g. the dispensing of condoms and lubricant)[1] or within a short period of time (e.g. HBV vaccination accelerated schedule), then it is appropriate to count the number of people who received the intervention during a specified time period (e.g. the last 12 months).

  If an intervention involves long-term or even indefinite treatment (e.g. ART for HIV), then it is appropriate to count the number of people who are receiving the intervention at a specified census date (i.e. at a single point in time).

- **The total number of times an intervention was provided**

  This may also be termed the number of "occasions of service". It is a count of all occasions, within a specified time period, when the intervention was provided to a person from a key population. Multiple contacts with the same client are included in this count. The data collection system does not require a unique identifier code to avoid double counting (see below). For example: the total number of HIV tests performed within the specified reporting period.

- **The number of items distributed**

  For example: the number of condoms and compatible lubricant or needles and syringes distributed within a specified time period.

In many countries data are collected routinely (daily or weekly) at the service delivery level and reported to the sub-national level at regular intervals (for example, every quarter). When counting events that occur within a certain period of time, it is common to report data for the last 12 months, this being a natural reporting period for many registry and programme data collection systems. It may be useful, however, and more appropriate in some contexts, to define specific reporting periods. In particular, donors such as The Global Fund to Fight AIDS, Tuberculosis and Malaria and The United States President's Emergency Plan for AIDS Relief (PEPFAR) may require reporting at 3- or 6-month intervals. Furthermore, some interventions need to be provided repeatedly, and it is desirable for people from key populations to access services more frequently than only every 12 months, such as the provision of condoms and lubricant and sterile injecting equipment. Accordingly it is useful to look at a shorter reporting periods when assessing these interventions.

To measure coverage among key populations, programmatic data needs to be disaggregated by each key population group. As discussed on page 12, while key population-focused programmes may be able to provide data specific to the populations they serve, programmes that provide services to many different groups or the general population more broadly (for example, ART programmes) typically do not have disaggregated data for different key populations. In light of this the coverage indicators included in this document that use programmatic data call specifically for data from *key population-focused programmes*. If data for key population groups are also available from *mainstream programmes* and are collected and recorded consistently across service providers, then these data can also be included in these indicators.

To determine the *number of people* who received an intervention during a specified period of time, it is necessary to avoid double counting those who may have received the intervention on more than one occasion during this time period. Data collection systems can use a *unique identifier* code for each individual client so that multiple visits by the same individual can be noted. It is essential that such a data collection system maintains clients' anonymity and confidentiality. Alternatively, the *recall last contact* method can be used, in which each individual is asked, when using a service if this is the first time they have done so within the reporting period. National-level coverage can be more accurately estimated if the same unique identifier coding system is used across different service providers.

Because of these various technical challenges, in most settings it is unlikely that a count of the total number people from a key population who received an intervention (the numerator) will be available. This makes it difficult to estimate the level of coverage relative to need or key population size (the denominator). The only indicators included in this document that attempt to measure coverage in this way are those for comprehensive condom programming; these indicators have been included because the number of condoms distributed by key population-focused services relative to the size of that key population is often available and can be a useful indicator of the overall reach of these services at the national level.

CCP–3 Percentage of the total key population provided with condoms and compatible lubricant by key population-focused programmes during the specified reporting period (page 34)

$$= \frac{[\text{Number of people provided with condoms from key population-focused programmes during specified reporting period}]}{[\text{Estimated key population size}]} \times 100$$

CCP–4 Total number of condoms distributed to people from key population during the specified reporting period (page 35)

$$= \frac{[\text{Number of condoms provided by key population-focused programmes during specified reporting period}]}{[\text{Estimated key population size}]}$$

Indicators using programme data to assess intervention coverage

		Page
CCP–3	Key population provided with condoms and compatible lubricant	**34**
CCP–4	Quantity of condoms and condom-compatible lubricant distributed	**35**
NSP–3	Quantity of needles–syringes distributed	**39**
NSP–4	People who inject drugs reached by NSPs	**40**
OST–3	Individuals receiving maintenance OST	**44**
ODM–2	Quantity of naloxone distributed	**48**
PRP–2	Men who have sex with men receiving oral pre-exposure prophylaxis (PrEP)	**52**
CMB–3	Key population receiving HBV vaccination	**59**
SRH–3	Key population attending sexual health services	**61**

These indicators require an estimate of the size of the key population in question; guidance on estimating key population size is presented below.

Population size estimates

It is important to have a clear definition of the population for which a size estimate is to be derived. If the size estimate is to be used for the purpose of estimating intervention coverage, the population definition should be relevant to the programme or intervention of interest. For example, if the coverage of a needle and syringe programme is to be estimated, a population definition for people who currently inject drugs would be more relevant than an estimate of people who have injected anytime in their life (so called "lifetime injecting drug use").

Determining the size of key populations can be challenging. Surveys of the general population, such as household surveys, may markedly underestimate the prevalence of some key populations. Respondents may be reluctant to disclose information about stigmatized behaviours or identity.

Indirect estimation methods, such as multiplier and benchmark calculations that make use of existing data sources or capture–recapture methods, are extremely useful; guidance on these methods is available (see box). When using information from multiple sources for the purpose of estimating population size, it is essential that confidentiality is always maintained.

When interpreting an indicator that has been calculated using an estimate of population size, it is important to consider the limitations of the method by which that estimate was derived as well as any tendency for that method to systematically over- or underestimate population size. When reporting the results for such indicators, these limitations should also be reported.

For the measurement of coverage indicators for prison and other closed settings, the number of people detained needs to be estimated. When deriving estimates for this purpose, it is important to keep in mind the high turnover of detainees and that further disaggregation by key population may be required. For example, coverage indicators for NSP and OST require estimates of the number of people in detention who inject drugs or who are opioid dependent.

It is recommended that national expert group meetings be held regularly to evaluate available data and to reach consensus on the estimate or range of estimates that should be used. These meetings should involve researchers and key government personnel, NGOs and organizations representing key populations.

Where recent, high-quality estimates are not available, it is recommended that countries make efforts to acquire such estimates. Technical and financial resources are required for such estimation research activities. If resource constraints exist, countries can seek external donor assistance for these types of research activities as part of funding for the broader response to HIV. The Global Fund encourages countries to include population size estimation activities in funding applications and in ongoing grants as one of the monitoring and evaluation system strengthening activities for improving the availability of data on key populations at risk *(7)*. Similarly, PEPFAR supports operational research and strengthening of monitoring and evaluation systems *(8)*.

If, for any indicator, an appropriate population size estimate is not available for use as the denominator, it is still useful and important to record and report the indicator numerator. The numerators alone can provide some useful, although more limited, indication of the extent of programme delivery and may be particularly useful in monitoring progress over time.

Indicators using population size estimates		Page
CCP–3	Key population provided with condoms and compatible lubricant	**34**
CCP–4	Quantity of condoms and condom-compatible lubricant distributed	**35**
NSP–3	Quantity of needles–syringes distributed	**39**
NSP–4	People who inject drugs reached by NSPs	**40**
OST–3	Individuals receiving maintenance OST	**44**

Further reading on population size estimation

- UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. *Guidelines on estimating the size of populations most at risk to HIV,* WHO, 2010.
  http://www.who.int/hiv/pub/surveillance/final_estimating_populations_en.pdf
- Centers for Disease Control and Prevention (CDC), GAP Surveillance Team. *Most at risk populations sampling strategies and design tool,* CDC, 2009.
  http://globalhealthsciences.ucsf.edu/sites/default/files/content/pphg/surveillance/CDC-MARPs/index.htm
- *Global assessment programme on drug abuse. Estimating prevalence: indirect methods for estimating the size of the drug problem,* UNODC, 2003 *(9)*.
  http://www.unodc.org/documents/data-and-analysis/statistics/Drugs/GAP_module_2.pdf
- Hickman M et al. Estimating the prevalence of problematic drug use: a review of methods and their application. *UN Bulletin on Narcotics,* 2002, 54:15–32 *(10)*.
  http://www.unodc.org/pdf/bulletin/bulletin_2002_01_01_Art2.pdf

Using surveys to assess intervention coverage

Intervention coverage can be estimated through surveys of people from key populations. These surveys are important sources of such information, especially when programmatic data disaggregated by key population group are not available.

Many of the indicators relating to key populations in the Global AIDS Response Progress Report (GARPR, previously referred to as UNGASS core indicators) involve this survey methodology. As noted, many countries use Family Health International's *Guidelines for repeated behavioural surveys in populations at risk of HIV (3)* as a basis for surveys among key populations; a revised edition of these guidelines is due for release in 2015.

In addition to capturing information on risk behaviours, surveys also can collect detailed information on individuals' service utilization history.

As discussed on page 10, the reliability of survey findings depends on how representative the survey sample is of the broader key population of interest. For example, if a sample is recruited only at a site where services are provided or if

community members are selected by peer educators working for the intervention, the sample is likely to be biased towards people who are in contact with services and so may overestimate levels of coverage.

The indicators in this document that use survey data to measure coverage follow the following basic formulation:

> Percentage of key population who answer "yes" to the question:
> "*In the last [X months] have you received [NAME OF INTERVENTION]?*"

An appropriate time period should be selected for these indicators. This time period should be relevant to the intervention of interest and the context in which it is being measured. Some indicators (for example those examining HIV testing and counselling and condom distribution) are also included in the GARPR. The GARPR indicators ask about receiving services at least once in the past 12 months. Because it is desirable for many interventions to be provided more frequently than once a year, it is appropriate to ask about receiving an intervention within a shorter time period, for example the last one, three or six months.

Indicators using surveys to assess intervention coverage		Page
CCP–5	Key population reporting they have received condoms and lubricant	36
NSP–5	People who inject drugs reporting they have received sterile injecting equipment	41
HTC–3	Key population reporting they have received HIV test and results	54
ART–2	Key population living with HIV reporting they currently receive ART	57
SRH–4	Key population reporting they have been tested for STIs	61
PKG–2	Key population reporting they have received a combined package of health sector interventions	63

4. Measuring intervention quality

The quality of an intervention makes a critical difference to its accessibility, coverage and impact. Quality encompasses the scope, completeness, effectiveness, efficiency and safety of an intervention, how it is delivered and, importantly, its acceptability to the intended clientele. Intervention quality can be understood in terms of *the way in which an intervention is delivered*. Quality standards are those factors that can either: a) enhance the effectiveness and desired impact of an intervention; or b) improve access to it and thus increase coverage.

The indicators assessing intervention quality listed in this document use information gathered from:

- review of programme policy and practice
- key population surveys
- programmatic or administrative data.

Review of programme policy and practice

Programme quality assessment checklist
For an intervention to be effective, it needs to be delivered in a way that responds to the needs of those it is intended to serve. This is especially important when providing an intervention for key populations, whose needs differ from those of the general community.

A number of factors important for effective programming and service provision for key populations have relevance to all the interventions in the evidence-based package. These common indicators are presented in a checklist that can be used to assess programmes or services providing any of the essential health sector interventions. The items on this checklist can also be used to evaluate whether or not a programme or service is adequately sensitized to meeting the needs of key populations; programmes that meet these criteria can be counted as a provider that *meets key population sensitization standards* for the purpose of reporting indicators on availability (see page 11).

The checklist can be used for evaluation at the programme level or site level, and results can be aggregated at the national level to determine what proportion of sites meet some or all of these criteria. The checklists can be completed by service providers themselves as a form or self-assessment or could be used in an external independent review, including evaluation by key population community representatives.

An important component of assessing intervention quality is gathering clients' opinions through satisfaction surveys. Whether or not a service conducts such client satisfaction surveys is an item on the programme quality checklist itself. These surveys should elicit clients' perceptions of the accessibility and appropriateness of an intervention and how it is delivered.

Indicators using programmatic quality assessment checklists		Page
ENV–1	Audit of current legislation and policy checklist	28
NSP–6	NSP-related policy and practice checklist	42
OST–4	OST-related policy and practice checklist	45

Health worker training
How an intervention is delivered depends on the workers responsible for providing the service. Service providers must be able to effectively and sensitively meet the needs of their clients. Workers should receive training on the specific health and welfare needs of men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people and ensure that they have the skills and understanding necessary to protect patient's rights to health, confidentiality and non-discrimination. Monitoring the percentage of new and current staff members who have received sensitization training also is useful.

Indicators examining health worker training		Page
Q–1	Sensitization training on key populations for service providers	31

Indicators measuring specific aspects of intervention quality using survey and programme data

A number of additional indicators are described that measure the extent to which important supplementary activities or services have been delivered, for example, the provision of compatible lubricant when condoms are distributed or the receipt of test results following an HIV test. Data on these indicators come from surveys or programme data or both. These indicators are similar in formulation to those for availability and coverage described above.

