National Strategic Information Framework for STIs and HIV/AIDS: 2018 – 2022

Papua New Guinea National Department of Health
STIs & HIV/AIDS Surveillance Unit

Foreword

The HIV/AIDS epidemic together with sexually transmitted infections (STIs) continue to be major public health problems in Papua New Guinea. These diseases considerably affect the most productive people in our society aged between 15 – 49 years. The burden is mostly concentrated among key populations and specific geographic locations in our society. In addition, they have had an enormous negative socio-economic impact on the development of our country.

The government remains very committed to address the scourge of STIs and HIV/AIDS in Papua New Guinea. A number of policy and legislative measures have been put in place to support this cause. The government is also party to a number of global commitments like the United Nations High Level Meeting Declaration 2016 to eliminate HIV by 2030. Our vision is to see that PNG will be HIV free and the country's social and economic development will prosper.

The new STI and HIV Strategy 2018 – 2022 builds on our experiences from previous strategies and emerging evidence to guide the country's efforts to end STIs and HIV/AIDS. The country has set ambitious targets that require a renewed sense of commitment to achieve. Strong leadership and guidance by the government plus close collaboration with development partners is needed to achieve the set goals and targets.

This National Strategic Information Framework (NSIF) for STIs and HIV/AIDS: 2018 – 2022 is a living document that will be used to monitor and evaluate the county's progress in meeting the goals and targets of the new STI and HIV Strategy 2018 – 2022. It details the specific roles as well as activities that government and its partners will carry out to meet the targets on key indicators. Guidance on how data on HIV/AIDS and STIs will be collected, collated, analysed, disseminated and used to make decisions to improve programme implementation is also provided.

The government calls all strategic partners and key stakeholders to make use of this key resource document and support the country's efforts to end the scourge of HIV/AIDS and STIs in Papua New Guinea.

May God bless our collective efforts.

Mr Pascoe Kase

Secretary for Health

Acknowledgements

The National HIV/AIDS and STIs Program is mandated to spearhead the country's efforts in delivering on the vision of a PNG free of HIV/AIDS and STIs. However this can only be achieved through strong partnerships and close collaboration between government non-government agencies, communities, healthcare workers (HCWs) plus local and international development partners. Successful implementation of the new STI and HIV Strategy 2018 – 2022 requires the concerted efforts of people from all levels of the health delivery system. As such the National HIV/AIDS and STIs Program would like to acknowledge the various contributions by key stakeholders in the development of the NSIF for HIV/AIDS and STIs 2018 – 2022 that helps to monitor and evaluate our progress. Specific mention is given to;

- Healthcare workers at all levels with their commitment to provide services to the farthest villages in the country;
- Peer counsellors and community healthcare workers that provide social support to people living with HIV (PLHIV) and/or affected by STIs particularly among key populations.
- District/Provincial Health Offices/Authorities that provide technical oversight to the HIV/AIDS and STIs clinics.
- International partners and non-government organizations for the continued support to the program by providing their technical expertise and financial assistance to the program.

Table of Contents

List of Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal care
ASHM	Australasian Society for HIV Medicine
ART	Anti-retroviral therapy
BCC	Behavior change communication
BSS	Bio-behavioral Survey
CBO	Community-based organization
CHAI	Clinton Health Access Initiative
CHASI	Catholic HIV and AIDS Services Inc.
CPHL	Central Public Health Laboratory
DBS	Dried blood spot
eNHIS	Electronic National Health Information System
GAM	Global AIDS Monitoring
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis & Malaria
HHISP	Health & HIV Implementation Services Provider
HIV	Human Immunodeficiency Virus
HPDB	HIV Patient Database
HPV	Human Papilloma Virus
IBBS	Integrated Bio-behavioral Surveillance
IPT	Isoniazid preventive therapy
JSS4D	Justice Services and Stability for Development Project
KP	Key population
KPMIS	Key Population Management Information System
MCH	Maternal and child health
MSD	Men with diverse sexualities

MSM	Men who have sex with men
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDoH	National Department of Health
NGO	Non-government organization
NHATU	National HIV and AIDS Training Unit
NNRTIs	Non-nucleoside reverse transcriptase inhibitors
NSIF	National Strategic Information Framework
NUIC	National Unique Identifier Code
OI	Opportunistic infection
PACS	Provincial AIDS Council Secretariat
PALJP	PNG/Australia Law and Justice Partnership
PHA	Provincial Health Authority
PHO	Provincial Health Office
PITC	Provider initiated HIV testing and counselling
PLHIV	People living with HIV
PMTCT	Prevention of mother to child (HIV) transmission
PNG	Papua New Guinea
PNG IMR	Papua New Guinea Institute of Medical Research
POC	Point of care
PPP	Public/private partnership
PrEP	Pre (HIV) exposure prophylaxis
RAC	Research Advisory Committee
RCU	Research Coordinating Unit
RH	Reproductive health
SDG	Sustainable Development Goal
STI	Sexually transmitted infection
TB	Tuberculosis
TWG	Technical Working Group

UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling & testing
VL	Viral load
WHO	World Health Organization

List of tables

List of figures

1 BACKGROUND

1.1 Epidemiology

The HIV epidemic in PNG has been referred to as 'mixed' in the recent years. Whilst the burden is significantly higher in a set of key populations, there are many people at risk of and affected by HIV who do not fit neatly into these populations.

