



World Health
Organization

Monitoring and reporting on the health sector's response towards universal access to HIV/AIDS treatment, prevention, care and support 2009-2010

WHO framework for global monitoring and reporting

1. OBJECTIVE AND PURPOSE

As countries scale up their national HIV/AIDS programmes towards the goal of universal access to prevention, treatment, care and support by 2010¹, it is increasingly important to strengthen strategic information on the epidemic and national responses to inform policies and programmes, improve the effectiveness of interventions and promote accountability.

At the international level, WHO is committed since the 59th World Health Assembly in 2006 to monitor and report annually on global progress in countries' health sector responses towards universal access to HIV prevention, treatment, care and support.² Progress in the health sector is a key measure of progress towards universal access, as well as broader Millennium Development Goals.

This framework proposes a core set of indicators to *monitor* progress in the health sector's response to HIV/AIDS. It includes indicators to monitor the scale-up of priority health sector interventions for HIV prevention, treatment, care and support; as well as policy and programmatic questions related to the national response³. The framework also provides a basis for WHO to report on global progress towards universal access over time.

In 2007, WHO collected data on the health sector response to HIV/AIDS from 143 countries in collaboration with national and international partners. These data were published in the second annual global progress report in 2008, complemented by data from other surveys and scientific literature.⁴ Experience from the first round of reporting has enabled improvements in the framework for the next year; however care has also been taken to keep changes to the minimum necessary in order to ensure consistency of indicators over time and assessment of trends. WHO is committed to continue to provide technical assistance to Member States to strengthen the generation and use of strategic information on the HIV epidemic and response in countries.

2. GUIDING PRINCIPLES

The framework has been designed to facilitate the generation of a standard set of core information to monitor and report on global progress in the health sector's response to HIV/AIDS. The main guiding principles for defining the framework have been:

- Build upon and collaborate with ongoing, related international efforts such as the *UNGASS Declaration of Commitment*, the *Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care and Treatment* and efforts by other partners
- Take responsibility for annual monitoring of health sector progress, while minimizing the burden of reporting on countries
- Promote investment in strengthening data generation and analysis in countries, including sex and age disaggregation

¹ United Nations General Assembly. *Political Declaration on HIV/AIDS*, New York, United Nations, 2006.

² HIV/AIDS. *WHO's contribution to universal access to HIV/AIDS prevention, treatment and care: report by the Secretariat*. Geneva, WHO, 2006.

³ It should be noted that this framework is designed to facilitate global reporting; and does not represent all indicators necessary to adequately monitor various components of HIV programmes, and regions and countries should collect what is important and useful in their setting beyond what this document lists.

⁴ WHO, UNAIDS and UNICEF. *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2008*. Geneva, WHO, 2008.

- Within WHO, streamline global reporting formats and schedule with existing regional and country processes.

Harmonizing with partners and minimizing the burden of reporting on countries

Building upon ongoing international efforts for monitoring and reporting is one of the key guiding principles of the WHO framework. The framework brings together a broad spectrum of indicators to cover the *health sector* response; which are aligned to the maximum extent possible with related processes of partner agencies.

Of the 43 indicators in the framework, 15 are also UNGASS indicators; 8 are collected by other WHO programmes (tuberculosis, blood safety; injection safety; and sexually transmitted infections); and 4 are being collected through population-based surveys. Also, data collection for the health sector response to HIV/AIDS in the coming year will be combined with that of the *Report Card on the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care and Treatment* in collaboration with UNICEF. WHO country offices will collaborate with partners at country level to ensure that data are collected through one channel, and are shared among all interested partners for harmonized reporting.

3. INDICATORS : MONITORING PRIORITY INTERVENTIONS FOR SCALING UP HIV/AIDS PREVENTION, CARE AND TREATMENT IN THE HEALTH SECTOR

The framework comprises of indicators to measure progress in scaling up priority interventions in the health sector; which are key areas where countries must invest in order to achieve progress towards universal access:

- Testing and counselling
- Prevention - PMTCT, prevention in the health care settings, prevention of sexual HIV transmission and prevention of transmission through injecting drug use
- Treatment and care - antiretroviral therapy, care, HIV/TB
- Sexually transmitted infections control
- Health systems - drug procurement and supply management, health financing, health information systems

The framework also includes a set of questions to monitor policy and programmatic components of the health sector response to HIV/AIDS.

4. MEASURING 3 DIMENSIONS OF PROGRESS TOWARDS UNIVERSAL ACCESS

Access is a broad concept that for the purpose of monitoring the health sector can be divided into the following three components:

- **Availability** defined in terms of reach-ability (physical access), affordability (economic access) and acceptability (socio-cultural access) of services that meet a minimum standard of quality⁵. To make services available, affordable and acceptable is an essential pre-condition for "universal access".
- **Coverage** defined as the proportion of the population who receive an intervention among those who need it. Coverage is influenced by supply (provision of services) and demand by people in need of services.