Indicators using programme and survey data to assess quality of interventions		Page
CCP–6	Consistent condom-compatible lubricant distribution	36
CCP–7	Key population reporting having received lubricant when receiving condoms	37
OST–5	Individuals receiving maintenance OST continuously for at least 6 months	46
OST–6	Individuals receiving maintenance dose of OST ≥ the recommended minimum dose	46
OST–7	Individuals on maintenance OST receiving psychosocial support	47
HTC–4	Key population reporting they received results following HIV testing	55

5. Measuring the outcome and impact of interventions

The strategies and interventions of the evidence-based package described in this document share common goals:

- to prevent new infections
- to reduce related morbidity and mortality
- to reduce risk behaviour
- to protect the rights and dignity of men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people.

Observed changes or progress towards these goals will always result from multiple factors and a combination of interventions. Changes are unlikely to be attributable to a single, isolated intervention or to a single project or programme. In fact, the success of one intervention may depend on the success of another. For example, an enabling environment is essential to maximize the impact and effectiveness of the recommended health sector interventions.

This document describes a set of *outcome* and *impact* indicators to measure progress toward the achievement of these goals. These indicators are relevant to health sector interventions and to strategies for an enabling environment, even if the influence of the latter on the measured outcomes and impacts is largely indirect.

Incidence (HIV, STIs, HBV and HCV)

Changes in incidence reflect the impact of interventions intended to prevent infection. Measuring incidence, however, is challenging. Various methods may be used to estimate incidence indirectly, but the limitations of each method must be considered when interpreting results.

Inferring incidence from case reporting systems for newly noted infections has limitations, generally resulting in an underestimate of the total number of new infections. Case reporting systems are able to count infections only among those who are tested, and they depend on robust and consistent notification procedures. Because individuals may undergo a test sometime after the date of seroconversion, case notifications reflect infections that may have occurred several years in the past in the case of HIV, HBV and HCV.

Limitations of currently available serological HIV incidence assays for recent infection testing algorithms (RITA) to detect new infections restrict their usefulness for estimating incidence at the population level. These methods also require laboratory and financial resources that are beyond the capacity of most HIV surveillance systems *(11)*.

Case reporting for highly symptomatic STIs such as gonorrhoea in men may be useful. In contrast, case reporting of STIs with few or subtle symptoms (such as chlamydia or syphilis) is unreliable as a direct measure of incidence; such case reporting is more likely a measure of screening practices. If screening practices and patterns of utilization are fairly stable over time, however, case reporting may be able to provide some insight into trends in prevalence.

An individual's drug use, sexual behaviour, transgender identity or participation in sex work may not be recorded in these case notification systems. The mode of transmission category recorded also may not identify an individual as a man who has sex with men or a sex worker. Testing and notification data from sentinel sites accessed by people from key populations may provide a more specific estimate of incidence, but consideration should be given to how representative these data are of the entire key population.

Mathematical modelling can estimate incidence. Tools such as the UNAIDS Spectrum Package can be used to estimate HIV incidence for various population groups. To produce estimates, these models require reliable surveillance and programme data such as information on modes of transmission, key population prevalence estimates, and data from ART programmes.

The prevalence of HIV among young people in key populations or those new to sex work or recently starting to inject drugs can be used as a proxy measure of incidence for the respective key population of interest. This requires surveillance data to be disaggregated by age and to include information on the duration of time since starting injecting drug use, sex work, or, for men who have sex with men, since becoming sexually active.

Longitudinal cohort studies of key populations also can estimate incidence if participants are tested regularly. The likely representativeness of the cohort and the generalizability of the findings to the wider key population should be considered. Undertaking prospective cohort studies is, however, typically complex, time-consuming and expensive.

Indicators examining incidence	Page
O–1 Infection incidence among key population	64

Prevalence (HIV, STIs, HBV and HCV)

Typically, HIV prevalence can be measured more easily than incidence, but is limited in its ability to determine the impact of interventions upon infection rates. Changes in observed prevalence may not even necessarily be due to changes in rates of infection. Changes in HIV prevalence could be the result of different surveillance and testing techniques used. Apparent decreases in prevalence could be the result of increased stigmatization and reluctance of members of key populations to be tested, while real decreases could be the result of mortality among people living with HIV. In addition, when access to effective HIV treatment and care is improved, HIV prevalence is likely to increase as the life expectancy of HIV-positive people increases, even if the incidence of HIV infection remains stable or decreases. Prevalence can be measured by sentinel surveillance of key populations.

Monitoring the STI prevalence of syphilis, gonorrhoea, or chlamydia in key populations through a sentinel system may also provide useful information on recent unprotected sexual activity.

Indicators examining HIV and STI prevalence	Page
O–3 Infection prevalence among key population	65

AIDS-related deaths

HIV treatment and care aim to prevent the progression of HIV to AIDS and to reduce AIDS-related deaths.

Direct measurement of AIDS-related mortality relies upon notification systems and death registries.

To monitor this outcome among men who have sex with men, people who inject drugs, sex workers and transgender people, *risk group status* needs to be recorded in these systems and death registries also must record AIDS-related causes of death and be linked with HIV registration databases. Deaths while in detention among people in prisons and other closed settings are likely to be recorded in registry systems; deaths that occur after release may be more difficult to identify.

Longitudinal cohort studies of key populations can provide estimates of the incidence of AIDS and related mortality. The likely representativeness of these cohorts should be considered when interpreting data.

Mathematical models, such as the UNAIDS Spectrum Package, can produce estimates of AIDS-related mortality.

Indicators examining AIDS-related deaths	Page
O–2 Incidence of AIDS-related mortality	64

Risk behaviours

Outcome indicators that examine changes in risk behaviour, such as condom use, can be useful in assessing the impact of related interventions.

Behaviour surveys can provide information on changes in the prevalence of risk behaviours. Many countries already undertake such surveys as part of the ongoing monitoring of the HIV epidemic and may periodically survey men who have sex with men, people in prisons or other closed settings, people who inject drugs, sex workers and transgender people as specific key populations. As noted, the 2000 Family Health International *Guidelines for repeated behavioural surveys in populations at risk of HIV (3)* is used in many countries as a basis for these surveys among key populations; a revised version of these guidelines is due for release in 2015.

Collecting demographic, socioeconomic and other data in surveillance studies allows for useful disaggregation and analyses. For example, differences between younger and older individuals can be discerned. As discussed on page 17, when undertaking behavioural surveys of key populations and when interpreting results, it is important to consider the representativeness of the samples recruited and the extent of potential bias associated with how and where participants are recruited.

Indicators examining risk behaviours	Page
O−4 Prevalence of risk behaviours and knowledge around HIV among key population	65

Stigma and discrimination

The *People Living with HIV Stigma Index* is a validated survey measuring stigma and discrimination experienced by people living with HIV, and remedies available to them. It includes a number of items on stigma and discrimination related specifically to men who have sex with men, sex workers and transgender people.

Attitudes towards key populations held by service providers, law enforcement officers and the general community can also be examined through surveys; relevant questions to be included in such surveys are proposed in this document. These indicators assess the following: the fear of casual transmission of HIV and refusal of contact with people living with HIV or members of key populations; value- and morality-related attitudes towards members of key populations, including blame, judgement and shame; and actions that reflect stigma or discrimination.

Indicators examining stigma and discrimination	Page
O−5 Stigma and discrimination experience by key population	66
O−6 Attitudes towards key population held by service providers	66

6. Disaggregating data to better understand diversity

There is significant diversity within key populations. Characteristics of various subgroups may be associated with differing HIV risks, rates of service utilization and health outcomes. When examining the coverage and impact of interventions, it is useful to separate the data collected into relevant subgroups to better understand any differences within the population that may need to be addressed.

In some cases, however, disaggregation may result in small numbers of individuals in a particular group. Relying upon only a very small sample to estimate prevalence or coverage results in substantial uncertainty around the estimate, and estimates may vary widely when measured at different points in time.

Disaggregation by age

In many settings young people have poorer rates of access to HIV prevention and care services than older people. There can be a variety of reasons, including age discrimination by programmes, laws denying services to people under a certain age without parental consent, and young people feeling that services do not meet their needs.

At a minimum, it is advisable to disaggregate indicator data for those younger than 18 years of age, those between 18 and 25 years of age and those 25 years and older. If the data are available, further disaggregation into narrower age ranges is useful, such as 10−14, 15−19, 20−24, 25+ for some indicators. Separating data on individuals younger than 18 is particularly important with respect to key populations in particular for legal issues such as age of consent and access to services and for sex work, the definition of which includes only consensual sex between adults; sex with people younger than 18 years should not be considered sex work *(1, 12)*. However, this may be challenging due to practical and legal considerations.

Disaggregation by gender

Data on those who participate in sex work, injecting drug use or those detained in closed settings should be disaggregated by gender including male, female, transgender men and women.

Transgender men and women have different health issues. Therefore, it is recommended to disaggregate data on transgender people by gender, including masculine-identifying, feminine-identifying or whatever local terms may be most appropriate.

Disaggregation by other characteristics

It is also useful to examine differing levels of risk within key populations.

It is particularly important to recognize the overlap between each of these key populations. For example, men who have sex with men, people in prisons and other closed settings, sex workers and transgender people may use and inject drugs and many people from these key populations may engage in sex work. Therefore, they are may be at greater risk of infection than those with only one type of risk factor. Hence, disaggregating data on a specific key population by these other key population groups helps develop a better understanding of the additional needs of the population concerned.

People from each key population are typically over-represented in prisons and other closed settings, often as a consequence of the criminalization of their identities or behaviours. The provision of services in prisons and other closed settings presents a number of challenges and important differences compared to the provision of the same services in a community setting *(13)*. Accordingly, data on people in closed settings should be collected and reported on separately

Subgroups of key-populations may have especially high risk for HIV infection, and it is informative to disaggregate data for these different subgroups. For example, when reporting indicators on sex workers, disaggregation distinguishing different types of sex work or sex work setting may be relevant, particularly if services appropriate for these groups differ. Disaggregation might include indoor versus street-based sex workers or might differentiate by frequency of sex work – for example, "sex work as regular paid employment" versus "occasional paid sex". It is important to use definitions that are appropriate to the local context.

Some men who have sex with men may also have female sexual partners and, therefore, have additional HIV and STI prevention needs. Disaggregation of data into groups of those who have female sex partner(s) and those who do not provides useful information for addressing these specific needs.

Disaggregating intervention data by service provider characteristics

Data on the provision of interventions also can be disaggregated by the type of service provider. In particular, as countries increase provision of interventions by community-led services, disaggregating data between community-led and other service providers can help with monitoring progress in this direction.

As described above, it is important to collect data describing the provision of services in prisons and other closed settings. Disaggregating data by prisons and other closed settings and community settings is important and can help identify disparities in access to health services between these settings and to evaluate whether the principle of equivalence of care is being upheld.

Disaggregating by geographic area

Reporting separately for different geographic areas will be relevant for many countries and is important to inform planning decisions on where services should be located. For example, disaggregation by rural and urban areas may be particularly relevant due to the different characteristics of key populations in these settings and different issues related to service provision.

7. Target setting

Setting targets for the indicators described in the preceding section assists with strategic, results-based planning to build an effective response to the epidemic.

Targets can be set for:

a) **Intervention and enabling environment indicators**
   These include target levels for *availability*, *coverage* and *quality* indicators and for enabling environment factors such as changes in legislation within a specific time frame. Target levels are set with the aim of achieving reductions in HIV risk sufficient to control the epidemic and ensuring the provision of appropriate management to those living with HIV.

b) O**utcome and impact indicators**
   These are targets for the impact on the HIV epidemics themselves (for example, reductions in incident HIV or STIs) or targets for changes in risk behaviours (for example, the percentage of people who use condoms consistently).

These targets identify specific areas that need to be addressed and the scale of programmatic responses required. Targets can assist with designing actions that contribute to meeting the high-level commitments that have been made by Member States including the United Nations General Assembly 2011 Political Declaration on HIV/AIDS *(14)*, see Box 4. While only one of these goals mentions a key population specifically, these targets are still relevant to the response to HIV among key populations more broadly.

Box 4. United Nations 2011 Political Declaration on HIV/AIDS – goals and targets to be achieved by 2015

1. Reduce sexual transmission of HIV by 50%

2. Halve the transmission of HIV among people who inject drugs

3. Eliminate HIV infections among children and reduce maternal deaths

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

5. Halve tuberculosis deaths among people living with HIV

6. Close the global AIDS resource gap

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

8. Eliminate HIV-related stigma, discrimination, punitive laws and practices

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

10. Strengthen HIV integration

Because of the complexity of the interaction of numerous factors that determine HIV risk and intervention impact in a particular setting, there is no universal formula for setting a target for a particular indicator. Targets need to reflect local factors such as the nature of the HIV epidemic, the current stage of the response, available resources and capacity and structural factors that shape risk and influence intervention impact. Therefore, countries must undertake a process for setting targets relevant and specific to their own epidemic and context. Targets should be aspirational but also achievable; a pragmatic approach is necessary.

The following general principles are important when setting targets (see also Fig. 1):

• Multiple interventions are more effective than single interventions alone, and they are essential to preventing HIV transmission in key populations. Without providing all needed interventions of the package of recommended interventions, a single intervention implemented alone will need to have a much higher level of coverage than if other interventions were available and even may not be able to produce an impact on its own.

