Agenda item 10

UNAIDS/PCB (49)/CRP2

THEMATIC SEGMENT CASE STUDIES

What does the regional and country-level data tell us, are we listening and how can we leverage that data and related technology to meet our 2025 and 2030 goals?

UNAIDS

7 – 10 December 2021 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 10 November 2021

DISCLAIMER

This compilation of submissions is for information only. With the exception of minor corrections to grammar and spelling, the submissions within this document are presented as they were submitted, and do not, implied or otherwise, express or suggest endorsement, a relationship with or support by UNAIDS and its mandate and/or any of its Cosponsors, Member States and civil society. The content of submissions has not been independently verified. UNAIDS makes no claims, promises or guarantees about the completeness and accuracy of the contents of this document, and expressly disclaims any liability for errors and omissions in the content. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Nor does the content of the submissions necessarily represent the views of Member States, civil society, the UNAIDS Secretariat or the UNAIDS Cosponsors. The published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. UNAIDS assumes no responsibility or liability for any consequence resulting directly or indirectly from any action or inaction you take based on or made in reliance on the information and material contained in this document nor shall UNAIDS be liable for damages arising from its use. While every reasonable effort has been made to use appropriate language in this compilation, UNAIDS expressly disclaims any responsibility for inadvertent offensive or insensitive, perceived or actual, language or pictures.

Table of Contents

Africa 6
1. Botswana 6
2. Central African Republic 8
3. Eswatini 10
4. Lesotho 13
5. Ghana 15
6. Liberia 17
7. Nigeria 19
8. Zimbabwe 21
Asia 23
9. Cambodia 23
10. Cambodia 26
11. Cambodia 29
12. Pakistan 32
13. Papua New Guinea 34
14. Sri Lanka 37
Eastern Europe and Central Asia 39
15. Belarus 39
16. Kyrgyz Republic 41
17. Ukraine 43
18. Ukraine 45
19. Ukraine 47
20. Russian Federation 49
Latin America and the Caribbean 51
21. Brazil 51
22. Ecuador 54
23. El Salvador 57
24. Jamaica 59
25. Peru 61
26. Peru 64
27. Peru 66
28. Uruguay 69
Middle East and North Africa 70
29. Iraq 70
30. Morocco 72

Western Europe and Others 74
31. Australia 74
32. Portugal 77
Multicountry 79
33. Global (in 2019, 57 countries for SDG 5.6.1 and 109 countries for 5.6.2) 79

Introduction

The Thematic Segment of the 49th UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 10th of December 2021 and will focus on “What do the regional and country-level data tell us, are we listening, and how can we better leverage that data and related technology to meet our 2025 and 2030 goals?”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of best practices and country case studies to inform the development of the background note to the thematic segment as well as the discussions during the day.

A total of 33 submissions were received. The submissions reflect the work of governments, civil society and other stakeholders, as well as collaborative efforts. The case studies highlight different approaches in data collection, analysis and use in the context of the HIV response.

Africa

1. Botswana

CONTACT PERSON

Name: Victoria Chuwa

Title: HIV/AIDS Manager

Organisation: UNICEF Botswana

Address: Plot 27, Matsitama Road, P.O. Box 20678, Gaborone, Botswana

Email: vchuwa@unicef.org

- **Timeline of the case study**: January 2018-December 2020
- **Data is collected by:** Government, UN or other international organisation

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** Government; UN or other international organisation; Civil society; Academic institution; National HIV Estimates Technical Working Group

- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change;

- **Background and objectives:** Botswana has a generalized HIV epidemic driven largely by sexual transmission. The burden of HIV is higher among women compared to men aged 15-49 years. Prevalence among pregnant women has declined from >30% in the early 2000's to 26% in 2015 and approximately 22% in 2019. Botswana provides free, universal health coverage to all citizens, including MNCH care, PMTCT, ART and comprehensive HIV services, and recently extended free HIV services to non-citizens. The PMTCT program also provides comprehensive support for HIV-exposed infants and mother-baby pairs, including infant ARV prophylaxis, early infant diagnosis (EID) and safe infant feeding support through breastfeeding or infant formula. Estimates of ANC attendance and facility-based deliveries are greater than 90%. As part of its ongoing commitment to PMTCT and its achievements over the past 20 years, the Government of Botswana with technical and financial support from UN agencies and CDC, over the last few years has been progressively building national capacity to collect, collate and analyze PMTCT data and meticulously address gaps identified. Having a well-established PMTCT data system in place has helped the country to apply for validation on the Path To Elimination of MTCT.

- **Contribution to the AIDS response:** With its strong government commitment and leadership and a robust national PMTCT programme linked with the ART programme, Botswana was well-positioned to be one of the first high burden countries in sub-Saharan Africa to move forward on the Path to Elimination for EMTCT. However, achieving recognition on the Path to Elimination requires reliable data systems for programme monitoring at national, district and facility level. In this regard, in May 2019, UN agencies undertook a joint regional technical support mission with the aim to improve Botswana PMTCT programme data quality in line with the Path to Elimination validation requirements. The mission team concluded that while EMTCT coverage indicators, such as % of pregnant women tested for HIV and % of pregnant women with HIV initiated on ART, are generally well-monitored, quality of data remained to be an issue mainly due to existence of various data collection systems in place. To fix the issue, the MOH has taken a number of steps to simplify, harmonize, reduce redundancy and roll-out the most reliable systems to all districts and health facilities. A well-established PMTCT M&E system, with defined roles from national office to facility level, was developed and a hybrid data collection system- paper-based at lower levels and electronic at district and higher levels - is in place to collect and collate data monthly using standardized forms and registers. Once data is entered into DHIS2, real time data can be assessed by decision and policy makers.

- **Results, outcomes and impact:** The availability of almost real-time data allows the government to monitor the situation more closely and take the necessary actions, which are critical especially in ensuring continuity of essential HIV services during the COVID-19 pandemic. The national PMTCT programme reports issued annually provide a standardized, brief analysis of the main PMTCT programme performance indicators disaggregated by districts including ANC1 coverage, ANC HIV testing coverage, uptake of ART, EID positivity and coverage, and MTCT rates. Having disaggregated data at sub-national level allows for a sharpened HIV programme response. As the next step the country is aiming to incorporate syphilis data into routine reporting and some practical steps have been undertaken.

- **Gaps, lessons learnt and recommendations:** Although the national DQA Standard Operating Procedure was adopted in 2013, quality of data collected and reported, especially over-reporting, remains an issue. In addition, PMTCT data reporting is affected by high turn-over and rotation of staff. Another concern is sub-optimal use of Spectrum “stacked bar,” to better understand and address programme gaps, including “breakthrough” infections.   With the country’s commitment to further advancing on the Path to Elimination, these gaps will be addressed to provide more learning from Botswana.

- **Annexes:** https://unicef.sharepoint.com/:w:/r/teams/BWA-CO/_layouts/15/Doc.aspx?sourcedoc=%7BB548F61E-E1F7-44F3-9E60-CBA32BED2770%7D&file=August%202021%20Botswana%20PTE%20Data%20Team%20Final%20Report%20.docx&action=default&mobileredirect=true

2. Central African Republic

CONTACT PERSON

Name: Dr. Marcel MASSANGA

Title: Coordonnateur National Adjoint du CNLS

Organisation: CNLS

Email: mass_marcel@hotmail.com

- **Timeline of the case study**: Mid 2019 - March 2020

- **Data is collected by:** Government; Civil society; Private sector; UN or other international organisation

- **Data collection is:** Supplemental collection of data

- **Data is analysed by:** Government; Civil society; Private sector; Academic institution; UN or other international organisation

- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change

- **Background and objectives:** To develop its national HIV strategy for 2021-2025, Central African Republic undertook a comprehensive review of its national HIV epidemic and response. With a generalized epidemic (3.6% national HIV prevalence, with prevalence as high as 11.9% in Haut Mbomou province) and inadequate outcomes across the HIV testing and treatment cascade (33% of people living with HIV have viral suppression), national partners confronted an urgent need to strengthen and accelerate the country's response to HIV. As a key element of this comprehensive review, the country conducted a National AIDS Spending Assessment (NASA), its first in a decade due to the persistence of conflict. With limited national capacity and facing a shortage of data in several recent years, the country sought technical support from UNAIDS to conduct the spending assessment.

- **Contribution to the HIV response:** NASA describes the flow of resources spent in the HIV response from their origin to the beneficiary populations. NASA is a tool within the national monitoring and evaluation framework. The NASA in CAR provided decision makers with strategic information to mobilize resources, have a stronger accountability and a more efficient and effective program implementation.

- **Results, outcomes and impact:** Central African Republic remains heavily dependent on international assistance, with donor funding accounting for well over 90% of HIV-related spending. The Global Fund alone contributes roughly 80% of all HIV funding. Altogether, available funding in 2018 was roughly 80% short of amounts needed to fully fund the previous national strategic plan. The assessment found that treatment and care consume more than half of HIV-related spending. Only about 7% of spending in 2016-2018 focused on HIV prevention – with prevention spending declining by 25% over the three years – and only 6% addressed societal enablers. Among prevention spending, less than 1% supported programmes for key populations, although the country significantly increased spending on prevention interventions for adolescent girls and young women. The new strategic plan for 2021-2025 took these gaps and trends into account. The findings of the National AIDS Spending Assessment were and are being used to advocate for increased domestic HIV funding and for particular increases in prevention spending. The findings of the spending assessment were leveraged to obtain a nearly three-fold increase in funding from the Global Fund.

- **Gaps, lessons learnt and recommendations:** During a review workshop of preliminary NASA results in country, it emerged that certain expenses needed to be readjusted, particularly those related to budget monitoring and pediatric care, which seemed to be underestimated. A draft of the report was made available to the Global Fund ahead of the Global Fund replenishment meeting of October 2019 where the President of the Republic of CAR took part

- **Annexes:** https://unaids.sharepoint.com/:w:/r/sites/FSWCA/_layouts/15/Doc.aspx?sourcedoc=%7B061DC30A-5856-47F0-BD1A-0061BB4B40EC%7D&file=Rapport%20REDES%20RCA%202016%2C%202017%2C%202018_V7.doc&action=default&mobileredirect=true

3. Eswatini

CONTACT PERSON

Name: Marelize Gorgens

Title: Digital Health Innovation Lead

Organisation: The World Bank

Address: 181 H Street, NW; Washington, DC 20433; USA

Email: mgorgens@worldbank.org

- **Timeline of the case study**: 2015-2019
- **Data is collected by:** Government
    - **Other:** Contracted agency for the Impact Evaluation - field work interviews, counselling and bio-medical testing (blood and urine samples) * for q7 note data collection involved both routine and supplemental data collection (routine = i. School enrolment and attendance data used to verify information for payment of conditional education incentives; and supplemental = i. Fieldwork used to interview study participants and conduct bio-medical testing AND also conducted one-on-one in depth interviews and focus group discussions under the qualitative research component).
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; UN or other international organisation
- **Data is used for**: Data-driven policy change
- **Background and objectives:** In 2015-2016, the Sitakhela Likusasa Impact Evaluation enrolled 4389 HIV-negative Eswatini adolescent girls and young women (AGYW) aged 15 - 22 years (half of whom were out of school). Half of the enrollees were eligible for financial incentives conditioned on staying in school, and half were eligible for raffle prizes conditioned on remaining negative for syphilis and Trichomonas vaginalis. Over the years 2016 to 2018, the Sitakhela Likusasa Impact Evaluation aimed to answer the following research questions: a) Do education incentives paid to AGYW aged 15 to 22 years contingent on school attendance or other forms of education engagement, reduce the incidence of HIV compared to AGYW not receiving cash incentives? b) Do raffle prizes paid to AGYW aged 15 to 22 contingent on being negative for curable STIs (Trichomonas vaginalis, syphilis) reduce the incidence of HIV compared to AGYW not enrolled in a raffle? c) Do raffle incentives and education incentives act in an additive or multiplicative manner to reduce the incidence of HIV amongst AGYW over time (acknowledging a possibly limited power to detect interaction)? d) Is the provision of incentives cost-effective as a method of HIV prevention in AGYW in Eswatini?

- **Contribution to the HIV response:** Data generated from the Sitakhela Likusasa Impact Evaluation, a randomized trial in Eswatini, strengthens the case for cash incentives as a strategy to keep girls in school and reduce their risk of acquiring HIV. The study found that cash transfers on their own reduced the risk of HIV acquisition by 25% among participating adolescent girls and young women (AGYW).1 The combination of cash transfers and the raffle had an even more pronounced effect, reducing new HIV infections by 38%.2 Data was collected, through structured, administered, detailed questionnaires, at enrolment, midline and endline and supplemented by interviews conducted from the qualitative research component. While data was ‘self-reported’ by the adolescent and young women enrolled onto the study, comprehensive data on sexual behaviour and fertility, employment and spending patterns, HIV knowledge, home and family circumstances and characteristics, education and perceived value of such, use of contraceptives, lifestyle and risk behaviours - including a rating against a risk loving profile using a multiple price listing - was collected. This comprehensive data set will add to the body of evidence to better understand AGYW and their relation to HIV and guide data driven policies, investments and interventions.

- **Results, outcomes and impact:** HIV incidence among participants in the education incentive arm was statistically significantly lower than in the education control arm, 6.34% vs 8.08% (p=0.041); OR: 0.766 [0.598-0.981]; aOR: 0.754 [0.585-0.972]. In the sub-arm offering both the education and raffle incentives, HIV incidence was significantly lower than in the sub-arm with no incentives , 5.79% vs 8.84%; OR: 0.634[0.443-0.907]; aOR: 0.622[0.433-0.893]. Financial incentives conditional on education participation significantly reduced adjusted odds of HIV infection among AGYW by 24.6%. Individually, raffle incentives didn’t lead to a statistically significant impact but amplified the education incentives effect: the combination of both incentives statistically significantly reduced adjusted odds of HIV incidence by 37.8%. Preliminary analysis has demonstrated a net-positive ROI. Where the cost per HIV averted in the education incentive arm was $16,474 versus $10,138 in the raffle arm. The present net value over a 20-year period using a 5% discount rate equated to $8,183,471 and $15,879 for the education and raffle treatment arms respectively. While the education treatment arm demonstrated a higher cost per-averted-HIV-infection, it produced a significantly higher benefit cost ratio of 17.08 compared to 1.07 for the raffle arm. Findings informed policy decision-making and spurred multiple follow-on programs benefitting AGYW (see study summary).

- **Gaps, lessons learnt and recommendations:** During implementation lessons learnt included: a) AGYW in Eswatini are a very mobile group, especially those older or out-of-school. Keeping track proved difficult and required concerted effort to ensure contact details were kept current. b) Dignity packs were better received than call-time vouchers as inconvenience fees. C) Using MTN Mobile Money system to transfer funds caused some challenges that had to be managed. Amongst them; age restrictions on opening an account, transfers attracted fees and inactive accounts. D) Data revealed that multiple reasons, other than financial, kept the girls out-of-school. These included: illness, disability, disinterest with school for several reasons including poor performance, withheld permission from partner, school too far from home, subsidies offered don’t fully cover costs, taking care of their own children. The qualitative research highlighted that participants valued the pre-test counselling (HCT) provided and attributed improved knowledge on HIV and STIs through counselling. HIV testing also increased, even post-study. These findings have since informed planning, led to further analytical work in Eswatini and other countries in the region to build the understanding and boost data systems, and spurred follow-on projects to improve outcomes in areas that have proven critical in strengthening the resilience of AGYW.

- **Annexes:** https://documents.worldbank.org/en/publication/documents-reports/documentdetail/381341620808712952/qualitative-research-report

4. Lesotho

CONTACT PERSON

Name: Maria Vivas

Organisation: UNICEF Lesotho

Email: mvivasalicea@unicef.org

- **Timeline of the case study**: 2018-present

- **Data is collected by:** Government; Civil society; UN or other international organisation

- **Data collection is:** Supplemental collection of data

- **Data is analysed by:** Civil society; Government; UN or other international organisation

- **Data is used for**: Maximising service coverage; Data-driven policy change

- **Background and objectives:** In Lesotho, adolescents and young people (AYP) 15-24 years old make up 20 per cent of the total population of Lesotho. Like young people elsewhere, they face complex and changing environments. However, in Lesotho, many of their challenges are particularly acute and concerning, especially in the context of widespread poverty where 67.3 per cent of adolescents aged 13–17 years are deprived in multiple dimensions of well-being such as healthcare, nutrition, education, safe water, housing and information. Lesotho has the second-highest HIV prevalence in the world. A quarter of its entire population is living with HIV/AIDS. While HIV related outcomes improved for other age groups, the rate of improvement has not translated for adolescents. An estimated 21.7% of Basotho between the ages of 15 and 49 are living with HIV. Every day, 8 adolescent girls and young women (AGYW) are infected with HIV. Low demand for adolescent-friendly services especially in rural areas, compounded by low quality and effectiveness of services, early sexual debut, high teenage pregnancy, and low parent/caregiver involvement in adolescent sexual and reproductive health and right (SRHR) issues do not ensure positive outcomes in the long term.

- **Contribution to the AIDS response:** The intervention has a three-pronged approach. First, adolescent engagement and empowerment enable young people to increase their awareness of their sexual and reproductive health rights, and to consult with their peers, service providers, and other stakeholders at community level to improve adolescent service delivery. Second, health system strengthening improves the capacity of service providers to respond to adolescent health challenges at health centre level, and their ability to advocate for change at district and national levels. Third, the activity enables youth participation in the Health Centre Committees, and liaison with the Village Health Workers to increase demand for health services, strengthening community facility linkages. In particular, the youth advocates support the Village Health Workers to facilitate public dialogues and community discussions on adolescent-friendly health services. The data collection has facilitated a feedback loop among adolescents, service providers and communities to ensure sustainability, in alignment with Lesotho's National Strategic Plan for HIV and The Global AIDS Strategy 2021–2026. It allows for improved quality of health care services for adolescents and the community, linked with quality improvements in interventions for maternal and child health. The data is generating knowledge and putting adolescent issues in the forefront for action at community, district, and national level. Additionally, aspects of the programme, such as social accountability and community monitoring data collection, have been adopted by other implementing partners and included in the new Global Fund grant envelope.

- **Results, outcomes and impact:** Overall, 44 health centers in the country (23% coverage) participated in the process. To date, 17,006 adolescents and young people (AYP) have been mobilized through the scorecard administration—identifying limited AYP knowledge of SRH rights and services, unfriendly health worker attitudes, long waiting hours, and inadequate opening hours as the major deterrents to service access. To address these concerns, score card action plans were developed and implemented. As a result, service provider knowledge on AFHS increased 40%, and youth advocates' knowledge on their SRH rights improved by 42%. Other achievements included the strengthening community-facility linkages, the institutionalization of AYP participation in Health Center Committees (100%), changes in facility opening hours to accommodate AYP, or the introduction of specialized days for adolescent services where time adjustment were not possible, re-allocating space for provision of services for young people, outreach clinics specifically targeting young people, placement of suggestions boxes for youth and lastly there was improved coordination of stakeholders in the provision of adolescent friendly health services (AFHS) at district level.