National HIV prevalence is estimated at 0.9%. It is estimated that there are 48,000 people living with HIV in PNG in 2017. Of these, around 3,000 are estimated to be new infections from the same year with sexual transmission being the leading transmission route. [1]. HIV prevalence in PNG is not uniform. The recent integrated bio-behavioural surveillance (IBBS) study revealed a prevalence of 14.9% among female sex workers and 8.5% among MSM and transgender people in NCD[2]. It is also higher than the national average in the Highlands region and National Capital District. Figure 1 shows the distribution of HIV by provinces.

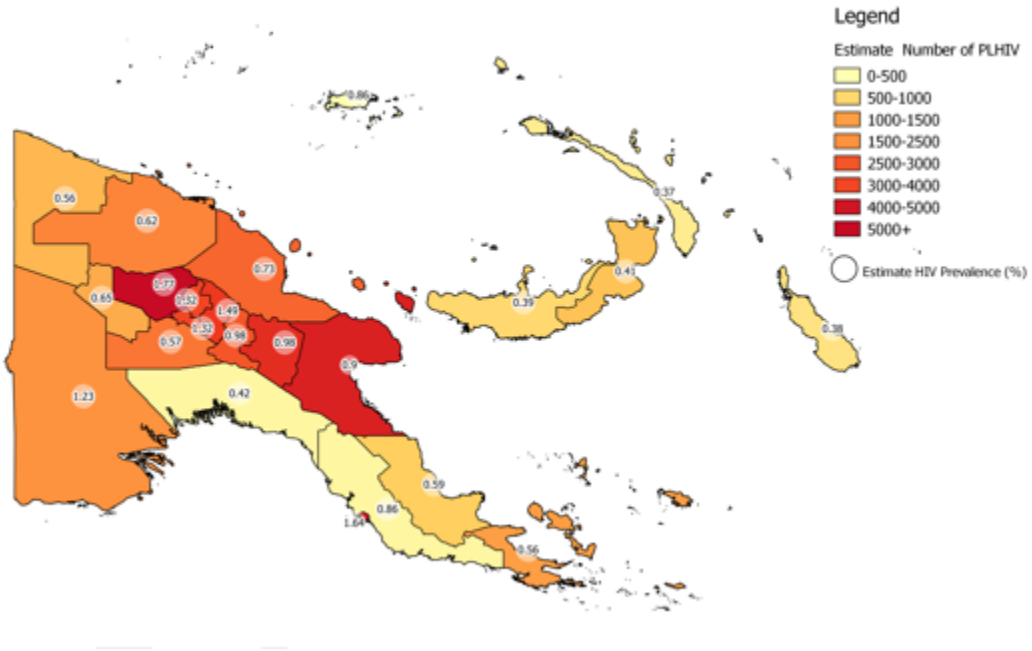


Figure 1: Estimates of provincial HIV prevalence in Papua New Guinea

[1] 2017 Spectrum estimates

[2] TU, K. M. "MULTI-SITE SUMMARY REPORT 2018." Available online at http://www.aidsdatahub.org/sites/default/files/publication/PNG_Kauntim_mi_tu_Multi-site_Summary_Report_from_the_Key_Population_IBBS_2018.pdf

1.2 The National HIV/AIDS and STIs Strategy 2018 – 2022

The National HIV/AIDS and STIs Strategy (NHS) 2018 – 2022 provides guidance to the national response against the two diseases. It aims to build on the progress made in the previous strategy and incorporate new and emerging evidence.

1.2.1 Vision

All Papua New Guineans are protected, and able to protect themselves, from STIs and HIV, and all people with STIs and HIV are able to access the treatment and support they need to maximise their health and the health of their families.

1.2.2 Guiding Principles

This NHS is based on the following principles:

- Universal healthcare coverage (in line with SDG 3)
- A public health approach
- A respect for human rights and gender equality (in line with SDG 5)
- The meaningful involvement of civil society, particularly people living with HIV and the populations most affected by HIV (in line with SDG 17)
- Respectful partnerships between national and provincial governments, non-government organisations and churches (in line with SDG 17)
- Use of the best available scientific evidence to drive program design
- Respect for the wide range of cultural traditions and beliefs across PNG
- No discrimination on the basis of gender, sexuality, age, faith, clan or disability (in line with SDG 17)
- Development of services and programmes that are scalable, sustainability and able to be embedded long-term into PNG's existing systems

1.3 National Strategic Information framework for HIV/AIDs and STIs: 2018 – 2022

The development of the NSIF 2018 to 2022 is guided by the new NHS. The NHS seeks to measure the burden of HIV, STIs and TB-HIV coinfections in the population, increase surveillance of behavioural risks among key populations and sentinel sites, and continuously monitor and evaluate selected indicators that measure program initiatives.

The NSIF 2018 – 2022 integrates national monitoring and evaluation, and surveillance of activities aimed at meeting the targets of the NHS into one comprehensive document. Monitoring and evaluation (M&E), and surveillance are mutually inclusive activities whereby the data to monitor and evaluate program and policy effectiveness are often contingent on surveillance data. The surveillance data are employed to estimate HIV prevalence, calculate vertical transmission, drug adherence, drug resistance, TB/HIV coinfection and mortality rates, to identify risk behaviours that contribute to infection/transmission of disease, identify and monitor key populations, and to inform resource needs to address the epidemic in PNG, plus to monitor and evaluate the program inputs.