• Higher-quality interventions deliver greater impact than those that are implemented at lower quality.

• Greater levels of coverage are superior to lower levels. While greater intervention coverage brings about greater reductions in HIV risk and, hence, incidence, this relationship is not necessarily linear.

- The higher the level of HIV prevalence (both in the general population and among key populations), the greater the level of intervention coverage that will be required.
- The earlier in an epidemic that an intervention is introduced the more effective it can be in controlling the spread of HIV.

How should countries go about setting targets?

The target setting process should be collaborative, involving input from community-led organizations and networks and other stakeholders including representatives of government and civil society, service providers and clinicians.

It is useful to measure first the scale of the current response, assessing the availability, coverage, and quality of interventions and to assess enabling environmental factors. Currently available resources and capacity must also be determined. This information serves as a baseline against which future progress can be measured.
It is then necessary to estimate how much scale-up is possible within a set time period, given available resources and technical capacity, and how much additional capacity and resources can be mobilized. From this, realistic, achievable target levels can be set, and the time period in which they are to be achieved can be defined.

It may be necessary to strengthen systems for programme monitoring to improve the tracking of progress toward these targets.

Fig. 1. **Relationships between intervention implementation and impact**

Higher coverage levels	↑ **impact**
Multiple interventions available (e.g. condom programmes + addressing STIs + ART + community mobilization)	↑ **impact**
High *quality* interventions	↑ **impact**
Early introduction of interventions	↑ **effectiveness**
If HIV prevalence is already high	↑ **coverage levels needed**
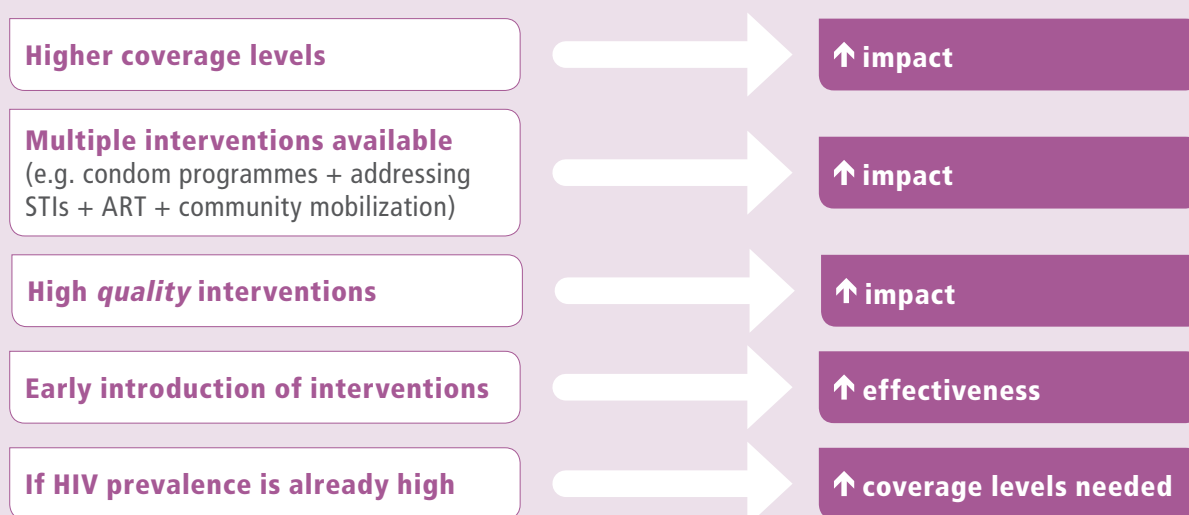
Indicative targets

In this document indicative targets have been proposed for a number of selected indicators. These targets are intended to provide those responsible for implementing programmes with a guide to help understand the target that might be required to make an impact and to what level services should be maintained or expanded to effectively control the epidemic.

These proposed targets should be considered as broadly indicative only, and countries will need to consider the local context to assess what levels they should aim to achieve. In the future, as new and more robust evidence emerges, these indicative target levels may be revised.

In a number of cases these targets are based on commitments made by countries as set out in various global declarations (see Box 4, above). Other targets are also considered including the ambitious, but achievable, *Fast-Track Targets* to mobilize global efforts and resources in order "to end the AIDS epidemic by 2030" (15), launched by UNAIDS at the end of 2014. These Fast-Track Targets include:

- By 2020, 90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving

treatment and 90% of people on HIV treatment having a supressed viral load, and by 2030 increasing each of these targets to 95% respectively;

• Reducing the number of new HIV infections among adults in low and middle income countries to 500,000 per year by 2020 and to 200,000 per year by 2030;

• Achieving "zero discrimination" with no new HIV discriminatory laws, regulations and polices passed and for those countries that have such laws and policies to repeal them.

These global targets have an important role in maintaining attention and action at the global level and require countries to make decisions as to how they should be translated and programmed for at the national level in response to the local epidemic and context. At the national level appropriate intermediate targets can be set to guide incremental progress towards achieving these Fast-Track Targets.

Further reading on target setting

■ *Target setting of HIV services*, USAID, 2012 *(16)*.
https://www.hfgproject.org/target-setting-hiv-services/
■ *Operational guidelines for monitoring and evaluation of HIV programmes for people who inject drugs.* Geneva, UNAIDS, 2011 *(17)*
http://www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs
■ *Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men and transgender people.* UNAIDS, 2012 *(18)*.
http://unaids.org.cn/en/index/Document_view.asp?id=712
■ *Fast-Track – Ending the AIDS epidemic by 2030.* UNAIDS, 2014 *(15)*.
http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report

PART 2
INDICATORS

This section describes indicators for assessing key factors related to the **enabling environment**, for measuring the **availability**, **coverage** and **quality** of specific health sector interventions, and for examining the **outcome and impact** of efforts to address HIV among men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people.

Except where specified, these indicators are relevant to each of these key populations. For this reason, the term "**key population**" is used instead of referring to each population separately. However, countries should develop programmes and plans and **measure progress for each key population separately**.

Each indicator and its component parts are described, and data sources are listed. Many of these indicators are common to other data collection processes (as noted). How each indicator can be used for target setting is also described.

Each indicator has a reference number describing the type of indicator or intervention it examines. The following convention is used:

Intervention: | ENV | Indicator number: | 1a |

Abbreviations:

ENV	Enabling environment
Q	Quality indicator (not specific to any single intervention)
CCP	Comprehensive condom programming
NSP	Needle and syringe programme
OST	Opioid substitution therapy
ODM	Overdose prevention and management
GDR	Reducing harms related to injecting substances for gender affirmation
BHV	Behavioural interventions
PRP	Pre-exposure prophylaxis
HTC	HIV testing and counselling
ART	HIV treatment and care, including antiretroviral therapy
CMB	Prevention and management of co-infections and other co-morbidities
SRH	Sexual and reproductive health
PKG	Combined package of health sector interventions
O	Outcome/impact indicator (not specific do any single intervention)

Strengthening the enabling environment

ENV–1	Audit of current legislation and policy checklist	
Does current legislation and policy include any of the following which may *negatively impact* key populations and efforts to address HIV?	
a	Laws criminalizing behaviours of key populations including: sex acts between consenting adults of the same gender; anal sex between consenting adults; involvement in sex work by consenting adults; "cross dressing" or "gender impersonation"; drug use or possession of drugs for personal use	
b	Legislation defining homosexual and heterosexual ages of consent as not equal	
c	Laws or policing practices criminalising or preventing the distribution of condoms or information on condom use and safe sex	
d	Laws criminalizing the carrying of condoms; or policing practices where carrying condoms can be used as evidence of sex work (if sex work is illegal)	
e	Laws or policing practices criminalizing or preventing the distribution of injecting equipment and information on safer injecting practices	
f	Laws or policies making provision for mandatory HIV testing of key populations	
g	Laws or policies making provision of mandatory testing in prisons or for the segregation of prisoners living with HIV	
Does current legislation and policy include any of the following, which are supportive of the rights of key populations and efforts to address HIV?	
h	The National HIV Strategy specifically addresses key populations	
i	Laws that protect against human rights violations and discrimination (generally – not specific to HIV or key populations)	
j	Laws that protect against human rights violations and discrimination on the basis of sexual orientation, gender identity, engagement in sex work or drug use	
k	Legislation that requires people in prisons and other closed settings have access to health care of equal standard as that available in the community	
l	Laws that recognize sex work as work	
m	Laws that criminalize all forms of exploitation and victimization, consistent with international law	
n	Laws that regulate occupational health and safety conditions to protect sex workers and their clients	
o	Regulations allowing transgender people to easily change their names officially and to acquire legal recognition and identification acknowledging their chosen gender identity	
p	Laws that unambiguously support the provision of maintenance opioid substitution therapy and needle and syringe programmes	

Data source:
Desk review and stakeholder consultation

Comments:
The items listed in the checklist above can be used as a guide when conducting an audit of current legislation and policy to identify laws and policies that might either support or negatively affect the rights, health or welfare of men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers or transgender people. An audit of this kind should be undertaken with the participation of government, civil society and community-led networks, and organizations of key populations. Where legislation or policy is found to be in need of reform, processes for change should be identified and evaluated. Guidance on undertaking an assessment of legislation is available.
See *Legal environment assessment for HIV: an operational guide to conducting national legal, regulatory and policy assessments for HIV*, UNDP, 2014.
http://www.undp.org/content/dam/undp/library/HIV-AIDS/Governance%20of%20HIV%20Responses/UNDP%20Practical%20Manual%20LEA%20FINAL%20web.pdf.

ENV–1 *continued*	Audit of current legislation and policy checklist

Setting targets:
Introducing legislation and policy that is supportive of the rights, health and welfare of key populations and removing any that adversely affect these groups should be the intended aim. While developing policy and legislation can be a slow process, countries where law and policy reform is required should set out a realistic but ambitious time frame for change and monitor progress toward these goals. It should be noted that the 2011 Political Declaration on HIV/AIDS included the commitment by Member States to eliminate HIV-related stigma, discrimination, punitive laws and practices by 2015 (14); in addition recent UNAIDS targets call for no new HIV-related discriminatory laws, regulations or policies and that 50% of countries that have such laws, regulations and policies repeal them by 2020 *(15)*.

ENV–2	Involvement of key population in national policy and strategy formulation

Are representatives from key population-led organizations members of the national multisectoral HIV coordinating body?

Data source:
Desk review and stakeholder consultation

Comments:
That representatives from key population-led organizations are members of national coordinating bodies does not necessarily indicate that key populations are meaningfully involved in the development of policy and strategy, but it is an essential element in achieving it.

Setting targets:
If the national multisectoral HIV coordinating body does not have representation from key population-led organizations, representatives should be recruited. If key population-led organizations are not established, an initial target would be to support their formation, and set a time frame for their establishment.

ENV–3	Legal support services for key populations

Number of services providing legal support to people from key populations

Data source:
Facility-based assessment/programme data

Comments:
Providing legal support to people from key populations is important to ensure access to justice. For this indicator the type of legal support should be documented. Legal support includes pro bono legal aid and support from community paralegals, including members of key populations trained as legal advocates. Where appropriate, legal support services may also facilitate access to traditional dispute resolution mechanisms with the support of traditional leaders.

Similarly, the type of service or programme providing this legal support should be reported. These might include services that provide legal support to key populations in addition to other health or welfare services, or legal services that might either specialize in legal issues related to key populations or that may be sensitive to the needs of people from these populations.

Setting targets:
Targets can be set for an increased number of services (or sites) where legal support is provided to people from key populations, and a time frame set for this scale-up. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 24 for further discussion).

ENV–4	Support services for people from key populations who experience violence
a	Number of sites where **key population-focused programmes** provide appropriate medical, psychological and legal support for those who have experienced violence
b	Total number of sites where **key population-focused programmes** are offered
c	$\dfrac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** where appropriate medical, psychological and legal support for those who have experienced violence is provided

Data source:
Facility-based assessment/programme data

Comments:
This indicator is based on the following UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) indicator and has been adapted to look at key populations specifically and, among them, those who are victims of physical, sexual and other forms of violence:

"Number or percentage of service-delivery points providing appropriate medical, psychological and legal support for women and men who have been raped or who have experienced incest".

When reporting on this indicator, the "site" definitions used should be documented.

See page 11 for further information on this type of indicator.

Setting targets:
Countries can set targets for an increased total number of sites providing medical, psychological and legal support for people from key populations who have experienced violence and set a time frame for scale-up. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 13 for further discussion).

Not every site where key population-focused programmes operate will be an appropriate place to offer medical, psychological and legal support to people who have experienced violence, but many will be. When setting targets for indicator **ENV–4c**, it is necessary to determine which sites not currently offering this type of support have the potential to do so.

It should also be noted that the 2011 Political Declaration on HIV/AIDS included the commitment by Member States to eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV by 2015 *(14)*.