⁵ "Access", "utilization", "availability" and "coverage" are often used interchangeably to reflect on whether "people in need of something for their health actually getting it". See e.g. Tanahashi T. Health services coverage and its evaluation. Bulletin of the World Health Organization, 1978. 56:295–303.

- **Outcome/Impact** defined in terms of behavioural change, reduced new infection rates or survival improvements; it is the result of coverage of services, modulated by the efficiency and effectiveness of the interventions and changes in other relevant factors. Impact goals have been set in the context of the MDGs and the UNGASS declaration on HIV/AIDS.

While the impact goals reflect the ultimate purpose of interventions, impact indicators alone will not sufficiently monitor programs to inform the scaling up of access. Therefore, systematic monitoring of progress towards universal access needs to include availability and coverage as well.

5. DATA SOURCES AND MEASUREMENT

The matrix presented below is mainly composed of quantitative indicators that can be collected and reported through health information systems, programme records or surveys including population-based surveys, behavioural surveillance surveys, or facility-based surveys. Some denominators are estimated through modelling and include varying uncertainty ranges.

It should be noted that this framework does not capture every component of 'access', for example acceptability and quality of services. Countries are encouraged to monitor and measure, through special studies or other means, other components of universal access which do not explicitly appear in the indicator matrix but are determinants influencing the attainment of universal access. Examples include:

- Affordability of services within a country
- Equity of intervention access and coverage (age/sex if not routinely disaggregated, occupational group, sexual orientation, socio-economic and other demographic categorizations, vulnerable groups, other groups that may receive differential treatment or less likely to receive services)
- Quality of interventions and services provided
- Acceptability of services, user perceptions of service provision
- Effectiveness of services provided (to improve implementation)

6. REPORTING PROCESS AND TOOL

WHO requests countries to report data on priority health sector HIV/AIDS interventions on an annual basis to enable global reporting. Data collection processes and timelines are aligned with complementary efforts of key **partners**, specially UNAIDS and UNICEF, and WHO colleagues at country and regional levels are committed to work with colleagues in partner agencies to ensure maximum synergy in efforts.

Data collection is facilitated through a **reporting form**, accompanied by a guidance note on indicator definitions and measurement. For indicators collected through programme statistics, it is the trend in *numerator* that is the most important to report. Wherever available, it is important to provide disaggregated data, specially by sex and by age, to monitor equity of access and progress in relation to the needs of specific populations.

It would also be useful for countries to share other achievements and best practices, including policies implemented to facilitate UA; various studies or analyses undertaken on different aspects of universal access within their settings; and lessons learned in operationalizing and scaling up interventions, which provide valuable input for the annual global progress reports.

FRAMEWORK FOR MONITORING THE HEALTH SECTOR RESPONSE TO HIV/AIDS:

1 - INDICATORS⁶

Intervention area	Availability	Coverage	Outcome/Impact
(A) Testing & counselling	<p>1. Number and percentage of health facilities that provide testing and counselling services</p> <p>2. Percentage of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS)</p>	<p>3. Number of individuals age 15 years and over who received HIV testing and counselling and know the result</p> <p>4. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results</p> <p>5. Proportion of sexually active young women and men aged 15-24 who had an HIV test in the preceding 12 months and who know the results</p> <p><i>[10. Percentage of pregnant women who were tested for HIV and received their results - same indicator as in PMTCT section]</i></p> <p>6. Percentage of most-at-risk population(s) who received an HIV test in the last 12 months and who know their results</p> <p>7. Percentage of TB clients who had an HIV test result recorded in the TB register</p>	8. Percentage of people 15-49 years who know their HIV status
(B) PMTCT	9. Percentage of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	<p>10. Percentage of pregnant women who were tested for HIV and received their results</p> <p>11. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission</p> <p>12. Percentage of infants born to HIV-infected women started on cotrimoxazole prophylaxis within two months of birth</p> <p>13. Percentage of infants born to HIV-infected women who received an HIV test (virological or antibody) within 12 months</p> <p>14. Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at 3 months</p>	15. Percentage of infants born to HIV-infected mothers who are infected
(C) Prevention in the health care setting	<p>16. Percentage of donated blood units screened for HIV in a quality-assured manner</p> <p>17. Percentage of health care facilities where all therapeutic injections are given with new, disposable, single use injection equipment</p>		

⁶ **Bolded** indicators are **UNGASS** indicators.