The National Department of Health (NDoH) working closely with the national HIV Technical Working Group (HIVTWG), have undertaken a comprehensive review process for the purpose of developing this 5-year strategic framework document that is fully aligned with the PNG NHS. This document replaces the previous PNG National HIV, AIDS and STI Surveillance Plan (2011-2015) and PNG National HIV, AIDS and STI M&E Framework (2011-2015). This current model is based on realistic activities that need to be implemented to meet the objectives of the NHS. The NSIF is a dynamic document that will be reviewed and revised to align with the emerging needs of the HIV/AIDS and STIs program.

1.3.1 The goals of the National M&E, and Surveillance plan

The goal of the NSIF is to generate high quality timely data to monitor and evaluate the HIV epidemic in PNG.

The framework seeks to build on the successes and achievements of previous work, while developing and implementing new and/or adjusted M&E and surveillance priorities that address the programmatic gaps and weaknesses in a timely manner.

This framework has been developed to guide HIV/AIDS and STIS monitoring, evaluation and surveillance activities in PNG. The scope of this plan is the national response to the STIs and HIV epidemics. As such the plan measures the totality of the national response and is not designed to be an M&E plan for any one program.

The main purpose of this NSIF is to;

1. Direct the M&E and Surveillance activities of the NHS
2. Guide the development of M&E and surveillance plans for programs under the NHS
3. Harmonise the implementation of strategic objectives and major activity areas of the NHS related to strategic information, surveillance and M&E.
4. Align M&E and surveillance activities as agreed to in the NHS 2018-2022;

To ensure that the M& E and surveillance activities meet the goals as outlined in the NHS four focus areas are identified to create a sustainable, credible and robust surveillance program. These are;

Focus Area 1 - Harmonised Data Systems: Increase NDoH data collection and analysis capacity by integrating HIV/AIDS and STIs program data and surveillance systems with the NDoH information technology infrastructure. Expand the functionality electronic National Health Information System (eNHIS) to include routine HIV/AIDS and STI M&E plus sentinel surveillance

Focus Area 2 - National Unique Identifier Code: Patient privacy and confidentiality need to be maintained by all M&E and surveillance systems. Data on key populations (KPs) will be captured using Key Populations Management Information System (KPMIS). The data will be stored using a National Unique Identifier Code (NUIC) to guarantee patient privacy and confidentiality. The eNHIS should also capture data on key populations (KPs) using the auto generated of NUIC.

Focus Area 3 -Data Collection Expansion and Strengthening: Increase the number of ART facilities with access to HIV Patient Database (HPDB) to increase case-based and surveillance and reporting. Integration of HIV Surveillance database to the NDoH server it can be accessed online by the M&E and Surveillance staff. Deploy Viral Load Sample Management System (VLSM) to manage and collect Viral Load testing data at the Central Public Health Laboratory (CPHL). Develop protocols to ensure data security and quality, and conduct data quality audits. This includes annual review of surveillance priorities and work plan development. Increase of capacity for STI data collection and reporting. The HPDB will be integrated into eNHIS which will be used as the National HIV Data hub for improved use of the HPDB data and programmatic decision making.

Focus Area 4 - Simplified and Consistent Data Collection Instruments: The national government is the primary source of HIV/STI data. There is need to leverage on NDoH and partner supported technology solutions such as the eNHIS, KPMIS, HPDB and VLSM to streamline data collection process and reduce the inefficiencies of a paper-based data collection system. This entails working with stakeholders to set the parameters/standards for data systems. NDoH in close collaboration with key stakeholders will develop and disseminate definitions and targets for key indicators. They will also develop simplified standard data collections instruments and reporting tools that address the programmatic needs of NDoH and all stakeholders.

Based on the above-mentioned goals, the NSIF for HIV/AIDS and STIs:

- Should not be used as a step-by-step guideline for developing program- and project-level M&E plans.

- Does not provide an exhaustive list of indicators to be used in monitoring and evaluating different programs and projects, especially at the input and output levels.
- Does not replace the National Research Agenda (NRA).
- Excludes costly research initiatives that while beneficial are not sustainable under current financial structure.

1.3.2 Components of a Sustainable HIV Surveillance program

The NHS calls for the stabilization of the core national surveillance system through infrastructure support and expanding capacity to capture critical data. The NSIF restores and expands upon the primary components required for a sustainable and reliable HIV surveillance program. These include;

- A stable and integrated data systems;
- Qualified and adequate personnel;
- Routine and timely analyses and reporting
- Increased support of provincial and community partners
- Sentinel surveillance and continuous program oversight at NDoH.

Sexually transmitted infections (STI) and tuberculosis (TB) are the most common opportunistic infections (OIs) that affect HIV transmission and mortality for PLHIV. As such, data on STIs and TB is routinely collected in conjunction with HIV data to predict potential population at increased risk of HIV infection, transmission or disease burden, as well as, identify populations with co-infections. Thus, in alignment with the NHS, the NSIF increases data collection and analyses activities for TB, STIs, co-infections especially among key populations.

2 INTEGRATED HIV/AIDS AND STIs SURVAILLANCE SYTEM

HIV and AIDS data and reports related to M&E and surveillance in PNG originate from a wide range of activities and these include service delivery, nation-wide studies/surveys (e.g. IBBS) and compiling secondary information. There is a separation of function between National AIDS Council Secretariat (NACS) and NDoH in terms of reporting of information related to the HIV/ADS and STIs national response.