ENV–5	Sensitization training on key populations for law enforcement officers

Number (and percentage) of law enforcement officers who received key population sensitization training over the specified reporting period.

Data source:
Records held by relevant police or justice authority

Comments:
Training should be in line with national endorsed standards. The training curriculum should cover: the rights of key populations; law enforcement officers' responsibilities for protecting these rights; and law enforcement practice guidelines on supporting the provision of HIV prevention and other services for key populations. This training should be part of the pre-service officer training programme and should also be provided on an ongoing and regular basis to officers in service. Community-led organizations and key population networks can make an important contribution to this training, if done in a safe and non-stigmatizing manner.

Setting targets:
If the current national law enforcement officer training curriculum does not include key population sensitization training, the first target will be to develop this. Targets should then be set for the rapid roll-out of this curriculum to all training sites.

As all new officers should receive this training, the target should be that all graduating officers complete key population sensitization training. A realistic but ambitious time frame for achieving this target should be set.

Targets can also be set for training current officers, with the goal that all officers should receive training on a regular and ongoing basis. The frequency of this training should be decided with input from stakeholders.

Quality indicators for all programmes and interventions

Q–1	Programme quality checklist
a	**All staff members have received training and sensitization relevant to working with key populations.** Service providers should receive anti-stigma and anti-discrimination sensitization and training on the specific health and welfare needs of key populations. Training should ensure they have the skills and understanding necessary to ensure that patient's rights to health, confidentiality and non-discrimination are protected. See also indicator Q-2 (below).
b	**The programme has a clear antidiscrimination policy and code of conduct.** This policy should also include a mechanism for oversight to ensure that standards are maintained.
c	**The programme has actively involved key population representatives in planning the provision of the service for the key populations.** This involves consultation with and meaningful involvement of people from the key population in the development of services to ensure these are appropriate and acceptable to the population of focus.
d	**The programme seeks regular anonymous feedback from clients.** Mechanisms are in place whereby clients can confidentially/anonymously provide feedback on the service, and the program reviews and is responsive to this information.
e	**People from key populations are not required to meet specific criteria in order to access the intervention.** Access is not restricted on the basis of minimum age, gender identity or expression, sexual orientation, occupation, drug use, citizenship or residency status, incarceration or criminal history. This includes restriction of access to ART on the basis of past or current drug use.
f	**The intervention is provided to people from key populations at no cost or at a cost that is affordable.** Cost can be a significant barrier to access if clients are required to cover these costs themselves but do not have the resources to do so. To increase accessibility, the intervention should be offered to members of the key population free of charge (where possible), the costs covered by health insurance provisions, the costs to patients partly subsidized, or the services provided free or at reduced costs specifically for financially disadvantaged patients.
g	**The programme maintains client confidentiality.** Services have systems in place to ensure that client records are kept securely and remain confidential. Client information is not shared with other services or law enforcement without client consent, unless required by law. Programme data collection systems do not contain clients' personal or identifying information.
h	**The programme has a clear chain of accountability to ensure that minimum standards for the provision of the intervention are met.**
i	**Long-term funding has been secured to ensure the sustainability of providing the intervention to the key population.** Long-term funding should be committed to the ongoing operation of programmes providing the intervention to the key population. If services are funded by external sources, the sustainability of this funding should be assessed, and contingencies for filling funding gaps should be determined.

Data source:
Facility-based assessment

Comments:
The items in this checklist can be used as a guide when conducting a service provider assessment. This checklist has relevance to all programmes that provide services to people from key populations and, along with indicator **Q–1**, can be used to determine whether a service meets defined key population sensitization standards. (See availability indicators **CCP–1, NSP–1, OST–1, HTC–1, ART–1** and **SRH–1** which make use of this information.)

Countries may wish to add or adapt items in this checklist, but there should be a clearly defined stakeholder-endorsed definition of a minimum set of standards.

Q–1 continued	Programme quality checklist

Setting targets:

Targets using this checklist can be set in various ways:

1. At the service level a time frame can be set for the achievement of items on the checklist that have not yet been achieved.

2. At the national level a target can be set for the percentage of all sites that meet a defined minimum set of standards, and a time frame for achieving these can be set.

3. At the national level a target can be set for the percentage of all sites that meet an individual item from this checklist, and a time frame for achieving this can be set.

Q–2	Sensitization training on key populations for service providers
a	Number of staff recruited in the last 12 months who have received key population sensitization training
b	Number of staff recruited in the last 12 months
c	$\dfrac{[a]}{[b]} \times 100 =$ Percentage of staff recruited in last 12 months who have received key population sensitization training
d	Number of current staff who have received sensitization training
e	Number of current staff
f	$\dfrac{[d]}{[e]} \times 100 =$ Percentage of current staff members who have received sensitization training

Data source:
Facility-based assessment

Comments:

These indicators are relevant to all programmes that provide services to key populations. Staff from these programmes should be trained in key populations' rights and needs.

The training provided should be consistent and include anti-stigma and antidiscrimination sensitization as well clinical competency training on the specific health and welfare needs of people from these key populations. Development of national training standards and guidelines can help to ensure that training is comprehensive and of good quality.

For indicator **Q–2d** the number of current staff members who have received training could be recorded for those who have ever received training or those who have received training within a defined time period, such as 12 or 24 months.

Setting targets:

All new and current staff of programmes that provide services to key populations should receive training in providing appropriate, acceptable, high-quality services to people from these key populations. Thus, it is appropriate for service providers to aim for targets of 100% for indicators **Q–2c** and **Q–2f**.

Countries should then set out an ambitious but realistic time frame to scale up sensitization training to reach these 100% targets.

Comprehensive condom and lubricant programming

CCP–1	AVAILABILITY: Sites providing comprehensive condom programming
a	Number of sites where **key population-focused programmes** provide condoms and compatible lubricant
b	Number of sites where **mainstream programmes meeting key population sensitization standards** provide condoms and compatible lubricant
c	Total number of all sites where any **key population-focused programmes** are offered
d	Total number of sites where **mainstream programmes** provide condoms and compatible lubricant
e	$\frac{[a]}{[c]}$ x 100 = Percentage of **key population-focused programme sites** where condoms and compatible lubricant are provided
f	$\frac{[a]+[b]}{[a]+[d]}$ x 100 = Percentage of **all sites where condoms and compatible lubricant are provided** that are either key population-focused programmes or mainstream programmes meeting key population sensitization standards

Data source:
Facility-based assessment/programme data

Comments:
This indicator counts only sites where condom-compatible lubricant is provided along with condoms.

For this indicator the definition of a "site" should be documented. Sites might include fixed-site services and locations where outreach and mobile services operate.

See page 11 for further information on availability indicators of this type.

Setting targets:
In most contexts the majority of sites where services are provided to key populations are likely to be appropriate condom and lubricant distribution points. Accordingly, in many countries a target of 100% of sites may be appropriate for indicator **CCP–1e**.

Similarly, people from key populations should be able to access mainstream services that provide condoms and lubricant, and, ideally, all mainstream services should meet key population sensitization standards. Accordingly, in many countries a target of 100% of sites may be appropriate for indicator **CCP–1f**.

Countries should then set out an ambitious but realistic time frame for scaling up comprehensive condom programming to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out condom programming to key population-focused programmes and key population sensitization training and procedures to mainstream services.

CCP–2	AVAILABILITY: Key population reporting condoms are readily accessible
a	Percentage of key population in sample who agree with the statement: *"Condoms are available when I need them."*
b	Percentage of key population in sample who answer "yes" to the question: *"In the last 12 months, have you ever had sex without a condom because you weren't able to either buy a condom or get one for free?"*

Data source:
Behavioural survey

Comments:
The time frame for this indicator can vary; for example, the question could be asked about condom use and availability in the last 1, 3 or 6 months.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for these indicators. Countries can then set targets and a time frame for achieving them, linked with targets for programme activities and scale-up.

CCP–3	COVERAGE: Key population provided with condoms and compatible lubricant
a	Number of people from key population provided with condoms and compatible lubricant by key population-focused programmes over the specified reporting period (e.g. the last 1, 3, 6 or 12 months).
b	$\dfrac{[a]}{\text{Estimated key population size}} \times 100 =$ Percentage of total key population provided with condoms and compatible lubricant by key population-focused programmes over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data
Population size estimates

Comments:
This indicator counts only clients who received both condoms and compatible lubricant; those who received condoms only, without also receiving lubricant, are excluded from this count.

If key population-specific data are also available from mainstream programmes, these can also be included in this indicator.

To avoid double counting, methods such as a unique identifier codes or the recall last contact method can be used (see page 15).

Different time periods may be selected when measuring this indicator. Time periods of different duration provide different insights into programme reach and frequency of service utilization. For example, reporting on access in the last one month provides a snapshot of current utilization and approximates the number who might regularly use the service.

If population size estimates are not available, monitoring changes in the number of people provided with condoms and lubricant over time can still provide valuable insights into programme implementation and progress in scaling up.

See page 15 for further information on this type of coverage indicator.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and a time frame for scaling up comprehensive condom programming to reach a greater total number and a greater proportion of people from the key population. These time frames and targets should be based on an assessment of the logistical issues and the resources required to roll-out condom programming to key population-focused programmes.

In setting targets it is important to recognize in nearly all countries that condoms and lubricant will be available for sale from different outlets. Hence, distribution by key population-focused services, while making a vital contribution to the accessibility of condoms and lubricant, does not constitute the only source of condoms contributing to overall condom coverage, this should be reflected in the targets set.

CCP–4	COVERAGE: Quantity of condoms and condom-compatible lubricant distributed	
a	Number of condoms provided to key population from **key population-focused programmes** over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)	
b	$$\frac{[a]}{\text{Key population size estimate}} =$$	Number of condoms distributed per member of key population over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)
c	Number of sachets of condom-compatible lubricant provided to key population from **key population-focused programmes** over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)	
d	$$\frac{[c]}{\text{Key population size estimate}} =$$	Number of sachets of condom-compatible lubricant distributed per member of key population over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data
Population size estimates

Comments:
If key population-specific data are also available from mainstream programmes, these can also be included in this indicator.

If lubricant is provided in tubes or other containers instead of in sachets, these should be counted.

Different time periods may be selected when measuring this indicator.

If population size estimates are not available, monitoring changes in the number of condoms distributed over time can still provide valuable insights into programme implementation and progress in scaling up.

See page 15 for further information on this type of coverage indicator.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up comprehensive condom programming to distribute a greater number of condoms both in absolute terms (**CCP–4a**; **CCP–4c**) and relative to estimated key population size (**CCP–4b**; **CCP–4d**).

These time frames and targets should be based on an assessment of the logistical issues and the resources required to roll-out condom programming to key population-focused programmes.

In setting targets, it is important to recognize in nearly all countries that condoms and lubricant will be available for sale from different outlets. Hence, distribution by key population-focused services, while making a vital contribution to the accessibility of condoms and lubricant, does not constitute the only source contributing to overall coverage. These factors need to be accounted for when setting targets for condom distribution from key population-focused services.

CCP–5	COVERAGE: Key population reporting they have received condoms and lubricant
Percentage in sample of key population who answer "yes" to the questions:	
a	*"In the last [X months], have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic.)"*
b	*"In the last [X months], have you been given sachets of lubricant? (e.g. through an outreach service, drop-in centre or sexual health clinic.)"*
c	*"In the last [X months], have you ever been unable to get a condom when you needed one?"*
d	*"In the last [X months], have you ever not used a condom when having sex because you were unable to get one?"*

Data source:
Behavioural survey

Comments:
The time period for these indicators can vary; for example, the question could be asked about condom use and availability in the last 1, 3, 6 or 12 months.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for these indicators. Countries can then set targets and a time frame for achieving them, linked with targets for programme activities and scale-up.

CCP–6	QUALITY: Consistent condom-compatible lubricant distribution
a	Number of sachets of lubricant provided to key population by **key population-focused programmes** over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)
b	Number of condoms provided to key population from **key population-focused programmes** over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)
c	$\frac{[a]}{[b]} \times 100 =$ Ratio of total number of sachets of lubricant distributed to total number of condoms distributed over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data

Comments:
See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
Condom-compatible lubricant should be provided with every condom given out. Accordingly, if single-use sachets of lubricant are distributed, the target for indicator **CCP–6c** should be "1:1".

Baseline levels should first be measured.

Countries should then set an ambitious but realistic time frame for increasing the practice of providing lubricant with all condoms distributed.

CCP–7	QUALITY: Key population reporting having received lubricant when receiving condoms
a	Percentage in sample of key population who answer "yes" to the question: *"The last time you were given condoms, were you also provided with lubricant? (e.g. through an outreach service, drop-in centre or sexual health clinic.)"*

Data source:
Behavioural survey

Comments:
See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
Condom-compatible lubricant should be provided with every condom given out. Accordingly, the target for this indicator should be 100%.

The results of an initial survey can be used to set a baseline for these indicators.

Countries should then set an ambitious but realistic time frame for increasing the practice of providing lubricant with all condoms distributed.

