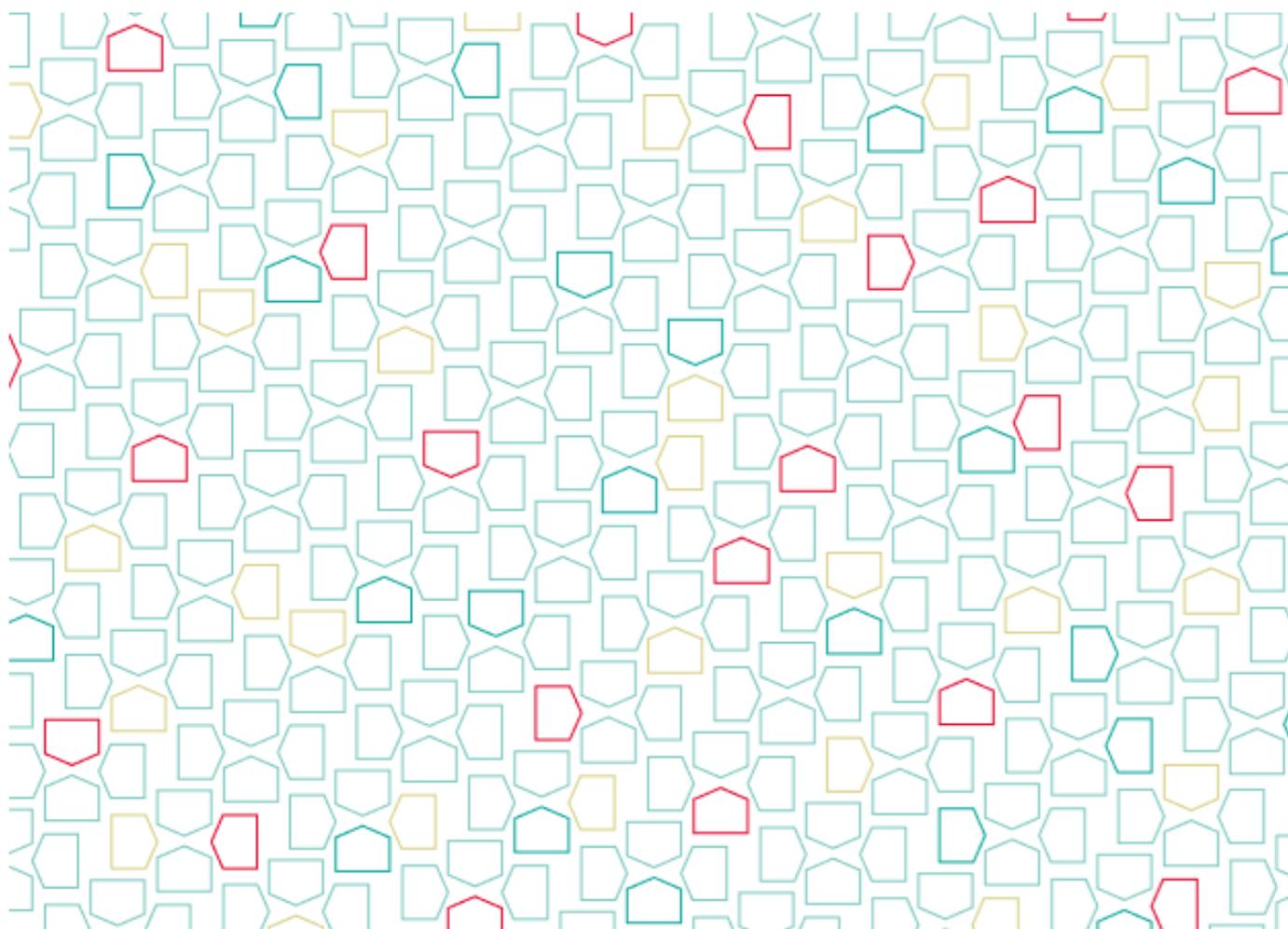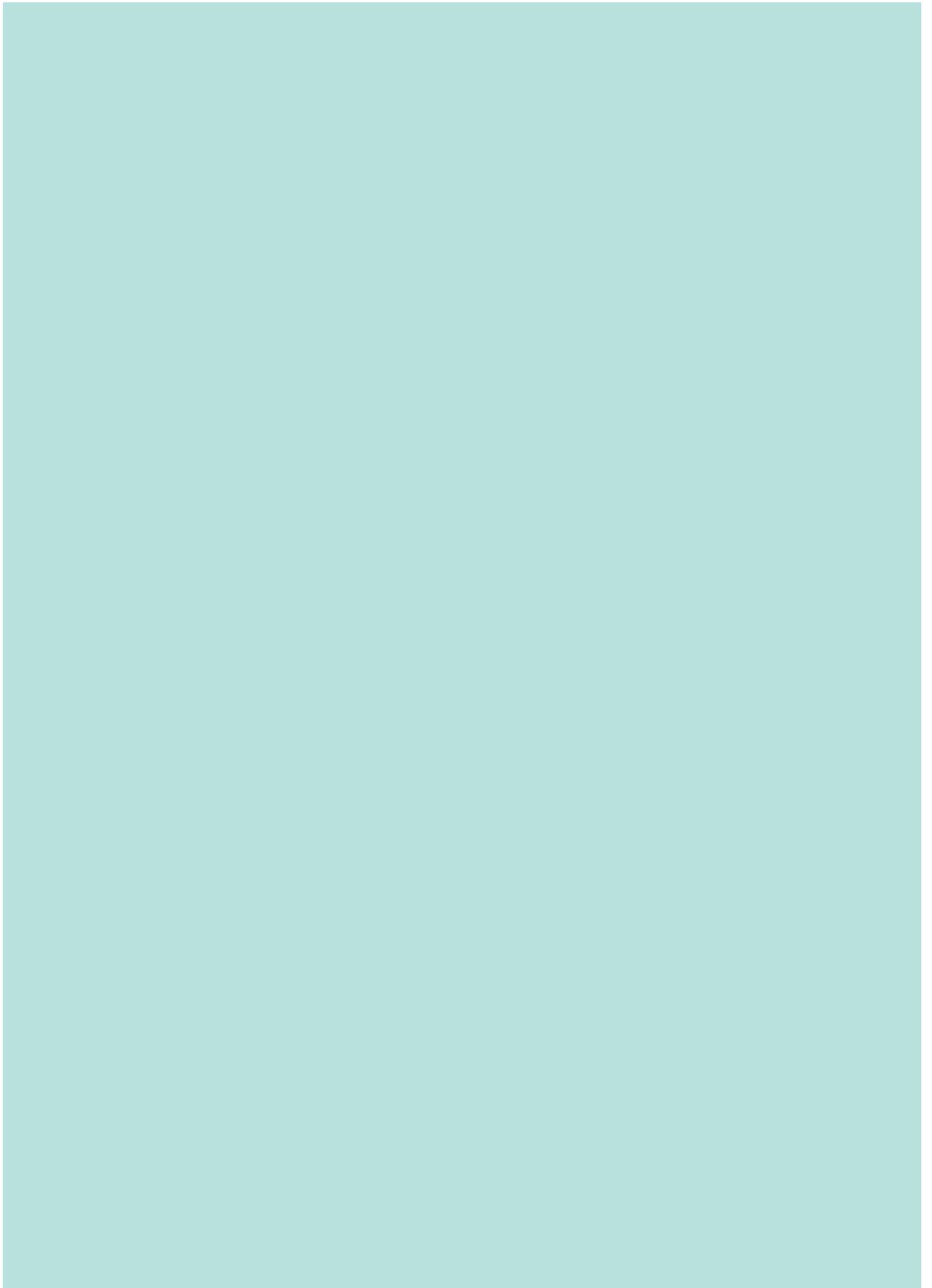# Scorecards, Country Posters and Consultations in the Global HIV Prevention Coalition