2.1 Reporting structure for the HIV/AIDS and STIs program

The NHS 2018 – 2022 has prioritised strengthening of HIV/AIDS and STIs strategic information systems and improve M&E, surveillance, research and utilisation of evidence. It gives an emphasis on ensuring effective management and coordination of strategic information. Different levels of the public health system have specific roles in the management of HIV/AIDS and STIs surveillance data and implementation of M&E activities.

Data flow is also influenced by the presence of multiple funding agencies and the operations of Non-Governmental Organisations (NGOs) and Faith Based Organisation (FBOs) which are conducting projects in various provinces. These organisations must also report their M&E data to PHAs and in some cases national authorities (NDoH and NACS) as well as their funders.

2.1.1 National Department of Health

The NDoH have been mandated by government to spearhead the national response against HIV/AIDS and STIs in PNG. They are the custodians of all the surveillance data and provide program oversight and leadership in the implementation of M&E activities.

NDoH is the custodian and manager of epidemiological data generated during service delivery for HIV/AIDS and STIs in health care facilities. Health facility services include HIV counselling and testing (HCT), treatment and care of HIV infection, STI diagnosis, care and treatment, and some prevention activities like prevention of parent-to-child transmission (PPTCT) and post-exposure prophylaxis.

NDoH is responsible for national level HIV/AIDS and STIs surveillance, data collection, management and analysis of the health sector activities and all key population programs. At NDoH, there are two units that collaborate to deliver on this mandate;

The HIV Surveillance Unit: It is responsible for monitoring of HIV testing, care and treatment services and surveillance activities (including HIV case reporting, ANC Syphilis surveillance, key population surveillance, sentinel surveillance and survey-based surveillance) reported at the NDoH. This unit is part of the HIV/AIDS and STIs program and is also responsible for STI sentinel surveillance, the development of indicators and program data.

Monitoring and Evaluation and Research Unit; It is responsible for the STI syndromic surveillance system. They also have oversight of the Rural Primary Health Project which is responsible for the development and implementation of the electronic eNHIS

2.1.2 *National AIDS Council Secretariat*

NACS is responsible for data from all other non-health sector services. These include social support and protection for people living with or affected by HIV, prevention interventions through awareness raising among the general population and key populations at higher risk, and other targeted promotion and education interventions. Some service delivery, like condom provision to the general population and key populations at higher risk, may be provided by both health care facilities and non-health services.

NACS has a Research Coordinating Unit (RCU) which is the main coordinating and supervisory body for all HIV-related research in PNG. The NACS is also in-charge of the Research Advisory Committee (RAC) which provides ethical clearance on for research.

2.1.3 HIV/AIDS and STIs Technical Working group

The HIV/AIDS and STIs Technical Working Group (HIVTWG) is made up of local experts and leaders involved in the national response to these diseases. Its composition includes government, the academia, NACS, and development partners. The HIVTWG provides technical advice on strategic information for all HIV/AIDS and STIs public health surveillance and M&E activities.

The terms of reference of the HIVTWG are to;

1. Coordinate and provide high-level oversight to ensure that the HIV/AIDS and STIs M&E and surveillance plan for the NHS is being effectively implemented, consistent with the aim of one national M&E and surveillance system.
2. Promote better collaboration and coordination amongst multi-sectoral agencies in regular data reporting and data use.
3. Ensure the multi-sectoral M&E and surveillance technical working groups have functional secretariats at NACS and NDoH respectively, and report on their progress and obstacles to HIVTWG.

4. Ensure that all stakeholders in the HIV and AIDS response who collect data based on either routine reporting of service delivery activities or other means (including research), comply with reporting deadlines, guidelines, tools and reporting lines and procedures as developed by the two technical working groups.
5. Report to NAC and all stakeholders about the situation of the HIV and AIDS epidemic and the give guidance on the national response.
6. Mobilise financial and other resources for the development and operation of the M&E system and monitor the functionality and sustainability of the system.
7. Advocate at all policy-making levels for an evidence-informed approach in decision making and management of the HIV response.
8. Ensure that all stakeholders at national and provincial levels have been informed about reports and analyses relevant to them.

2.1.4 Provincial Health Authority

The Provincial Health Authorities (PHAs) have direct oversight in the surveillance and implementation of M&E activities for HIV/AIDS and STIs in their respective provinces. They are responsible for collecting reports from all districts and health facilities and ensure they are submitted on time to NDoH and/or NACS. PHAs continuously review and analyse the data being reported as well as provide feedback to the districts and health facilities to improve program implementation. They also supervise implementation of HIV/AIDS and STIs activities by the district health authorities and facilities.

2.1.5 Health Facilities

These are responsible for service delivery and implementation of activities to address HIV/AIDS and STIs as outlined in the NHS. They routinely collect and report on HIV/AIDS surveillance and implement M&E activities to the PHAs. Before forwarding the reports to the PHAs these reports are analysed and information collected is used to improve program implantation.

2.2 HIV/AIDS and STIs surveillance reports

Currently several systems and tools are being used in HIV/AIDS and STIs surveillance and M&E system. Table 1 and 2 summarises the reporting forms and database that are being used currently.