Needle and syringe programmes

NSP–1	AVAILABILITY: Sites providing injecting equipment – needle and syringe programmes (NSPs)
a	Total number of sites where sterile needles and syringes are provided free of charge (i.e. NSP sites)
b	Total number of pharmacies or other outlets where needles and syringes are available for purchase
c	Number of sites where **key population-focused programmes** provide sterile needles and syringes
d	Number of **NSP sites meeting key population sensitization standards**
e	Total number of sites where **key population-focused programmes** are offered
f	$\dfrac{[c]}{[e]}$ x 100 = Percentage of **NSP sites meeting key population sensitization standards**
g	$\dfrac{[c]}{[a]}$ x 100 = Percentage of **key population-focused programme sites** where sterile needles and syringes are provided
f	$\dfrac{[a]+[b]}{[a]+[d]}$ x 100 = Percentage of **all sites where sterile needles and syringes are provided** that are either key population-focused programmes or NSPs meeting key population sensitization standards

Data source:
Facility-based assessment/programme data

Comments:
The number of NSPs sites (**NSP–1a**) is an important indicator for monitoring NSP scale up.

NSP sites are, by definition, key population-focused services in so far as their primary intention is to provide sterile injecting equipment to people who inject drugs.

As noted, people who inject drugs include men who have sex with men, people in prisons and other closed settings, sex workers and transgender people. As such it is important that NSPs are accessible to people from these key other populations and sensitized to meet their needs. Many sites that focus on providing various services to these key populations may also be appropriate sites for the distribution of sterile injecting equipment (see below).

The definition of a "site" should be documented. NSPs may operate in a variety of locations and service models, including fixed sites, mobile services and outreach. For the purpose of reporting this indicator, it is recommended that, for a location to be considered a "site", the following conditions must be met:

• It is the location of a fixed site or site that is serviced by a mobile or outreach service.

• If a fixed site, it must have frequent and regular hours of operation.

• If a mobile service, the service must operate at the site on a frequent and regular basis.

• If an outreach service, the specific site or defined area must be accessed on a frequent and regular basis by outreach workers.

In some countries injecting equipment may be available for purchase from pharmacies, while in others the sale of injecting equipment may be more restricted. For example, only certain pharmacy outlets may provide needles and syringes.

Setting targets:
Many sites where services are provided to key populations may be appropriate distribution points for needles, syringes and other injecting paraphernalia. When setting targets for indicator **NSP–1e**, it is necessary to determine which sites not currently distributing needles and syringes might have the potential to provide this intervention.

People from key populations should be able to access mainstream NSPs without fear of facing stigma or discrimination. Ideally, all mainstream services should meet key population sensitization standards. Accordingly, in many countries a target of 100% may be appropriate for indicators **NSP–1f** and **NSP–1g**.

Countries should then set an ambitious but realistic time frame for scaling up NSPs accessible to key populations to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out NSP capacity to key population-focused programmes and key population sensitization training and procedures to mainstream NSPs.

NSP–2	AVAILABILITY: People who inject drugs reporting sterile needles–syringes are readily accessible
a	Percentage of people who use drugs in sample who agree with the statement: *"Sterile needles and syringes are available when I need them."*
b	Percentage of key population in sample who answer "yes" to the question: *"In the last [X months], have you ever injected with a used needle or syringe because you weren't able to either buy or get for free sterile injecting equipment?"*

Data source:
Behavioural survey

Comments:

The time period for this indicator can vary. For example, the question could be asked about sterile injecting equipment use and availability in the last 1, 3, 6 or 12 months.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:

The results of an initial survey can be used to set a baseline for these indicators. Countries can then set targets and a time frame for achieving them, linked with targets for programme activities and scale-up.

NSP–3	COVERAGE: Quantity of needles–syringes distributed
a	Total number of needles–syringes distributed by NSPs in the last 12 months
b	Total number of needles–syringes sold to people who inject drugs by pharmacies or other outlets in the last 12 months
c	$\dfrac{[a] + [b]}{\text{Estimated number of people who inject drugs}} =$ Number of needles–syringes distributed per person who injects drugs per year

Data source:
Programme data
Pharmacy retail data
Population size estimates

Comments:

This indicator looks at the total quantity of new/sterile needles–syringes that are distributed and, hence, estimates the total number of clean units of injecting equipment in circulation that might be used by the population of injecting drug users.

NSPs may provide various types of needles and syringes, including separate needles and syringe or syringes with needles attached. For the purpose of counting the number of needles–syringes for this indicator, it is recommended to count the total number of equivalent single sterile injecting units distributed. For example, if 10 separate syringes and 20 separate needles are dispensed, a total of 10 sterile injecting units (each comprising 1 needle and 1 syringe) would be counted; similarly, if 12 separate syringes and 6 separate needles are dispensed, a total of 6 sterile injecting units would be counted.

This indicator should still be calculated even if data on the number of needles–syringes sold by pharmacies is not available. If such data are collected and collated, however, a more complete picture of the total number of needles and syringes in circulation and, hence, of coverage can be obtained.

If population size estimates are not available, monitoring changes in the quantity of injecting equipment distributed over time can still provide valuable insights into programme implementation and progress in scaling up and should be reported.

This indicator is included in the Global AIDS Response Progress Reporting guidelines *(19, 20)*.

See page 15 for further information on this type of coverage indicator.

NSP–3 continued	COVERAGE: Quantity of needles–syringes distributed

Setting targets:

Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up needle-syringe distribution both in absolute terms (**NSP–3a; NSP–3b**) and relative to estimated key population size (**NSP–3c**).

The following indicative target can be used as a benchmark against which a country's own targets can be compared:

Possible targets:
Low ← 100 ← Mid → 200 → High

These target levels are based upon studies in developed-country settings and mathematical modelling investigating the levels of syringe distribution and its impact on HIV transmission *(21, 22)*. Note that the levels required for the prevention of HCV are likely to be much higher than those proposed here. Time frames and targets set should be based on an assessment of the logistical issues and the resources required to roll-out NSP capacity to key population-focused programmes.

NSP–4	COVERAGE: People who inject drugs reached by NSPs	
a	Number of people who inject drugs who accessed an NSP over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)	
b	$\dfrac{[a]}{\text{Estimated number of people who inject drugs}}$ x 100 =	Percentage of people who inject drugs accessing an NSP over the specified reporting period
c	Number of people who inject drugs who accessed an NSP at least once per month over the specified reporting period (e.g. the last 3, 6 or 12 months)	
d	$\dfrac{[c]}{\text{Estimated number of people who inject drugs}}$ x 100 =	Percentage of people who inject drugs accessing an NSP at least once per month over the specified reporting period
e	Number of NSP occasions of service (total contacts) in the specified reporting period (e.g. the last 1, 3, 6 or 12 months)	
f	$\dfrac{[e]}{\text{Estimated number of people who inject drugs}}$ x 100 =	Ratio of the number of NSP occasions of service for the specified reporting period per 100 people who inject drugs

Data source:
Programme data
Population size estimates

Comments:

These indicators examine utilization of NSPs relative to the estimated population size of people who inject drugs.

NSP–4a and **NSP–4c** require services to have a data collection system using methods such as a *unique identifier code* or the *recall last contact method* to avoid double counting (see page 15).

People who inject drugs regularly require an ongoing supply of injecting equipment and, therefore, continual access to NSPs. If the quantity of injecting equipment that a client is able to obtain per visit is limited, it may be necessary to access an NSP more regularly to have a sufficient supply of clean injecting equipment and avoid used needles and syringes. **NSP–4d** provides an indication of "regular reach", for this purpose defined as accessing an NSP once per month.

A 1-month reporting period for **NSP–4a** can be used as a proxy for recent or current coverage.

NSP–4e counts the total number of NSP client service events or occasions of service and does not require the use of a unique identifier code. This includes every visit to an NSP service in which needles–syringes were dispensed. Multiple visits by the same client are included in this count.

See page 15 for further information on this type of coverage indicator.

NSP–4 *continued*	**COVERAGE: People who inject drugs reached by NSPs**

Setting targets:

Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up NSPs to increase reach both in absolute terms (**NSP–4a, NSP–4c, NSP–4e**) and relative to estimated key population size (**NSP–4b, NSP–4d, NSP–4f**).

The following indicative target can be used as a benchmark against which a country's own targets for **NSP–3d** (*Percentage of people who inject drugs accessing an NSP at least once per month over 12 months*) can be compared:

Possible targets:
Low ← 20 ← Mid → 60 → High

The high target level is based on a retrospective analysis of the coverage among people who inject drugs in an urban setting in a high income country *(23)*.

Target levels for **NSP–4b** should be set higher as this does not measure regular reach, but rather access at any point over the reporting period. Target levels for **NSP–4f** should also be set higher as this indictor includes double counting of individuals who access on multiple occasions.

Time frames and targets set should be based on an assessment of the logistical issues and the resources required to roll-out NSP capacity to key population-focused programmes.

NSP–5	**COVERAGE: People who inject drugs reporting they have received sterile injecting equipment**
a	Percentage in sample from key population who inject drugs and who answer "yes" to the question: *"In the last [X months], have you been given clean needles or syringes? (e.g. by an outreach worker or through a needle and syringe program.)"*

Data source:

Behavioural survey

Comments:

The time period for this indicator can vary; for example, the question could be asked about receiving sterile injecting equipment in the last 1, 3, 6 or 12 months.

Depending on the nature of the sample investigated, the number of people from key populations who report injecting drugs may be quite small relative the rest of the sample.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:

The results of an initial survey can be used to set a baseline for this indicator. Countries can then set a target and a time frame for its achievement.

NSP–6	QUALITY: NSP-related policy and practice checklist
Do current national guidelines and policy include the following stipulations which maximize the impact of needle and syringe distribution through NSPs?	
a	**National guidelines stipulate that there be no limit on the quantity of injecting equipment provided by NSPs.** This distribution policy seeks to maximize the quantity of injecting equipment dispensed (i.e. there is no rationing of equipment provided).
b	**National guidelines stipulate that the return of used injecting equipment is not a prerequisite for clients to receive new injecting equipment.** While returning used injecting equipment should not be a prerequisite for receiving new injecting equipment, people who inject drugs should be encouraged and helped to dispose of injecting equipment safely.
c	**National guidance stipulates that NSPs provide a range of injecting equipment that is appropriate for local injecting practices and substances injected and that is acceptable to the target population.** Needles and syringes provided should be suited to the local drug market and context and acceptable to clients. People who inject drugs should be consulted to determine the most appropriate and acceptable equipment for distribution. Ideally, the smallest gauge needles should be provided in order to cause minimal tissue damage at the site of injection. Larger gauge needles may be required for the injection of some drugs, including those that are more viscous in solution and in some instances where drugs may be of poor quality. Syringes should be of appropriate volume (larger for substances that are injected in greater volumes, such as methadone, which may require dilution). Needles and syringes should have minimal dead-space, as larger syringe dead-space may retain greater quantity of infective particles, thus increasing risk of infection on reuse *(24, 25)*. Other related materials should also be provided where appropriate, including sterile water, safe sharps disposal containers, filters, mixing vessels (e.g. spoons), disposable tourniquets, acidifiers (e.g. ascorbic or citric acid powders) and materials to encourage non-injecting routes of administration as a safer alternative to injecting, such as sterile pipes, papers or foil.

Data source:
Desk review and stakeholder consultation

Comments:
The items listed in the checklist above can be used as a guide when conducting an audit of current legislation and policy to identify laws and policies that might either support or negatively affect the rights, health or welfare of men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers or transgender people.

Where policies and guidelines are found to be in need of reform, processes for change should be identified and evaluated.

Setting targets:
Aligning polices and guidelines with recommended practice should be the intended aim. Countries should set out a realistic but ambitious time frame for change and monitor progress toward these goals.

Opioid substitution therapy

OST–1	AVAILABILITY: Sites providing maintenance opioid substitution therapy (OST)
a	Number of sites where maintenance OST is prescribed and/or dispensed
b	Number of sites where maintenance OST is prescribed or dispensed that **meet key population sensitization standards**
c	$\dfrac{[b]}{[a]}$ x 100 = Percentage of **maintenance OST sites meeting key population sensitization standards**

Data source:
Facility-based assessment/programme data

Comments:
The definition of a "site" should be documented.

The number of sites where OST is provided (**OST–1a**) is an important indicator for monitoring OST scale-up. Sites where OST is prescribed may include: specialist services, general practitioner prescribers/office-based and other primary care settings. Sites where OST is dispensed may include: pharmacies, specialist services, mobile dispensing services.

This indicator can be disaggregated by the opioid agonist prescribed, including: methadone; buprenorphine; diamorphine (pharmaceutical heroin); slow-release morphine preparations; tincture of opium.

To a certain extent OST sites are, by definition, key population-focused services in so far as their primary intention is to provide drug treatment to people who use drugs and who are opioid dependent.

As noted, people who use drugs include men who have sex with men, people in prisons and other closed settings, sex workers, and transgender people. As such, it is important that OST services are accessible to people from these other key populations and sensitized to meet their needs.