A country guide to reviewing and consultation

October 2021

Contents

Introduction

In October 2017, the Global HIV Prevention Coalition (GPC) was established to strengthen and sustain political commitment for primary prevention by setting a common agenda among United Nations Member States, donors, civil society organizations and implementers. With countries and communities at the centre, the GPC seeks to ensure accountability for delivering prevention services at scale in order to achieve the targets of the 2016 Political Declaration on Ending AIDS, including a 75% reduction in HIV infections towards fewer than 500 000 infections by 2020, and to ending the AIDS epidemic by 2030.

GPC Member States adopted the use of HIV prevention score cards to ensure accountability and monitor progress in implementing the HIV Prevention 2020 Road Map, a guiding framework for prevention efforts in all low- and middle-income countries, particularly in those with high numbers of new HIV infections among adolescents and adults.

The Road Map is based on a 10-point action plan for accelerating HIV prevention at country level (Figure 1) and focuses on 5 priority pillars that need strengthening in national HIV primary prevention responses, depending on the context of countries' local epidemics (Figure 2).

The scorecards assess status and track progress against HIV prevention targets in Coalition countries and other priority Fast Track countries. They seek to summarize existing data on prevention progress, provide an orientation and an entry point for comparison and stimulate learning across programmes.

Since its inauguration, the GPC has launched four progress reports (last one published in November 2020) that have highlighted the need for intensified efforts to closing gaps on the 10 Road Map actions, in particular related to accelerated programme coverage for key populations and adolescent girls and young women and their male partners in high incidence locations, strengthening national prevention management capacity and systems with reinforced community leadership, and preparedness for prevention financing in country.

Figure 1. 10-point plan for accelerating HIV prevention at the country level

Figure 2. Combination prevention: five pillars

The scorecards and posters that will be published in 2021 describe progress made on HIV prevention generally reflecting data as of the end of 2020. A summary report on this data will be launched at a virtual High-Level Ministerial meeting of the GPC to be held in November 2021.
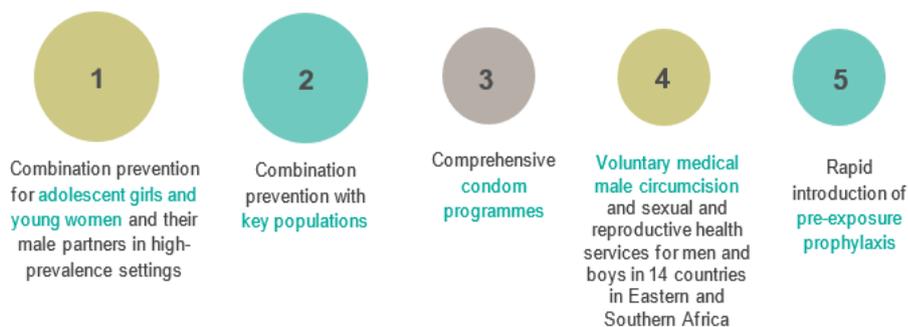
This Country Guidance Note describes the process for review (not validation as before) of scorecards and HIV prevention posters, as well as for multi-stakeholder consultations at country level. Extensive background information regarding the Global HIV Prevention country scorecards and posters is provided in an Annex.

1. Guidance –Review of Global HIV Prevention Coalition country scorecards / posters

In earlier years we asked countries to validate the data included in the scorecard / poster. This year, there are some important changes to the process:

- The data validation for the scorecards/posters has been integrated into the Global AIDS Monitoring (GAM) and National Commitments and Policy Instrument (NCPI) process to reduce burden on you and to avoid validating the same data twice. The scorecards/posters will strictly cover data up till the end of 2020, so there is no further need to validate indicator data (or scores based on this data) from these sources in country. This is also the case for data/scores coming from sources that have also undergone a validation process (surveys e.g. DHS, UNICEF, UNPD, PEPFAR and Global Fund). Note that for some indicators (e.g. key population coverage) more countries have "insufficient data" due to the move of using GAM data only. A triangulation exercise with Global Fund and PEPFAR data will still take place, however, this highlights the importance for countries to report all available data in GAM.

- Countries (UNAIDS country directors, government focal points, prevention technical working groups) are only requested to review (not validate) the final data. This largely comes down to checking if there are any data included that are not in line with e.g. the final GAM submission (reflecting data as of the end of 2020), plus checking if the latest survey data has been included. To calculate the condom need we used the UNAIDS estimates tool, but countries might have conducted their own calculations using this tool (for 2020). Finally, the COVID-19 related data comes from the UNAIDS portal, but it should be checked if this reflects the current status in the country.

- Confirmation that the data has been reviewed and possible feedback (including the name of the indicator, the old and new value, and source documentation e.g. copy of the latest survey report) can be emailed to: Gerritsen.annette@gmail.com, CC: BenediktC@unaids.org; ZembeL@unaids.org. The review process will need to be done within a weeks time. If no feedback is received it will be assumed that the data is correct.

Note that information on the sources of all indicators, as well as more in-depth information on the calculation of the scores and some of the tools / methods used to calculate certain indicators (e.g. condom needs estimation tool, % of priority districts with dedicated programs for AGYW & partners, PrEP composite score) can be found in the Background to the Global HIV Prevention Scorecard (Annex 4).

2. Guidance –Conducting (virtually) multi-stakeholder consultations on Global HIV Prevention Coalition your country progress

Background

Monitoring progress against targets and establishing accountability for achieving them remains a powerful motivational tool in the global AIDS response. The HIV Prevention 2020 Road Map calls for prevention programmes that are evidence-informed, community-owned and rights-based, with local stakeholders (Governments, civil society organizations and communities) at the centre of the response. The Global HIV Prevention Coalition (GPC) recommends a joint results framework as a basis for monitoring progress with

Road Map implementation in country, reviewing performance of national prevention programmes and ensuring accountability for results across all relevant stakeholders at the national and subnational level. Previous GPC progress reports have shown that meaningful engagement of nongovernmental, community structures and other stakeholders in prevention efforts need to be strengthened.

Building on these key principles, the country HIV prevention poster consultation process should be country-led, with communities engaged and provide an accountability platform for all stakeholders. Following the scorecard validation and poster review by the prevention technical working groups, multi-stakeholder consultations are suggested as forums for different stakeholders involved in countries' prevention responses to reflect on the performance of their national HIV prevention programmes and review the prevention poster messages across the five HIV prevention pillars.

Objectives

- Strengthening meaningful engagement of all stakeholders involved in national HIV prevention responses across the five HIV prevention pillars in the review of performance of national HIV prevention programmes and finalisation of key messages & next steps reflected in country posters.

- Ensuring accountability across stakeholders for results in Road Map implementation.