- **Gaps, lessons learnt and recommendations:** During implementation, we learned that building on human resources (Sub-Recipients; youth advocates) from the Global Fund to Fight AIDS, Tb, Malaria and focusing on their geographical coverage adds to the layer of interventions provided to AYP. Additionally, during the COVID-19 pandemic and Lesotho's lockdown measures, adapting to the use of internet communication technologies (ICTs) to collect the data enabled the AYP to remain safe and allow the MOH to monitor use of AFHS during the lockdown. Finally, Despite the achievements, the programme still needs strengthening in terms of scaling up to all health facilities providing adolescent friendly health services in the country and addressing data quality and turnaround, analysis and reporting through integration into DHIS2. Based on programmatic reviews with the Ministry of Health, UNICEF, and beneficiaries, there is a need to scale up the programme and digitalise the scorecard to sustain the gains made in the last 3 years. To further build on the gains made by the Ministry of Health and its partners in delivering quality adolescent friendly health services, the Ministry of Health and UNICEF will collaborate to enhance the HIV programme in Lesotho through scaling-up and digitalising the adolescent score card to all health facilities in the country (n=216) and ensuring the data reported in the scorecard is integrated into DHIS2 for prompt action and decision making.

- **Annexes:** N/A

5. Ghana

CONTACT PERSON

Name: Felix Osei-sarpong

Title: Health Specialist

Organisation: UNICEF Ghana

Email: fosei-sarpong@unicef.org

- **Timeline of the case study**: 2020 - Q2 2021

- **Data is collected by:** Government; Civil society; UN or other international organisation

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** Government; Civil society; UN or other international organisation

- **Data is used for**: Resource allocation; Maximising service coverage; Data-driven policy change; Target setting;

- **Background and objectives:** Paediatric HIV treatment coverage in WCA region is among the lowest in the world (33%) and the gap between adult and paediatric treatment is widening. A big challenge is that large proportions of children living with HIV in the region are not being diagnosed. Family-based index HIV testing has been found as an effective way to identify undiagnosed HIV-positive children and link them to treatment. Ghana is among nine countries in WCA region contributing to 90% of new pediatric HIV infections and has low pediatric anti ART coverage (~ 20%). To address the pediatric HIV gap, the National Acceleration Plan for Pediatric HIV Services (2016 – 2020) identified Family HIV Testing as a game-changer that can deliver quick gains for the pediatric HIV response in Ghana. By end June 2021, over 300 health facilities were enrolled in family HIV Testing from initial 40 facilities in January 2019.

- **Contribution to the AIDS response:** At regional level, UNICEEF has been collecting data on acceptance, testing, diagnoses, and treatment status. Those data fed into a regularly updated "regional dashboard" allows for tracking and comparing implementation, challenges and scale-up in countries across the region (see Dashboard link in the annex). In Ghana national data on acceptance, testing, diagnoses, and treatment status provided the evidence that family testing is a high yield strategy to identify children often missed through the health system and informed its scale up in high burden facilities in the Volta Region. Evidences provided by collected data contributed to the advocacy to mobilize emergency funds for the continuity of HIV services in the context of COVID 19. Ghana data have been used in in country strategic planning, especially the review of the National Acceleration Plan for Paediatric HIV Services (2016-2020) and the development of a guidance document to support Paediatric HIV intervention delivery for the period 2021-2025. Availability of data facilitated South to south learning.

- **Results, outcomes and impact:** During the first half of 2021, a total of 2,480 persons living with HIV have been offered Family HIV testing. Of these, 2,245 have accepted (91% acceptance rate), leading to the identification of 14,320 family members. Among these were 2,909 children and adolescents that were tested. Of those, 295 tested positive, and 275 were linked to treatment and care (93%). To add on to the gains made in the other regions and contribute to a better the treatment coverage for paediatric and adolescent HIV clients nationally, the family-based index testing to high burden facilities in the Volta Region was scaled-up in Q4 2020 to Q1 2021. A non-residential training was conducted for four participants per facility from 10 high burden facilities in the Volta Region, by both National and Regional facilitators. To assess the level of uptake and provide context- specific support for implementation of family-based index client testing and other Paediatric HIV services, a five-day monitoring visit was conducted to all the participating facilities. As an outcome, forty (40) participants, made up of prescribers, Pharmacists, ART Nurses, Midwives, Community Health Nurses, Data officers and Biomedical Scientists were trained from 10 facilities in the Volta region. Following the training in November 2020, family testing acceptance rate increased from 57 to 68% with a paediatric HIV positive testing yield of 14% and early paediatric HIV diagnosis and linkages to care of 82%.

- **Gaps, lessons learnt and recommendations:** To address key gaps and bottlenecks in data collection, Index testing has been introduced in National HIV testing register and is being reported in DHIMS disaggregated by age and gender.

- **Annexes:** 1.Ghana Family HIV Testing case study; 2.Operational Guidance for National Roll-Out of Family HIV Testing in WCA 3. Region Family HIV Testing dashboard

6. Liberia

CONTACT PERSON

1)

Name: Ms Samretta Caldwell

Organisation: Ministry of Health

2)

Name: Ms Pepukai Chikukwa

Organisation: UNAIDS

Email: chikukwap@unaids.org

- **Timeline of the case study**: March 2020 to December 2020

- **Data is collected by:** Government

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** Government

- **Data is used for**: Maximising service coverage; Data-driven policy change;

- **Background and objectives:** HIV and syphilis during pregnancy remain a public health concern especially in developing countries. Syphilis in pregnant women can cause miscarriages, stillbirth, or neonatal deaths. Women co-infected with HIV and syphilis co-infection are 2.5 times more likely to transmit HIV to their babies. After the WHO recommendation for HIV/syphilis dual testing in 2019, Ministry of Health through the National AIDS and STI Control Program (NACP) partnered with Evidence Action to pilot dual testing. The aim of the pilot was to assess the feasibility and acceptability of HIV/syphilis dual testing during ANC visits instead of single HIV testing.

- **Contribution to the AIDS response:** In Liberia, prevalence of syphilis in pregnant women was 2.7% in 2017, with an HIV prevalence of 1.5%. However, less than 10% of all pregnant women were tested for syphilis, despite having 95% pregnant women with at least one ANC visit in 2019. HIV screening has consistently been high above 80% since 2018. Low syphilis testing is due to limited STI funding and laboratory capacity. For HIV, progress towards eliminating new HIV infections among children (aged 0-14 years) has stalled, with annual infections of close to 500 in Liberia since 2012. In 2020, children accounted for 8% of all people living with HIV but comprised 15% of all AIDS-related deaths. Effective screening and treatment for syphilis during pregnancy contributes to a reduction in AIDS-related deaths amongst children.

- **Results, outcomes and impact:** Between March and December 2020, 8 908 pregnant women and 9 male partners from 5 health facilities were screened for both HIV and syphilis using the dual test. Syphilis prevalence was found to be 1.26% (0.15% - 4.14%) with an HIV prevalence of 1.54% (0.94% - 2.27%). Close to 20% of those testing positive for HIV were co-infected with syphilis. Uptake of dual test was high, with no had no adverse events reported. Close to 70% (69.6%) pregnant women infected with syphilis were successfully treated. These pilot results showed an increase in syphilis treatment from a low of less than 10% to a high of close to 70% within a 9-month period. The pilot also showed that dual testing for HIV/syphilis was acceptability to both health care providers and pregnant women. Ministry of Health is now looking at ways to make dual HIV/syphilis testing widely available in the country. Availability of syphilis testing will therefore contribute to a reduction in miscarriages, stillbirth, or neonatal deaths in Liberia.

- **Gaps, lessons learnt and recommendations:** The pilot found very high levels of acceptance among healthcare providers and pregnant women. Based on the results of the pilot, the following are recommended: 1. HIV/Syphilis dual tests should be introduced in all antenatal care facilities. 2. The provision of short on-the-job training is an effective means for equipping healthcare providers with the skills needed to counsel, screen, and treat pregnant women for HIV and syphilis. 3. Availability of dual tests and benzathine penicillin are the key barriers to healthcare providers delivering syphilis screening and treatment services. Stock outs must be reduced where possible. 4. Additional training should be provided on how healthcare providers are to capture whether a syphilis-positive pregnant woman received treatment 5. There should be increased emphasis on testing of male partners and implementation research on strategies that increase male partner testing in Liberia

- **Annexes:** N/A

7. Nigeria

CONTACT PERSON

Name: Ademola Oladipo

Title: Branch Chief Monitoring, Evaluation and Data Science

Organisation: US Centers for Disease Control and Prevention

Address: Abuja Nigeria

Email: lyn8@cdc.gov

- **Timeline of the case study**: Continuous data collection
- **Data is collected by:** Government
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; UN or other international organisation
- **Data is used for**: Target setting; Maximising service coverage; Data-driven policy change; Resource allocation
- **Background and objectives:** The Nigeria National Data Repository (NDR) is a central data warehouse that collects, stores, and manages de-identified patient-level data from site-level electronic medical record (EMR) systems at HIV treatment sites in Nigeria. The data is collected based on patient management, monitoring tools and registers approved by the Government of Nigeria (GON).
- **Contribution to the AIDS response:** All the 36+1 States are currently report HIV program data routinely from 1,658 Health Facilities to the NDR. The NDR is designed to receive patient level data from any EMR platform that meets the requirements of the NDR, based on the national implementation guide, and currently, the NDR receives data from about 80% of HIV treatment facilities in the country, including PEPFAR and non-PEPFAR supported facilities. Data in NDR provides key variables required to generate key indicators for program monitoring and evaluation. Users can access these data via the NDR dashboards on the web portal. Currently, 100% of treatment numbers from PEPFAR supported facilities are in the NDR. The facilities have started reporting HIV testing data with 42% of PEPFAR HIV testing (HTS_TST) data 77% of PEPFAR HIV positive results presently in the NDR. HIV recent infection data is also available on the NDR as recency surveillance is being scaled up across the country.
- **Results, outcomes and impact:** The NDR provides patient appointment line lists by facilities to help facility teams send appointment reminders via Unstructured Supplementary Service Data and thereby improve patient show rate. It also generates list of clients who have missed appointment for tracking within 24 hours of appointment missed. When a clients interrupt treatment the NDR alerts the facility. Kaplan-Meier analysis on patient retention predict LTFU time and distribution of treatment interruption over time. The NDR is also used for regimen analysis to track transition of TLD among TLD-eligible patients, as well as pediatric regimen

optimization. Other functionalities of the NDR include treatment analysis, and Finance Output indicators by budget codes to track performance by budget. The NDR facilitates tracking of sample collection as well as viral load coverage and suppression. NDR is at the heart of the rapid scale-up of an Antiretroviral Therapy (ART SURGE) Program. In April 2019, through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), an 18-month ART Surge program in 11 Nigerian states to rapidly increase the number of persons with HIV infection receiving ART. Programmatic data gathered during March 31, 2019–September 30, 2020, is analyzed and used to describe the ART Surge program's progress on case finding, ART initiation, patient retention, and ART Surge program growth. Overall, the weekly number of newly identified persons with HIV infection who initiated ART increased approximately eightfold, from 587 (week ending May 4, 2019) to 5,329 (week ending September 26, 2020). Other and still evolving uses of the NDR include integration into Data-to-Care activities, Support HIV Surveillance for Monitoring Epidemic Control – HIV Case-Based Surveillance, and Mortality Surveillance. HIV Case-Based Surveillance is a patient-centered passive surveillance system using de-identified EMR line-list on the NDR to systematically analyze sentinel events during patient care in HIV program. The Case-Based Surveillance complements findings of population-based HIV survey by providing updated status on the countries progress towards epidemic control using real-time data for indebt analysis of new HIV cases, HIV recent infections, HIV treatment, treatment interruptions, viral load status and deaths to improve patient care, HIV case finding, re-initiation into care and focus HIV programing to priority sub-populations.

- **Gaps, lessons learnt and recommendations:** Greater acceptance and use of patient unique identification system will improve patients access to HIV care and treatment across the country.

- **Annexes:** N/A

8. Zimbabwe

CONTACT PERSON

Name: Beula Senzanje

Title: HIV Specialist

Organisation: UNICEF Zimbabwe

Email: bsenzanje@unicef.org; aarmstrong@unicef.org

- **Timeline of the case study**: 2018 to 2021
- **Data is collected by:** Government; Civil society; Academic institution
- **Data collection is:** Part of routine and supplemental data collection
- **Data is analysed by:** Government; Civil society; Academic institution
- **Data is used for**: Maximising service coverage; Resource allocation
- **Background and objectives:** To ensure improved outcomes for adolescents and young mothers (AYM) living with HIV and their babies, the Zimbabwean Ministry of Health and Childcare (MoHCC) and Zvandiri adapted the existing evidence-based Community Adolescent Treatment Support model for adolescents and young people living with HIV. The Young Mentor Mothers (YMM) programme works alongside health providers to support AYM living with HIV, at health facilities and within communities through home visits and digital health. YMM provides adherence counseling, follow up of missed appointments, reminders for EID, couples HIV counselling, and screening and referrals for nutrition, mental health and social protection.
- **Contribution to the AIDS response:** In 2019, UNICEF and SIDA (under the 2gether4SRHR programme) funded research to improve the model through better understanding the clinical and social experiences of this cohort. The study found substantial mental health risks associated with poor adherence, and opportunities of supported disclosure, HIV testing and linkages of partners and infants. the MoHCC has developed a national E-tracker to track data on mother-baby pairs that feeds into DHIS2. YMM have been trained to use the E-Tracker ensuring that AYM living with HIV are captured in national data systems and the MoHCC plans to further disaggregate this data by age. the MoHCC has developed a national E-tracker to track data on mother-baby pairs that feeds into DHIS2. YMM have been trained to use the E-Tracker ensuring that AYM living with HIV are captured in national data systems and the MoHCC plans to further disaggregate this data by age.
- **Results, outcomes and impact:** Programme data as of July 2021, indicates 97 percent of the 1,671 mothers participating in the programme to achieve viral suppression and a mother-to-child-transmission of HIV rate of two per cent, well below the national average of 8 per cent at 24 months.1 The majority of sexual partners were mobilized to learn their HIV status; 99 per cent of partners testing HIV

positive were initiated on treatment while 72 percent of those testing negative were linked to Pre-Exposure Prophylaxis.

- **Gaps, lessons learnt and recommendations:** The efforts to improve data for AYM living with HIV have demonstrated the effectiveness of data usage in programming and resulted in the approval for further scale-up of the YMM programme, as part of Global Fund investments.

- **Annexes:** Documents available on request.

Asia

9. Cambodia

CONTACT PERSONS

1)

Name: Dr Ly Penh Sun

Title: Director

Organisation: National Center for HIV/AIDS, Dermatology and STD (NCHADS)

Address: No. 245H, Sreet 6A, Phum Kean Khlang, Sangkat Prekleap, Khan Chroy Changva, Phnom Penh, Cambodia

Email: penhsun@nchads.org

2)

Name: Dr Kim Rattana

Title: Director

Organisation: National Maternal and Child Health Center (NMCHC)

Address: Address: No. 31A, Street 47(France Street), Sangkat Srah Chak, Khan Daun Penh, Phnom Penh city, Cambodia

Email: rattanamch@gmail.com

3)

Name: Dr Khin Cho Win Htin

Title: Country Director (a.i)

Organisation: Joint United Nations Programme on HIV/AIDS (UNAIDS)

Address: No.221, St. Pasteur 51, Sangkat Boeung Keng Kang 1, Khan Chamkar Mon, Phnom Penh

Email: WinhtinK@unaids.org

- **Timeline of the case study**: 2021 June to 2021 August
- **Data is collected by:** Government; Civil society; Academic institution; UN or other international organisation
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** Government; Civil society; Academic institution; UN or other international organisation
- **Data is used for**: Maximising service coverage

- **Background and objectives:** Cambodia has successfully turned the epidemic around through phases of Cambodia 1.0, 2.0, and 3.0 responses coupled with strong commitments towards ending the AIDS epidemic as a public health threat by 2025. PMTCT coverage was 86% in 2020, a significant increase from 42% in 2010. Similarly, vertical transmission rate reduced from 26% in 2010 to 11.8% in 2020 with less than 100 new child infections. The National Roadmap for the elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis was jointly developed by National Centre for HIV/AIDS Dermatology and STDs (NCHADS) and National Maternal and Child Health Center (NMCHC) and was adopted by the Ministry of Health in July 2018. The set objectives and commitments on elimination of mother-to-child transmission of HIV and syphilis are reaffirmed again in the National Strategic Plans (multi-sector and health sector) and the National PMTCT Strategy. Bold commitments to eliminate vertical transmission of HIV and syphilis by 2025 demands systematic assessment in the form of virtual mock review to take stock of progress and challenges and come up with recommendations for timely and appropriate actions to pave the path towards elimination of vertical transmission (eVT).

- **Contribution to the AIDS response:** eMTCT mock review in Cambodia is the first ever virtual mock-review in Asia and the Pacific. It was the systematic review by the independent experts through virtual arrangement, conducted under the leadership of NCHADS, NMCHC, NAA with coordination and technical support from UNAIDS, WHO, FHI360-EpiC, CHAI, US-CDC, and the community partners. International experts from academic institutions such as the Albion Centre Australia, National Reference Laboratory Australia (NRL), Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) provided pro bono services as their contribution to the strides towards eVT in Cambodia. The mock review processes followed the WHO preliminary checklist and validation assessment tools for the four components: Programme; Data; Laboratory; Human Rights, Gender Equality, Community Engagement - with participation and engagement of national stakeholders including women living with HIV and key populations communities. This is a classic example of national, UN, technical, community partners and academic institutions joining hands in a collaborative partnership to ensure that commitments towards elimination of vertical transmission by 2025 in Cambodia will not be deterred or derailed by the COVID-19 pandemic related shortfalls. This is also an act of resilience that COVID-19 related restrictions did not stop systematic progress tracking of eVT to inform needed advocacy, coordination, and programme optimization. The virtual mock-review processes brought together key partners to collect, collate and triangulate both qualitative and quantitative information; assess the progress and identify the gaps and bottlenecks through evidence informed discussions that apply inequality lens and zooming in on the rights of PLHIV, key and other vulnerable populations; to achieve consensus on the way forward to address the gaps and challenges. Contributions of the joint mock review goes beyond the mere findings and recommendations. It bolsters partnerships, recognizes best practices to replicate or sustain, and most importantly, reinvigorates commitments of eVT in Cambodia.

- **Results, outcomes and impact:** Responding to the mock review findings, Cambodian Red Cross (CRC) through the National Champion of Asia-Pacific Leadership Forum on HIV/AIDS and Development in Cambodia and National Champion of the United Nations Secretary General‘s Joint Plan of Action on Women’s and Children’s Health, advocating to strengthen coordination between NCHADS/NMCHC, and enhance multi-sectoral collaboration at national and sub-national levels. At sub-national level, working closely with the Provincial Health Department, CRC Provincial branches and sub-branches act as catalyst to support eVT service cascade - from pregnant women HIV testing to infant outcome and linkages to care. Currently Provincial Governors/ Deputy Governors in four provinces have been actively involved in these efforts. At national level, in close collaboration between CRC network, national health programs and the National Television, a video clip that promote quality and equitable service provision along the continuum of eVT cascade including social protection has been made and disseminated in September 2021 through eight TV channels. Following recommendations from the mock-review - NCHADS, NMCHC and National TB Programme commit to work together to improve point of care viral load testing and early infant diagnosis using GeneXpert machines of National TB programme particularly in remote locations to improve equitable access to services.