Table 1: HIV/AIDS and STIs reporting forms

Surveillance form	Description
NHIS1	National Health Information System Monthly Report. This captures activities implemented at each facility and is forwarded to the PHAs and another copy is sent to NDoH
SURV1	HIV Monthly Testing Summary Report. This captures activities implemented at each facility and is forwarded to the PHAs and another copy is sent to NDoH (see Annex G)
SURV2	HIV/ART Monthly Report. This captures activities implemented at each facility and is forwarded to the PHAs and another copy is sent to NDoH (see Annex H)
SURV3	STI Clinic Patient Record Form (this form is kept at health facilities)
SURV4	Notification Form for HIV Cases. This captures activities implemented at each facility and is forwarded to the PHAs and another copy is sent to NDoH
SURV4.1	Laboratory Request Form for HIV Confirmatory Test.
SURV5.1	HIV Sentinel Surveillance Form for ANC/PPTCT Clinic
SURV5.2	HIV Sentinel Surveillance Form for STI Clinic
SURV5.3	HIV Sentinel Surveillance Form for TB Clinic

2.3 Data Collection Systems

There are six major databases used by NDoH to collect information critical for the HIV/AIDS and STIs surveillance program. These are HPDB, National Health Information System (NHIS), eNHIS, HIV Surveillance database, KPMIS and VLSM, and one TB surveillance database. NACS maintains the National HIV and AIDS Database which is the data centre for all HIV-related reports produced through service provision, surveillance and studies. This data centre is used for all

national and international reporting, unless other sources of data are needed. The HIV/AIDS and STIs surveillance database/systems are describes below;

2.3.1 NHIS

The NHIS database is paper-based and contains sexually transmitted infection (STI) information and limited HIV data. The STI data captures syndromic treatment visits and there is no testing data. The HIV data capture sex, testing location, the number of tests and positive results, partial aged groupings, supply chain and ART treatment. However, the NHIS HIV data does not fully meet data needs of the HIV program. The NHIS captures routine antenatal visits by visit number.

2.3.2 eNHIS

The eNHIS is piloted in five provinces (230 healthcare facilities) and is capturing real time data for tuberculosis (TB), STI and HIV using SURV 1, and 2 aggregated reports and SURV 4 reactive case forms. However, the HIV surveillance data captured in the pilot sites are limited for two reasons, currently the reporting formats do not comply with the most current surveillance reporting formats and end-users are not trained on how to enter the HIV data into the system.

While the eNHIS currently can generate Surv1, Surv2 and Surv4 reporting forms, it has not been used by end-users due to a general lack in capacity. As such the eNHIS will need to be reviewed and updated so that it can be efficiently used to replace the Surv1, Surv2 and Surv4 reporting forms. Harmonisations of these systems will reduce redundancy and amount of reports being generated by healthcare workers (HCWs) at peripheral facilities. A phased approach will be used to integrate these systems starting in the five provinces that have eNHIS currently in place. The plan will also focus on ensuring that end-users have the capacity to enter data on eNHIS and generate reports at local level that can be used to improve program implementation. The PHAs and NDoH staff will carry out regular data quality audits and supervisory to ensure that quality of reporting being done.

The eNHIS uses an electronic tablet platform that captures geospatial data in addition to clinical data and allows the facilities to automatically upload the data to the provincial authority for final approval before submission to the national eNHIS database. Surveillance data may be viewed and exported at the line and aggregate level. End-users may also quickly view stock out, reporting coverage and facility, district and provincial level reports.

By 2018, eNHIS will expand to three more provinces. The national government plans to implement eNHIS across the country and to most healthcare facilities. The roll-out includes government as well as Anglicare and Church Services' facilities. It is expected that by 2022 more than 90% of reporting facilities will use eNHIS for reporting. Figure 2 shows the flow of HIV/AIDS and STIs surveillance data on eNHIS