Participants

Depending on the context of the country's local epidemics and the existence of different groups, the following stakeholders could be involved in the dedicated (virtual) consultations or a combined multi-stakeholder consultation. (For set-up and timeline, see Figure 4).

- Key population communities

- Representation of adolescent girls and young women

- Representation of men

- Civil society including people living with HIV, implementers and civil society advocates

- Development partners including the donor community, the United Nations, the private sector and foundations

Methodology

The different consultations should be opened by a standardised presentation ('Setting the stage') to introduce the country poster and discuss what the data means for the in-country response.

Consultations should rely on interactive methods to facilitate dynamic discussions and a joint review of the national HIV prevention programmes to identify progress, bottlenecks and recommendations to accelerate Road Map implementation.

In order to strengthening accountability for Road Map implementation and for future follow-up, a list of participation (name, email contact, affiliation) joining the consultations should be produced (Annex 2), together with a documentation of the main outcomes related to the following aspects (Annex 3).

If useful, individual stakeholder groups can be brought together in one consultation, rather than organising separate meetings.

An illustrative set of guiding questions for different stakeholder groups is provided (Annex 4).

As COVID-19 might limit travel, physical consultations could be replaced by virtual ones.

Annex 1. List of Participation – Multi-Stakeholder Consultation on Global HIV Prevention Coalition Progress

Country name: [type country name]

Date: [DD/MM/YYYY]

Please indicate stakeholder groups involved in the consultation (mark with X):

☒ Key populations   ☐ Development partners
☐ Adolescent girls and young women   ☐ Other (please specify
☐ Men and boys   _____
☐ Civil society

→ Complete the table below

Name (first name, surname)	**Title**	**Affiliation**	**Email**

[More rows can be added.]

Annex 2. Template for Documentation of Outcomes – Multi-Stakeholder Consultation on Global HIV Prevention Coalition Progress

Country name: [type country name]

Date: [DD/MM/YYYY]

Please indicate stakeholder groups involved in the consultation (mark with X):

☐ Key populations
☐ Adolescent girls and young women
☐ Men and boys
☐ Civil society
☐ Development partners
☐ Other (please specify _____

→ Complete the table below

Topic discussed	Main outcomes
National HIV Prevention Coalition Forum	
HIV Prevention Technical Working Groups	
Adolescent girls and young women	
Key populations	
Men and HIV prevention forum (settings with high HIV prevalence)	
Civil society prevention forum	
Donors – bilateral and multilateral, private foundations, and business community	

Other comments and/or observations during the consultation(s):

………
………

Oriented along the 10-point action plan of the Road Map, generic guiding questions are provided below to guide country reflections on prevention progress, bottlenecks, and recommendations for further refining the country posters and implementing concrete actions.

National HIV Prevention Coalition Forum

1. Based on the poster presentation on overall progress, pillar specific gaps and the 10 action points as shown on the country posters, what are the key recommendations by the national prevention coalition to accelerate progress?

2. The national HIV prevention coalitions were set up as mechanisms to maintain a sense of purpose and urgency around prevention and to strengthen accountability as part of monitoring progress towards targets and commitments, what are some of the achievements and lessons learnt? What have been concrete examples on country level in this regard?

3. How can the national HIV prevention coalition mechanisms reinforce participatory approaches in programme design, implementation and assessing progress for HIV prevention and seize opportunities re-vitalize primary HIV prevention as a public good?

4. Accountability for results is one of the key areas of focus for national HIV prevention coalitions. What are some of the issues that hinder and/or promote regular review of progress against key targets?

5. What support is needed to strengthen HIV prevention management, capacity and systems. What are the implications for the National AIDS Commissions and other stakeholders involved in the national HIV prevention response?

HIV Prevention Technical Working Groups

1. Based on the poster presentation, to what extent does the overall progress or lack of it as presented on the poster trigger specific actions (pillar specific) to accelerate actions to achieve the HIV prevention 2020 targets?

2. Global HIV Prevention Coalition Member States committed to address four main reasons for insufficient progress with HIV prevention: gaps in political leadership, gaps in HIV prevention financing, policy gaps and lack of systematic programme implementation at scale. What are some of the pillar-specific effective solutions to bridge these gaps? What has since been put in place? What can be done better?

3. What support is needed to strengthen HIV prevention management, capacity and systems. What are the implications for the National AIDS Commissions and other stakeholders involved in the national HIV prevention response?

4. What are some of the evidence-based innovations and new technologies that remain under-utilized to accelerate achievement of pillar specific targets?

5. Coordination and monitoring of HIV prevention programmes is critical, what are some of the best practices, gaps, and solutions?

Adolescent girls and young women

1. The country HIV prevention poster shows progress in HIV prevention, or lack of it. What do young people do, to better hold governments and other stakeholders accountable? What is the current state of engaging young people in the national prevention response?

2. One of the desired outcomes of the HIV Prevention 2020 Roadmap is to bring to scale (at least 90% coverage for adolescent girls and young women. Based on (country specific coverage on the poster) who and where are the adolescents and young people being left behind without access to HIV prevention package of services?

3. The country HIV prevention poster highlights financial, policy, human rights, and legal barriers that should be prioritized to positively impact on access to HIV prevention services for adolescent girls and young women. What actions should the young people take to catalyze change in these areas?

4. One of the key principles of the HIV Prevention 2020 Road Map is to engage communities in design, implementation, and monitoring of progress. What are some of the gaps in meaningfully engaging adolescent girls and young women in HIV prevention and how can they be bridged?

Key populations

1. The country HIV prevention poster shows progress in HIV prevention, or lack of it? What do key population communities do, to better hold governments and other stake holders accountable? What is the current state of engaging key population communities in the national prevention response?

2. One of the desired outcomes of the HIV Prevention 2020 Roadmap is to bring to scale (at least 90% programme coverage for key populations). Based on (country specific coverage on the poster) who and where are the key populations being left behind without access to HIV prevention package of services?

3. Strong and bold political leadership and plans are required at all levels to address sensitive issues and defend progressive public health, social policies, laws and ambitious prevention targets for key populations. What are some of the gaps and opportunities that remain untapped for key population prevention programmes?

4. One of the key principles of the GPC is to engage communities in design, implementation and monitoring of progress. What are some of the gaps in the engagement of key population communities and how can these gaps be addressed?

Men and HIV prevention forum (settings with high HIV prevalence)

1. The country HIV prevention poster shows progress in reducing new HIV infections, or lack of it? What are some of the areas that can benefit from reinforced male engagement in HIV prevention?

2. Engaging men as clients, partners and agents of change in high HIV prevalence setting for prevention and treatment remain sub-optimal. What are some of the strategies that remain untapped?

3. Progress or lack of it? Reducing new HIV infections among adolescent girls and young women is impacted by the sub-optimal engagement of their male sexual partners, How can prevention programmes be re-designed to achieve a more pro-active role of men and boys in bringing positive change on social enablers such as reduction of gender-based violence, stigma and discrimination and teenage pregnancies?

Civil society prevention forum

1. The country HIV prevention poster shows progress in reducing new HIV infections, or lack of it? Does the poster reflect realities on the ground? What has been the critical role of civil society?

2. What opportunities remain untapped for a renewed HIV prevention activism on addressing policy and legal factors holding back progress in HIV prevention and addressing defunding of effective community driven programmes?