- **Gaps, lessons learnt and recommendations:** As the review was undertaken during the COVID-19 pandemic, it imposed significant limitations on its reach. With virtual arrangements of mock review, it was not possible to conduct onsite evaluations or evaluations of sub-national data. Findings indicated that integration of data systems, and improved data availability and data quality are urgently required to improve the provision of the continuum of services at site level, monitoring and program management at sub-national and national levels, and ultimately to effectively track mother-baby pairs and to provide the data for reporting of impact, process and other important indicators for validation of eVT. Even within one month after the mock review findings and recommendations were disseminated, NCHADS and NMCHC are working in tandem and start taking actions to address the gaps and recommendations including enhancement of data collection, reporting and monitoring of service cascade indicators. Data collection and reporting processes also take into consideration and apply inequality lens to ensure that women and partners of key populations community, women who live in remote locations, and women with socio-economic vulnerabilities are reached and received needed services for eVT.

- **Annexes:**
    - 1. Concept note of eMTCT mock review: https://unaids.sharepoint.com/:b:/s/FSAP/EWiXKFK_-GtNm6Iq6MlEjngBBX0LvMZUeytROl_mMrJ2XA?e=dOmLLp
    - 2. TORs of sub technical working groups: https://unaids.sharepoint.com/:b:/s/FSAP/EYlJKlUYb_VDlt6w_zZ20wABWNzSHnY1xn3vBJu-aObY4Q?e=bwylUp
    - 3. Draft technical report of eMTCT mock-review: https://unaids.sharepoint.com/:b:/s/FSAP/ERPBQXaGfddJniARJ_cL0CUBOCx5SZWFdg7Gyp-nMOziCA?e=D85s7H

10. Cambodia

CONTACT PERSON

1)
Name: Dr Ly Penh Sun

Title: Director

Organisation: National Center for HIV/AIDS, Dermatology and STD (NCHADS)

Address: No. 245H, Sreet 6A, Phum Kean Khlang, Sangkat Prekleap, Khan Chroy Changva, Phnom Penh, Cambodia

Email: penhsun@nchads.org

2)

Name: Dr Khin Cho Win Htin

Title: Country Director (a.i)

Organisation: Joint United Nations Programme on HIV/AIDS (UNAIDS)

Address: No.221, St. Pasteur 51, Sangkat Boeung Keng Kang 1, Khan Chamkar Mon, Phnom Penh

Email: WinhtinK@unaids.org

- **Timeline of the case study**: 2019 January to 2021 June
- **Data is collected by:** Government
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; UN or other international organisation
- **Data is used for**: Maximising service coverage
- **Background and objectives:** AIDS response in Cambodia is nothing short of remarkable. In 2010, Cambodia received Millennium Development Goals (MDG) Award for its outstanding progress towards achievement of Goal 6 in halting and reversing the spread of HIV. In 2017, Cambodia was recognized as an early achiever of 90-90-90 treatment targets and maintained its achievement ever since through people-centred services. Success of treatment programme in Cambodia is nested in national commitments and leadership, partnerships with UN and technical partners, pursuance of up-to-date global guidance, continued use of data to inform programme scale-up, prioritization and evidence-informed decision making. The first imported case of COVID-19 in Cambodia was reported in January 2020 and as in many other countries around the world, impact of COVID-19 hits hard to all aspects of society and services including treatment services for people living with HIV (PLHIV). It is imperative to sustain hard-earned achievements and this calls for effective use and analysis of routine programme data to inform actionable and agile approaches to

minimize the disruption of needed services for PLHIV including same-day treatment initiation of the newly diagnosed.

- **Contribution to the AIDS response:** Rapid and early treatment initiation of newly diagnosed PLHIV was recommended in Cambodia since 2015 through National HIV Clinical Management Guidelines for Adults and Adolescents. With WHO recommendation on same-day ART initiation in 2017, Cambodia quickly adapted the global recommendations into local action. Similarly, for MMD, National Center for HIV/AIDS, Dermatology and STD (NCHADS) issued a letter to all ART sites in February 2017 to provide 3 to 6 months of refill/appointment to PLHIV who are stable on ART. In parallel with adoption of global recommendations and implementation guidance, data collection and reporting systems are updated to capture the time lapse between time of diagnosis and initiation of treatment (for SD-ART) and interval between last ARV pick-up and next appointment/visit (for MMD). Both data availability and data quality are ensured through orientation, coaching and mentoring to all ART sites and it is continuously monitored through Continuous Quality Improvement (CQI) activities. However, expansion and scale-up of both SD-ART and MMD were not yet optimum until early 2020. With imminent threats of treatment service disruption due to COVID-19 related restrictions and lockdowns, NCHADS turned these challenges into opportunities and scaled up SD-ART and MMD to mitigate treatment service disruption in time of pandemic. By 2021 June, 100% of ART sites (71 sites) are implementing SD-ART and MMD. Availability of routine treatment programme data informed the rapid and strategic expansion of SD-ART and MMD to protect the gains of HIV response . Rapid scale up of SD-ART minimizes loss to follow-up and delayed ART initiation particularly in the context of COVID-19 and MMD expansion warrants treatment adherence with continued viral suppression to maximize the benefits of U=U while reducing the number of patient visits to treatment sites as well as the workload of health care providers.

- **Results, outcomes and impact:** PLHIV who received same-day ART initiation in first half of 2021 is almost quadrupled as compared to the same period in 2019 with almost 1100 newly diagnosed PLHIV received same-day ART initiation between January to June 2021. Similarly, MMD coverage among eligible PLHIV has risen from 29% in 2019 June to 52% in 2021 June with almost 31,000 PLHIV are on MMD with at least 3 months supply. Community ART Delivery (CAD) as part of mechanism for MMD scale-up has proven to contribute not only to the rapid expansion but also for adherence support in the context of COVID-19 pandemic. In first half of 2021, 445 key populations received SD-ART, two times increase from 232 in the same period of 2020. As compare to first half of 2019, impressive MMD scale up has been made in Steung Treng (7% in 2019 to 42% in 2021) , Rattanakiri (0% in 2019 to 20% in 2021), Mondulkiri (0% in 2019 to 30% in 2021) and Oddar Meanchey provinces (1% in 2019 to 29% in 2021). These are the provinces with relatively remote locations with challenges to access services particularly in time of COVID-19 and MMD-scale up reduced inequalities in access to services.

- **Gaps, lessons learnt and recommendations:** Though ARV stock-out is not an issue at the national level, there were concerns of ARV supply/stock at the site level that led to clinician's hesitancy to prescribe MMD. Issues of ARV supply at the site level are mainly due to communications and coordination oversights between clinicians, pharmacists, and logistics personnel. Improved logistic information management systems with clinicians and pharmacists in the feedback loop will ensure optimum stock management at the site level. Qualitative information such as data from Patient Satisfaction Feedback (PSF) as part of community-led monitoring is not yet fully utilized in tandem with routine programme data. Triangulation and use of PSF data through inequality lens will improve quality of services in future. Persistent gap in general is the sustainability of data work force since certain proportion of data personnel are contractual staff funded by donor agencies. This gap is already identified in the Sustainability Roadmap with recommended actions to transition contracted positions to government staff positions or absorbed by provincial budget as part of decentralization. Ongoing efforts to link prevention database and ART database allow analyses on prevention and care continuum of key populations living with HIV but data is still incomplete for generate KP specific cascade.

- **Annexes:**
    - 1. Supporting data slide deck - https://unaids.sharepoint.com/:b:/s/FSAP/EQhYHg-frnpAsv-aY2XaeIQB3KEpnEC554L3cAB95Q756Q?e=BnooA1
    - 2. Guidelines and SOPs - https://unaids.sharepoint.com/:f:/s/FSAP/EiKvqWG1rRdPnP_a9nhDG5gBzTslw1HLWa_mmJnaj6QSIw?e=MSc9GN

11. Cambodia

CONTACT PERSON

1)

Name: Dr Ly Penh Sun

Title: Director

Organisation: National Center for HIV/AIDS, Dermatology and STD (NCHADS)

Address: No. 245H, Sreet 6A, Phum Kean Khlang, Sangkat Prekleap, Khan Chroy Changva, Phnom Penh, Cambodia

Email: penhsun@nchads.org

2)

Name: Mr Ung Polin

Title: Community Support Adviser

Organisation: Joint United Nations Programme on HIV/AIDS (UNAIDS)

Address: No.221, St. Pasteur 51, Sangkat Boeung Keng Kang 1, Khan Chamkar Mon, Phnom Penh, Cambodia

Email: ungp@unaids.org

- **Timeline of the case study**: January 2019 to June 2021
- **Data is collected by:** Government; Civil society
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; UN or other international organisation
- **Data is used for**: Maximising service coverage; Data-driven policy change
- **Background and objectives:** This case study is to showcase how improvement of data collection, granular data analysis, and use guides HIV prevention programming, and policy changes, particularly differentiated prevention modalities for key population (KPs). Cambodia's HIV prevention programme focusing on KPs: sex workers (called entertainment workers (EWs) in Cambodian context), gay men and other men who have sex with men (MSM), transgender women (TG), and people who inject drugs (PWID) have been implemented by Civil Society Organizations (CSO). National prevention data was not systematically available and analysed in the past and data collection was mainly done by individual CSOs only for the purpose of donor reporting with limited analysis to guide and inform the programme. To optimize data-informed programming, National Center for HIV/AIDS, Dermatology and STD (NCHADS) established a National Prevention Database in April 2018 to ensure collection, consolidation, analysis and use of granular HIV prevention data for continued feedback and improvement of HIV prevention and testing programming for KPs. Data informed programming is proven to be of utmost importance particularly in

the context of reaching the unreached (including partners of KPs) and to boost agility and adaptation to continue needed services for KPs even in time of Covid-19 pandemic.

- **Contribution to the AIDS response:** Establishment of National Prevention Database has led to improvement in data quality; timely and granular data analysis; data use for strategic targeting of high risk and unreached KPs using differentiated HIV prevention approaches including hybrid of physical and virtual outreach, to overcome the challenges of physical outreach posed by COVID-19 pandemic related restrictions. Timely analysis of routine prevention programme data indicated limited coverage of HIV prevention through physical outreach, and it calls for expansion of virtual outreach to continue reaching and maximizing HIV prevention coverage among KPs amidst of Covid-19, in particular for MSM and TG populations. Similarly, with COVID-19 related disruption of community-based HIV testing services, virtual outreach services are rapidly expanded to ensure that KPs are linked to HIV testing through appointed community-based testing, HIVST or facility-based testing. That has led to reaching the unreached KPs who have never tested before and proving efficiency gains to reach first 95 target. The data has also informed policy and strategy changes in HIV prevention. National Strategic Plan for HIV and STI Prevention and Care in Health Sector 2021-2025 recognised virtual outreach and interventions as effective differentiated HIV prevention approaches. The strategy endorsed introduction, strengthening and scale up of virtual interventions, to bolster achievement of elimination of new HIV infections by 2025. This strategic plan also informed Cambodia's Global Fund proposal development and funding allocations. Boosted Continuum of Prevention to Care and Treatment (BCoPCT) Standard Operating Procedures (SOP) adopted in 2012 and revised in 2018, was recently updated and adopted to include key virtual interventions and services packages for KPs to guide HIV prevention services delivery. In addition, operational guidelines for virtual intervention has developed by NCHADS with support of UNAIDS Cambodia to provide guidance for effective virtual interventions for HIV prevention education, linking to PrEP, and prevention and care continuum.

- **Results, outcomes and impact:** Responding to disruption of physical outreach amidst Covid-19, rapid expansion of virtual prevention interventions reached 14,000 EWs, 18,640 MSM, and 4,372 TG in first half of 2021 (only 4 MSM and 1TG reached via virtual outreach in 2019 same period). Virtual outreach expansion resulted in 127% and 420% increase in HIV case detection among virtually reached MSM and TG as compared to same period in 2020 (166 MSM and 73 TG in 2021 vs 73 MSM and 14 TG in 2020). This contributed to improved case finding with 24% and 30% increase in case detection among MSM and TG compared to 2020 same period (404 MSM and 172 TG in 2021 vs 326 MSM and 132 TG in 2020). High HIV yield among virtually reached MSM and TG, 17% and 30% respectively, indicated that it reached higher risk KPs. Impressively 99% of newly diagnosed KPs were enrolled in ART. 472 (49%) of MSM and 153 (64%) of TG virtually reached in 2021 were first ever HIV testers with HIV yield of 33% and 44% respectively. This implies that high risk and unreached KPs are reached through virtual interventions, and it will be the game changer to achieve 95-95-95 targets.

- **Gaps, lessons learnt and recommendations:** Data collection has been conducted by different CSOs implementing HIV prevention programme. Though standard data collection tools are in place and oriented to those CSO, some inconsistencies remain in data collection processes. Regular, and systematic data quality assurance and verifications are important in addition to regular capacity building of CSO on use of data collection tools to ensure data quality and consistency across HIV prevention programme. Data analysis has been improved including more granular data analysis and prevention data analysis is regularly presented at a quarterly meeting of National Prevention TWG, an important forum for timely and immediate actions to ensure rapid improvement of services responding to the emerging needs of KPs. Increased data use has been seen at national level, but there is still limitations at subnational level to inform actions and interventions particularly at high priority provinces especially Fast Track Cities/Provinces to guide local strategic direction and programming. Strengthening subnational capacity on data analysis and use is required to ensure sufficient capacity and skills are in place to support the use of strategic information to guide subnational HIV response, resource mobilization and efficient allocations.

- **Annexes:** https://unaids.sharepoint.com/:f:/s/FSAP/Eqb_NUYiUDNKsbG7uB5qGi4Bhx3RaMaz9cCp75FyBmZXtA?e=uFN6Rp

12. Pakistan

CONTACT PERSON

Name: Ms Yuki TAKEMOTO
Title: Country Director
Organisation: Joint United Nations Programme on HIV/AIDS (UNAIDS) Pakistan
Address: Level 5 Serena Business Complex, Islamabad
Email: takemotoy@unaids.org
2)
Name: Mr Taoufik BAKKALI
Title: Regional Director a.i.
Organisation: Joint United Nations Programme on HIV/AIDS (UNAIDS), Regional Support Team for Asia and the Pacific
Address: 9th Floor, Block A, United Nations Building, Rajadamnern Nok Avenue, Bangkok 10200 Thailand
Email: bakkalit@unaids.org

- **Timeline of the case study**: During March 2020 to July 2020
- **Data is collected by:** Government; UN or other international organisation
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** UN or other international organisation; Government
- **Data is used for**: Target setting; Resource allocation; Data-driven policy change
- **Background and objectives:** This case study is to showcase how the regional data platform can contribute to national AIDS response and guide HIV programming, policy changes, target setting in national AIDS strategy, and the resource allocation particularly domestic resource for AIDS response in national and provincial annual development plans. Pakistan is one of the key countries in Asia-Pacific region with major increase in HIV epidemic, particularly among key populations. The country has continuously attempted to bring the AIDS epidemic under control, but the challenges remain in scaling up services, introducing the innovative tools and re-energizing the existing HIV programmes that call for a comprehensive National AIDS Strategy with clear target setting. HIV and AIDS Data Hub for Asia-Pacific (hereafter, the Data Hub) of the UNAIDS is a regional entity that responds specifically to the strategic information needs of country and regional partners, community and civil society through its web portal and through direct technical support. Working hand in hand with national and provincial AIDS authorities and all relevant stakeholders, the Data Hub has provided a wide array of technical support that are fundamental in development of The Pakistan AIDS Strategy 2021-2025 (PAS IV).

- **Contribution to the AIDS response:** 1) Review of key population size estimates, prevention, testing, treatment coverage supported in identifying the critical issues in country AIDS response and in formulating targets of national and provincial AIDS strategy by 2025 2) Sub-national level in-depth analyses were conducted particularly on the service gaps among key populations highlighting the inequalities in service provision and thus KP were left behind. These analyses on gaps and inequalities in service provision led to the consensus among provincial and national stakeholders on setting up ambitious targets and endorsement of high-impact service delivery models including age-group tailored, HIV prevention services for key populations 4) Constructing national and provincial AIDS response scenarios and conducting the epidemiological impact analysis led to the ambitious target setting along with the endorsement of the service delivery that are tailored to local epidemic contexts 5) Evidence drawn from the epidemiological impact analysis are used in formulating the monitoring framework of provincial and national AIDS strategies that guide the implementation roadmap for achieving the ambitious targets. The national AIDS strategy also endorses introduction and scale up of innovative interventions, such as HIV self-testing and PrEP, to enhance the progress towards the achievement of ambitious targets by 2025.

- **Results, outcomes and impact:** 1) Provincial and national AIDS strategies developed with more ambitious targets set on key populations services disaggregated at the sub-national level, and are used to guide scaling up provincial and national AIDS response 2) Provincial and national AIDS strategies were used for resource mobilization for country’s AIDS response not only from the Global Fund Grant that allocated over 71 million US$ for a three year grant period of 2021-2023, but also for allocation of domestic resources from the Federal and provincial governments for AIDS response in their annual development programme - 400 million Pakistani rupees (PKR) allocated in Punjab, about 50 million (PKR) in Khyber Pakhtunkhwa, 54 million (PKR) in Balochistan, more than 289 million in Sindh and 10 million (PKR) from Federal Government for the financial year 2021-2022.

- **Gaps, lessons learnt and recommendations:** The national AIDS strategy that is well informed by data and strategic information is proven to be utmost importance in formulating the strategic interventions that are tailored to the specific needs of key and marginalized populations. Bottom-up approach – using local/sub-national data to construct provincial scenarios, targets and strategies that were formulated into national strategy – leads to the implementation plan that responds to the local epidemic contexts Inclusiveness - extensive consultations and inputs from provincial and national key stakeholders including key populations and community representatives – was key to successful development of The Pakistan AIDS Strategy 2021-2025 (PAS IV).

- **Annexes:** N/A

13. Papua New Guinea

CONTACT PERSON

Name: Marielle Sander
Title: Country Representative
Organisation: UNFPA Papua New Guinea
Address: 14th Floor Kina Bank Bldg, Port Moresby, PNG
Email: sander@unfpa.org

- **Timeline of the case study**: 2021

- **Data is collected by:** Government; Civil society; UN or other international organisation

- **Data collection is:** Supplemental collection of data

- **Data is analysed by:** Government; Civil society; UN or other international organisation

- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change

- **Background and objectives:** Papua New Guinea (PNG) has the highest prevalence of both HIV and STIs in the Pacific region. The prevalence of HIV among adults 15 – 49 years was estimated at 0.7% in 2010 and has increased to 0.9% in 2020. Ten of the 23 provinces are rated as high-burden. 2018 IBHSS showed that HIV prevalence was also significantly higher among key populations - female sex workers, men who have sex with men and transgender people. The estimated prevalence of STIs is also increasing among the general population and is significantly higher than WHO global estimates for chlamydia and gonorrhea. PNG is also among the countries with the highest positivity rate of syphilis among pregnant mothers attending ANC at 4.6% for the Western Pacific Region. About 12% of girls aged 15-19 have given birth or have started childbearing (NDHS 2016-2018). Condom uptake has stalled in the absence of comprehensive HIV prevention programs particularly for key populations (UNFPA-supported 2021 Condom Study). Low condom usage among key demographics and the general population will continue to drive transmission of both HIV and STIs in PNG. Lack of transport preventing ART access was the biggest issue for HIV during the COVID-19 state of emergency in 2020.