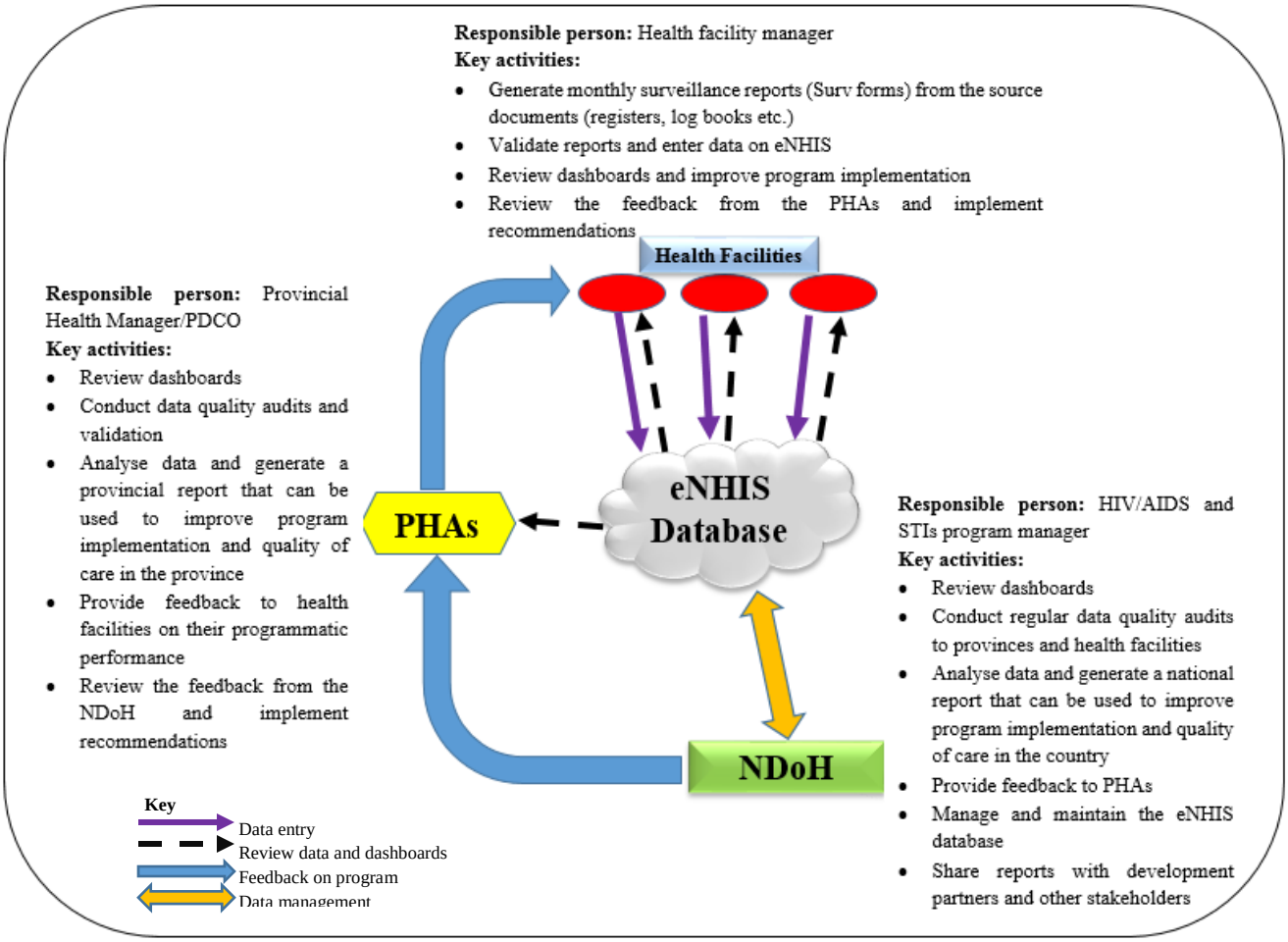


Figure 2: Flow of HIV/AIDS and STIs surveillance data using eNHIS

2.3.3 HPDB

The HPDB is utilized for case-based surveillance. The HPDB contains the clinical information for people living with HIV (PLHIV) including TB test results and treatment, risk and demographic information but lacks data for sexually transmitted infections. Currently 35 ART facilities use the HPDB. The HPDB uses an Access single entry platform. It also contains the SURV 2 aggregate reporting form. In 2018, 10 more facilities will be utilizing HPDB and submission of HPDB Datasets will be done using the newly design HDPB Data Portal.

The HPDB Data portal is a web based portal that allows for HPDB sites to submit their HPDB Datasets on a monthly basis. The Data Portal provides a dashboard that summarizes the reporting coverage, timeliness and geographical scope of all HPDB sites in country. The submitted data is appended to a central HPDB which is located at NDoH. The HPDB is maintained and managed by NDoH, Centre for Disease Control (CDC) and World Health Organisation (WHO). Limited HIV surveillance staff have access to this system. There is a formalized process to conduct data quality assurance audits on localized systems and the main database, or to ensure the end users

have the continuing capacity to use the system and submit data to NDoH. The data are used to monitor and evaluate HIVQUAL indicators, to report annually on GAM indicators for TB/HIV and HIV/HepB and to provide data for the estimation of annual ARV requirements for forecasting.

In 2019 the HPDB Data Portal will be upgraded to a national HPDB Datahub to allow for automated aggregation of national HPDB data. This will allow integration with eNHIS and when combined with HIV Surveillance data and viral load data will allow for the generation of national and subnational HIV Care and Treatment cascades and real-time monitoring of HIVQUAL QI Indicators.

2.3.4 HIV Surveillance Database (SURV)

The SURV database stores HIV demographic, risk, laboratory, testing and treatment data, and antenatal care Syphilis results and non-specific STI results, as well as TB testing and treatment data. Some TB testing sites are also testing clients for HIV which is reported through the SURV 1 form and those also providing ART report via SURV 2, the data are entered into the SURV database. The platform is SQL and it is housed on its own server with three computers for multiple use data entry.

Three data reporting tools are used to collect HIV specific data. Unified data collection forms for each facility are provided by NDoH or the PHAs to reflect the data collection needs at provincial, program or national level.

SURV 1: is used to collect HIV counselling and testing data, syphilis testing and treatment data for ANC, and ANC specific data including primary visits and known positive pregnant women. The form collects information for rapid screening and rapid confirmation testing, Data is collected from several points of care including voluntary counselling and testing (VCT) in stand-alone sites, other testing facilities or by provider-initiated testing and counselling in paediatric clinics, labour and delivery, ANC clinics, STI or TB or other clinical facilities, as well as screening of all blood donors;

SURV 2: is used to collect data regarding antiretroviral therapy (ART) for both adults and children regimens, prevention of parent-to-child transmission (PPTCT) as well as post-exposure prophylaxis;

SURV 4: is used by facilities to report new cases of HIV which are sent to the PHO on a monthly basis and forward to NDoH.

The HIV program relies on PHAs and facilities to submit monthly paper reports for SURV 1, 2 and 4. The source of data for these forms are HIV surveillance log books and registers at health facilities where service delivery is done. SURV 1, 2 and 4 Reports are collated by the PHIO and then are forwarded to the HIV Surveillance Unit at NDoH. The reports are captured on the National HIV Database. There is a formalized process to actively collect data, track missing reports, file analyse data and disseminate the findings, or archive paper and electronic data.