3. One of the commitments of the GPC Member States is to provide mechanisms for social contracting for HIV prevention. What are some of the strategic actions that civil society can undertake to demand for the fulfilment of this commitment? What is the current role of civil society in social contracting mechanisms in place in the country (if any)?

4. . What are some of the unfulfilled promises on integration of HIV and sexual and reproductive health rights? What can civil society do better in holding governments and other stakeholders accountable?

Donors- bilateral and multilateral, private foundations and business community

1. The country HIV prevention poster shows progress in reducing new HIV infections, or lack of it? What are some of the achievements on HIV prevention and what are the missed opportunities by the international community to drastically bring down the numbers of new infections?

2. The global and country commitments to reduce new HIV infections are being championed amidst shrinking fiscal spaces. What are some of the solutions that will accelerate achievement of the ambitious prevention targets (in line with the Road Map 10-point action plan)? What specific roles can the donor and/or business community play in this regard?

3. The Global Fund recently made a commitment to contribute to the drastic reduction of new HIV infections among adolescents and young people in the 13 worst hit countries in Africa. What are some of the catalytic actions other donors can take to support this commitment?

4. Community engagement is critical to achieve HIV prevention targets. How can the donor community address the recent and continuous de-funding of effective community interventions?

5. Strong National AIDS Commissions are critical for country leadership and a coordinated HIV prevention response; How can the donor community contribute to strengthening the capacities of the National AIDS Commissions in HIV prevention?

6. The HIV Prevention 2020 Road Map recommended a joint results-based framework to serves as the basis for monitoring implementation progress and ensuring accountability for results at the national and subnational level. What are some of the areas the donor community can invest in to strengthen specific and mutual accountability?

Annex 4. Background to the Global HIV Prevention country scorecards / posters

Introduction

In 2017, a global coalition of United Nations Member States, donors, civil society organizations and implementers was established to support global efforts to accelerate HIV prevention. Original membership included the 25 highest HIV burden countries, UNAIDS Cosponsors, donors, and civil society and private sector organizations. The overarching goal of the Global HIV Prevention Coalition is to strengthen and sustain political commitment for primary prevention by setting a common agenda among key policymakers, funders, and programme implementers.

With countries and communities at the centre, it seeks to ensure accountability for delivering prevention services at scale in order to achieve the targets of the 2016 Political Declaration on Ending AIDS, including a 75% reduction in HIV infections towards fewer than 500 000 infections by 2020, and to ending the AIDS epidemic by 2030.

The performance of HIV prevention responses is often not easy to understand for policy makers and even implementers may find it hard to compare the performance of programs in their own country to what other countries have achieved.

The coalition aspires to maintain a global accountability process with prevention scorecards, assessing the status and tracking progress on HIV prevention in the priority Fast-Track countries.

The scorecard seeks to:

- Summarize existing data on prevention progress (and is not a new reporting tool);
- Provide an orientation and be an entry point for comparison (not ignoring differences in context);
- Stimulate learning from high-performing programmes (without passing final judgements);
- Encourage digging deeper into issues of supply, demand, structures, and data at the sub-national level.

The choice of indicators included in the scoring was both informed by what is most important to measure and what is realistically available in most countries, preferably through the Global AIDS Monitoring (GAM). Other frequently used data sources are Demographic Health Surveys (DHS) or other surveys (e.g. Population-based HIV impact assessment (PHIA), Aids Indicator Survey, Multiple Indicator Cluster Survey, Integrated Bio-Behavioural Survey, mapping, and population size estimate studies) and program data. The data for the country scorecards go through the normal validation processes of the GAM / NCPI / UNAIDS HIV estimations data, as well as validation processes from surveys e.g. DHS, UNICEF, UNPD, PEPFAR and Global Fund. Countries have done a final review of this data.

Note that the aggregate scores provided on the scorecard are only indicative; it is important to drill down to the source indicators. Furthermore, it is important to understand social, cultural, and other structural factors when interpreting the scores.

The scorecards are continuously under development: in some areas, currently available indicators are used as proxy indicators, while additional information is being collected for future updates of the scorecard; the scoring approach is further improved; estimations are developed (e.g. estimated pre-exposure prophylaxis (PrEP) need); new coalition countries are added. Furthermore, possibilities for sub-national level scorecards are looked at.

Different sheets in the scorecard file

The "Start" sheet gives the user the option to go straight to the country scorecards or posters for countries with a mixed or concentrated epidemic, as well as the option to go to the summary scorecards (big picture) or each of the five pillar-specific summaries.

1. Country scorecards

Each country has a scorecard showing the values of the included coverage, outcome and impact indicators, as well as a summary of the scores for the five priority pillars whereby separate scores are given for the key population pillars – for sex workers, men who have sex with men, and people who inject drugs. A scoring scale with colours attached to it is used to determine if the country is doing very good, good, medium, low or very low on the respective indicator or score (or if there is insufficient data or the indicator is not applicable).

Note that for countries with a mixed epidemic the scorecards can be created choosing the country name from the dropdown menu in the Scorecard M sheet (displaying data for all pillars), while the same can be done for countries with a concentrated epidemic in the Scorecard C sheet (no data is given for Condoms, VMMC and AGYW).

The target audience for the country summaries are country policy makers and country technical leads/program managers.

2. Country posters

To effectively present and visualise the country state of prevention, country posters are available besides the scorecards.

The country HIV prevention posters provide an overview of country performance in terms of progress in reducing new HIV infections against global HIV prevention 2020 targets; illustrate progress and gaps across the 5 HIV prevention pillars based on data from the scorecard.

The data from the scorecard is automatically included in the poster, and short narratives for the trend in new infections and each of the pillars are automatically generated. The posters include some additional indicators to those of the scorecard/pillar thematic sheets: number of new HIV infections all ages; change in new HIV infections over time for adults, young women and children; change in HIV prevalence over time for young women and young men; number of people using PrEP over time and annual change; number on ART by sex; several indicators on the prevention of vertical transmission of HIV; and the status of the COVID-19 HIV prevention adaptions.

Indicator	Source
Prevention of vertical transmission of HIV indicators: MTCT rate; Percentage of HIV-positive pregnant women receiving ART; Number of estimated births to women living with HIV; Number of new child infections due to vertical transmission (percentage because of mother acquired HIV during pregnancy or breastfeeding; percentage because mother did not receive antiretroviral therapy during pregnancy or breastfeeding; percentage because mother did not continue with treatment during pregnancy or breastfeeding; percentage because mother was on antiretroviral therapy but not virally suppressed).	Estimates
HIV prevention adaptations during COVID-19: Safe continuation of outreach and Online counselling (for young women and key populations); Adapted multi-month dispensing (condoms, PrEP, HIV treatment, safe injecting equipment) and expanded alternative access (condoms, PrEP, HIV treatment), OST take home dosages	UNAIDS COVID-19 portal

Note that similar to the scorecards, posters can be created for countries with a mixed epidemic (Poster M) and a concentrated epidemic (Poster C).

The target audience for the country summaries are country policy makers, country program managers and the wider public.

3. Summary (Big picture)

In the big picture overview overall (composite) scores are presented for each of the GPC countries for the five pillars plus one additional category:

1. Adolescent girls and young women (AGYW) & male partners

2. Key populations – separate scores for sex workers, men who have sex with men, people who inject drugs)

3. Condoms

4. Voluntary medical male circumcision (VMMC) (13 priority countries only)

5. ARV-based prevention – HIV treatment and PrEP

6. Elimination of mother-to-child transmission (eMTCT)

In addition, graphs are included displaying the number of new infections in adults over time (source: UNAIDS estimates), together with the 2020 and 2025 target.