- **Contribution to the AIDS response:** Availability and use of quantitative data from IHBSS has helped identify the situation and severity of HIV and STI in the country as a whole (vis-à-vis the rest of the Western Pacific region) and its disaggregation by sex, age and whether urban or rural. Provincial health authorities in PNG learned about the HIV and STI situation in their respective provinces. Qualitative data from a UNFPA-supported study gave a better understanding of the influence of cultural norms and beliefs and influencers on the use of condoms and on access to family planning. IHBSS data had helped inform the comprehensive review of the National Comprehensive Condom Programming Strategy in PNG from 2010 to 2020 which, in turn, will inform the development of a new five to 10-year national condom strategy. UNFPA-supported focus group consultations with key populations and young people helped document current social, cultural, institutional and economic barriers to uptake of condom use & behaviors aimed at reducing the risk of STI to inform the updating of the PNG Adolescents and Youth Health Policy. Overall, however, there is still insufficient access to accurate and timely data on STI and HIV in PNG that can be used to effectively guide national AIDS response and drive service and program improvements. The eNHIS has been slow and the system continues to face data quality, completeness and timeliness issues. Notable is the lack of data on people tested for HIV by key population as surveillance tools do not capture that and data systems and practice make it difficult to differentiate PLHIV health by key population. Data is collected by occasions of one-to-one and group support (not by individuals serviced) and frequency of data reporting is erratic. Qualitative data on STI and HIV are hampered by stigma and discrimination, security problems, partner/spousal pressures, and inaccessibility.

- **Results, outcomes and impact:** The National STI and HIV Strategy 2018-2022 states that the government aims to have the “right services, provided in the right places, accessed by the right people” and importantly integrates condom programming for the prevention and reduction in transmission of STIs and HIV, both in key/high risk demographics and the general population. The current health burden of both STIs and HIV and the health needs that exist for all people in PNG, however, remains significant and extremely critical. Key indicators for HIV/AIDS in PNG in 2010 and 2020 based on the UNAIDS estimates revealed that the 90-90-90 knowledge on HIV status on average was about 75% and 90-90-90 ART coverage was about 65% respectively in 2020. Data on 90-90-90 viral suppression is not available. Mainly funded by the national government with minimal donor support, public health expenditure as a share of GDP fluctuated substantially between 2004 to 2018, ending at 2.4 % in 2018. The National AIDS Council (NAC) and the NAC Secretariat (NACS) has experienced severe management and accountability crisis during the decade which resulted, in part due to the decline or withdrawal of donor funding that resulted in the closure of provincial AIDS committees (PACs) in all provinces.

- **Gaps, lessons learnt and recommendations:** The NAC and NACS need to review organizational structures, human capital requirements and M&E framework in the formulation of the new comprehensive condom programming (CCP) strategy in PNG. NAC/NACS will have to take ownership and coordination of the new CCP strategy and establish MOUs with Provincial Health Authorities and other stakeholders for the efficient management, coordination, monitoring, accountability and delivery of the new CCP strategy in the next 5-10 years and beyond. Despite 60 % of the total population of PNG being below 25 years old, there is no national government response to addressing the sexual and reproductive health needs of adolescents and young people. NDoH together with NACS, PHAs and key stakeholders need to prioritize the S&RH of young people through urgent condom service delivery and education. Government needs to invest on STI and HIV data collection & analysis. Level 2 facilities have begun to use eNHIS-loaded android tablets but unstable network connectivity and capacity issues hamper good data management. Trained and coached KP outreach workers, VHV and Mentor Mothers will need to take a much more active role in identifying people lost to follow-up and supporting them in communities to re-engage with clinical services, support and treatment.

- **Annexes:**

- https://docs.google.com/document/d/1ZVVbipacVxHdEC7BMubMjo2SqTJ4M5ap/edit
- https://docs.google.com/document/d/1Tk489fpQ7IIB_F3d7xDbWK7NmVUBMGW2/edit
- https://dhsprogram.com/publications/publication-fr364-dhs-final-reports.cfm
- https://www.aidsdatahub.org/resource/factsheets-2018-integrated-hiv-behavioral-serologic-surveillance-ihbss

14. Sri Lanka

CONTACT PERSON

Name: Dr Ariyaratne Manathunge

Title: Coordinator Strategic Information

Organisation: National STD/AIDS control programme

Address: 29, De Saram place Colombo 10 Sri Lanka

Email: ariyaratne1@gmail.com

- **Timeline of the case study**: N/A

- **Data is collected by:** Government; Civil society

- **Data collection is:** Supplemental collection of data

- **Data is analysed by:** Government; Civil society

- **Data is used for**: Data-driven policy change

- **Background and objectives:** National STD/AIDS Control Programme (NSACP) of Sri Lanka is responsible for coordinating the national response to HIV and sexually transmitted infections in collaboration with national and international stakeholders. NSACP networks with 41 district STD clinics islandwide providing full time service delivery, and 30 clinics among these are providing antiretroviral treatment services. The vision of the NSACP is to contribute to a healthier nation free of new sexually transmitted infections including HIV, discrimination, and AIDS related deaths, while the mission is to improve the quality of sexual health services to prevent new HIV and sexually transmitted infections and provide comprehensive care and treatment services.

- **Contribution to the AIDS response:** Unique Identifier Code (UIC) Continuous monitoring of coverage indicators is an important aspect of any HIV prevention programme for key populations (KPs). The majority of coverage indicators involve the use of programmatic data and population size estimates. Most of the programme data are required to be distinguished between the number of clients accessing a service (or package of services) and the number of client contacts for that service (or package of services). This could be achieved only through introducing a suitable UIC into HIV Programme. A UIC is effective only if it can identify individuals while keeping their confidentiality. Therefore, usual citizen identification methods such as National identity card number or passport number cannot be considered as suitable UICs for key populations since certain behaviours of key populations are stigmatized and even illegal according to the current legal system of the country. Therefore, a special code was designed in collaboration with the key population stakeholders, and it was field-tested to see the suitability of the code. The agreed upon Unique identification code uses six prompts. The properties of each item/prompt are defined using fields as explained below. 1. First letter of first name 2. First letter of the second name 3. Month of birth as two digits 4. Date of birth as two digits 5. District of birth as two-character code 6. Biological sex at birth In this unique code, all information should be used as per the client's national identity card or birth certificate. The below graphic was designed and displayed at places where UIC is generated to explain the process of UIC development.

- **Results, outcomes and impact:** The same UIC is being used by government and non-government agencies who are working to provide HIV services for key populations. There are 4 electronic information systems involved in monitoring and documenting key population HIV services. All these systems use the same UIC. 1. EIMS (Electronic Information Management System) - A medical record system used in STD clinics 2.MEMIS (Monitoring and Evaluation Management Information System) – Used by NGO PR. 3.PIMS (Prevention Information Management System)- This is nearly completed and will be used to monitor physical outreach activities of government and NGO service providers 4.know4sure.lk- This is a platform used to reach key population virtually. Key populations will be able to log on to this platform and book clinic appointments and order health products such as condoms, lubricants, HIV self-test kits and receive them via post. Since all platforms use the same UIC, monitoring of individual key population clients through the HIV prevention and testing services to treatment and care up to viral load suppression made possible.

- **Gaps, lessons learnt and recommendations:** However, there are some limitations of the UIC as it is dependent on the information of the users, and biometrics such as fingerprints, facial recognition, retinal scan etc. are not being used. Therefore, this type of UIC will uniquely identify all the key populations fully accurately only in a key population empowered society. However, based on the initial filed testing, the current UIC identifies an acceptable proportion of key populations while maintaining their confidentiality. Training of health workers and key population advocates are essential for the successful rollout of the UIC in island wide service centers.

- **Annexes:** N/A

Eastern Europe and Central Asia

15. Belarus

CONTACT PERSON

Name: Tatsiana Zhurauskaya

Title: Chairman

Organisation: Republic public association "People PLUS", Belarus

Address: Svetlogorsk, Internationalnaya street, building 1, office 70

Email: svetlotanya@mail.ru

- **Timeline of the case study**: October 2017 - present
- **Data is collected by:** Civil society
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** Government; Civil society; UN or other international organisation
- **Data is used for**: Data-driven policy change
- **Background and objectives:** The organization worked towards changing the existing legislation in the country, and also defended the rights of people living with HIV. The organization collected data and strategic cases on bringing people living with HIV to criminal and administrative responsibility under the article "HIV infection".The collection of cases was broken down by parts of this article and by gender identity. At the same time, every six months, information on the article "HIV infection" was requested from government agencies. All people were provided with legal, consulting and psychological assistance.
- **Contribution to the AIDS response:** During 2017 - 2019, round tables were held, working meetings with decision-makers in the country using case studies, and presentations of victims. There was a regular information campaign in the media. Case-based training of medical personnel and journalists was carried out. Together with the Ministry of Health, with the support of the country WHO and UNAIDS, they submitted a proposal to the Parliament to revise this article, using case studies data (86 cases). On July 19, 2019, the article was revised. it was amended. This made it possible to terminate criminal cases under this article, which came up under the amendment, to release 78 people from prisonsThe action of becoming "Infection with HIV" has softened and people have become less afraid to go to medical institutions, register, and receive treatment. Blackmail and domestic violence were ruled out.
- **Results, outcomes and impact:** The article was edited on July 19, 2019. it was amended. This made it possible to terminate criminal cases under this article, which appeared in accordance with the amendment, and to release 78 people from prisons.

About 60% of criminal and administrative cases were against women and girls. Women are less afraid of starting families and having children.

- **Gaps, lessons learnt and recommendations:** When collecting data, difficulties arose due to the fact that people living with HIV were afraid of disclosing their diagnosis, did not agree to submit for a reconsideration of the case, and were afraid to hire a lawyer. The organization had very little funding for this research activity, as well as for legal assistance to the victims of this article. Much of the activity was carried out on a volunteer basis.

- **Annexes:**

  - http://hiv.by/news/ludi-plus/o-tekushchej-deyatelnosti-uchastie-v-sudebnykh-zasedaniyakh
  - http://hiv.by/news/
  - http://www.ewna.org/3497-2/
  - http://hiv.by/news/ludi-plus/kruglyj-stol-o-dekriminalizatsii-peredachi-vich-v-semejnykh-parakhludi-plus/primechanie-k-st-157-uk-rb-chto-dalshe

16. Kyrgyz Republic

CONTACT PERSON

Name: Dr. Cholpon Imanalieva

Title: Health Specialist

Organisation: UNICEF

Address: Chui ave. 160, Bishkek, Kyrgyz Republic

Email: cimanalieva@unicef.org

- **Timeline of the case study**: July - November 2020
- **Data is collected by:** Ministry of Health of the Kyrgyz Republic (Osh Oblast AIDS Center)
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** UN or other international organisation; Minister of Health of the Kyrgyz Republic (Republican AIDS Center, Osh Oblast AIDS Center)
- **Data is used for**: Maximising service coverage; Data-driven policy change
- **Background and objectives:** Under the State Program to Overcome HIV Infection in the Kyrgyz Republic 2017–2021, the country committed to reducing mother-to-child transmission of HIV to less than 2% by 2021. Prior to the pandemic, the Kyrgyz Republic had been working steadily to integrate PMTCT services within the perinatal health care delivery system. The first cases of COVID-19 were detected in the Kyrgyz Republic on March 24, 2020. On March 25, 2020 the government declared a state of emergency that was extended to various parts of the country. As the COVID-19 pandemic progressed, a number of factors converged that threatened to disrupt delivery of PMTCT services and presented new challenges to reaching vulnerable pregnant women with HIV testing. As the global pandemic worsened, large numbers of Kyrgyz citizens working in Russia, Turkey, and Kazakhstan, began returning home, including pregnant women. In July 2020, Osh Oblast AIDS Center in coordination with the Territorial Hospital in Osh, approached the Republican AIDS Center, the Ministry of Health of the Kyrgyz Republic, and UNICEF to develop a plan to identify vulnerable pregnant returnees; ensure they were offered PMTCT services, namely HIV testing; and develop measures to minimize disruptions to PMTCT services.
- **Contribution to the AIDS response:** With support from UNICEF, the Osh Oblast AIDS Center in collaboration with specialists from the Ministry of Health, Republican AIDS Center, and maternity hospital developed an algorithm for HIV testing of pregnant returnees who were facing pandemic-related barriers to receiving PMTCT services. The algorithm was developed to facilitate identification of hard-to-reach patients and promote easier access to timely HIV testing while minimizing risk of exposure to COVID-19 for both pregnant women and health care providers. The algorithm incorporated strategies that had previously been successfully used with key populations to promote HIV testing, but had not been used in the provision of PMTCT

services for pregnant women in the past. These strategies included: the use of rapid HIV self-testing kits as a screening tool for pregnant women who faced barriers to accessing in-person ELISA HIV testing at PHC locations and the use of instant messaging services like WhatsApp and Telegram to directly communicate with pregnant women to encourage HIV testing, obtain informed consent, and provide pre/post-test counseling through video calls to support HIV self-testing. The algorithm was reviewed and approved by decree of the Ministry of Health (Ministry of Health Order No. 621 8/14/2020). Importantly, Order No. 621 also authorized the use of HIV rapid self-testing kits for pregnant women and their sexual partners (supported with pre/post-test counseling by trained PHC health care providers and AIDS health specialists). In addition, Order No. 621 included a provision to provide distance education training on PMTCT to strengthen the quality and ensure continuity of services under difficult pandemic-related circumstances.

- **Results, outcomes and impact:** To support the implementation of these strategies on promotion of access to PMTCT services during the COVID-19 pandemic, the Osh Oblast AIDS Center received funding from UNICEF to: (1) develop an e-version of an educational leaflet on the importance of PMTCT for distribution to women and health care providers; (2) develop and conduct refresher training on PMTCT that included information on the new protocols related to supported rapid HIV self-testing for pregnant women; (3) carry out phone-based interviews with pregnant women and health facility staff to identify barriers to accessing PMTCT services. As a result of the project over a four-month period from July – November 2020, Osh AIDS center ensured access of vulnerable women to PMTCT services, through introduction of rapid HIV tests for self-testing, use of mobile platforms in the testing and tracking processes. Thus, Rapid HIV self-test kits were a helpful tool in ensuring timely HIV screening for a highly mobile population, while WhatsApp offered a flexible platform for conducting outreach and support for vulnerable women. A total of 123 women or 55% of all pregnant returnees were identified as being in need of an HIV test (either because they had never enrolled in antenatal care, or had not yet received an HIV test as part of their antenatal care services in the host country).

- **Gaps, lessons learnt and recommendations:** Fear of HIV stigma poses a barrier to uptake of HIV testing for pregnant women. Osh AIDS Center conducted telephone interviews with 113 pregnant women and 27 pregnant women who were HIV positive. Interviewed described worries and fears related to possible stigmatization and discrimination associated with HIV. Women expressed initial resistance to testing as they feared the act of getting tested would reflect negatively on their character and reputation. Attitudes about HIV among family members influenced woman's decision regarding testing. Gender inequalities pose increased risks for HIV positive pregnant women and increase their vulnerability. HIV stigma remains a serious barrier to uptake of services. Attitudes towards HIV held by family members play a role in determining acceptance of PMTCT services. Ways in which inequalities interact with HIV stigma and influence women's decision-making regarding uptake and adherence to PMTCT services has received little focused attention. Women's concerns about social stigma, abandonment, divorce, family violence related to HIV disclosure need to be further explored and addressed with psycho-social support. Community education can improve public awareness about HIV, reduce stigma, and promote social acceptability of PMTCT as an important component of perinatal care for the protection of the health of infants and mothers.

- **Annexes:**

17. Ukraine

CONTACT PERSON

Name: Olena Brahinska

Title: HIV/AIDS Officer

Organisation: UNICEF Ukraine

Address: Kyiv

Email: obrahinska@unicef.org

- **Timeline of the case study**: October-December 2020
- **Data is collected by:** Inter-Sectoral Working Group on Validation of Elimination of HIV Mother-to-Child Transmission, MOH Ukraine with UNICEF's support
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** Government; Civil society; UN or other international organisation
- **Data is used for**: Data-driven policy change; Resource allocation
- **Background and objectives:** At the end of 2020 UNICEF supported Inter-Sectoral Working Group on Validation of Elimination of HIV Mother-to-Child Transmission, MOH Ukraine (EMTCT IWG) to conduct the Study "Assessment of COVID Impact on Quality of Medical Services for HIV-Positive Women in Ukraine". Due to limitations caused by COVID-related lock down that led to increased poverty in key populations, limited access to medical and social services there was a necessity to better strategize regional HIV and PMTCT activities for women and children. The study included interviewing of 300 HIV positive women of reproductive age all over the Ukraine. Interviewing was conducted by interviewers mostly by phone or on-line means of communication based on developed questionnaire. The interviewing was voluntary and confidential. The Questionnaire contained of several parts: 1) socio-demographic data and social determinants; 2) access to medical care for their children; 3) access to contraception; 4) access of women to medical services (incl. ARVs, lab testing, etc.); 5) access to COVID-related medical services; 6) emotional status of HIV-positive women.
- **Contribution to the AIDS response:** Results were used by Partners for preparation of GFATM proposal in 2021 to mitigate COVID – related consequences in key populations. The study served as background information to justify specific COVID-related support to HIV positive pregnant women and mothers and their children. The study was also used by EMTCT IWG as one on the evidence-based document for the development of new PMTCT Clinical Guide.
- **Results, outcomes and impact:** The Study identified following COVID-related impact. 28% worsening of family relationship. 71% of women claimed reduction of their income 32% of respondents have children under 18 months old, and only 85% were provided with milk formula for their babies by Government. 22% of mothers did

not receive due governmental financial aid. 97% of mothers noticed the same or even improved access to ARVs for their children. However, only 16% of children have an access to co-trimoxazole prevention. 20% claimed limited access of their children to pediatricians. Women noted worsening access to different medical services during the COVID pandemic, namely 40% to family doctor; 26% to AIDS Centers; 20% to gynecologists; 22% to contraception. 99% of women-received ART. The 95% were provided with ARVs for 1 to 3 months. 15% of respondents had treatment interruptions mostly due to transportation problems. 81% of undetectable viral load that is insufficient treatment result. 30% of respondents had COVID contact and 10% developed COVID disease. 53% had access to free COVID testing and none of respondents had access to COVID vaccination. 66% of respondents noticed worsening of their emotional status due to COVID situation. More than 50% requested for psycho-social support.

- **Gaps, lessons learnt and recommendations:** The study covered very limited number of key issues that were assumed to be hampered due to COVID situation. However, study was not aimed to cover increased health system gaps due to COVID and simultaneous change of finding mechanisms due to health reform. The had limited number of respondents that is sufficient for statistically reliable results but could not be used for disaggregation per oblasts. The study design considered time and financial constrains and aimed to cover the limited number of key findings to be used for preparation of recent normative documents. The questionnaire was designed to cover points that are common for HIV-positive women with children of different ages to be able to assess EMTCT medical services, HIV-services as well as general medical services for HIV-positive women and their children. Given that this study was the only one to provide statistically proven data by the time of GFATM application for COVID mitigation in key populations, it was used to justify such services as transportation, intensified psycho-social support, and some others. The study was used by HIV-service NGOs to improve services for women within current GFATM proposal. At the same time, HIV-service NGOs together with EMTCT IWG intensified efforts to revive Oblast EMTCT Committees that were created in 23 Oblasts of Ukraine about 2 years ago but reduced their activities because of COVID.