	18. Percentage of health facilities with PEP services available on site		
(D) Prevention of sexual transmission of HIV and prevention of HIV transmission through IDU	19. Number of needle and syringe programme sites per 1000 injecting drug users 20. Number of opioid substitution therapy sites per 1000 injecting drug users	21.(a) Percentage of sex workers reached with HIV prevention programmes in the last 12 months 21. (b) Percentage of injecting drug users reached with HIV prevention programmes in the last 12 months 21. (c) Percentage of men who have sex with men reached with HIV prevention programmes in the last 12 months 22. Number of syringes distributed per injecting drug user per year by NSP	23. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected 24. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse 25. Percentage of female and male sex workers reporting and use of a condom with their most recent client 26. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner 27. Percentage of most-at-risk populations who are HIV infected
(E) Care		28. Percentage of adults and children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) currently receiving CTX prophylaxis <i>[12. Percentage of infants born to HIV-infected women started on cotrimoxazole prophylaxis within two months of birth - same indicator as in PMTCT section]</i>	
(F) ART	29. Percentage of health facilities that offer ART	30. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	31. Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy 32. Percentage of patients initiating antiretroviral therapy at the site during a selected time period who are taking an appropriate first-line regimen 12 months later
(G) HIV/TB		33. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV 34. Percentage of newly registered TB patients who are recorded to be HIV+, who were started on or continued on CPT 35. Percentage of adults and children newly enrolled in HIV care given treatment for latent TB infection (Isoniazid Preventative Therapy) 36. Percentage of individuals enrolled in HIV care who had TB status assessed and recorded during their last visit	

(H) Sexually transmitted infections	37. Number of targeted service delivery points for sex workers where STI services are provided per 1000 sex workers	38. Proportion of women accessing antenatal care (ANC) services who are tested for syphilis in the last 12 months	39. Prevalence of syphilis among sex workers 40. Prevalence of syphilis among, men who have sex with men 41. Prevalence of syphilis among antenatal attendees
(I) Health systems	42. Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one ARV in the last 12 months		
	43. Percentage of facilities providing ART using CD4 monitoring in line with national guidelines/policies, on site or through referral		

FRAMEWORK FOR MONITORING THE HEALTH SECTOR RESPONSE TO HIV/AIDS :

2 - NATIONAL POLICY AND PROGRAMMATIC QUESTIONS

<i>Intervention</i>	<i>Indicator</i>
National health sector planning	<ul style="list-style-type: none"> ▪ Does the country have a national health sector strategic plan for HIV/AIDS? ▪ What is the time period covered by the plan? Is there a schedule to review and renew the plan?
National targets	<ul style="list-style-type: none"> ▪ For each intervention area, please provide any national targets that have been set. ▪ Does the country have plans to review or set any targets between now and 2010? If yes, when?
Testing and counselling	<ul style="list-style-type: none"> ▪ Does the country have a national policy on HIV testing and counselling (TC)? ▪ Does the policy promote provider-initiated TC in health facilities? For which population groups and at which types of health facilities? Does the policy include coverage for the cost of HIV tests? For which population groups? Please send us a copy (preferably in electronic form) of this policy. ▪ Does the country have national guidelines on how to implement provider-initiated TC at health facilities? If yes, does it include guidance on obtaining consent? Ensuring confidentiality? Facilitating disclosure? Please send us a copy (preferably in electronic form) of these guidelines. ▪ For generalized epidemic countries: Does your policy/guidelines state that providers should initiate TC in all patient encounters (regardless of presenting symptoms or facility type)? If yes, please attach the actual text that states this. ▪ For low-level and-or concentrated epidemic: Does your policy/guidelines indicate that providers target most-at-risk and vulnerable populations with TC (according to your epidemic profile)? Please list MARP and vulnerable groups relevant to your setting and indicate whether providers initiate TC to them <i>in health care facilities</i> in accordance with your policy/guideline.
PMTCT	<ul style="list-style-type: none"> ▪ Does the country have a national policy on PMTCT? ▪ Does the country have a PMTCT scale-up plan? ▪ Does the country have national PMTCT guidelines? If yes, when were the national PMTCT guidelines last updated? ▪ Do the guidelines recommend the use of more efficacious ARV regimens to prevent mother-to-child transmission of HIV?
Prevention in the health care setting	<ul style="list-style-type: none"> • Does the country have a national policy/protocol for post-exposure prophylaxis (PEP)? • If yes, does it cover: <ul style="list-style-type: none"> Occupational exposure (e.g. exposure through needlestick prick in health care setting)? Non-occupational exposure (e.g. violence against women)? Or both? • Is PEP implemented and available : <ul style="list-style-type: none"> - In reference hospital/centres (tertiary level) ? - At regional or district levels? - At all ART centres including at community level? • Are there efforts to provide prevention in the health care setting for high HIV-prevalence groups such as TB patients and their families/partners?
Prevention of sexual transmission and transmission through injecting drug	<ul style="list-style-type: none"> • How many districts (or other administrative units) in your country is there evidence that MARPS(SW, IDU, MSM) play an important role (>10% of cases) in HIV transmission? (by MARPS) • How many of these districts ensure availability of condoms/needles targeted to MARPS? (by MARPS) • Which of the following components of the comprehensive package of HIV prevention, treatment and care interventions for injecting drug users are implemented in the country? <ol style="list-style-type: none"> 1. Needle and syringe programmes (NSP)