Note that Summary M generates the summary not only for the GPC countries, but via the drop down menu also for regions including countries with mixed epidemics (high prevalence of HIV, "general epidemic"). While Summary C generates the summary for regions including countries with concentrated epidemics and for those no data is given for Condoms, VMMC and AGYW.

The target audience for the big picture scorecard are global decision-makers and country policy makers.

4. Five priority pillars

There are five thematic summaries including data on the five priority pillars. The thematic summaries can be created for different regions using the drop-down menu. The target audience for these scorecards are country technical leads/program managers, regional and global technical advisors.

The five thematic scorecards are as follows:

Adolescent girls and young women & male partners

This scorecard includes outcome and output related indicators sourced from DHS, other surveys, GAM, NCPI and partners (UNICEF. A scoring scale with colours attached to it is used to determine if the country is doing very good, good, medium, low or very low on the respective indicator (or if there is insufficient data or the indicator is not applicable).

To calculate the % of priority districts (administrative areas) with dedicated programs for young women & male partners (full package) the following was done: It was determined how many sub-national areas had a high (≤0.3, <1 per 100 person-years), very high (≤1, <2) or extremely high (≤2) HIV incidence. Then it was determined how many sub-national areas were covered with a full package. This was defined as areas covered by AGYW programmes (PEPFAR DREAMS, Global Fund, UNICEF).

	Indicator	Source
Outcome	Condom use with non-regular partners (young women, 15-24)	DHS, other surveys
	Condom use with non-regular partners (young men, 15-24)	DHS, other surveys
	% who had multiple sexual partners (sexually active young women 15-24)	DHS, other surveys
	% who had multiple sexual partners (men 15-49)	DHS, other surveys
	% of ever-married or partnered women 15-19 and 15–49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	GAM

	Indicator	Source
	% of adolescent girls who completed lower secondary education	UNICEF or national data
	Knows a formal source for condoms (young women 15-24)	DHS, other surveys
	Knows a formal source for condoms (young men 15-24)	DHS, other surveys
Output	% of priority districts (administrative areas) with dedicated programs for young women & male partners (full package)	Global Fund, PEPFAR (DREAMS) and UNICEF records (coverage) and UNAIDS HIV estimates
	% of adolescent girls and young women in high-HIV incidence communities reached with two interventions in the past three months	Program records
	Educational policies on HIV & sexuality education (secondary school)	NCPI
	Laws requiring parental consent for adolescents to access HIV testing services	NCPI
	Provider-initiated condom promotion integrated into SRH services	NCPI
	HIV testing services integrated with SRH services	NCPI

Key populations

This scorecard includes outcome and output related indicators sourced from DHS, other surveys, GAM and NCPI. A scoring scale with colours attached to it is used to determine if the country is doing very good, good, medium, low or very low on the respective indicator (or if there is insufficient data or the indicator is not applicable).

	Indicator	Source
	HIV prevalence (sex workers, <25 years)	GAM 3.3A
	HIV prevalence (sex workers, all ages)	GAM 3.3 A
	HIV prevalence (men who have sex with men, <25 years)	GAM 3.3B
Impact	HIV prevalence (men who have sex with men, all ages)	GAM 3.3B
	HIV prevalence (people who inject drugs, <25 years)	GAM 3.3C
	HIV prevalence (people who inject drugs, all ages)	GAM 3.3C
	HIV prevalence (transgender people, <25 years)	GAM 3.3D
	HIV prevalence (transgender people, all ages)	GAM 3.3D
	Condom use of sex workers with most recent client (reported by sex workers)	GAM 3.6A
	Condom use at last anal sex among men who have sex with men	GAM 3.6B
	Condom use among transgender people	GAM 3.6D
Outcome	Condom use at last paid sex act (reported by men)	DHS, other surveys
	% of PLHIV on ART – sex workers	GAM3.5A*
	% of PLHIV on ART – men who have sex with men	GAM3.5B*
	% of PLHIV on ART – people who inject drugs	GAM3.5C*
	Safe injecting practices (people who inject drugs)	GAM 3.8
	% of opioid users who receive opioid substitution therapy	GAM 3.1
	Sex workers	
	Population size estimate for female sex workers in 1000s	GAM 3.2A**
	% of all sex workers who received at least two HIV prevention interventions in the past three months	GAM 3.7 A
Output	Prevention strategy includes core elements of SW prevention package (All if 7 out of 7 services included; >half if 4-6 services included; <half if 0-3 services included. Services: Community empowerment and capacity-building; Community-based outreach and services; Condom distribution; Clinical services; Legal support services; Actions to address gender-based violence; Actions to reduce stigma and discrimination in health settings)	Based on NCPI

	Criminalization of sex work ('"Yes" when there is any criminalization or punitive regulation of sex work; "No" if sex work is not subject to punitive regulations or is not criminalized).	Based on NCPI, UNAIDS Global Report 2021
	% of sex workers who avoided health care because of stigma and discrimination	GAM 4.2A
	Men who have sex with men	
	Population size estimate for men who have sex with men in 1000s	GAM 3.2B**
	% of all men who have sex with men who received at least two HIV prevention interventions in the past three months	GAM 3.7B
	Prevention strategy includes core elements of MSM prevention package (All if 9 out of 9 services included; >half if 5-8 services included; <half if 0-4 services included. Services: Community empowerment and capacity-building; Community-based outreach and services; Condom and condom-compatible lubricant distribution; STI prevention, screening and treatment services; Clinical servicesPsychosocial counselling and/or mental health services; Legal support services; Actions to address homophobic violence; Actions to reduce stigma and discrimination)	Based on NCPI
	Criminalization of same-sex sexual acts ("Yes" if Death penalty or Imprisonment or no penalty specified; "No" if Laws penalizing same-sex sexual acts have been decriminalized or never existed, or no specific legislation)	Based on NCPI, UNAIDS Global Report 2021
	% of men who have sex with men who avoided health care because of stigma and discrimination	GAM 4.2B
	People who inject drugs	
	Population size estimate for people who inject drugs available	GAM 3.2C**
	% of all people who inject drugs who received at least two HIV prevention interventions in the past three months	GAM 3.7C
	Prevention strategy includes core elements of PWID harm reduction package (All if 3 out of 3 services included; Some if 1 or 2 services included; None if 0 services included. Services : Naloxone available through community distribution; Opioid substitution therapy programmes operational; Needle and syringe programmes operational)	Based on NCPI
	Criminalization of drug use/consumption or possession for personal use (Yes if Drug use / consumption / possession for personal use is specified as criminal; "Partial" if Allows possession of a certain amount; "No" if specified as non-criminal offence or no offence)	Based on NCPI
	Needles and syringes per person who inject drugs	GAM 3.9
	% of people who inject drugs who avoided health care because of stigma and discrimination	GAM 4.2C
	Transgender people	
	Population size estimate for transgender people	GAM 3.2D**
	% of all transgender people who received at least two HIV prevention interventions in the past three months	GAM 3.7D
	% of transgender people who avoided health care because of stigma and discrimination	GAM 4.2D
	Prevention strategy includes core elements of Transgender package	Currently no indicator in NCPI
	Criminalization of transgender people ("Yes" if criminalized and prosecuted; "No" if Neither criminalized nor prosecuted)	Based on NCPI, UNAIDS Global report 2021
	Prisoners	
	Prisoners: national strategy includes critical elements of the programme package: "All" if 3 out of 3 services included; "Some" if 1 or 2 services included; "None" if 0 services included. Services: Needle and syringe programmes operational in prisons; Opioid substitution therapy programmes operational in prisons; Prisons: condoms and lubricants available.	Based on NCPI

	Population size estimate prisoners	Prison studies.org***

* Note that data reported into GAM can either be from surveys or programmes, and the latter usually give higher values.