See page 11 for further information on availability indicators of this type.

Setting targets:
People from key populations should be able to access OST without fear of facing stigma or discrimination. Ideally, all mainstream services should meet key population sensitization standards. Accordingly, in many countries a target of 100% may be appropriate for indicators **OST–1c**.

Countries should set an ambitious but realistic time frame for scaling up OST and ensuring that services are accessible to key populations. Targets and time frames set should be based on an assessment of the logistical issues and the resources required to roll-out OST and key population sensitization training.

OST–2	AVAILABILITY: OST programme capacity
a	Number of people on a waiting list for OST on specified date

Data source:
Programme data

Comments:
In some countries OST programmes may have a fixed number of OST treatment places or slots.

This indicator provides a measure of the extent to which demand for OST is matched by the capacity of the programme.

Setting targets:
Countries should aim for OST capacity to meet demand, and as such, the number of people waiting for OST, as well as the duration of the waiting time, should be minimized.

OST–3	COVERAGE: Individuals receiving maintenance OST
a	Number of all individuals on OST at a specified date
b	$\dfrac{[a]}{\text{Estimated number of opioid-dependent people}} \times 100 =$ Percentage of opioid-dependent people on OST
c	Number of all individuals on OST at a specified date
d	$\dfrac{[c]}{\text{Estimated number of opioid-dependent people}} \times 100 =$ Percentage of opioid-dependent people who use drugs receiving OST

Data source:
Programme data
Population size estimates

Comments:
These indicators examine the coverage of OST assessed at a specific census date.

It is important to recognize that not all people who inject drugs are dependent upon opioids and want or need OST, and not all people receiving OST will be injecting drug users. Accordingly, it is important to ensure that the numerators and denominators of indicators measuring OST coverage match. That is, if the numerator is the number of all individuals on OST (**OST–3a**) the denominator should be all opioid-dependent people (including people who inject and those who do not) (**OST–3b**). Similarly, to estimate the coverage of OST among people who use drugs (**OST–3d**), the numerator needs to count only those on OST who inject drugs and the denominator the number of people who inject drugs who are opioid dependent.

See page 15 for further information on this type of coverage indicator.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up OST to increase reach both in absolute terms (**OST–3a, OST–3c**) and relative to estimated population size (**OST–3b, OST–3d**).

The following indicative target can be used as a benchmark against which a country's own targets for **OST–3b** and **OST–3d** can be compared:

Possible targets:
Low ← 20 ← Mid → 40 → High

The high target level is based on levels of coverage achieved in countries with well-established OST programmes.

Time frames and targets set should be based on an assessment of the logistical issues and the resources required to roll-out OST capacity to key population-focused programmes.

OST–4	QUALITY: OST-related policy and practice checklist
Do current national guidelines and policy fulfil the following?	
a	**National OST guidelines are developed at the country level or lower.** These guidelines are detailed, comprehensive and evidence-based, reflect local laws, policies and conditions, and are consistent with international guidance. See *Guidelines for psychosocially-assisted pharmacotherapy for the management of opioid dependence*, WHO, 2009. http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf These should include clear guidance on: • patient assessment • gaining informed consent for treatment • dosing and duration of treatment • provision of psychosocial support • dispensing protocols • patient review and follow-up • provision of OST for pregnant women
b	**National policy requires OST prescribers to receive accredited training and to be registered.** OST prescribers are required to take accredited post-graduate training in OST, participate in continuing education, monitoring and evaluation, and be registered to prescribe OST. Prescribers are respectful towards people who inject drugs, have credibility with the target population and are non-judgemental in their attitudes towards drug users.
c	**National policy includes provision to ensure that OST is affordable, so as to maximize access.** The cost of OST can be a significant barrier to treatment access for many opioid-dependent people. To increase accessibility, OST may be offered free of charge (this would be the best practice but likely not possible in the majority of resource-limited settings); the costs covered by health insurance provisions; or the costs to patients partly subsidized or at reduced cost especially for financially disadvantaged patients.

Data source:
Desk review and stakeholder consultation

Comments:
The items listed in the checklist above can be used when conducting an audit of current policy and guidance. If these are found to be in need of reform, processes for change should be identified and evaluated.

Setting targets:
Aligning polices and guidelines with recommended practice should be the intended aim. Countries should set out a realistic but ambitious time frame for change and monitor progress toward these goals.

OST–5	QUALITY: Individuals receiving maintenance OST continuously for at least 6 months
a	Number of people starting OST during time period defined as the cohort recruitment period
b	Number of people in the cohort still in treatment 6 months after starting OST
c	$\dfrac{[b]}{[a]}$ x 100 = Percentage of individuals receiving OST who received treatment for at least 6 months

Data source:
Programme data

Comments:
This indicator examines the retention of patients in OST for a minimum period of 6 months; evidence demonstrates that maximum benefit from OST is gained when treatment lasts at least 6 months *(1)*. Hence, this indicator can be understood as a measure both of how OST is prescribed and of patient retention.

This indicator makes use of OST register data, using a cohort study-type approach. This approach is similar to that used to monitor ART retention and survival and has been piloted in the monitoring of programmes funded by the Global Fund. OST register data can be used to determine the number of people starting OST in the defined period, as a cohort, and the number of those who are still in treatment 6 months after starting OST.

Setting targets:
Baseline levels should first be measured. Countries should then set ambitious but realistic targets aiming to maximize the percentage of people maintained on OST for the minimum period demonstrated to provide benefit.

The following indicative target can be used as a benchmark against which a country's own targets for **OST–5c** can be compared:

Possible targets:
Low ← 60 ← Mid → 80 → High

OST–6	QUALITY: Individuals receiving maintenance dose of OST greater than or equal to the recommended minimum dose
a	Number of people, at a specified date, maintained on methadone receiving a dose ≥60 mg or currently maintained on buprenorphine receiving a dose of ≥12 mg
b	Number of people receiving maintenance dose of methadone or buprenorphine at a specified date
c	$\dfrac{[a]}{[b]}$ x 100 = Percentage of patients receiving maintenance dose of OST greater than or equal to the recommended minimum dose

Data source:
Programme data

Comments:
OST register data can be used if these registers record patients' OST dose received. Alternatively, service-level data can be used. If service-level data collection systems do not include patient dose, then an audit of patient charts (medical records) can be undertaken; this could be limited to a random sample of patient records or could be a review of all patients, if resources allow.

This indicator does not include those patients currently being inducted on OST and who are yet to reach the maintenance dose, nor does it include those patients on reducing doses of OST.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets aiming to maximize the percentage of people receiving the recommended minimum maintenance dose.

The following indicative target can be used as a benchmark against which a country's own targets for **OST–6c** can be compared:

Possible targets:
Low ← 60 ← Mid → 90 → High

OST–7	QUALITY: Individuals on maintenance OST receiving psychosocial support
a	Number of OST patients who have received psychosocial support in the last 12 months
b	Number of patients receiving OST in the last 12 months
c	$\dfrac{[a]}{[b]}$ x 100 = Percentage of OST patients receiving psychosocial support

Data source:
Programme data

Comments:
Psychosocial support may include, as a minimum:
• assessment of psychosocial needs
• supportive counselling
• links to existing family and community services.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets aiming to maximize the percentage of people on maintenance OST receiving a minimum package of psychosocial support.

The following indicative target can be used as a benchmark against which a country's own targets for **OST–7c** can be compared:

Possible targets:
Low ← 50 ← Mid → 80 → High

Overdose prevention and management

ODM–1	AVAILABILITY: Sites providing community-based distribution of naloxone
a	Number of sites where naloxone is dispensed to lay providers (including people who use opioids, their peers and family members) for management of opioid overdose

Data source:
Facility-based assessment/programme data

Comments:
The definition of a "site" should be documented.

The number of sites where naloxone is dispensed is an important indicator for monitoring the scale-up of community-based distribution.

See page 11 for further information on availability indicators of this type.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up community-based distribution of naloxone for overdose management. In principle NSP and OST sites will be well placed to provide community-based naloxone distribution.

ODM–2	COVERAGE: Quantity of naloxone distributed
a	Number of naloxone doses/kits dispensed through community-based distribution programmes over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data

Comments:
This indicator looks at the total quantity of naloxone doses or kits for the management of opioid overdose distributed to people who use opioids, their peers and family members.

See page 11 for further information on availability indicators of this type.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up community-based distribution of naloxone for overdose management.

Reducing harms related to injecting substances for gender affirmation

GDR–1	AVAILABILITY: Number of sites providing equipment for safe injecting of substances for gender affirmation
a	Number of sites where programmes serving transgender people provide equipment for safe injecting of substances for gender affirmation

Data source:
Facility-based assessment/programme data

Comments:
This indicator is specific to transgender people. It may not be relevant to all transgender people, however, as not all inject substances for gender affirmation.

The definition of a "site" should be documented. Sites might include fixed-site services and locations where outreach and mobile services operate and provide equipment for safe injecting of substances for gender affirmation.

See page 11 for further information on availability indicators of this type.

Setting targets:
Many sites where services are provided to transgender people may be appropriate distribution points for the provision of equipment for safe injecting of substances for gender affirmation. NSPs that provide equipment for drug injecting should also have equipment appropriate for safe injecting of substances for gender affirmation and these sites should be sensitized to the needs of transgender clients.

When setting targets for this indicator, it is necessary to determine which sites not currently providing such equipment might have the potential to become a provision site.

Countries should then set an ambitious but realistic time frame for scaling up the provision of safe injecting equipment accessible to transgender people to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required.

Behavioural interventions

BHV–1	AVAILABILITY: Sites providing behavioural interventions for sexual risk reduction
a	Number of sites where **key population-focused programmes** provide behavioural interventions for sexual risk reduction
b	Total number of sites where **key population-focused programmes** are offered
c	$\dfrac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** where behavioural interventions for sexual risk reduction are provided

Data source:
Facility-based assessment/programme data

Comments:
The "site" definitions used should be documented.

See page 11 for further information on this type of indicator.

Setting targets:
When scaling up services for key populations, it is useful to track the total number of sites providing behavioural interventions for sexual risk reduction (**BHV–1a**). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 11 for further discussion).

Not every site where key population-focused programmes operate will necessarily be appropriate for offering behavioural interventions for sexual risk reduction. For example, certain structured behavioural interventions that involve multiple, regular sessions may be difficult to provide through outreach. When setting targets for **BHV–1c**, it is necessary to determine which sites where sexual health services are not currently offered have the potential to provide this intervention.

Countries should set out an ambitious but realistic time frame for scaling up behavioural interventions to reach the target. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out training to service providers.

BHV–2	AVAILABILITY: Sites providing brief intervention counselling for problematic substance use
a	Number of sites where **key population-focused programmes provide** "brief intervention counselling" for problematic drug and alcohol use
b	Total number of sites where **key population-focused programmes** are offered
c	$\dfrac{[a]}{[b]}$ x 100 = Percentage of **key population-focused programme sites** where "brief intervention counselling" for problematic drug and alcohol use is provided

Data source:
Facility-based assessment/programme data

Comments:
Brief intervention counselling is a type of evidence-based motivational counselling technique and is used extensively in addressing problematic substance use. It can be delivered in non-specialized settings (i.e. those that are not specialized drug treatment services).

The "site" definitions used should be documented. See page 11 for further information on this type of indicator.

Setting targets:
When scaling up services for key populations, it is useful to track the number of sites providing brief intervention counselling for problematic drug and alcohol use to people from key populations (**BHV–2a**). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 11 for further discussion).

In many settings, if workers are appropriately trained, sites where services are provided to key populations are likely to be appropriate locations for brief intervention counselling for problematic drug and alcohol use.

When setting targets for **BHV–2c** it is necessary to determine which sites where counselling for problematic drug and alcohol use is not currently offered have the potential to provide this intervention.

Countries should then set out an ambitious but realistic time frame for scaling up brief intervention counselling for problematic drug and alcohol use to reach the set target. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out training in brief intervention counselling.

Pre-exposure prophylaxis (PrEP)

PRP–1	AVAILABILITY: Oral pre-exposure prophylaxis (PrEP) for HIV prevention is available for men who have sex with men
a	Is oral PrEP for HIV prevention available for men who have sex with men?

Data source:
Desk review, stakeholder consultation or facility-based assessment

Comments:
This indicator examines whether ART is currently approved for use as oral PrEP for HIV prevention and is offered to men who have sex with men, in line with WHO recommendations *(1)*.

PRP–2	COVERAGE: Men who have sex with men receiving oral pre-exposure prophylaxis (PrEP) for HIV prevention
a	Number of men who have sex with men prescribed oral PrEP during the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data

Comments:
This indicator looks at the total number of men who have sex with men who are prescribed oral pre-exposure prophylaxis and is an important indicator to track the uptake of PrEP.

Sites where PrEP is provided will need to be identified in order to collect relevant programmatic data.

See page 11 for further information on availability indicators of this type.

Setting targets:
Baseline levels should first be measured.