use	<p>2.(a) Opioid substitution therapy (OST) 2.(b) Other drug dependency treatment 3. HIV testing and counselling 4. Antiretroviral therapy 5. Sexually transmitted infection (STI) prevention and treatment 6. Condom programming for injecting drug users and their sexual partners 7. Targeted information, education and communication (IEC) 8. Viral hepatitis diagnosis, treatment and vaccination 9. Prevention diagnosis and treatment of tuberculosis among IDUs</p>
Antiretroviral therapy/Care	<ul style="list-style-type: none"> ▪ When were the national ART guidelines last updated? ▪ When was the national ART programme first implemented? ▪ Are there guidelines on CTX provision for HIV patients? If yes, when were they last updated?
TB/HIV (3 Is)	<ul style="list-style-type: none"> ▪ Are services providing HIV care and treatment implementing and documenting efforts to screen people living with HIV for TB? ▪ Does the country have guidelines on INH prophylaxis for people living with HIV? Does the HIV programme include IPT as part of its essential approach to HIV care? ▪ Does the country have an infection control policy for TB to be applied in facilities?
Surveillance	<ul style="list-style-type: none"> ▪ Does the country carry out systematic surveillance in: <ul style="list-style-type: none"> - ANC attendees - Most-at-risk populations (IDUs, sex workers, MSM) - Other specific populations And report annually? ▪ Does the country carry out DHS surveys with HIV testing? What is the periodicity of these surveys? ▪ Have sexual and drug use behavior surveys (general population surveys or behavioural surveillance surveys) been conducted in the country? In which year? Which population groups were included?
M&E	<ul style="list-style-type: none"> • Does the country have a national M&E plan covering HIV/AIDS response in the health sector? (with identified collection tools and clear indication of data flow to collect national indicators based on and harmonized where appropriate with internationally recognized indicators). • When was a review of the M&E system last conducted for ART? for PMTCT? for T&C? <p>Please send us a copy (preferably in electronic form) of any M&E plan/framework and/or documents describing your M&E system.</p>
HIV Drug Resistance	<ul style="list-style-type: none"> ▪ Does the country have an HIV drug resistance prevention and assessment strategy in place? ▪ Does the HIV drug resistance strategy include the following elements? <ul style="list-style-type: none"> - Regular evaluation of HIVDR "early warning" indicators from ART sites - Surveys to monitor HIVDR prevention and associated factors in sentinel ART sites - HIV transmission threshold surveys in one or more areas where ART has been widespread for 3 years or more - Preparation of national annual HIVDR report and recommendations
Procurement and Supply Management	<ul style="list-style-type: none"> ▪ Are there national policies or guidelines for procurement and supply management of ARVs and other essential medicines and commodities including test kits?
Human resources	<ul style="list-style-type: none"> • Does your country have policies to address the health human resources shortages, such as tasking shifting from physicians to lower level health workers, if relevant? Please elaborate.
Health financing	<ul style="list-style-type: none"> ▪ Does your country have a policy (in the public sector) to provide for free the following: drugs for ART; CTX; laboratory monitoring; HIV testing ?

Appendix: List of abbreviations used in the WHO UA framework

ANC	Antenatal Care
ART	Antiretroviral Therapy
CHW	Community Health Worker
CPT	Co-trimoxazole preventive therapy
CTX	Co-trimoxazole
DHS	Demographic and Health Surveys
EHT	Essential Health Technologies (WHO)
FTE	Full Time Equivalent
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCW	Health Care Worker
HMIS	Health Management Information Systems
IATT	Inter Agency Task Team (on PMTCT)
IDU	Injecting drug user
INH	Isoniazid
IPT	Isoniazid Preventative Therapy
IR	Indicator Registry (IR Cat.2 refers to the proposed list of non-UNGASS nationally recommended indicators currently being finalised)
L&D	Labor and Delivery
LMIS	Logistic Management Information Systems
MARPS	Most At Risk Populations
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MERG	Monitoring and Evaluation Reference Group
MF	Mixed feeding
MSM	Men who have Sex with Men
PEP	Post Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counselling
PMTCT	Prevention of Mother to Child Transmission
PSM	Procurement and Supply Management
SAM	Service Availability Mapping
SPA	Service Provision Assessment
STB	Stop TB (WHO)
SW	Sex Workers
TC	Testing and Counselling
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
VAW	Violence against women
VCT	Voluntary Counselling and Testing