** The PSE reported into GAM can either be nationally representative or only for a region in the country.

*** https://www.prisonstudies.org/highest-to-lowest/prison-population-total?field_region_taxonomy_tid=All

Condoms

This scorecard includes outcome and output related indicators sourced from DHS, other surveys, GAM, National Commitments and Policy Instrument (NCPI) or calculated using a tool.. A scoring scale with colours attached to it is used to determine if the country is doing very good, good, medium, low or very low on the respective indicator (or if there is insufficient data or the indicator is not applicable).

The total condom need per male is estimated using a UNFPA/UNAIDS condom tool. The tool considers the size of priority populations for condom programming, baseline coverage, the average number of sexual acts per year requiring protection, condom use targets, and condom wastage.

	Indicator	Source
Outcome	Condom use with non-regular partners (women 15-49)	GAM 3.18
	Condom use with non-regular partners (men 15-49)	GAM 3.18
	Knows condom as prevention method (women 15-49)	DHS, other surveys
	Knows condom as prevention method (men 15-49)	DHS, other surveys
	Woman justified to insist on condom use if husband has a sexually transmitted infection (STI) (women 15-49)	DHS, other surveys
	Woman justified to insist on condom use if husband has STI (men 15-49)	DHS, other surveys
Output	Number of condoms distributed/sold (in millions)	GAM
	Number of condoms distributed/sold per couple-year* (age range 15-64 - 2020)	Calculated from GAM, World Population Prospects (UNPD)
	% of condom distribution need met	UNAIDS Condom needs estimation tool

** The number of condoms per couple-year represents the total number of condoms distributed and sold in a year, divided by half the population aged 15-64 in a country (assuming that each condom is used in a sexual act involving two persons). Both male and female condoms are included in the number of condoms distributed and sold. The total male population 15-64 was used as a proxy for the denominator mathematically, while acknowledging that condoms are used between women and men, between two men and by people with other gender identities. The indicator as a whole provides a proxy for comparing condom distribution numbers in different countries relative to population size. The following indicator on % of condom distribution need met provides a more granular estimate of the proportion of condom need met among sexually active people of all ages including key populations for prevention of HIV, STIs and unintended pregnancy.

Voluntary medical male circumcision

This scorecard includes outcome and output related indicators sourced from GAM, DHS and other surveys. A scoring scale with colours attached to it is used to determine if the country is doing very good, good, medium, low or very low on the respective indicator (or if there is insufficient data or the indicator is not applicable).

	Indicator	Source

	Outcome	National male circumcision (MC) prevalence (15-24)	DHS, other surveys
		National MC prevalence (15-49)	GAM 3.16
		% of cumulative (2016-current) global VMMC target achieved (2016-20 target) by country	GAM 3.17, targets derived from global fast-track model (Stover et al)
	Output	% of annual (current year) VMMC target achieved	GAM 3.17, targets derived from global fast-track model (Stover et al)
		Number of VMMCs performed per year (in thousands) – current year	GAM 3.17
		Number of VMMCs performed per year (in thousands) – previous year	GAM 3.17/program records
		% Change in number of VMMCs performed between current and previous year	Calculation

The VMMC Fast Track targets were set for the period 2016-2020 with an age focus of the 10-29-year-old. To calculate the % of cumulative (2016-current year) VMMCs performed towards the global VMMC Fast Track targets, a 93% (based on granular age disaggregated programme data) proportion of the 2016-current year cumulative VMMCs was applied.

ARV-based prevention

This scorecard includes outcome and output related indicators sourced from GAM, NCPI or calculated. A scoring scale with colours attached to it is used to determine if the country is doing very good, good, medium, low or very low on the respective indicator (or if there is insufficient data or the indicator is not applicable).

No data is available yet for the % of national need for PrEP met, as the PrEP needs estimation tool is still under development.

		Indicator	Source
	Outcome	% of national need for PrEP met	PrEP needs estimation – under development
		% of all PLHIV diagnosed	GAM 1.1
		% of all PLHIV on antiretroviral treatment (ART)	GAM 1.2
		% of all PLHIV virally suppressed (overall and separate for men and women 15+ years)	GAM 1.4
	Output	Regulatory approval in place (0 = no, 1 = = yes)	NCPI
		PrEP guidelines in place (0 = no, 1 = in preparation, 2 = yes)	NCPI data triangulated with WHO validated data published in Lancet HIV 2021, Robin et al,2021
		Number of people who received PrEP at least once in the past 12 months (previous year)	GAM/Program records
		Number of people who received PrEP at least once in the past 12 months (current year)	GAM
		% Change in PrEP coverage between current and previous year*	Calculation
		PrEP coverage score	Explained in Scoring approach section
		Composite PrEP score (0-10 points)	Explained in Scoring approach section

*Note that due to the alignment with GAM data, for the 2021 scorecards and posters this will be the change between July 2020 and December 2020.

5. Validation sheet

This sheet contains all of the indicators with the respective country data (except new HIV infections data) that is referred to in the country scorecards and posters. For each indicator it includes also the source of the indicator.

Scoring approach

Since indicators based on absolute numbers (e.g. number of condoms distributed, number of people on PrEP) cannot be compared across countries, scores will be based on standard definitions of denominators to estimate availability and /or coverage.

All scores are expressed on a continuous scale of 0–10. All outcome and coverage indicators, which go into the score, have a specific weight. If either coverage or outcome information is unavailable, the score will be based on only one dimension.

Each of the overall scores are based on a combination of two dimensions:

- outcome (utilization/behaviour at population-level)
- programmatic coverage (people covered by programs)

The specific definition of composite and coverage scores in the five priority pillars of prevention is summarized below:

1. Adolescent girls and young women & male partners

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
25%	Population-level outcome (PO1)	Condom use at last sex with a non-regular partner (young women 15-24)	DHS, other surveys
25%	Population-level outcome (PO2)	% of adolescent girls who completed lower secondary education This is collected by UNICEF using the following definition: Lower secondary completion rate among population aged 3-5 years above lower secondary graduation age (Percentage)	UNICEF or national data
50%	Programmatic coverage (PC)	% of priority districts (administrative areas) with dedicated programs for young women & male partners (full package)	Global Fund, PEPFAR (DREAMS) and UNICEF records and UNAIDS HIV estimates
Scoring/ Formula	General formula: (((PO1+PO2)/2) + PC) /2*10 Example: Outcome (PO1): use DHS data, e.g. 43% of young women reported condom use at last sex with a non-regular partner (score of 4.3) Outcome (PO2): Completion of lower secondary education = 75% (score of 7.5)		

Coverage (PC): All administrative areas with HIV incidence among young women 15-24 above 0.3 in 100 person years = 15 out of 60 districts = 25% (score of 2.5). *Formula for composite score applied to example:* (((4.3+7.5)/2) + 2.5)/2 = 4.2 = rounded score of 4.		