This data centre is used for all national and international reporting, unless other sources of data are needed. The program routinely hires consultants to analyse and report data, and relies on M&E and surveillance staff to enter data and to comply with partner reporting requirements. In addition, NDoH works in collaboration with UNAIDS, CDC and WHO to calculate annual Global AIDS Monitoring Measures for publication and dissemination. Figure XX shows the flow of HIV/AIDS and STIs surveillance data in where eNHIS is not being used.

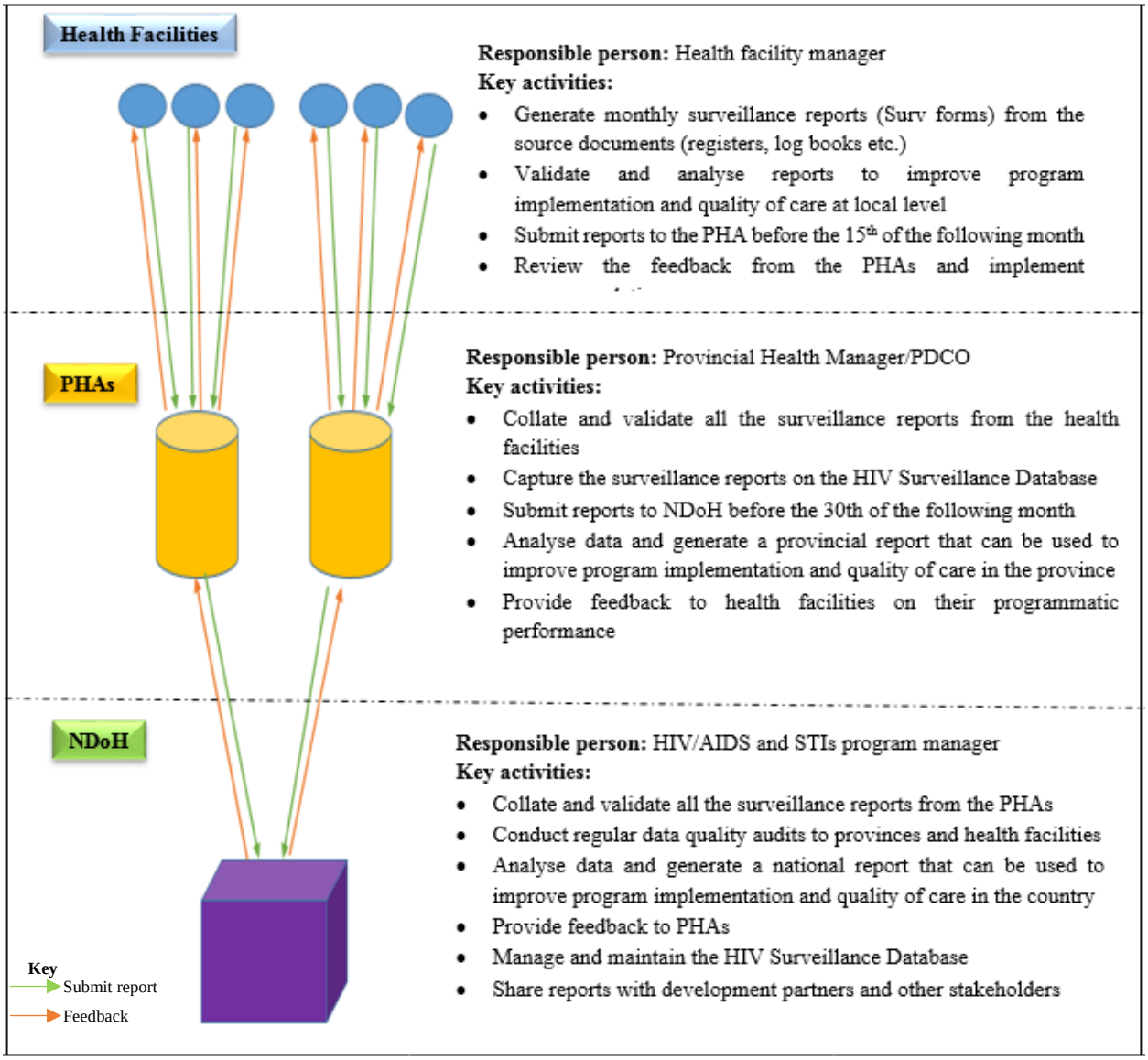


Figure 3: Flow of HIV/AIDS and STIs surveillance data where eNHIS is not used

2.3.5 TB Database

The final data is system is used by the TB surveillance program which is not integrated into other database systems. Unlike the HIV surveillance program which calls for monthly reports for from all facilities, the TB program collects quarterly reports. These reports are entered into a SQL database. There is a concerted effort to incorporate the TB data into the eNHIS system, and a pilot project is planned for Port Moresby General Hospital's paediatric TB clinic.

The TB database is a distinct and separate surveillance system, and is under the management of the National TB Program, thus, not reflected in the data flow.

In some circumstances, health services may be required to send a copy of their reports directly to relevant units at NDoH. Where this occurs, it is the responsibility of the health service facility to also submit their reports and send them to the PHA. In summary, health service providers send data to the PHA as their first-line M&E reporting authority. In addition, some data is sent to NDoH as the second line or national authority, as a backup in situations when the reporting to PHA is not working properly.