- **Annexes:**

https://phc.org.ua/sites/default/files/users/user90/Report_COVID19_HIV_women.pdf

18. Ukraine

CONTACT PERSON

Name: Oleksandr Kulchenko

Title: Senior Specialist

Organisation: CO "100 PERCENT LIFE"

Address: Mezhyhirska Str., 87B

Email: a.kulchenko@network.org.ua

- **Timeline of the case study**: January1, 2021 - June 30, 2021
- **Data is collected by:** Civil society
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Civil society
- **Data is used for**: Data-driven policy change; Resource allocation; Target setting; Maximising service coverage
- **Background and objectives:** Data management system “DATACHECK UKRAINE” is used to track programmatic activities related to community outreach, case management and community monitoring of human rights violations, including stigma and discrimination issues towards vulnerable populations. The service-provision projects clients directly verify the provided services using interactive digital solutions or mobile phone. Thus, the 100 PERCENT LIFE projects monitoring and evaluation use data collected through this system. It allows real time on-line field programmatic data collection, processing and analysis.
- **Contribution to the AIDS response:** Use of DataCheck Human Rights module allows to improve access of key affected populations to basic paralegal and legal services. Having abtained legal support representatives of these groups have higher chances to receive proper medical and social assistance, enroll and be retained in treatment and social services thus leading to decrease in a number of new cases of HIV infection. The Data collected by the paralegal hub and the app allows for better planning of activities aimed at counteracting the gender based violence and violations of human rights both on national and sub-national levels by the coordinating mechanisms.
- **Results, outcomes and impact:** As a result, using the Datacheck mobile application representatives of groups vulnerable to HIV and TB in 24 regions of Ukraine (PLHIV, MSM, PWID, sex workers, trans* people, women living with HIV, adolescents living with HIV, TB patients) are able to receive paralegal assistance and, if necessary, support to obtain when needed human rights and psychological assistance in the framework of other Global Fund interventions. Training and involvement of at least200 paralegals in 24 regions of Ukraine provided paralegal assistance in cases of gender-based violence against the representatives of groups vulnerable to HIV and TB. Paralegals also provide assistance in recovering lost documents (passport,

birth certificate, etc.), escort to social services and services that provide assistance to victims of gender-based violence, as well as referral to sign a declaration with a friendly family doctor in case a person has no signed declaration.

- **Gaps, lessons learnt and recommendations:** The major bottleneck in rollout of this intervention is the need to familiarize the paralegals with the application. For proper collection of cases of violations of human rights the app must also be used by the clients. To ensure proper implementation of this intervention training sessions were organized for the paralegals involved. Information about the app was distributed within the networks of communities of people most vulnerable to HIV.

- **Annexes:** N/A

19. Ukraine

CONTACT PERSON

Name: Naira Sargsyan

Title: Strategic Information Adviser

Organisation: UNAIDS Country Office

Address: 36V Saksaganskogo Street, Kyiv 01033

Email: sargsyann@unaids.org

- **Timeline of the case study**: 2017-2021
- **Data is collected by:** Government
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government
- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change
- **Background and objectives:** Ukraine has the second-largest HIV epidemic in Eastern Europe and Central Asia. By the end of 2020 the estimated number of people living with HIV (PLHIV) was 257,548. The HIV response remains a priority in Ukraine, particularly in reducing infection and mortality rates, as well as providing adequate care for PLHIV. One of the key problems in combating HIV/AIDS is that management decisions are not sufficiently comprehensive, timely, or substantiated. One reason behind this was the lack of a unified approach in the mechanisms used to collect and process information at State medical institutions between the national (Public Health Centre of the Ukrainian Ministry of Health (PHC of the MOH of Ukraine)), regional, and local (private consulting offices and antiretroviral medicine distribution points in local clinics and hospitals) levels. The development and introduction of the medical information system “HIV-infection in Ukraine” (MIS HIV) in 2015 aimed to solve this problem with the creation of a unified repository for routine HIV/AIDS epidemiological surveillance data, medical results of PLHIV as well as to optimize monitoring and evaluation, drug procurement planning and the registration and control of health commodities. Currently, HIV MIS is a comprehensive system that is constantly evolving, receiving new modules, including a module on substitution maintenance therapy and tuberculosis, monitoring of recent HIV infection, pre-exposure prophylaxis, the possibility of online recording and counseling, monitoring of treatment interruption.
- **Contribution to the AIDS response:** The introduction of MIS HIV has had a number of positive outcomes at the various administrative levels. At the local level, for example, the system guarantees a reduction in the number of errors in completing medical documentation and the efficiency of information exchange. At the regional level, it allows to maintain records and audit drugs and medical devices at health-care facilities. Ukraine adopted a public health approach to countering epidemics. The Cabinet of Ministers of Ukraine approved a new unified HIV/TB/Hepatitis

strategy up to 2030 with Fast Track targets in 2019. The strategy uses a patient-centered, combined approach that focuses on prevention programs targeting key populations while expanding access to treatment. Ukraine uses ambitious global goals 95-95-95 for its national strategy. MIS HIV data was a main source for data-driven interventions and target setting. Ukraine updates its HIV prevention and treatment guidelines in a timely manner, but the current system of routine reporting is quite inflexible. Only due to MIS HIV is it possible to track the achievements, identify gaps and plan the expansion of such programs as Test and Start, OST, and PrEP, monitor recent infection. The ongoing medical reform provides payment at the capitation rate or treated case. In the case of HIV, MIS HIV is the only source of information about the number of patients receiving treatment. Institutions that provide care to PLHIV receive State Funding based HIV MIS data.

- **Results, outcomes and impact:** By the end of 2020, 69% of PLHIV were aware of their status, 83% were on treatment. Of those on treatment, 94% were virally suppressed. In 2020 were reported 29% less than in 2019 AIDS-related deaths and 4% less newly diagnosed HIV cases accordingly. In 2020, 60% of newly diagnosed started ART in the first 7 days. Another example of the use of data obtained from MIS HIV is a study on the national assessment of the introduction of optimized ART regimens. The study was launched by the PHC of the MOH of Ukraine in 2018 in order to build an evidence base for the effective transition of ART treatment regimens from an enhanced Lopinavir to a Dolutegravir (DTG) regimen. At the end of 2020, among 122 thousand PLHIV in the territories controlled by the Government of Ukraine, 50% of people received ART schemes with DTG. Pre-exposure prophylaxis (PrEP) was introduced in 2017 as part of a pilot project for MSM and transgender people. The pilot project contributes to the development of a sustainable PrEP delivery model for these groups. Since 2017 more than 6000 persons from different groups with a high risk of infection had started PrEP.

- **Gaps, lessons learnt and recommendations:** A significant problem is the lack of data from territories not controlled by the Ukrainian Government (Crimea, part of the Donetsk and Luhansk regions). Only NGOs may have access to data from mentioned territories but it still remains unreliable. Medical reform and the transition of patients from specialized institutions to family physicians, introduction of different medical information systems has led to the need to create a mechanism for data exchange within the electronic health care system of Ukraine. Appropriate mechanisms are currently being developed in the MIS HIV. The protection of HIV patients' personal data also requires restrictions on access to this information. To address this problem, MIS HIV has a system for differentiating levels of access to patients' medical records, as well as an analytical module that contains depersonalized data.

- **Annexes:** https://www.euro.who.int/__data/assets/pdf_file/0003/398343/short-comm-HIV-Ukraine-eng.pdf

20. Russian Federation

CONTACT PERSON

Name: Ms. Daria Chaadaeva

Title: Specialist

Organisation: Department of International Cooperation and Public Relations, Ministry of Health of the Russian Federation, Moscow

Email: ChaadaevaDS@minzdrav.gov.ru

- **Timeline of the case study**: Since 2017 till present day
- **Data is collected by:** Government; Private sector; Academic institution
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; Academic institution
- **Data is used for**: Target setting; Resource allocation; Maximising service coverage
- **Background and objectives:** Since 2017, the Russian Federation has been using a protected federal information resource “The Federal Register of Persons Infected with HIV”, developed in order to record information on HIV cases and containing information on all identified cases of HIV infection in the country. The Federal Register unites a wide network of country’s medical organizations which provide medical care to people living with HIV; currently, 965 medical organizations are entering data into the Register. The rules for maintaining the register are enshrined in a decree of the Government of the Russian Federation. Several blocks of information are entered into each register entry: epidemiological, clinical, laboratory, and therapeutic. When new patient data appears, the information is updated in an online mode.
- **Contribution to the AIDS response:** The Federal Register is a flexible tool that allows to obtain the most objective data on fluctuations in morbidity in a particular territory and in the country as a whole, movement of patient population, clinical forms of the disease, HIV transmission routes and many other parameters, as well as to track the dynamics of their change. Also, information on antiretroviral therapy is entered into the Federal Register, which allows the state to form the structure of medicines provision on a personalized basis and ensure patients are continuously receiving their prescribed treatment regimens. And thanks to the possibility of transferring information between medical centers, uninterrupted medicines supply is guaranteed also when the patient changes his place of residence.
- **Results, outcomes and impact:** Using the capabilities of the Federal Register made it possible to timely identify problem regions and territories, carry out targeted work to improve the epidemic situation, and, ultimately, helped to achieve a steady trend towards a decrease in the incidence of HIV infection in Russia.

- **Gaps, lessons learnt and recommendations:** None.
- **Annexes:** N/A

Latin America and the Caribbean

21. Brazil

CONTACT PERSON

Name: Gerson Fernando Mendes Pereira, MD., PhD.

Organisation: Department of Diseases of Chronic Condition and Sexually Transmitted Infections, Ministry of Health of Brazil

Address: Address: SRTVN Quadra 701, lote D, PO700 - Brasília/DF Zip code: 70719-040, Brazil

Email: gerson.pereira@aids.gov.br; cooperacao_internacional@aids.gov.br

- **Timeline of the case study**: From 2019 to 2021

- **Data is collected by:** Government

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** Government

- **Data is used for**: Data-driven policy change

- **Background and objectives:** The current effect of COVID-19 on public health has been of great proportions and it goes far beyond controlling the pandemic. Despite many studies suggesting that people living with HIV (PLHIV) with viral load suppression are not at higher risk of COVID-19 infection nor at higher risk of clinical severity, they are particularly vulnerable, since HIV continuum of care interruption and consequently compromised immune system put them at higher risk for contracting SARS-CoV-2 and experiencing complications related to both COVID-19 and HIV infection progression. There is a growing concern about HIV services delivery disruptions, during COVID-19, which might lead to a rise in HIV-related deaths and onward transmission. According to UNAIDS, the complete interruption in HIV treatment for six months could lead to more than 500,000 (471,000-673,000) deaths from AIDS-related illnesses. The Ministry of Health of Brazil (MoH) continuously monitors HIV indicators and revises its directives to timely respond to the HIV epidemic. This study aims to analyze the effects of COVID-19 on the HIV continuum of care in Brazil and to summarize the main timely actions taken by the MoH to guarantee proper health care for PLHIV during the COVID-19 pandemic.

- **Contribution to the AIDS response:** In April 2020, Brazil registered drops in PrEP withdrawals and in new PrEP users. In March, MoH encouraged PrEP withdrawals for four months and, in May, telehealth platforms were adopted, which has simplified and streamlined procedures for PrEP initiation, facilitating and enabling PrEP services continuity during quarantine. When comparing April to January 2020, Brazil experienced a decrease of 48% in the number of PLHIV who had the first CD4 and HIV viral load (VL) tests before ART initiation, and of 25% in the number of PLHIV starting ART, what may be related to fewer HIV case identification. The MoH has emphasized HIV self-testing for key and priority populations. People in higher vulnerability for HIV infection or on PrEP may get one HIV self-test (HIVST) for personal use and five others for sexual partners or peers during medical appointments or PrEP dispensations. PLHIV on ART, especially those newly diagnosed, with poor ART adherence, lost to follow-up, or with ART failure history may get up to five HIVST for sexual partners as well. A provider-initiated counseling and testing (PICT) strategy has also been recommended, targeting not only pregnant women, but also patients diagnosed with tuberculosis, STIs, viral hepatitis, or with immunosuppression - and in case of patients' hospitalization due to respiratory syndrome. Finally, great effort was done to increase HIVST offer. Moreover, during 2020, the proportion of people overdue ART dispensation for 30 days or more increased 45%, compared to 2019. The MoH recommended ART dispensation to cover up to 90 days, telemedicine for patients' follow-up, and annual HIV VL test for those clinically and immunologically stable and asymptomatic.

- **Results, outcomes and impact:** From January to April 2020 there was a drop of 49% and 70% in the number of PrEP withdrawals and new PrEP users, respectively. However, by September 2021, an increase of 58% in PrEP dispensations and 83% in new PrEP users were observed, considering the same period in 2020. In 2020, there was an increase of 39% in PrEP withdrawals and 20% in new PrEP users, compared to 2019. During 2020, there was an increase of 5% on the number of PLHIV that had at least one ART dispensation and 106% on ART withdrawals for 60 days or more, compared to 2019. By September 2021, as ART withdrawals for 60 days or more remained close to the reported on the same period in 2020, the number of PLHIV that had at least one ART dispensation further increased by 5%. The number of PLHIV linked to public health services and those on ART upon viral suppression did not modify throughout 2019 to 2021. Fortunately, Brazil has been able to maintain its ARVs' supply chain, not only for HIV treatment but also for PrEP and PEP. Likewise, measures already underway before the pandemic were accelerated, such as the multi-month-dispensation of ARVs.

- **Gaps, lessons learnt and recommendations:** The unprecedented COVID-19 pandemic called for global commitment and urgent response and innovation. Brazil would not have been able to face these challenging times, had we not had a universal health system, so called Unified Health System - SUS. Our three decades' Constitutional commitment to universal health access has been a fundamental tool in coping with the COVID-19 pandemic. Thanks to SUS, Brazil was able not only to maintain treatment to approximately 700K people but also to keep the supply-chain of prevention inputs without any disruption, including for PrEP and PEP. Since the beginning of the pandemic, SUS programmatic data, presented above, has allowed the MoH to monitor, on a monthly basis, HIV strategic indicators, followed by actions to diminish the impact of the pandemic on the care of PLHIV. In this context, once again Brazil defends Universal Health Access and Universal Health Coverage as a motor of equity, inclusive development and prosperity for all, and also a driver for rapid crisis response. In the context of Universal Health Access, innovative actions implemented by the MoH, grounded on the robustness of our public health information systems, provided that evidence-based decisions could be taken in due course.

- **Annexes:**
  - http://www.aids.gov.br/pt-br/painelcovidHIV
  - http://www.aids.gov.br/pt-br/pub/2020/relatorio-de-monitoramento-clinico-do-hiv-2020

- https://www.in.gov.br/en/web/dou/-/portaria-n-454-de-20-de-marco-de-2020-249091587 https://www.in.gov.br/en/web/dou/-/portaria-n-356-de-11-de-marco-de-2020-247538346 https://www.in.gov.br/en/web/dou/-/lei-n-13.989-de-15-de-abril-de-2020-252726328#:~:text=Art.,emergencial%2C%20o%20uso%20da%20telemedicina
- http://www.aids.gov.br/pt-br/legislacao/oficio-circular-no-82020cgahvdccisvsms-0
- http://www.aids.gov.br/pt-br/legislacao/oficio-circular-no-132020cgahvdccisvsms
- http://www.aids.gov.br/sites/default/files/legislacao/2020/portarias_e_oficios_ministeriais_-notas_informativas/oficio_circular_n.15-2020_-_distribuicao_de_autotestes_de_hiv.pdf
- http://www.aids.gov.br/sites/default/files/legislacao/2020/-notas_informativas/sei_ms_-_0014517283_-_oficio-circular_no_12.pdf
- SWAMINATHAN, N. et al. COVID-19 in HIV-infected patients: A case series and literature review. J Med Virol, v. 93, n. 5, p. 2557-2563, 05 2021. ISSN 1096-9071 (https://www.ncbi.nlm.nih.gov/pubmed/33200823)
- NAGARAKANTI, S. R. et al. Clinical outcomes of patients with COVID-19 and HIV coinfection. J Med Virol, v. 93, n. 3, p. 1687-1693, 03 2021. ISSN 1096-9071 (https://www.ncbi.nlm.nih.gov/pubmed/32949148) XU, Z.; ZHANG, C.; WANG, F. S. COVID-19 in people with HIV. Lancet HIV, v. 7, n. 8, p. e524-e526, 08 2020. ISSN 2352-3018 (https://www.ncbi.nlm.nih.gov/pubmed/32473658) KANWUGU, O. N.; ADADI, P. HIV/SARS-CoV-2 coinfection: A global perspective. J Med Virol, v. 93, n. 2, p. 726-732, 02 2021. ISSN 1096-9071 (https://www.ncbi.nlm.nih.gov/pubmed/32692406) BHASKARAN, K. et al. HIV infection and COVID-19 death: a population-based cohort analysis of UK primary care data and linked national death registrations within the OpenSAFELY platform. Lancet HIV, v. 8, n. 1, p. e24-e32, 01 2021. ISSN 2352-3018 (https://www.ncbi.nlm.nih.gov/pubmed/33316211) MIRZAEI, H. et al. COVID-19 Among People Living with HIV: A Systematic Review. AIDS Behav, v. 25, n. 1, p. 85-92, Jan 2021. ISSN 1573-3254 (https://www.ncbi.nlm.nih.gov/pubmed/32734438)

22. Ecuador

CONTACT PERSON

Name: Jakeline Calle,

Title: Health Consultant Ecuador

Organisation: UNICEF

Email: jcalle@unicef.org

- **Timeline of the case study**: Start September 2019, end March 2020

- **Data is collected by:** UN or other international organisation

- **Data collection is:** Supplemental collection of data

- **Data is analysed by:** UN or other international organisation

- **Data is used for**: Data-driven policy change; Resource allocation; Target setting; Maximising service coverage

- **Background and objectives:** Ecuador recorded 4077 new cases of HIV in 2018, 70,64% of them correspond to men, 29,36 to women and the cases are concentrated in eight provinces. In the same year, 230 cases of HIV positive pregnant women were notified – 71,40% of these are located in the provinces of Guayas, Los Rios, Esmeraldas and Santo Domingo, a similar number of perinatal exposure cases were recorded. This research was carried out in 10 municipalities through the detection of critical chains, London Protocol and the patient tracer methodology. Ecuador recorded 4077 new cases of HIV in 2018, 70,64% of them correspond to men, 29,36 to women and the cases are concentrated in eight provinces. In the same year, 230 cases of HIV positive pregnant women were notified – 71,40% of these are located in the provinces of Guayas, Los Rios, Esmeraldas and Santo Domingo, a similar number of perinatal exposure cases were recorded. This research was carried out in 10 municipalities through the detection of critical chains, London Protocol and the patient tracer methodology. General Objective a. Identify unsafe actions that resulted in vertical HIV transmissions in Ecuador during 2018 at the institutional and community level as a strategy to generate improvement plans and avoid the occurrence of new cases. specific objectives a.Determine and analyze contributing factors in the health system that may have occurred mother to child HIV transmission cases in Ecuador. b. Identify the difficulties faced by health care professionals and health establishments in the attention of mother to child HIV transmission in the regions with existing cases during 2018. c.Identify the difficulties or circumstances faced by the communities and families. a.Identify unsafe actions that resulted in vertical HIV transmissions in Ecuador during 2018 at the institutional and community level as a strategy to generate improvement plans and avoid the occurrence of new cases. Objetivos específicos a. Determine and analyze contributing factors in the health system that may have occurred mother to child HIV transmission cases in Ecuador. b. Identify the difficulties faced by health care professionals and health establishments in the attention of mother to child HIV transmission in the regions with existing cases during 2018. c.Identify the difficulties or circumstances faced by the communities and families.