The coverage score is as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	% of priority districts (administrative areas) with dedicated programs for young women & male partners (full package) An exercise has been conducted whereby for each of the areas with a high HIV incidence was covered by interventions for this age group supported by Global Fund, PEPFAR (DREAMS) or UNICEF.	Global Fund, PEPFAR (DREAMS) and UNICEF records and UNAIDS HIV estimates
Scoring	<u>Example:</u> Coverage (PC): All administrative areas with HIV incidence among young women 15-24 above 0.3 in 100 person years that are covered (by Global Fund , PEPFAR (DREAMS) or UNICEF) = 15 out of 60 districts = 25%. *Scoring applied in example:* 25% = score of 2.5 = rounded score of 3.		

2. Key populations

<u>Sex workers</u>

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
25%	Population-level outcome (PO1)	Condom use of sex workers with most recent client (reported by sex workers)	GAM 3.6A
25%	Population-level outcome (PO2)	Condom use at last paid sex act (reported by men)	DHS, other surveys
50%	Programmatic coverage (PC)	% of all SW who received at least two HIV prevention interventions in the past three months	GAM 3.7 A
Formula	<u>General formula:</u> (((PO1+PO2)/2)+PC)/2*10 Due to the high risk of HIV transmission in sex work settings and high HIV incidence being reported even with fairly high self-reported condom use at last sex, the scoring for self-reported condom use by sex workers was adjusted. The scale for scoring basically starts at 50% condom use with a score of 0 (rather than 5, which it would be for other indicators) and 55% condom use represents a score of 1, 95% condom use represents a score of 9 and only condom use of 97.5% and above will be rounded to a full score of 10. Very high condom use reported by sex workers was shown to be achievable. <u>Example:</u> Outcome (PO1): Reported condom use by sex workers at last paid sex in GAM = 90% (score of 8.0) Outcome (PO2): Reported condom use by men who paid for sex in DHS = 72% (score of 7.2) Coverage PC: GAM indicator 3.7A on program coverage (reached in last three months with at least two services). As described in GAM guidance it can be derived from IBBS or program records. Example: if indicator = 40% use that value. *Formula applied to example:* (((8.0+7.2)/2)+4.0)/2= 5.8 = rounded score of 6		

The coverage score is as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	% of all SW who received at least two HIV prevention interventions in the past three months	GAM 3.7A
Scoring	Example: Coverage PC: GAM indicator 3.7A on program coverage (reached in last three months with at least two services). As described in GAM guidance it can be derived from IBBS or program records. Example: if indicator = 40% use that value. *Scoring applied in example:* 40% = rounded score of 4.		

Men who have sex with men

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
50%	Population-level outcome (PO)	Condom use at last anal sex	GAM 3.6B
50%	Programmatic coverage (PC)	Percent of men who have sex with men reached by HIV prevention programs	GAM 3.7B
Formula	General formula: (PO+PC)/2*10 The formula is the same as for sex workers. However, there is an added level of complexity for men who have sex with men, because not all men who have sex with men will require intensive program coverage as a proportion of men who have sex with men will be in stable relationships with concordant HIV status. This sub-group of men who have sex with men would not require intensive program coverage. It is therefore important to understand if the population size estimate includes men who have sex with men at low risk. For calculating coverage this sub-group of men who have sex with men should be removed from the denominator. Example: Outcome (PO): Reported condom use by men who have sex with men at last paid sex in GAM = 70% (score of 7.0); Coverage (PC): GAM indicator 3.7B on program coverage (reached in last three months with at least two services). As described in GAM guidance it can be derived from IBBS or program records. Example: if indicator = 40% use that value *Formula for composite score applied in example:* (7.0+4.0)/2= 5.5 = rounded score of 6		

The coverage score is as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	% of all MSM who received at least two HIV prevention interventions in the past three months	GAM 3.7B
Scoring	Example: Coverage PC: GAM indicator 3.7B on program coverage (reached in last three months with at least two services). As described in GAM guidance it can be derived from IBBS or program records. Example: if indicator = 40% use that value. *Scoring applied in example:* 40% = rounded score of 4.		

People who inject drugs

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
50%	Population-level outcome (PO)	Use of safe injecting equipment during last injection	GAM 3.8
25%	Programmatic coverage (PC1)	% of all people who inject drugs who received at least two HIV prevention interventions in the past three months	GAM 3.7C
25%	Programmatic coverage (PC2)	Number of needles and syringes distributed per PWID (250 = 100%)	GAM 3.9
Formula	General formula: (PO + ((PC1 + PC2)/2))/2*10 Due to the higher infectivity of injecting practices versus sexual practices, high use during last injection may be insufficient. As data on consistent use over longer time periods is not available a standard correction is applied to the reported use at last injection. This is the same adjustment made that is done for condom use reported by sex workers. To express this in a simple way, the gap towards 100% is multiplied by two. This implies the following outcome scores: 100% safe use = 10; 95% safe use = 9; 90% safe use = 8; 85% safe use is 7; 80% safe use is 6; 70% safe use = 4; 60% safe use = 2, 50% safe use or less = 0. This only refers to the outcome score. Example: Outcome (PO): Reported use of safe injecting equipment by people who inject drugs at last paid sex in GAM = 90%, ie gap of 10% towards 100% safe use = score of 8. Coverage PC1: GAM indicator 3.7C on program coverage (reached in last three months with at least two services). As described in GAM guidance it can be derived from IBBS or program records. Example: if indicator = 40% use that value. *Formula for composite score applied in example:* (8.0 + ((4.0+5.0)/2))/2= 6.25 = rounded score of 6		

The coverage score is as follows:

Weight	Level (acronym)	Indicator	Source
50%	Programmatic coverage (PC1)	% of all people who inject drugs who received at least two HIV prevention interventions in the past three months	GAM 3.7C
50%	Programmatic coverage (PC2)	Number of needles and syringes distributed per PWID (250 = 100%)	GAM 3.9
Formula	General formula: (PC1 + PC2)/2*10 Example: Coverage PC1: GAM indicator 3.7C on program coverage (reached in last three months with at least two services). As described in GAM guidance it can be derived from IBBS or program records. Example: if indicator = 40% use that value. Coverage PC2: 1,250,000 needles were distributed; divided by 10,000 PWID = 125 needles per person = 50% of 250 needles (estimated need). *Formula for composite score applied in example:* (4.0+5.0)/2= 4.5 = rounded score of 5		

3. Condoms

The composite score is composed as follows:

Weight	Level (acronym)	Indicator	Source
25%	Population-level outcome (PO1)	Condom use at last sex with a non-regular partner among males 15-49	GAM
25%	Population-level outcome (PO2)	Condom use at last sex with a non-regular partner among females 15-49	GAM
50%	Programmatic coverage (PC)	Percent of national condom distribution need met (actual number of condoms distributed divided by total estimated condom need as per Condom need estimation tool; the total condom need is calculated taking into account the size of different populations, sexual behaviour and partnership types, sexual frequency).	Calculated from NCPI, World Population Prospects and Condom needs estimation tool
Formula	General formula: (((PO1+PO2)/2)+PC)/2*10 Example: Outcome PO1: Condom use for males is 62% (score of 6.2) Outcome PO2: Condom use for females is 48% (score of 4.8) Coverage PC: Condom distribution need met (PC) = 65% (score of 6.5) *Formula applied in example:* (((6.2+4.8)/2) + 6.5)/2*10= 6.0 = rounded score of 6.		