Countries should then set ambitious but realistic targets and time frames for scaling up PrEP for men who have sex with men.

HIV testing and counselling

See also *Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes: field-test version*, 2011, WHO *(26)*.

HTC–1	AVAILABILITY: Sites providing HIV testing and counselling
a	Number of sites where **key population-focused programmes** provide HTC
b	Number of sites where **mainstream programmes meeting key population sensitization standards** provide HTC
c	Total number of sites where **key population-focused programmes** are offered
d	Total number of sites where **mainstream programmes** provide HTC
e	$\frac{[a]}{[c]} \times 100 =$ Percentage of **key population-focused programme sites** where HTC is provided
f	$\frac{[b]}{[d]} \times 100 =$ Percentage of **mainstream programme sites** where HTC is provided that meet key population sensitization standards
g	$\frac{[a]+[b]}{[a]+[d]} \times 100 =$ Percentage of all **sites where HTC is provided** that are either key population-focused programmes or mainstream programmes meeting key population sensitization standards

Data source:
Facility-based assessment/programme data

Comments:
The "site" definitions used should be documented. These sites might include fixed-site services where HTC is available or locations where outreach and mobile services operate and provide HTC. All sites included here should meet national service quality standards for HTC.

See page 11 for further information on this type of indicator.

Setting targets:
When scaling up HTC for key populations, it is useful to track the total number of sites providing HTC to people from key populations (i.e. key population-focused services (**HTC–1a**) and mainstream services meeting key population sensitization standards (**HTC–1b**)). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 11 for further discussion).

In all contexts the provision of HTC must meet minimum standards *(26, 27)*. Not every site where key population-focused programmes operate will be appropriate for offering HTC, but many will be. When setting targets for indicator **HTC–1e**, it is necessary to determine which sites where HIV testing and counselling is not currently offered have the potential to provide this intervention.

People from key populations should be able to access mainstream services that provide HTC without fear of facing stigma or discrimination. Ideally, all mainstream services should meet key population sensitization standards. Accordingly, in many countries targets of 100% may be appropriate for indicators **HTC–1f** and **HTC–1g**. While voluntary HTC should be available in prisons and other closed settings, HIV testing should *never* be mandatory in these or any other setting *(28)*.

Countries should then set out an ambitious but realistic time frame for scaling up testing and counselling to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out HIV testing and counselling to key population-focused programmes and key population sensitization training and procedures to mainstream services.

HTC–2	AVAILABILITY: Key population reporting HIV testing and counselling is readily accessible
Percentage in sample of key population who answer "yes" to both these questions:	
a	*"Do you know where you can go if you wish to receive an HIV test?"*
b	*"Would you be comfortable with using this service if you wanted to be tested for HIV?"*

Data source:
Behavioural survey

Comments:
HTC–2a is included in the GAPR 2014 (Indicator 1.11). It provides some indication of the potential accessibility of HTC to people from key populations. **HTC–2b** provides additional and valuable information on the acceptability of the service to people from key populations, which directly affects accessibility.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
Results of an initial survey can be used to set a baseline for these indicators. Countries can set targets for increases over baseline levels and a time frame for their achievement.

HTC–3	COVERAGE: Key population reporting they have received HIV test and results
a	Percentage in sample of key population who answer "yes" to both the following questions: *"Have you been tested for HIV in the last [X months]?"* *"I don't want to know the results, but did you receive the results of that test?"*

Data source:
Behavioural survey

Comments:
The time period for this indicator can vary; for example, the question could be asked about being tested for HIV in the last 1, 3, 6 or 12 months.

This indicator is included in the GARPR 2014 guidelines on core indictors with survey participants asked to report on HIV testing in the last 12 months.

Individuals diagnosed HIV-positive prior to the specified reporting period will (almost certainly) not have been tested again within that time period. Accordingly, it is desirable, when reporting on this indicator, to exclude people who were aware that they were HIV-positive prior to the specified reporting period. There are a number of ways that this can be done. For example:
- If a respondent answers "no" to the question, "Have you been tested for HIV in the last [X months]?", the survey can ask, "Was this because you already knew you were living with HIV?" All those answering "yes" to this follow-up question can be excluded from the denominator for this indicator.
- The question can be asked "If you believe your HIV status to be negative or you don't know, have you tested in the past [X months]?"
- Or a skip pattern in the questionnaire can be formulated for those who report they are HIV positive, in which case only respondents who report they are HIV negative or that they don't know their HIV status will be asked whether or not they were tested in the past [X months].

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for this indicator. Countries can then set targets and a time frame for their achievement.

In 2014, UNAIDS launched ambitious new targets for the scale-up of antiretroviral treatment, the so-called *90:90:90 targets*. This includes the target: *By 2020, 90% of all people living with HIV will know their HIV status (29)*. If the indicator **HTC–3** is included in an integrated bio-behavioural survey, it can provide insight into the achievement of this goal among key populations.

HTC–4	**QUALITY: Percentage of key population reporting they received results following HIV testing**
a	Number of people in sample of key population who answer "yes" to both questions: *"Have you been tested for HIV in the last [X months]?"* *"I don't want to know the results, but did you receive the results of that test?"*
b	Number of people from key population in sample who answer "yes" to the question: *"Have you been tested for HIV in the last [X months]?"*
c	$\dfrac{[a]}{[b]} \times 100 =$ Percentage of key population tested for HIV in the last [X months] who report having received the results of that test

Data source:
Behavioural survey

Comments:
The time period for this indicator can vary; for example, the question could be asked about being tested for HIV in the last 1, 3, 6 or 12 months.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
Efforts should be made to ensure that people who are tested for HIV receive their results. Accordingly, the target for indicator **HTC–4c** can be set at 100%. The results of an initial survey can be used to set a baseline for these indicators. Countries should then set out an ambitious but realistic time frame for increasing the proportion of tests for which the results are provided.

HIV treatment and care, including antiretroviral therapy

ART–1	AVAILABILITY: Sites providing antiretroviral therapy (ART)
a	Number of sites where **key population-focused programmes** provide ART
b	Number of sites where **mainstream programmes meeting key population sensitization standards** provide ART (including services for the prevention of mother to child transmission(PMTCT))
c	Total number of sites where **key population-focused programmes** are offered
d	Total number of sites where **mainstream programmes** provide ART
e	$\dfrac{[a]}{[c]}$ x 100 = Percentage of **key population-focused programme sites** where ART is provided
f	$\dfrac{[b]}{[d]}$ x 100 = Percentage of **mainstream programme sites** where ART is provided that meet key population sensitization standards
g	$\dfrac{[a]+[b]}{[a]+[d]}$ x 100 = Percentage of all **sites where ART is provided** that are either key population-focused programmes or mainstream programmes meeting key population sensitization standards

Data source:
Facility-based assessment/programme data

Comments:
The "site" definitions used should be documented.

See page 11 for further information on this type of indicator.

Setting targets:
When scaling up services for key populations, it is useful to track the total number of sites providing ART to people from key populations (i.e. key population-focused services (**ART–1a**) and mainstream services meeting key population sensitization standards (**ART–1b**)). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 13 for further discussion).

In all contexts the provision of ART must meet minimum standards *(30)*. Not every site where key population-focused programmes operate will be appropriate for providing ART, but some may be. When setting targets for indicator **ART–1e**, it is necessary to determine which sites where ART is not currently offered have the potential to provide this intervention.

People from key populations should be able to access mainstream services that provide ART without fear of facing stigma or discrimination and to be able to receive care from health-care workers who have the clinical knowledge to meet their specific needs. Ideally, all of these mainstream services should meet key population sensitization standards. Accordingly, in many countries a target of 100% may be appropriate for indicators **ART–1f** and **ART–1g**.

Countries should then set out an ambitious but realistic time frame for scaling up ART to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out ART provision to appropriate key population-focused programmes and key population sensitization training and procedures to mainstream services that offer ART.

ART–2	COVERAGE: Key population living with HIV reporting they currently receive ART
a	Number of people from key population in sample who answer "yes" to the question: *"Are you currently receiving treatment for HIV?"*
b	Number in sample of key population who test positive for HIV
c	$\dfrac{[a]}{[b]}$ x 100 = Percentage of key population testing positive for HIV who report currently receiving treatment

Data source:
Integrated bio-behavioural survey

Comments:
Not all those living with HIV will meet eligibility criteria for ART. See page 9 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for this indicator. Countries can then set a target and a time frame for its achievement.

In 2014 UNAIDS launched *Fast-Track Targets* to mobilize global efforts and resources in order "to end the AIDS epidemic by 2030". These targets include: by 2020, 90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving treatment and 90% of people on HIV treatment having a supressed viral load, and by 2030 increasing each of these targets to 95%, respectively *(15)*. **ART–3** can provide insight into the achievement of this goal among key populations.

Prevention and management of co-infections and other co-morbidities

CMB–1	AVAILABILITY: Sites providing TB prevention, screening and management
a	Number of sites where **key population-focused programmes** provide TB infection control
b	Number of sites where **key population-focused programmes** provide TB preventive therapy
c	Number of sites where **key population-focused programmes** provide TB screening for people from key populations living with HIV
d	Number of sites where **key population-focused programmes** provide TB management
e	Total number of sites where **key population-focused programmes** are offered
f	$\frac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** where TB infection control is provided
g	$\frac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** where TB preventive therapy is provided
h	$\frac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** where TB screening for people from key populations living with HIV is provided
i	$\frac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** where TB management is provided

Data source:
Facility-based assessment/programme data

Comments:
The "site" definitions used should be documented. Sites might include fixed-site services and locations where outreach and mobile services operate and provide these TB-related interventions.

See page 11 for further information on this type of indicator.

Setting targets:
When scaling up TB programmes for key populations, it is useful to track the total number of sites providing each of these TB-related interventions to people from key populations (**CMB–2a, b, c** and **d**). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 11 for further discussion).

Not every site where key population-focused programmes operate will be appropriate for offering these TB-related interventions, but many will be. When setting targets for indicators **CMB–2f, g, h** and **i**, it is necessary to determine which sites that currently do not offer TB interventions have the potential to do so.

Countries should then set an ambitious but realistic time frame for scaling up TB interventions to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out TB interventions to key population-focused programmes.

CMB–2	AVAILABILITY: Sites providing HBV vaccination
a	Number of sites where **key population-focused programmes** provide HBV vaccination
b	Total number of sites where **key population-focused programmes** are offered
c	$\dfrac{[a]}{[b]}$ x 100 = Percentage of **key population-focused programme sites** where HBV vaccination is provided

Data source:
Facility-based assessment/programme data

Comments:
The "site" definitions used should be documented. Sites might include fixed-site services and locations where outreach and mobile services operate and provide HBV vaccination.

See page 11 for further information on this type of indicator.

Setting targets:
When scaling up HBV vaccination for key populations, it is useful to track the total number of sites providing HBV vaccination to people from key populations (**CMB–1a**). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 13 for further discussion).

Not every site where key population-focused programmes operate will be appropriate for offering HBV vaccination, but many will be. When setting a target for indicator **CMB–1c**, it is necessary to determine which sites where HBV vaccination is not currently offered have the potential to provide this intervention.

Countries should then set an ambitious but realistic time frame for scaling up HBV vaccination to reach the target. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out HBV vaccination to key population-focused programmes.

CMB–3	COVERAGE: Key population receiving HBV vaccination
a	Number of people from key population provided with HBV vaccination at **key population-focused programmes** over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data

Comments:
If key population-specific data are also available from mainstream programmes, these can also be included in this indicator.

Different time periods may be selected when measuring this indicator.

See page 15 for further information on this type of coverage indicator.

Setting targets:
Baseline levels should first be measured.

Countries should then set an ambitious but realistic target and time frame for scaling up HBV vaccination for people from key populations. The time frame and target should be based on an assessment of the logistical issues and the resources required to roll-out HBV vaccination services to key population-focused programmes.

Sexual and reproductive health

SRH–1	AVAILABILITY: Sites providing sexual and reproductive health services
a	Number of sites where **key population-focused programmes** provide sexual and reproductive health services
b	Number of sites where **mainstream programmes meeting key population sensitization standards** provide sexual and reproductive health services
c	Total number of sites where **key population-focused programmes** are offered
d	Total number of sites where **mainstream programmes** provide sexual and reproductive health services
e	$\frac{[a]}{[c]}$ x 100 = Percentage of **key population-focused programme** sites where sexual and reproductive health services are provided
f	$\frac{[b]}{[d]}$ x 100 = Percentage of **mainstream programme** sites where sexual and reproductive health services are provided that meet key population sensitization standards
g	$\frac{[a]+[b]}{[a]+[d]}$ x 100 = Percentage of **all sites where sexual and reproductive health services are provided** that are either key population-focused programmes or mainstream programmes meeting key population sensitization standards

Data source:
Facility-based assessment/programme data

Comments:
For this indicator, the definition of what constitutes a site providing sexual and reproductive health services should be documented. This documentation should include not only the type of location or method of service delivery (such as fixed sites and sites where mobile services operate) but also the nature of the sexual and reproductive health services provided. These might include screening/diagnostic services, sexual health counselling and treatment, contraceptive counselling, screening and referral for reproductive tract cancer (cervical, ano-rectal, prostatic) and breast cancer, and safe abortion and post-abortion care. Services should meet national standards for the provision of sexual health services.