- **Contribution to the AIDS response:** This research was carried out in health facilities where deliveries were attended, and mother-to-child HIV transmission cases occurred. This research also investigates the actions executed during prenatal controls in both public and private health facilities. The research included interviews with health care professionals and mothers of HIV positive children and each case was analyzed one by one. Unsafe contributory factors were identified to support the creation of recommendations to all health care facilities where pregnant women were treated, included hospitals where births took place – recommendations were also made for the different administrative levels of the Ministry of Health. As result of this research and with the support from the National HIV Department improvement plans were developed for each of the health establishments analyzed, this to ensure that unsafe actions are not repeated. Moreover, course on the elimination of mother to child transmission (EMTCT) was developed for health care professionals. The course included a human rights approach, the EMTCT Plus strategy and triage, diagnostics and decision-making pathways, as well as communication and teamwork skills. A course module and training were developed so that health care professionals replicate the methodology in new cases of mother to child transmission - at the moment three provinces use this methodology in their audits.

- **Results, outcomes and impact:** As part of this research, the weaknesses hindering the quality of health services in the participating establishments were identified. These weaknesses are these are similar to those identified in the evaluated health facilities and represent an opportunity to improve the quality of care. Some of the findings of this research are the lack of knowledge of health care professionals in the management of HIV in pregnant women and newborns; lack of training in the Guidelines to Prevent, Treat and Control HIV; prescription of suboptimal or excessive doses of ARVs during the intrapartum; poor availability of ARVs for mothers and perinatal exposed newborns; HIV screening tests were not carried out during health care consultations as per the normative due to lack of knowledge on the technique, fear of the sting and lack of rapid tests; external health providers such as the Social Security Institute does not contemplate in their agreement with the Ministry of Health the performance of rapid tests on pregnant woman; the time of care of the pregnant woman is insufficient and the algorithm is inadequate there is an inadequate and incomplete filling of clinical histories; there was no training or monitoring of the care provided to pregnant women by the health facilities in any of the administrative levels of the health system.

- **Gaps, lessons learnt and recommendations:** As this was a retrospective study, the main difficulties were the collection of information, especially the interviews with health care professionals in charge of the care of HIV positive pregnant women; it was also difficult to interview mothers of children living with HIV as many of them have already changed their residential address. Additionally, many of the women lived in suburban areas or rural areas, and in one case the mother had died as a result of the disease. This process highlighted the need to build on a strategy to improve the quality of care for pregnant woman and the newborn; generate capacity building processes in HIV and mother-to-child transmission; and provide rapid tests and ARV to health facilities attending pregnant women. The process also showed the importance of accompanying, monitoring and follow-up the operational level of the health system by all administrative levels. Based on this research model, the Ministry of Health implemented similar auditing processes in cases of mother-child transmission of HIV.

- **Annexes:** https://unicef-my.sharepoint.com/:p:/g/personal/jcalle_unicef_org/EeJe7Bq8votFntAcj5UBPoUB0zU4ygGzgDv2WA6oPX32rw?email=aullauri%40unicef.org&e=eePCB5

23. El Salvador

CONTACT PERSON

Name: Salvador Sorto

Email: jsalvador.sorto@salud.gob.sv

- **Timeline of the case study**: 2007 to date
- **Data is collected by:** Government
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; Civil society; UN or other international organisation
- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change
- **Background and objectives:** In El Salvador since 2007 we have the Single System for Monitoring and Evaluation and Epidemiological Surveillance of HIV (SUMEVE), which is updated in real time; Therefore, the data is dynamic and changes from one report to another, new records are entered or changes in the classification system, quality controls are made constantly. The information ranges from demographic data, identification of key populations, date of diagnosis, risk factors, information on women of sexually reproductive age, PMTCT, disability, the five pillars of the continuum of care, among others.
- **Contribution to the AIDS response:** With the entry of information as the five pillars of the care continuum, we have updated data and the cascades of the care continuum are elaborated in general and also for pregnant women, for key populations. SUMEVE is a valuable tool that allows real-time generation of data that helps us make decisions in the National Response to HIV. The generation of these data builds the annual National report which is analyzed with Civil Society, cooperation partners, United Nations agencies represented in the joint group.
- **Results, outcomes and impact:** The generation of these on key populations generates the cascade and with this information we see the gaps in diagnosis, uptake, retention, initiation of treatment and suppression of viral load, it allows us to analyze these data and the generation of strategies to correct gaps.
- **Gaps, lessons learnt and recommendations:** GAP The system is affected by the non-updating of deceased persons since it must be linked to another system of the Ministry called SIMOW, the one that generates the deceased. To compensate for the death data, a component of inactive people from 5 years ago has been incorporated. The data are only from the Ministry of Health since the Social Security Institute is in the process of incorporation In 2015, the necessary variables for the analysis of key populations were incorporated, but the gap is that CUI is generated, they can have duplicates, the same happens in Penal Centers.The quality of the data depends on the input of information made by the local levels and this becomes the largest gap

- **Annexes:**
    - https://sumeve.salud.gob.sv/
    - https://www.salud.gob.sv/programas/unidad-del-programa-de-its-vih/#

24. Jamaica

CONTACT PERSON

Name: Juliet Cuthbert-Flynn,

Title: Minister of State

Organisation: Ministry of Health and Wellness

Email: juliet.flynn@moh.gov.jm

- **Timeline of the case study**: Annual

- **Data is collected by:** Government; Civil society; UN or other international organisation

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** Government; UN or other international organisation

- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change

- **Background and objectives:** Through the Ministry of Health & Wellness (MOHW), the government has agreed to work collaboratively with UNAIDS to undertake a range of interventions that would help in reducing stigma and discrimination faced by key and vulnerable populations and enable greater access to health services toward ending the AIDS epidemic in Jamaica. A five-year operational plan was developed after thorough consultations with civil society organizations, government partners and other stakeholders, stemming from the enabling environment and human rights (EEHR) component in the new National Strategic Plan (NSP). A capacity assessment was conducted in November 2020 which found there are several gaps around funding, communications, recruitment and monitoring and evaluation for which support is needed to strengthen civil society organisations working in the HIV response. As part of the process of ensuring greater efficiency and better decision-making by strengthening monitoring, evaluation and learning, an online reporting dashboard was proposed early in the work of the Jamaica Partnership. The Partnership focuses on ensuring coordination, coherence, and accountability among stakeholders to bolster efforts to end HIV-related stigma and discrimination. The dashboard is aligned to the operational plan and allows stakeholders to utilize a user-friendly platform to report on activities and obtain information.

- **Contribution to the AIDS response:** A five-year operational plan was developed using available data and after thorough consultations with civil society organizations, government partners and other stakeholders, stemming from the enabling environment and human rights (EEHR) component in the new National Strategic Plan (NSP). The draft five-year operational plan for EEHR was shared with partners and was reportedly used by at least three entities to develop their proposals for Jamaica’s concept note to TGF. Due to the importance of the UNAIDS social indicators to the success of the HIV response, the five-year operational plan and interventions planned for 2021, by each entity, are mapped along these lines to engender greater awareness and buy-in by allowing partners to better understand how their work contribute to these global targets. The online reporting dashboard that is to be launched before the year ends also include the targets and data in terms of how the country is performing. Some indicators for the monitoring, evaluation and learning framework for the operational plan were developed using the GAM and 10-10-10 targets so the national programme is focused and actively working to contribute to these global goals. As part of ensuring coordination and coherence, a scorecard was completed and disseminated to stakeholders in the HIV response. The scorecard features 138 interventions across ten entities. The report shows alignment to the UNAIDS social indicators, TGF Baseline Assessment and the five-year Operational Plan for EEHR. A midterm assessment for January to June was done to ascertain the extent to which organisations are implementing according to their plans. To undertake this, a tool was developed to capture information on interventions undertaken. The Partnership provided support to the Jamaica Country Coordinating Mechanism (JCCM) to convene consultations for the Country Dialogue. A consultation guide and tool were created to facilitate consultations around the five-year operational plan as well as other areas of the HIV response and the Global Fund Concept Note development. In collaboration with NGOs, sixteen consultations were scheduled and over ten completed.

- **Results, outcomes and impact:** A five-year operational plan was developed using the Global Fund Baseline Assessment and UNAIDS Guidance for Addressing Stigma and Discrimination. A scorecard was completed and disseminated to stakeholders in the HIV response which features 138 interventions across ten entities and shows alignment to the UNAIDS social indicators, TGF Baseline Assessment and the five-year Operational Plan for EEHR. A midterm assessment for January to June was done to ascertain the extent to which organisations are implementing according to their plans. The online reporting dashboard has now been completed and an online training was done to familiarise stakeholders on how to use it. A training bootcamp to help partners understand how to use the dashboard and undertake data entry is scheduled for January 2022 in partnership with MOHW.

- **Gaps, lessons learnt and recommendations:** The dearth of information about HIV-related stigma and discrimination and the lack of a strong monitoring, evaluation, and learning (MEL) framework to track more effectively and efficiently, measure and report on progress toward addressing the issues faced by people living with and affected by HIV. It is critical to align indicators to global indicators for the GAM. Good data allow entities working to remove human rights barriers to HIV and other health services to better understand the human rights situation of people living with HIV and key and vulnerable populations and establish baselines and goals that are needed for effective project management. Therefore, data, whether qualitative or quantitative, are important because it enables stakeholders to measure the effectiveness of a strategy or intervention. Good data provide the evidence that is needed to take meaningful action throughout the programme or project cycle. When programme implementers and managers collect data, they can determine how well initiatives are doing to address an identified issues as well as what modifications may be needed to get the intended result.

- **Annexes:** N/A

25. Peru

CONTACT PERSON

Name: Julia Campos Guevara

Organisation: GIVAR - Red SIDA Perú

Address: Ignacio Merino 1855 ofic. 301 Lince- Lima. Peru

Email: juliacamposguevara@gmail.com; coordinacion@givarperu.org

- **Timeline of the case study**: The data collection started in 2010 with the support of Civil society organizations, community-based organizations, and people living with HIV, and continues up to date. It is a continuous monitoring of the provision of antiretroviral drugs in public health facilities.

- **Data is collected by:** Civil society

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** Civil society

- **Data is used for**: Maximising service coverage;Data-driven policy change;

- **Background and objectives:** One of the advances in the fight against HIV in Peru has been introduction of the free and universal antiretroviral treatment in public health facilities (2004). However, despite its sustained impact on the morbidity and mortality of people with HIV, the country has not achieved the universal access goals by 2020 (90-90-90) due to a series of programmatic and management problems in the continuum of care, particularly, the management of the supply chain (from procurement planning to the dispensing of medicines), with the consequent “stockout” (shortage) or fractioning in the provision of treatments. Shortages conspire against adherence to treatment and threatens the quality of life of people with HIV who must face the unexpected change of schemes and even the appearance of viral resistance. Faced with this situation, the Antiretroviral Supply Surveillance Group (GIVAR, in Spanish) was born, a civil society initiative created on June 1, 2010, with the purpose of monitoring and producing information that help improving supply chain management as a community contribution to the response to HIV. In recent years, GIVAR has been working tirelessly on promoting access to ARV treatment for migrants, channeling the cases, not only through health facilities but also for the migrant to access some sort of temporary permit.

- **Contribution to the AIDS response:** The Community lead Monitoring Model implemented by GIVAR is based on the registration of complaints about shortages of medicines provided by users of public health facilities, through virtual and anonymous channels. This information is verified, contrasted, registered and used to generate meetings with the authorities responsible for the supply of medicines, both at the level of health facility; at the national level, with the Ministry of Health and Social Security, and other entities such as the Ombudsman's Office. The data is also systematized in graphics that are used for advocacy actions through social networks and the media. This registry has been improving every year, as well as the database, the number and quality of the indicators that are registered, and also the various tools to make complaints: website, text messages, APP, social networks and, recently, the WhatsApp; guaranteeing confidentiality. This continuous and systematic action has contributed to raising awareness of the problem of stockouts, making it visible and allowing building alliances with other civil society organizations, working on other aspects of the shortage problem: price regulation, intellectual property aspects, monopoly of the pharmaceutical industry, lack of access to universal health coverage, among other issues. The main contribution to the response to AIDS has been to generate an early warning system to avoid and solve supply interruptions, promote a multisectoral discussion on procurements mechanisms and how they affect timely supply and give a voice to communities to express their legitimate demands. We consider GIVAR has changed the way civil society advocate for the respect of human rights in Perú, moving from a mere speech of the importance of guaranteeing the access to health for people with HIV to show evidence of how their right is being neglected.

- **Results, outcomes and impact:** The main impact achieved by GIVAR is based on the information collected from the community and the articulation with a series of government actors to find sustainable solutions to supply problems. Thus, a credible monitoring system has been generated and, based on the empowerment of users of health services and an autonomous social surveillance and humanitarian aid, a network has been established with the community. The complaints collected have made it possible to identify inequities in the system that causes disease and death of the most vulnerable, to make them visible and channel them to the corresponding government entities; for example the lack of access to Comprehensive Health Insurance or the fragmented provision of ARVs. GIVAR's work, coordinated with its allies, has generated legislative initiatives such as the recognition of the concept of health vulnerability that allows access to fully subsidized Comprehensive Health Insurance for people with HIV and TB, we have also dealt with intellectual property issues and their impact on prices, in particular in the case of atazanavir. Givar is also a benchmark in the work for the protection of the health of migrants. Through a WhatsApp group communication is maintained with government agencies to guarantee their access to health and treatment.

- **Gaps, lessons learnt and recommendations:** 1) Since we're dealing with human beings in extreme vulnerability; we are faced with the challenge of collecting “hard” data with “cold” instruments and traceable indicators. For this reason, we consider as relevant the use of qualitative techniques that allow us to reconstruct, based on life histories, the data we need (demographics, treatment required, insurance situation, hospital). 2) Fear of reprisals from health providers, especially the “punishment” of limiting or denying drugs, discourages reporting. To remedy this, it is important to create institutional protection mechanisms for complainants. 3) Despite limited resources, empowering people with HIV and engaging them in community monitoring is an invaluable resource that contributes to overall well-being and needs to be prompted. 4) The rigorous handling of complaints, contrasting the information with various sources, has allowed the generation of a credible and legitimate community systems that pave the way to be a benchmark for state agencies and work with them in an articulated manner without losing community identity. Recommendations • GIVAR experience is also an opportunity to generate and promote new forms of activism such as digital activism, using new technologies. • It is important to escalate from a complaints registry to an integrated information system.

- **Annexes:**

- Protestas por pedido de afiliación al SIS a personas con VIH. (Protests demanding enrollement to Comprehensive Health Insurance for people living with HIV) https://wayka.pe/personas-con-vih-exigen-afiliacion-al-seguro-integral-de-salud/ Decreto Supremo declara a las personas con VIH en condición de vulnerabilidad sanitaria y autoriza su afiliación al SIS gratuito con cobertura del 100% en salud (Supreme Decret that declare PLHIV in a vulnerable situation and autorizes its enrollement to Comprehensive Health insurance) https://busquedas.elperuano.pe/normaslegales/decreto-supremo-que-reglamenta-la-primera-disposicion-comple-decreto-supremo-n-002-2020-sa-1847046-1/
- Crean APP gratuita para denunciar falta de medicinas para el VIH y SIDA (Givar launched its APP to gather complaints of stock outs or ARV) https://www.eleconomistaamerica.pe/telecomunicacion-tecnologia-pe/noticias/8778990/11/17/Crean-APP-gratuita-para-denunciar-falta-de-medicinas-para-el-VIH-y-SIDA.html
- Reportaje de Univisión: Situación de migrantes con VIH (Univision report: situation of migrants living with HIV) https://www.univision.com/noticias/vih-y-sida/cuando-el-medico-te-receta-migrar-para-no-morir-venezolanos-con-vih-ponen-a-prueba-al-sistema-de-salud-en-peru
- Movilización social: Personas con VIH realizarán plantón. (People with HIV will protest) https://larepublica.pe/sociedad/2019/09/19/ministerio-de-salud-pacientes-con-vih-realizaran-planton-frente-a-minsa-antirretrovirales/
- Perú: compras de antirretrovirales con sobreprecio y entregas a destiempo (Perú: overpriced ARV and delayed supply) https://saludconlupa.com/noticias/peru-compras-de-antirretrovirales-con-sobreprecio-y-entregas-destiempo/
- Minsa y pacientes supervisarán el abastecimiento de medicamentos para el VIH (MoH and patients Will monitor the supply of ARVs) http://www.givarperu.org/component/k2/item/14-minsa-y-pacientes-supervisaran-el-abastecimiento-de-medicamentos-para-el-vih
- Tratamiento antirretroviral bajo la lupa: un análisis de salud pública en Latinoamérica y el Caribe – año 2013 https://www.idhbolivia.org/images/pdf/Prevencion/GuiaTARV.pdf
- Se registró cifra record de denuncias de personas con VIH por pandemia. (Record number of complaints) https://larepublica.pe/sociedad/2020/11/30/se-registro-cifra-record-de-denuncias-de-personas-con-vih-en-pandemia/
- Version final del Informe Nacional de Progresos sobre VIH / SIDA 2010-2012 reportado a ONUSIDA y firmado por el Viceministro de Salud del Peru, Dr Percy Minaya https://issuu.com/comite_vigilancia-coremusa-ll/docs/informe_de_progresos_peru_2012

26. Peru

CONTACT PERSON

Name: Tania Goossens
Title: Country Director
Organisation: WFP
Address: Las Moreras 145, San Isidro, Lima, Peru
Email: tania.goossens@wfp.org

- **Timeline of the case study**: August 2020 to February 2022
- **Data is collected by:** UN or other international organisation
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** Government; Civil society; UN or other international organisation
- **Data is used for**: Maximising service coverage; Data-driven policy change
- **Background and objectives:** Peru has an estimated 87,000 people living with HIV (PLH). Most prevalent groups are transgender women (31.8%) and MSM (10%). Indigenous people from the Amazonia (1.8% prevalence) and female sexual workers (0.6%) are also considered vulnerable populations and are prioritized by the public policies on HIV. About 47% of PLH have experienced stigma and discrimination. According to a household survey by the Ministry of Justice, PLH, LTGBI community and migrants and refugees are perceived by 70% of the population as the most affected groups by stigma and discrimination nationwide. Migrants living with HIV, LGBTIQ+ community members and other key populations report high levels of stigma and discrimination in Peru because of their country of origin, serostatus, sexual orientation, harassment, and xenophobia, especially in public services including healthcare facilities and their workplaces. Evidence shows COVID-19 measures have deeply impacted groups that are vulnerable to HIV. 78% of this population report having no economic income and only 6% had access to government emergency assistance. 43% report having interrupted their treatment during lockdown along with difficulties to access life-saving HIV prevention, care, and treatment. (Alianza Liderazgo en Positivo en Perú, 2020)
- **Contribution to the AIDS response:** UNAIDS and WFP in Peru are jointly implementing the project “Humanitarian assistance to vulnerable population, which includes migrants and refugees, affected by the context of COVID-19 in Peru”. According to WFP´s latest remote food insecurity assessment (August 2021), moderate and severe food insecurity affect 57% of migrant and refugees and 52% of Peruvians. This alarming data guided the design of a broader intervention that seeks to mitigate the impact of COVID-19 in food security. In the case of this joint UNAIDS/WFP operation, cash transfers are prioritized for vulnerable groups like female sex workers, transgender women, people with HIV, people affected by tuberculosis, and migrants not included in the government social protection scheme.