The coverage score is composed as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	Percent of national condom distribution need met (actual number of condoms distributed divided by total estimated condom need as per Condom need estimation tool; the total condom need is calculated taking into account the size of different populations, sexual behaviour and partnership types, sexual frequency).	Calculated from NCPI, World Population Prospects and Condom needs estimation tool
Scoring	Example: Condom distribution need met (PC) = 65% *Scoring applied in example:* 65% = score of 6.5 = rounded score of 7.		

4. Voluntary medical male circumcision (VMMC)

The composite score is composed as follows:

Weight	Level (acronym)	Indicator	Source
50%	Population-level outcome (PO)	% of cumulative global VMMC target achieved by country (2016-20 target)	GAM 3.17, targets derived from global fast-track model (Stover et al)
50%	Programmatic coverage (PC)	% of annual VMMC target achieved (in current year: annual target derived from country 2020 target/5 years)	GAM 3.17, targets derived from global fast-track model (Stover et al)
Formula	General formula: (PO+PC)/2*10		

For the current baseline version of the tool, the level of achievement of cumulative 2015 targets (PO 2015) has been used as a basis for the score.
Formula: (PO2015*10), i.e. 40% of cumulative 2015 target means a score of 4.
For subsequent years the following formula will be used:
(PO*5/YI+PC)/2*10
… where YI stands for years of implementation (2016 = 1 year, 2017 = 2 years, … 2020 = 5 years).

Example:
Outcome PO: VMMC target for 2016-2020 is 1 million. 100 000 achieved in 2016, 170 000 achieved in 2017 and 180,000 in 2018 so 450,000 or 45% of cumulative national VMMC target achieved. Expected progress after 3 out of 5 years (2016-2020) would be 60% of 1 000 0000, i.e. 600,000; hence 450,000 represents only 75% of expected progress (score of 7.5).

Coverage PC: VMMC target for 2016-2020 is 1 million; annual target is 200 000. 180 000 achieved in 2018, so 90% of annual VMMC target achieved (score of 9).

Formula applied to example: (7.5+9)/2 =8.25 = rounded score of 8

The rationale of this formula is to include both annual progress and overall progress towards 2020 targets into the score. Once a country has reached 90% of the 2020 target and/or moved to the VMMC maintenance phase, the country formula will be adjusted accordingly.

The coverage score is composed as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	% of country annual VMMC target achieved (the target is derived from country 2020 target/5 years)	GAM 3.17, targets derived from global fast-track model (Stover et al)
Scoring	Example: PC: VMMC target for 2016-2020 is 1 million; annual target is 200 000. 150 000 achieved in 2017, so 75% of annual VMMC target achieved. *Scoring applied to example:* 75% = score of 7.5		

5. ARV-based prevention

HIV treatment

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	% of all PLHIV on ART	Estimates
Formula	General formula: PC/10 Example: The proportion of all people living with HIV that are on treatment is 47%. The score will be 5 (4.7 rounded to the nearest whole number).		

There is only a composite, not a separate coverage score. The % of all PLHIV on ART measures both coverage of treatment services by the health system as well as use (outcome) for all those living with HIV (whether they know their status or not). The decision was made not to use viral load suppression as an outcome indicator as this measures consistent use, and that is also not done for other pillars. Furthermore, the available data on ART coverage is higher compared to viral load suppression.

<u>PrEP</u>

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	**Regulatory approval for PrEP in place?** No = 0 points, Yes = 1 point **PrEP guidelines in place?** No = 0 points, in preparation = 1 point, Yes = 2 points 200 or more people on PrEP per 100 new infections: 7 points 100-199 people on PrEP per 100 new infections: 5 points 30-98 people on PrEP per 100 new infections: 3 points 10-28 people on PrEP per 100 new infections: 2 points Any number of people on PrEP: 1 point No people on PrEP: 0 points	Program records
Formula	<u>General formula:</u> Sum of points <u>Example:</u> Regulatory approval in preparation (1), PrEP guidelines in place (2), 19 people on PrEP per 100 new infections (2). Sum of points = 5 = score of 5.		

There is only a composite, not a separate coverage score .

6. eMTCT

The composite score is as follows:

Weight	Level (acronym)	Indicator	Source
100%	Programmatic coverage (PC)	HIV treatment coverage among pregnant women living with HIV	Estimates
Formula	<u>General formula:</u> If PC<50 the score is 0. If PC ≥50 then the score is: (PC-50)/5 <u>Example:</u> The proportion of all pregnant women living with HIV that are on treatment is 68%. The score will be (68-50)/5 = 4 (3.6 rounded to the nearest whole number).		

There is only a composite, not a separate coverage score. The % of pregnant women living with HIV on ART measures both coverage of treatment services by the health system as well as use (outcome) for all those pregnant women living with HIV (whether they know their status or not). Note that different from the ART score, the eMTCT score includes a threshold of 50% as a minimum coverage for pregnant women. The success of the programme is only measured starting from that point. This because it is critical to prevent transmission to the child.

Processes for updating the scorecards

1. Collecting the data

Once a year (after the new data from the GAM, NCPI and UNAIDS HIV estimates has become available) the data for the scorecard will be collected at UNAIDS headquarters to update the scorecard. Data from the GAM is downloaded via the Epidemiology Database Management System (EDMS); data from surveys from

the StatCompiler website. This data is then merged into an Excel spreadsheet. Other datasheets are added from other sources / websites e.g. NCPI, UNAIDS HIV estimates, UNICEF, UNPD. Furthermore, data is sourced from partner organisations (e.g. Global Fund and PEPFAR, UNICEF for AGYW programme coverage), surveys (UNAIDS COVID-19 portal) or estimated (condom needs estimation tool). If no new data is available, the earlier available data can be (manually) included.

2. Internal validation

During the internal validation process at UNAIDS headquarters, the scores on the updated versions of the scorecards are compared with those on the previous version (big picture as well as country scorecards). Large changes in scoring (e.g. going from not applicable to a score, big increase or decrease in a score) are checked against any changes in the data underlying the score (e.g. data has become available for which there was previous no data, more recent data has become available, data that was available has been outdated and is hence not reported anymore). Changes in the scores can occur due to changes in the data, but also due to changes in the scoring itself compared to the earlier version, or a change in the data source for an indicator, or a change in the approach for modelled data (e.g. condom needs). If there is missing data while data was available before, this will be manually checked with the source of the data and possibly older data will be used if recent data is not available.

3. Country review

Countries (UNAIDS country directors, government focal points, prevention technical working groups) are given the option to review the final data included in the scorecard and poster. This largely comes down to checking if there are any data included that are not in line with e.g. the final GAM submission, if the latest survey data has been included, if the condom need is correctly estimated, and if the COVID-19 related data reflects the current status in the country.

4. Publication

Once the country scorecards have gone through the above processes, they are published on the Global HIV Prevention Coalition website, together with the main scorecards (big picture and coverage) and technical summaries (for the five pillars). Each of the scorecards can be downloaded from the website.