See page 15 for further information on this type of indicator.

Setting targets:
When scaling up services for key populations, it is useful to track the total number of sites providing sexual and reproductive health services to people from key populations (i.e. key population-focused services (**SRH–1a**) and mainstream services meeting key population sensitization standards (**SRH–1b**)). Countries can set targets for increases in the total number of sites over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 13 for further discussion).

In all contexts the provision of sexual and reproductive health services must meet minimum standards (see page 31). Not every site where key population-focused programmes operate will necessarily be appropriate for offering integrated sexual and reproductive health services, but some will be. When setting targets for indicator **SRH–1e**, it is necessary to determine which sites where sexual and reproductive health services are not currently offered have the potential to provide this intervention.

People from key populations should be able to access mainstream services that provide sexual and reproductive health services without fear of facing stigma or discrimination and to be able to receive care from health-care workers who have the clinical knowledge to meet their specific needs. Ideally, all mainstream sexual and reproductive health services should meet key population sensitization standards. Accordingly, in many countries targets of 100% may be appropriate for indicators **SRH–1f** and **SRH–1g**.

Countries should then set out ambitious but realistic time frames for scaling up sexual and reproductive health services to reach these targets. These time frames should be based on an assessment of the logistical issues and the resources required to roll-out sexual health services to key population-focused programmes and key population sensitization training and procedures to mainstream services that provide sexual and reproductive health services.

SRH–2	AVAILABILITY: Key population reporting sexual health services are accessible
Percentage in sample of key population who answer "yes" to both these questions:	
a	*"Do you know where you can go for a STI/sexual health check-up?"*
b	*"Would you be comfortable using this service if you wanted to have an STI/sexual health check-up?"*

Data source:
Behavioural survey

Comments:
SRH–2a provides some indication of the accessibility of STI/sexual health services to people from key populations.

SRH–2b gives some indication of the acceptability of the service to people from the key population, which directly affects accessibility.

See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for this indicator.

Countries can set targets for increases against baseline levels and a time frame for their achievement.

SRH–3	COVERAGE: Key population attending sexual health services
a	Number of people from key population attending sexual health services at **key population-focused programmes** over the specified reporting period (e.g. the last 1, 3, 6 or 12 months)

Data source:
Programme data

Comments:
If key population-specific data are also available from mainstream programmes, these can also be included in this indicator.

Different time periods may be selected when measuring this indicator.

See page 15 for further information on this type of coverage indicator.

Setting targets:
The baseline level should first be measured.

Countries should then set an ambitious but realistic target and a time frame for scaling up sexual health services for people from key populations to increase the number of people from key populations receiving sexual health consultations.

The time frame and target should be based on an assessment of the logistical issues and the resources required to roll-out sexual health services to key population-focused programmes.

SRH–4	COVERAGE: Key population reporting they have been tested for STIs
a	Percentage in sample of key population who answer "yes" to the question: *"Have you been tested for STIs in the last 12 months?"*

Data source:
Behavioural survey

Comments:
See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for this indicator. Countries can then set a target and a time frame for its achievement.

Combined package of interventions

PKG–1	AVAILABILITY: Sites providing defined package of health sector interventions
a	Number of sites where **key population-focused programmes** provide a defined subset of interventions from the evidence-based package
b	Total number of sites where **key population-focused programmes** are offered
c	$\frac{[a]}{[b]} \times 100 =$ Percentage of **key population-focused programme sites** providing a defined subset of interventions from the evidence-based package

Data source:
Facility-based assessment/programme data

Comments:
This indicator attempts to measure the extent to which multiple interventions are provided at the same location in an integrated model of service delivery. For most countries, it would be unusual for a single site to provide all the interventions in the evidence-based package. It is more useful, for the purpose of this indicator, to select a subset of these interventions and identify sites where they are all present. This subset could include some or all of these interventions:

• legal support to people from key populations
• appropriate medical, psychological and legal support for those who have experienced violence
• distribution of condoms and compatible lubricant
• behavioural interventions for sexual risk reduction
• brief intervention counselling for problematic drug and alcohol use
• HIV testing and counselling
• sexual and reproductive health services
• HIV treatment
• needle and syringe distribution
• opioid substitution therapy
• hepatitis B vaccination.

The selection of interventions to be included in this subset could be based on various rationales such as data availability or the priority of specific interventions in a particular context. The interventions included must be clearly indicated when reporting this indicator.

"Site" definitions used should also be documented. Sites might include fixed-site services and locations where outreach and mobile services operate.

See page 15 for further information on this type of indicator.

Setting targets:
When scaling up interventions for key populations, it is useful to track the total number of key population-focused sites providing multiple or combined interventions to people from key populations (**PKG–1a**). Countries can set targets for increases in the total number of sites providing combined interventions over a specific time period. An increase in the total number of sites does not necessarily correlate with increased accessibility, however (see page 11 for further discussion).

As noted in preceding indicators on the availability of each intervention, not every site where key population-focused programmes operate will be appropriate for providing all the interventions included in the evidence-based package or even a particular subset of interventions.

Countries should set an ambitious but realistic target and time frame for scaling up more programmes to provide combined interventions so as to reach these targets. This time frame should be based on an assessment of the logistical issues and the resources required to roll-out additional interventions to key population-focused programmes.

PKG–2	COVERAGE: Key population reporting they have received a combined set of health sector interventions
	Percentage in sample of key population who answer "yes" to *all* of the following questions (including [f] if sample of people who use drugs):
a	*"In the last [X months], have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic.)"* [**CCP–5a**]
b	*"In the last [X months], have you been given sachets (or other containers) of lubricant? (e.g. through an outreach service, drop-in centre or sexual health clinic.)"* [**CCP–5b**]
c	*"In the last [X months], have you received information on condom use and safe sex? (e.g. through an outreach service, drop-in centre or sexual health clinic.)"*
d	*"Have you been tested for HIV in the last [X months]?"* [**HTC–2a**] *"I don't want to know the results, but did you receive the results of that test?"* [**HTC–2b**]
e	*"Have you been tested for STIs in the last [X months]?"* [**SRH–4a**]
f	*"In the last [X months], have you been given clean needles or syringes? (e.g. by an outreach worker or through a needle and syringe program.)"* [**NSP–5a**]

Data source:
Behavioural survey

Comments:
This indicator gives a sense of how many within the key population have received multiple health sector interventions within the specified time periods.

At the programme or service provider level, it may be possible to report, using programmatic data, on the number of people who have received all components of this set of health sector interventions. (The Global Fund recommends reporting such indicators on the programmes it funds *(31)*). This may be difficult at the national level, however, as it requires all service sites to use a common unique identifier system and for data to be disaggregated by key population group. As discussed on pages 15 and 17, when multiple service providers offer interventions, including some which might not be specific to a key population, comparable data will not typically be available. For this reason, in many settings the percentage of a key population receiving a combined set of health sector interventions may be more readily estimated through behavioural surveys than from programme data. See page 17 for further information on gathering data from behavioural surveys.

Setting targets:
The results of an initial survey can be used to set a baseline for this indicator. Countries can then set a target and a time frame for its achievement.

Outcome and impact indicators

O–1	Infection incidence among key population
a	Estimated incidence of **HIV** among key population
b	Estimated incidence of hepatitis C among key population
c	Incidence of **STIs** among key population, including: • *Neisseria gonorrhoea* • *Chlamydia trachomatis* • syphilis • hepatitis B

Data source:
Notification from sentinel sites
Registries
Longitudinal cohort studies
Prevalence among young members of key population
Projection modelling
Recent infection testing algorithms (RITA) for HIV

Comments:
Changes in incidence can be an indication of the impact of prevention efforts, but are difficult to measure directly.

See page 20 for further information on how to measure and interpret estimates of incidence.

Setting targets:
When setting national targets for reductions in new HIV infections, countries should consider relevant global targets and commitments. The 2011 Political Declaration on HIV/AIDS included the commitment by Member States to reduce sexual transmission of HIV by 50% and to halve the transmission of HIV among people who inject drugs by 2015 *(14)*. In 2014, UNAIDS launched *Fast-Track Targets* to mobilize global efforts and resources in order "to end the AIDS epidemic by 2030", including: reducing the number of new HIV infections among adults in low and middle income countries to 500,000 per year by 2020, and to 200,000 per year by 2030 *(15)*.

O–2	Incidence of AIDS-related mortality
a	Number of AIDS-related deaths among key population in the past 12 months

Data source:
Projection modelling
ART registries and death registries (linked data facilities)
Longitudinal cohort studies

Comments:
Available data may have significant limitations. National mortality data are unlikely to include information on the key population. This indicator may be more easily reported if there is data linkage between HIV/AIDS registries and mortality records; in many countries, however, that will be unlikely.

If cohorts of the key population are followed, data from these studies may also be useful, but representativeness and potential bias need to be considered.

O–3	Infection prevalence among key population
a	Prevalence of **HIV** among key population
b	Prevalence of **STIs** among key population
c	Prevalence of **HCV** among key population

Data source:
Integrated bio-behavioural surveys

Comments:
Limitations of sampling strategies used, associated bias and likely representativeness of the sample should be considered when interpreting results.

Serial measurements of prevalence over time should be interpreted with caution; see page 21 for further information. Prevalence data may be used in mathematical models to project incidence.

O–4	Prevalence of risk behaviours and knowledge around HIV
a	Percentage of sex workers in sample who report using a condom with their *most* recent client
b	Percentage of sex workers in sample who report *always* using a condom with all sex work clients during the past 1 month
c	Percentage of sex workers in sample who report using a condom *during last sex* with non-commercial partner
d	Percentage of sex workers in sample who report *always* using a condom with all non-commercial partners during the past 6 months
e	Percentage of men who have sex with men in sample who report using a condom the *last time* they had anal sex
f	Percentage of men who have sex with men in sample who report *always* using a condom with all anal sex partners in the past 6 months
g	Percentage of transgender people in sample who report using a condom the *last time* they had anal or vaginal sex
h	Percentage of transgender people in sample who report *always* using a condom with all anal or vaginal sex partners in the past 6 months
i	Percentage of people who inject drugs in sample who report using a condom the *last time* they had anal or vaginal sex
j	Percentage of people who inject drugs in sample who report *always* using a condom with all anal or vaginal sex partners in the past 6 months
k	Percentage of people in prisons or other closed settings in sample who report using a condom the *last time* they had anal or vaginal sex
l	Percentage of people in prisons or other closed settings in sample who report *always* using a condom with all anal or vaginal sex partners in the past 6 months
m	Percentage of key population in sample who inject drugs and who report using sterile injecting equipment the *last time* they injected drugs
n	Percentage of key population in sample who inject drugs who report *always* using sterile injecting equipment every time they injected drugs in the past 6 months
o	Percentage of key population in sample able to correctly identify ways to prevent HIV and who reject common misconceptions

Data source:
Behavioural surveys

Comments:
Limitations of sampling strategies used, associated bias and likely representativeness of the sample should be considered when interpreting results.

O–5	Stigma and discrimination experienced by key population
a	Percentage of sample from key population reporting stigma and discrimination

Data source:
Behavioural survey including relevant items from the *People Living with HIV Stigma Index*

Comments:
The People Living with HIV Stigma Index includes items relevant to members of key populations, including those who are HIV-negative. The International Planned Parenthood Federation (www.ippf.org) can provide guidance to countries wishing to implement the Index and can provide access to the questionnaire.

O–6	Attitudes towards key population held by service providers
Percentage of service providers surveyed responding that they "agree" or "strongly agree" to the following statements (responses on five-point scale: "strongly disagree"/"disagree"/"neutral"/"agree"/"strongly agree"):
a	*"I would prefer not to provide services to men who have sex with men."*
b	*"I would prefer not to provide services to sex workers."*
c	*"I would prefer not to provide services to transgender people."*
d	*"I would prefer not to provide services to people who inject drugs."*
e	For those answering that they "agree" or "strongly agree", ask: *"Do you agree or strongly agree because:* • *"They put me at higher risk for disease"?* • *"This group engages in immoral behaviour"?* • *"I have not received training to work with this group"?* • *"I am worried that people will think I am part of this group"?*

Data source:
Survey of service provider staff. Include medical and government social service staff.

Comments:
When reporting these data, results should be disaggregated by different types of staff and services providers.
These questionnaire items are taken from: Stangl AL, Brady L, Fritz K. *Measuring HIV stigma and discrimination – technical brief.* London School of Hygiene and Tropical Medicine, International Centre for Research on Women, 2012 *(32)*.

It should be noted that the 2011 Political Declaration on HIV/AIDS included the commitment by Member States to eliminate HIV-related stigma, discrimination, punitive laws and practices by 2015 *(14)*.

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