Households are selected by a community-based organization (CBO) following the agreed targeting criteria. More than 1,000 households have been reached as of October 2021. Cash transfers are redeemed at Western Union, which has a global long-term agreement as financial service provider for WFP operations. The First phase of the project, carried out from August to October 2020, reached 200 vulnerable families (PLH, KP and poor families). The Second phase was carried out from November 2020 to March 2021. A total of 636 vulnerable families were reached. More CBOs were involved (PLH, KP and poor families) and a network was built for referring special cases to other social services (comprehensive health, food baskets, mental health, documentation, maternal services for pregnant women, etc.). The third phase, currently in process from July 2021 to February 2022, will reach 1,900 vulnerable families (PLH, KP and poor families).

- **Results, outcomes and impact:** 1) Over 1,000 households of PLH, KP and TB patients, both migrants and refugees (80%) and Peruvians (20%) benefited from unconditional cash transfers. Although the assistance mainly focuses on facilitating access to food, beneficiaries also report using the assistance to cover health, housing and other basic needs and to catalyze small businesses for income generation. The project was implemented in 8 regions, but UNAIDS intervention was limited to Lima (Capital City) and Callao. 2) 80% of beneficiaries were identified through 30 CBOs of PLH, KP and TB patients. The remaining 20% includes people that directly contacted the project or were referred by other beneficiaries. 3) Two reports were developed as part of this project. The first one systematizes the experience and the second one reflects the needs and demands of the population living with HIV and key populations. Both reports are valuable resources to advocate for the inclusion of populations within social protection programs coordinated by the State, taking in account that an economic subvention that considers the relevance of an adequate and healthy nutrition among people with HIV would significantly support the effectiveness of HIV treatment.

- **Gaps, lessons learnt and recommendations:** 1. This joint UNAIDS/WFP operation allowed to incorporate HIV related vulnerabilities (e.g., registering gender identity or sexual work as an income generation activity) in the instruments and score card of the project. This allowed to highlight the vulnerability faced by people affected by HIV. Next step will be to include these criteria in the national social protection policies. 2. The project promoted synergies with the civil society, community-based organizations, and private sector. This model that actively involves CBOs in beneficiary identification and enrollment and monitoring was the main driver of the project's success. Twenty-four CBOs were involved in beneficiary identification and enrollment and monitoring. Moreover, UNAIDS managed to coordinate actions with other internal operations like FM and SES to benefit from a broader base of information to timely inform decision making for this type of emergency interventions. 3. For the project's third phase, UNAIDS is developing a capacity building component for participating CBOs. This will consider topics such as support services, human rights and stigma and discrimination, food security and improving adherence to HIV treatment. It will be addressed to national stakeholders, including the National AIDS Programme, WFP and the Municipality of Lima within the framework of the Paris Declaration.

- **Annexes:** N/A

27. Peru

CONTACT PERSON

1)

Name: Edgardo Rodríguez Gómez / Dirección:

Title: Director General de Derechos Humanos

Organisation: Ministry of Justice and Human Rights

Email: erodriguezgo@minjus.gob.pe

2)

Name: Angel Antonio González Ramírez

Title: Director de la Dirección de Políticas y Gestión en Derechos Humanos

Organisation: Ministry of Justice and Human Rights

Address: Scipión Llona 350, Miraflores, Lima, Perú

Email: agonzalez@minjus.gob.pe

- **Timeline of the case study**:
    - Fecha en que se inició la recopilación de datos de la II Encuesta Nacional de Derechos Humanos: 2019
    - Tiempo que duró el recojo de información: un mes aproximadamente
    - Fecha de finalización de recopilación de datos: 2019

- **Data is collected by:** Government

- **Data collection is:** Supplemental collection of data

- **Data is analysed by:** Government; Civil society; Academic institution; UN or other international organisation

- **Data is used for**: Target setting; Data-driven policy change

- **Background and objectives:** En el Perú, actualmente, 7 de cada diez 10 peruanos y peruanas sienten que los derechos humanos son poco o nada protegidos. Se percibe que los derechos están peor protegidos que hace 5 años (51%) y que no mejorará en los próximos años (62%). Así, 1 de cada 3 personas ha sufrido discriminación, principalmente, en la calle (28%) y en sus centros laborales (29%). La mayoría no toma acción porque piensan que es una pérdida de tiempo ya que las instancias encargadas no toman acciones. La II Encuesta Nacional de Derechos humanos (ENDDHH), es una herramienta desarrollada en el marco de la implementación del Plan Nacional de Derechos Humanos del Perú (PNDDHH); orientado a medir la discriminación estructural que vulnera los derechos humanos, recogiendo percepciones sobre los estereotipos y actitudes discriminatorias, que afecta el libre ejercicio de derechos de las personas que viven con VIH, población clave, y otras poblaciones en situación de vulnerabilidad. La implementación del PNDDHH se sustenta en la información estadística que arroja la ENDDHH, de nueve (9) grupos de especial protección: personas adultas mayores, personas con discapacidad, población indígena, población LGBT, personas con VIH, mujeres, extranjeros, personas privadas de su libertad y, niños, niñas y adolescentes.

- **Contribution to the AIDS response:** Según la II Encuesta Nacional de Derechos Humanos, en el Perú, las poblaciones que se perciben como más discriminadas son las personas LGBTIQ y las personas con VIH, seguido por las poblaciones indígenas. Para el Ministerio de Justicia y Derechos Humanos, son estas poblaciones, quienes más sufren vulneración de sus derechos humanos a consecuencia de la discriminación. Teniendo en cuenta que la discriminación relacionada con el VIH ha sido abordada de manera insuficiente en las políticas públicas, la generación de información estadística, a través de la ENDDHH, está permitiendo reflexionar, en mayor profundidad, la respuesta al VIH desde un enfoque más integral. En el segundo informe de avance del PNDDHH 2018-2021, se señaló que las personas con VIH/Sida y personas con TBC, en el contexto de la pandemia generada por la COVID-19, constituyeron un grupo vulnerable ante la COVID-19, tomando en cuenta su situación de derechos humanos. Entre las acciones tomadas, en este contexto, se adecuaron la organización de los servicios de salud, con énfasis en el primer nivel de atención, para el seguimiento de casos de VIH; activándose, también, la supervisión del tratamiento recuperativo a través de los DOTS implementados (Directly observed treatment): DOTS domiciliario, DOTS con soporte familiar y DOTS institucional; entre otras. Así, la ENDDHH, además de contribuir al monitoreo de las acciones dispuestas en el PNDDHH; se constituye en una herramienta sustantiva para el actual proceso de diseño de la Política Nacional de Derechos Humanos al 2030; ya que el análisis de la discriminación estructural, es identificado como el principal eje de análisis para su desarrollo y definición de acciones estratégicas que favorezca la recuperación y ejercicio de los derechos humanos de las personas viviendo con VIH y la población clave, entre otras, históricamente dejadas atrás.

- **Results, outcomes and impact:** Además de su impacto en el diseño de políticas, la II Encuesta Nacional de Derechos Humanos, ha sido una herramienta que provee evidencia para la abogacía de las organizaciones y personas viviendo con VIH; fortaleciendo su participación igualitaria e incidencia en la vida civil, política, social, económica y cultural, libre de prejuicios, estigmas, discriminación, violencia o persecución; con mayor presencia en los procesos de definición de las políticas de Derechos Humanos y las políticas públicas en general. Lo señalado anteriormente, se puede ver, por ejemplo, en el trabajo de la Mesa de trabajo de Personas viviendo VIH/TB, impulsado por el Ministerio de Justicia y Derechos Humanos. Este espacio define los objetivos y acciones estratégicas para los grupos de especial protección en el marco del PNDDHH 2018-2021. En este espacio participan, en diálogo horizontal, representantes de organizaciones de sociedad civil y las entidades de Estado concernidas en la atención de la problemática. La ENDDHH provee elementos esenciales para el fortalecimiento de las políticas, la sociedad civil y la capacidad institucional del Estado (mejora de su función normativa, presupuestal, capacidad instalada, etc.). Esto último, como herramienta que fortalece la transversalización del enfoque de DDHH en la gestión pública, junto al enfoque de género e interculturalidad.

- **Gaps, lessons learnt and recommendations:**
    - Poner fin a la epidemia del VIH requiere un enfoque integral que permita que todas las personas puedan acceder a servicios de prevención, tratamiento, atención y apoyo de calidad que salve y mejore la vida contra el VIH.
    - Los resultados de la ENDDHH son una línea de base a partir del cual se puede analizar el impacto de la Covid 19, la situación de emergencia sanitaria sobre la población y la percepción sobre los derechos humanos de las personas viviendo con VIH.

  - El compromiso institucional para su realización periódica (cada dos años) de la ENDDHH, hace posible analizar cambios sustantivos en la percepción de la población sobre los derechos humanos de las personas que viven con VIH y la población clave.
  - La asignación presupuestal resulta fundamental para desarrollar con periodicidad la encuesta que ha sido afectada por la emergencia. Se requiere interiorizar su importancia y asegurar su presupuestación desde diversas fuentes.
  - El diseño y aplicación de la ENDDHH, es una buena práctica en la generación de evidencia estadística, cuya finalidad es brindar conocimiento sobre la situación actual y la evolución de los derechos humanos; generando insumos para el diseño de estrategias concretas y medir sus impactos.

- **Annexes:**
  - La II Encuesta Nacional de Derechos Humanos – 2019: https://www.gob.pe/institucion/minjus/informes-publicaciones/1599344-informe-completo-de-la-ii-encuesta-nacional-de-derechos-humanos
  - Informe analítico de la II Encuesta Nacional de Derechos Humanos:https://cdn.www.gob.pe/uploads/document/file/1611168/1.-Informe-anali%CC%81tico-de-la-II-Encuesta-Nacional-de-Derechos-Humanos.pdf.pdf.
  - Acceso a la Base de datos de la II Encuesta Nacional de Derechos Humanos: https://www.gob.pe/institucion/minjus/informes-publicaciones/1599351-base-de-datos-de-la-ii-encuesta-nacional-de-derechos-humanos
  - Plan Nacional de Derechos Humanos 2018-2021: https://cdn.www.gob.pe/uploads/document/file/1539318/PLAN-NACIONAL-2018-2021.pdf.pdf
  - Primer informe de implementación del Plan Nacional de Derechos Humanos 2018-2021: https://cdn.www.gob.pe/uploads/document/file/1539329/Informe-sobre-los-avances-del-primero-a%C2%A7o-de-implementaci%C2%A2n-del-PNDH-2018-2021-resumen-ejecutivo_compressed.pdf.pdf
  - Segundo informe de implementación del Plan Nacional de Derechos Humanos 2018-2021: https://cdn.www.gob.pe/uploads/document/file/1580685/Segundo%20Informe%20PNDH.pdf.pdf

28. Uruguay

CONTACT PERSON

Name: Renee Diverio

Organisation: Ministry of Public Health

Email: rdiverio@msp.gub.uy

- **Timeline of the case study**: N/A
- **Data is collected by:** Ministry of Public Health
- **Data collection is:** Supplemental collection of data
- **Data is analysed by:** Ministry of Public Health
- **Data is used for**: Data-driven policy change
- **Background and objectives:** Es de notificación obligatoria, pero recibimos del departamento de laboratoio de salud pública (DLSP) al SVL (sistema de vigilancia longitudinal) los confirmatorios de VIH por WB.De alli es que tenemos los casos positivos de VIH de la población.
- **Contribution to the AIDS response:** Ha contribuído a estimular el testeo y el tratamiento inmediato al saber el diagnóstico oportunamente.El tener datos ha contribuído para saber que el 70% de los casos afectados son hombres y que el 71% de los pacientes diagnosticado está en TARVestá están tratados con ARTV.
- **Results, outcomes and impact:** Tenemos cobertura universal de TARV tanto en prestadores públicos como privados, logramos detectar retraso en el inicio de tratamiento por falta de adherencia o no consulta. Por eso este año estamos monitoreando eso con el agregado de los indicadores de fecha de inicio al TARV entre otros al formulario de notificación obligatoria.
- **Gaps, lessons learnt and recommendations:** En la recopilación de datos aún nos queda poder tener un sistema online como el que tenemos del DLSP (departamento de laboratorio de salud Publica) que nos envía todos los casos confirmados x WB.Lo mismo necesitariamos que los prestadores de salud nos envien esa información automaticamente al SVL(sistema de vigilancia longitudinal) con datos de TARV, inicio del mismo, CV y CD4.
- **Annexes:**
    - https://www.gub.uy/ministerio-salud-publica/comunicacion/publicaciones/informe-epidemiologico-dia-nacional-del-vihsida-2020
    - https://www.gub.uy/ministerio-salud-publica/tramites-y-servicios/formularios/formulario-notificacion-caso-vih

Middle East and North Africa

29. Iraq

CONTACT PERSON

Name: Hussain Ali Mahdi

Organisation: Iraqi Ministry of Health, public health of directorate / alkaradah

Email: alkazrage78@yahoo.com

- **Timeline of the case study**: March 2018 to March 2020
- **Data is collected by:** Government; Academic institution
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government; Academic institution
- **Data is used for**: Target setting; Resource allocation; Maximising service coverage
- **Background and objectives:** Background: HIV/AIDS is considered as one of the most important public health concern faced by many developed and developing countries. Objective: To study the basic socio-demographic characteristics of the newly reported HIV Iraqi cases during the period extending from 1986 to 2019. Subjects and Methods: This is across sectional study conducted using data from newly reported HIV Iraqi cases from March 2018 to March 2020. These data were available from the patient's records at the Iraqi National HIV/AIDS Program Centre. Annual registration statistics covering the period from 1986 to 2019 were reviewed. The diagnosis was done through identification of anti-HIV antibodies using primarily ELISA as screening test and positive cases were confirmed by Western blot assay. The obtained data were categorized according to the socio-demographic variables and were analyzed statistically. Results: A total number of newly reported HIV Iraqi cases covering the period from 1986 to 2019 was 892 cases. The majority of the cases were males (83%), from 21-39 years old (60.3%), alive (65.7%), and single (53.4%). Most of them were from low educational level (45.1%), low socio-economic status (48.3%), and living in urban areas (75.6%) from Central origin (63.2%). Conclusions: Identification of these findings may provide important directions for targeting certain sociodemographic characteristics of the HIV infections to provide specific support for accessing healthcare services and evaluating the effectiveness of prevention and control measures.
- **Contribution to the AIDS response:** To study the basic socio-demographic characteristics of the newly reported HIV Iraqi cases during the period extending from 1986 to 2019.
- **Results, outcomes and impact:** A total of 892 NHIVC were reported from 1986 to 2019. Table 1 shows the socio-demographic characteristics of the NHIVC in Iraq 1986-2019.It shows that the highest rates of the cases were reported in those aged 20-29 years (33.1%) and aged 30-39 years (27.2%), while the lowest rates were

detected in those aged 40-49 years (15.2%) and aged ≥50 years (6.5%). The difference was found to be statistically significant (P<0.0001). This table also shows that the majority of the NHIVC were males (83%) and the remainder (17%) were females, giving a male to female of 4.9:1 and there was a highly statistically significant difference (P<0.0001). Concerning survival status of the NHIVC, the large majority of them were alive (65.7%) and 34.3% were dead. This difference was statistically of significant (P<0.0001) (Table 1). In the present study, the majority of the NHIVC in Iraq was single (53.4%) and married (40.2%), while divorced and widowed contributed to 2.5% and 1%of the cases, respectively. This difference was highly significant (P<0.0001) (Table 1). Regarding educational status, the vast majority of NHIVC (86.6%) were living in a low educational level (45.1%) and medium level (41.5%), while high educational level constituted 13.4% of the cases. (P<0.0001). (Table 1). In this study, the proportion of the NHIVC was higher among those with low socio-economic status (48.3%) than those with medium socio-economic status (29.4%) and high socio-economic status (22.3%). This difference was of statistically significant (P<0.0001) (Table 1). Concerning the residence of the NHIVC in Iraq, the bulk of the cases were living in urban areas (75.6%) and less in rural areas (24.4%), with a statistically significant difference (P<0.0001). Geographic distribution of NHIVC shows that most of the them are living in Central Provinces (regions) of Iraq (63.2%), followed in order by Southern provinces (19.3%), Northern provinces (13.1%), Eastern provinces (3.0%), and Western province (1.4%).This difference was statistically of significance ((P<0.0001) (Table1). Figure 1 shows that the highest percent of NHIVC in our country was unemployed (23.7%), followed by students (17.9%), while the lowest percent of the cases were healthcare workers (2.1%) and military (1.3%). The difference was found to be of statistically of significant (P<0.0001). Figure 2 shows that more than half of the NHIVC were living in Baghdad Province (56.2%) followed by Arbil province (5.2%) while Dohok and Anbar provinces represented the lowest percentages of the illness (0.3%- 0.4%) (p<0.0001).

- **Gaps, lessons learnt and recommendations:** Identification of these findings may provide important directions for targeting certain sociodemographic characteristics of the HIV infections to provide specific support for accessing healthcare services and evaluating the effectiveness of prevention and control measures.

- **Annexes:** 1094 Indian Journal of Forensic Medicine & Toxicology, July-September 2021, Vol. 15, No. 3.

30. Morocco

CONTACT PERSON

Name: Dr Ibtissam Khoudri

Organisation: Ministère de la santé, Direction Epidemiologie Et Lutte Contre Maladies

Address: 63 Av. Ibn Sina, Rabat 10100

Email: ibtissamkhoudri@gmail.com

- **Timeline of the case study**: Since 2017, ongoing data collection of combination prevention programmes for key populations

- **Data is collected by:** Civil society

- **Data collection is:** Routine data collection

- **Data is analysed by:** Gouvernement; Société civile; ONU ou autre organisation internationale

- **Data is used for**: Goal setting; Resource allocation; Maximizing service coverage; Data-driven policy change

- **Background and objectives:** Community monitoring information system of the combined prevention cascade for key populations, based on the unique identification code (UIC). As part of the capacity building of associative actors who offer combination prevention services to key populations (female sex workers (FSWs), men who have sex with men (MSM), people who inject drugs (PID), people who use drugs (PUD), prisoners and migrants), the National AIDS Control Programme in Morocco (PNLS) has developed with the support of UNAIDS and the Global Fund an information system for monitoring the cascade of combination prevention programmes for key populations. This system, based on the unique identification code (UIC), is composed of a set of modules using web technology and geographic information systems that helps field actors and decision-makers to analyze real-time data for monitoring the cascade of coverage of combination prevention programmes for key populations.
- **Contribution to the AIDS response**: Les populations clés sont souvent cachées et mobiles due à la stigmatisation et la discrimination qu'elles subissent et elles rencontrent des difficultés d'accès aux services de soins et services sociaux. La confidentialité est critique pour fidéliser ces populations et pour le suivi des programmes. Pour maintenir ces populations clés dans le circuit des programmes de prévention de proximité et répondre aux soucis de confidentialité, le PNLS en collaboration avec les ONG qui travaillent avec ces populations a développé le code d'identification unique (CIU) pour le suivi des bénéficiaires. Le CIU permet de suivre toute personne ayant bénéficié d'un service dans le cadre de prévention combinée : comportementales (sensibilisation, information, éducation, préservatif, gel). Biomédical (dépistage VIH, IST), et structurel (référencement aux services juridiques

et aux instances de lutte contre la violation des droits humains). Ces services sont offerts par 11 ONG avec plus de 40 sections opérationnelles aux niveaux des différentes régions du Maroc et des unités mobiles à plus de 100000 personnes, répartis par population selon le graphique ci-dessous. La mise en place de ce système a démarré en 2014 avec la conception de la structure du code unique et les outils de collecte des données et le test du système sur le terrain suivi d’une phase pilote. Le code retenu est basé sur 7 positions.

- **Results, outcomes and impact:** Key populations are often hidden and mobile due to the stigma and discrimination they face and have difficulty accessing health and social services. Confidentiality is critical for retaining these populations and for programme follow-up. To keep these key populations in the loop of prevention outreach programmes and to address confidentiality concerns, the NACP, in collaboration with NGOs working with these populations, has developed a unique identification code (UIC) for tracking beneficiaries. The UIC allows for the tracking of any person who has benefited from a service within the framework of combined prevention: behavioral (awareness, information, education, condoms, gel). Biomedical (HIV and STI testing), and structural (referral to legal services and human rights bodies). These services are offered by 11 NGOs with more than 40 operational sections in the different regions of Morocco and mobile units to more than 100,000 people, distributed by population according to the graph below. The implementation of this system started in 2014 with the design of the unique code structure and data collection tools and the testing of the system in the field followed by a pilot phase. The selected code is based on 7 positions.
- **Gaps, lessons learnt and recommendations:** The UIC contains information that does not change over time, thus reducing identification error. The results of the pilot project showed a rate of use of the same code for different people of 2%, which is still a very acceptable value for statistical data. The NGOs working with the UIC use a simple card to record the UICs used by the information system to track the benefits received by these populations. Field data collection needs to be strengthened with the provision of tablets and internet connection to have real-time situations. The rich information collected has not been exploited to date.
- **Annexes:** https://unaids-my.sharepoint.com/:b:/g/personal/elrhilanih_unaids_org/ESGAThpuQXtPnaGoq7PSYfsBufxM-D4lbCaM8mg9nflMMg?e=owx4CZ

Western Europe and Others

31. Australia

CONTACT PERSON

Name: Professor Andrew Grulich

Title: Head, HIV Epidemiology and Prevention Program

Organisation: Kirby Institute

Address: UNSW Sydney, NSW, Australia

Email: agrulich@kirby.unsw.edu.au

- **Timeline of the case study**: 2015-2019
- **Data is collected by:** Government; Civil society; Private sector; HIV community-based organisations
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Academic institution; Government
- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change
- **Background and objectives:** New South Wales (NSW) is the most populous state of Australia and has an HIV epidemic that is concentrated mainly in gay, bisexual and other men who have sex with men (GBMSM). To inform the writing of a new NSW HIV Strategy 2021-2025[1], we reported on trends in HIV diagnoses and prevention indicators among GBMSM during the period of the NSW HIV Strategy 2016-2020.[2] We analysed 2015-2019 data from three sources: 1. HIV surveillance data on all new HIV diagnoses, including stage of infection at diagnosis, and associated demographic data 2. Data on sexual behaviour, HIV testing and PrEP from GBMSM collected in the annual Sydney Gay Community Periodic Surveys (GCPS)[3] 3. Patient record data on HIV testing, PrEP and HIV treatment in GBMSM from the ACCESS sentinel surveillance clinic and laboratory network The objective was to assess overall trends, and to identify disparities in trends in HIV notifications, HIV testing, PrEP and HIV treatment among sub-populations of GBMSM according to country of birth, age, sexual identity, and area of residence according to whether the estimated proportion of gay men who were locally resident was high (>20%), medium (5-19%), or low (<5%).
- **Contribution to the AIDS response:** A research program on developing prevention indicators for monitoring and evaluation during the 2016-20 Strategy was used to document prevention successes, and to develop a new data-driven 2021-25 HIV Strategy. The Strategy sets an ambitious target for a 90% reduction in the rate of preventable HIV infection with a strengthened focus on sub-populations who have experienced less HIV prevention success. The program was co-led by Kirby Institute researchers and the NSW Ministry of Health, with community based and clinical

organisations as partners. Results were published in a data report[4] that was used by stakeholders during a consultation process to identify prevention interventions in the new Strategy that were better tailored and targeted to contribute to HIV elimination. The report reviewed the highly-successful HIV prevention response, but also highlighted disparities in HIV notifications and the uptake and impact of HIV testing and PrEP among sub-populations of GBMSM in NSW. For example, newly available data on the estimated proportion of gay men resident in each postcode enabled us to calculate HIV trends and uptake of preventive behaviours by area of residence. This revealed previously unrecognised disparities in HIV notifications and prevention indicators by geography, enabling geo-targeting of prevention responses. The diverging trends in new HIV diagnoses between Australian and overseas-born GBMSM had previously been recognised through the NSW HIV surveillance system, which includes the quarterly publication of detailed data.[5] The analysis for the report included trends in the uptake of HIV prevention strategies. The gaps we identified in the report were addressed in the targets and priorities of the NSW HIV Strategy 2021-2025.[1] The concentration of HIV in more marginalized sub-groups we identified was an important impetus to include a major focus on stigma reduction in the new Strategy. Many of our analyses are now incorporated into routine HIV surveillance in NSW.[5]

- **Results, outcomes and impact:** 1. HIV diagnoses: Between 2015-2019, HIV diagnoses among GBMSM declined by 40% overall, however, they declined by 56%, 23% and 10% in postcodes with a high, medium and low-concentration of gay men respectively. Early-stage infections declined by 75% in the high-concentration postcodes. Declines in early HIV diagnoses were smaller among men aged under 25 (6%) compared with older age groups (38-67% declines). Late HIV diagnoses declined by 47% among Australian-born but increased by 32% among overseas-born men. 2. HIV testing: The proportion of GBMSM who had an HIV test in the previous 12 months was about 10% lower among men in low-concentration postcodes compared to those with medium and high GBMSM concentrations. 3. PrEP use: PrEP coverage during condomless sex was more likely in postcodes with a higher concentration of gay men (74%), compared to low-concentration postcodes (54%). PrEP coverage was lower among men aged under 25 (42%) and 55 or older (about 50%) compared to those aged 35-44 (73%). PrEP coverage among bisexual/other identifying men was lower than among gay men. 4. HIV treatment and viral suppression levels did not vary across demographic variables. These results were incorporated into targets and actions in the 2021-25 Strategy.

- **Gaps, lessons learnt and recommendations:** Gaps: We need more detailed socio-behavioural data to measure the extent to which GBMSM who do not identify as gay are not taking up HIV prevention methods. These data are difficult to collect in HIV surveillance, and existing behavioural surveillance has been mostly focussed on gay community samples. New research will broaden recruitment to include a more diverse sample of GBMSM. The identification of newly-arrived overseas-born men as a group who are not adequately engaged in HIV prevention highlighted our limited understanding of how these men engage with Australia’s healthcare system and the GBMSM community. New research will target the HIV prevention engagement journey of newly-arrived GBMSM. Lessons learned: The improved evaluation of HIV prevention in NSW was funded by a 5-year Partnership research grant. The governance structure of the Partnership meant that policymakers, researchers, and community and clinician representatives met quarterly in working groups focussed on HIV testing, treatment, PrEP and behaviour. This helped ensure the ongoing engagement of all relevant stakeholders and to ensure that research could directly inform the prevention response. Recommendations: As improved methods of HIV prevention emerge, targeted monitoring and evaluation must constantly evolve to guide optimal implementation of biomedical and behavioural prevention.

- **Annexes:**
    - NSW Ministry of Health. NSW HIV Strategy 2021-2025. Sydney, 2021. Available at: https://www.health.nsw.gov.au/endinghiv/Publications/nsw-hiv-strategy-2021-2025.pdf
    - NSW Ministry of Health. NSW HIV Strategy 2016-2020. Sydney, 2016. Available at: https://www.health.nsw.gov.au/endinghiv/Publications/nsw-hiv-strategy-2016-2020.PDF
    - Sydney Gay Community Periodic Survey reports, Centre for Social Research in Health, UNSW Sydney. Available at: https://www.unsw.edu.au/arts-design-architecture/our-research/research-centres-institutes/centre-social-research-health/our-projects/gay-community-periodic-surveys
    - Grulich AE, Nigro S, Chan C, Patel P, Bavinton BR, Holt M, Prestage G, Callander D, Murray C, Power C, Pinto A, Mao L, Broady T, and Keen P on behalf of the NSW HIV Prevention Partnership Project (2020). Trends in HIV and HIV prevention indicators in gay, bisexual and other men who have sex with men in NSW, 2015-2019: implications for new interventions and for monitoring and evaluation in a new NSW HIV strategy. Kirby Institute, UNSW Sydney: Sydney, Australia. Available at: https://kirby.unsw.edu.au/report/trends-in-hiv-in-nsw-2015-2019
    - NSW HIV Strategy Quarterly and Annual Surveillance Reports. Available at: https://www.health.nsw.gov.au/endinghiv/Pages/tools-and-data.aspx

32. Portugal

CONTACT PERSON

Name: João Castel-Branco Goulão

Title: General Director

Organisation: General-Directorate for Intervention on Addictive Behaviours and Dependencies

Address: Parque de Saúde Pulido Valente, Alameda das Linhas de Torres, n.º 117, Edifício SICAD, 1750-147 Lisboa - Portugal.

Email: joao.goulao@sicad.min-saude.pt

Tel: (+351) 21 111 91 83 | Tlm: (+351) 91 728 43 60

- **Timeline of the case study**: 2001-2021
- **Data is collected by:** Government; Academic institution; Civil society
- **Data collection is:** Part of routine data collection
- **Data is analysed by:** Government
- **Data is used for**: Target setting; Resource allocation; Maximising service coverage; Data-driven policy change;
- **Background and objectives:** The Law 30/2000 defines "the legal framework applicable to the consumption of narcotics and psychotropic substances …". This law is part of a set of policies and measures that characterize the "Portuguese model" in the approach of addictive behaviours and dependencies, favouring interventions developed by health and social areas. The decriminalisation law brought coherence to the measures adopted specially harm and risk reduction activities. Seeking for health care and information about safe practices ceased to be a problem among problematic drug users. Also the families feel safer to help and to be helped. According to this Law, consumption and possession of narcotics and psychoactive substances continue to be prohibited. However, the use and possession of quantities up to the limit considered necessary for the average individual consumption during a 10 day period (quantities defined for each substance) are not a crime. Users are not brought to court and do not incur to imprisonment, do not get a criminal record, but may be subject to administrative sanctions determined by the Commissions for the Dissuasion of Drug Addiction (CDT). The Decriminalisation Law is based on the assumption that the drug user is a citizen that needs health and social support.
- **Contribution to the AIDS response:** The Portuguese national information system, managed by SCAD, collects, analyses and disseminates information on drug use and other issues namely infectious diseases. SICAD guaranties the quality of data and the efficiency of the processing and interpretation of information, to prioritize research lines, to develop processes that support evidence-based decisions and best practices, and promote the sharing and transmission of information and knowledge. The Nacional Program for AIDS/HIV and the National Institute of Health (INSA),

which are responsible for the epidemiological surveillance of HIV infection, it is one of our source services, and the knowledge produced have allowed, at every moment, to better know the needs of answers and services, and the definition of policies that respond to the identified problems. In 2001, when the decriminalization regime was adopted, the available data pointed to a very serious situation regarding the infection among drug addicts. It was this knowledge that led the country to adopt harm-reduction and treatment measures to curb the growing trend among problematic injecting drug users.

- **Results, outcomes and impact:** Portugal decriminalised all drugs. Didn't legalize them or regulated the use. The decriminalisation policy is part of a balanced and integrated approach that links prevention, treatment, harm and risk reduction and social reintegration, on a national public specialized services network. The paradigm of the Portuguese drug policy is not solely defined by decriminalization of drug use. In fact, and although being an important postulate that brings logic and coherence to its main axiom, drug addicted citizens are most of all patients and not criminals, decriminalisation by itself would not be able to generate the results that allowed to curb down AIDS numbers as evaluations showed. Infeção VIH e SIDA em Portugal – 2020. Fonte: Direção-Geral da Saúde / Instituto Nacional de Saúde Doutor Ricardo Jorge (2019). Infeção VIH e SIDA em Portugal - 2019. Lisboa: DGS – Programa Nacional para a Infeção VIH e SIDA / INSA – Departamento de Doenças Infecciosas. If we observe a general positive trend of all available indicators regarding drug use and AIDS comorbidity, this is also due to the multiplication of accessible responses for citizens with drug problems, on a set of measures that acquired a bigger coherence and consistency within the legal framework of decriminalization.

- **Gaps, lessons learnt and recommendations:** The fully acceptance of the Humanistic Principle that consider an addicted person essentially a patient, drug addiction is an health matter, and therefore policy and governance of all matters related to this phenomenon should be put under the sanitary scope, with citizen centered approach, leading to the assessment of the drug user situation regarding severity of pattern of drug use and / or other correlated biopsychosocial problems and comorbidities. We can refer some issues very important for the results achieved. The increased access to treatment with national public network of specialized services, including prison facilities; diminishment / suppression of waiting lists; increased access to treatment (specific) – Opiate Substitution Treatment: increased number of slots for OST administration in the communities and syringe exchange among other measures. With regard to the management of national information system, this task is facilitated since the law determines "………the services and bodies of the Ministry of Health, as well as other services and bodies of public administration, private entities or the social sector, shall communicate to SICAD any data and information concerning their activity requested from them." And that makes the difference for the monitoring of the phenomena and assess the needs of the policymakers.

- **Annexes:** https://www.sicad.pt/EN/Paginas/default.aspx
  SinopseEstatistica19_SubstanciaIlicitas_EN (sicad.pt)
  SinopseEstatistica18_SubstanciasIlicitas_EN (sicad.pt)

Multicountry

33. Global (in 2019, 57 countries for SDG 5.6.1 and 109 countries for 5.6.2)

CONTACT PERSON

Name: Emilie Filmer-Wilson

Title: Human Rights Adviser

Organisation: UNFPA

Address: 605 3rd Ave, New York, NY 10158, USA

Email: filmer-wilson@unfpa.org

- **Timeline of the case study**: The first data was provided from 2019, and is being provided biannually thereafter.

- **Data is collected by:** Government; UN or other international organisation

- **Data collection is:** Part of routine data collection

- **Data is analysed by:** UN or other international organisation; Government. [nb: 5.6.1 is part of routine data collection, 5.6.2 is supplemental collection of data]

- **Data is used for**: Target setting; Maximising service coverage; Data-driven policy change

- **Background and objectives:** UNFPA is the custodian agency of SDG indicators 5.6.1 and 5.6.2, which through SDG target 5.6 mark the first time that an international development framework includes not only targets on sexual and reproductive health services but also targets that address the barriers and human rights-based dimensions of sexual and reproductive health and reproductive rights. SDG 5.6.2 reflects the extent to which prevailing laws enable or disable women's and men's full and equal access to this health and rights, while SDG 5.6.1 reflects whether women, irrespective of the country's legal framework, are able to decide on their sexual and reproductive health and reproductive rights. This allows a complementary examination of whether a country has a positive enabling legal and normative framework, and whether its provisions go the last mile to empower all women and girls. The data and research provides important evidence-based arguments to advocate and support rights and choice for all.

- **Contribution to the AIDS response:** Meeting the Indicator 5.6.1 criteria is associated with better reproductive health knowledge and outcomes, as women who met this indicator are more likely to be able to identify how to prevent HIV, have the number of prenatal visits recommended by the World Health Organization, and have their most recent delivery with a skilled birth attendant. There also appears to be significant associations between meeting Indicator 5.6.1 and gender-equal outcomes. Women who meet the three criteria are more likely to own their home and land (alone or jointly with their partner), be currently working and have health insurance coverage. They are also significantly less likely to have ever experienced intimate partner violence. Indicator 5.6.2 seeks to provide the first comprehensive global assessment of legal and regulatory frameworks regarding access to SRHR. In doing so, it aims to increase the number of countries with laws and regulations that guarantee women and men full and equal access to sexual and reproductive health care, information and education, and to compel countries to remove legal barriers that interfere with this full and equal access. It measures 13 components in four sections: Maternity Care, Comprehensive Sexuality Education (CSE) and Information [including CSE Law and CSE Curriculum], Contraception and Family Planning, and Sexual Health and Well-Being [including HIV Testing and Counselling, HIV Treatment and Care, Confidentiality of Health Status for Men and Women Living with HIV, and HPV Vaccine].

- **Results, outcomes and impact:** Among the 75 countries with complete data on 5.6.2, countries have in place, on average, 73 per cent of the laws and regulations needed to guarantee full and equal access to SRHR. With this access guaranteed in laws and regulations for many countries, the focus should therefore be on ensuring that policies, budgets and actions can translate the laws into practice. The findings from these data are particularly encouraging when it comes to HIV: on average, countries have achieved 87 per cent of enabling laws and regulations for HIV counselling and test services; 91 per cent for HIV treatment and care services; and 96 per cent for HIV confidentiality. Meanwhile, countries have an average of 79 per cent of relevant enabling laws and regulations that stipulate full, free and informed consent of individuals before they receive contraceptive services, including sterilization. This indicates a mostly supportive protection framework from coerced or forced practices. However, among countries with enabling laws and regulations, 24% still have minimum age requirements for voluntary HIV counselling and testing services.

- **Gaps, lessons learnt and recommendations:** The section that is weakest in terms of positive laws and regulations is sexuality education curriculum. Countries have an average of 57 per cent of enabling laws, regulations or national policies that make sexuality education a mandatory component of the national school curriculum. In the sexual health section of the indicator, countries only have an average of 45 per cent of enabling laws or regulations that guarantee human papillomavirus (HPV) vaccine to adolescent girls. The data also tells us that legal barriers to full and equal SRHR access exist in a number of areas. Such barriers are most prevalent in the case of legal access to abortion, with an average of just 31 per cent achievement in this component. Although abortion is legal on some or all grounds6 in 93 per cent of reporting countries, a husband's consent is required for married women to access the service in 28 per cent of these countries, and judicial consent is required for minors in 29 per cent. In regard to 5.6.1, one of the major challenges is that most of the data is collected from developing countries only, and a large percentage of those countries are in Africa. This is because the data is reliant on DHS and MICS. However, efforts are being taken to broaden coverage of 5.6.1, for example, by integrating the 5.6.1 questions into the European Generations and Gender Population Survey and by working with national statistical offices all around the world to support data collection.

- **Annexes:**
    - (UNFPA, 2020) Ensure universal access to sexual and reproductive health and reproductive rights: Measuring SDG Target 5.6 - https://www.unfpa.org/sdg-5-6
    - (UNFPA, 2020) Women's Ability to Decide: Issue Brief on Indicator 5.6.1 of the Sustainable Development Goals -

https://www.unfpa.org/resources/womens-ability-decide-issue-brief-indicator-561-sustainable-development-goals

[End of document]