2.3.6 KPMIS

Partners at the World Health Organization have developed the KPMIS tool to collect key population data at facilities providing HIV services. The tool will be implemented by NDoH staff to KP sites in an effort to capture key population data, as well as identify potential areas to increase HIV intervention activities for key populations.

The KPMIS data collection tool is currently piloted at two locations in NCD. The data is emailed as an excel file and re-entered into an aggregate Excel spreadsheet. Health care facilities and key population programs submit their biannual reports to the designated KPMIS M&E officer at their facility. The KPMIS officer, compiles and summarizes data which is then transmitted to KPMIS M&E Officer at NDoH. Once the system is rolled out to all key population programs, the data flow will integrate with the existing HIV data flow.

2.3.7 VLSM

In support of the national scale up of Viral Load testing, CDC PNG has been working with the Central Public Health Laboratory (CPHL) to implement a lab information system (LIMS) that can manage viral load sample requests, automate result importing and improve the efficiency of viral load result reporting. CDC International Laboratory Branch (ILB) have developed a lightweight, open-source VL-specific LIMS that is currently being implemented in hundreds of Viral load laboratories across the world. CPHL with the support of CDC PNG will be implementing customized version of VLSM in 2018. The system will manage all requests for VL testing using plasma and dried blood spots (DBS) on the Roche platform at CPHL. The system will allow for analysis of population viral load suppression at clinic, district, provincial and national levels and

is intended to interface with the eNHIS and HPDB to generate the care and treatment cascades at national and sub-national levels.

2.4 Data Management and Storage

Data management is the process of acquiring, validating, storing, protecting, and processing the HIV program data. This is particularly important in ensuring that the data are accessible to approved users, reliable, secure, and patient information is kept confidential. PNG continues to have high levels of stigma towards PLHIV and those affected by it. There is need to ensure that patient privacy and high ethical standards are adhered to when managing HIV/AIDS and STIs program data.

This section describes some of the data management processes for the different databases used in the HIV program. Some issues have been already been discussed in the previous sections of this NSIF. Table 2 summarises the data management process for the HIV/AIDS and STIs surveillance systems.

Table 2: Data management plan

Database	Data Storage	Data processing and quality	Data analysis and use
eNHIS	- Data is entered at the health facilities on a tablet which regularly uploads the data to a central server which is at NDoH - The server is password protected and an external backup is kept by NDoH M&E department	- Regular data quality audits are done to identify errors and correct them.	- Data in eNHIS is used by the health facility staff to track and monitor their program performance. - At the provincial level data and reports on key program indicators can be generated and used to monitor program implementation. - The NDoH is also able to view performance of key program indicators and generate reports
HPDB	- The completed admission charts or follow-up forms for PLHIV attended at the health facility are validated and entered into HPDB on a password protected computer at the health facility. The hard copies are stored in the patient file which is kept in a locked cabinet at the facility. - The data entry officer or HCWs who conduct data entry use their unique login credentials to access HPDB. Once they have captured the data and logged off, an automatic backup is run daily and stored on the local computer. - Once a month the facilities generate a report from the health facility from the backend of HPDB. The encrypted file is uploaded online to a secured cloud server. They are downloaded and personal identifiers removed before they analysis. The backup copy is kept in an external hard drive by the HIV Surveillance M&E officer.	- HPDB has a module developed to detect common errors that occur during data capturing and also identifying missing values. Once the data entry clerk identifies these errors they can cross-reference with the source document and make appropriate corrections - All health facilities are encouraged to submit their reports on time and ensure that reports are complete. Reports that come late are captured and the database is updated. - The HPDB also has a data quality audit tool that is used to assess the accuracy and completeness of data entered at the clinic. The tool randomly selects 20 registrations or follow up visits which can be cross-checked with the patient charts. Feedback can be provided to the individuals doing data entry to improve the quality of data.	- The clinics use HPDB as a patient management tool. It is used to schedule appointments for VL or CD4, identify patients that have missed their appointments or due for isoniazid preventive therapy (IPT). HCWs can also see a summary of the clinical history of the patient and including weight gain/loss and trends of CD4 count and VL - HPDB can be used to generate the Surv2 report for the health facility. In addition the facility is able to get a summary of their performance on key program indicators. - Data from the health facilities is collated and merged for analysis at NDoH. The data can be used to carry out cohort analysis for key program indicators.

HIV Surveillance Database	- Health facilities complete surveillance forms using their registers and log book. One copy is retained at the facilities, filed and stored in a locked cabinet by the health facility manager for at least five years. - Hard copies of the Surv1, Sur2 and Surv4 forms are forwarded to both the provincial level by the health facilities. At the province the reports are validated TB/HIV coordinator and/or Health Information Officer. A copy is retained at the provincial level, filed and stored in a locked cabinet for at least five years. - The HIV surveillance team at NDoH receives the surveillance forms and validates them before encoding them on to the HIV Surveillance database. Hard copies and filed and stored in a locked cabinet for at least five years. - The encoded data is encrypted and stored in a password protected NDoH central server. Once a week the data is also backed up onto and external hard drive which in kept by the HIV Surveillance M&E Officer	- The health facility manager reviews and validates the surveillance forms before submitting them to the province. - At the province data validation is also carried out. They also coordinate with all the health facilities to ensure that the reports are all submitted on time. Facilities that have errors in their reports or incomplete data are followed up and the report is updated - The reports are validated at NDoH and encoded in the HIV surveillance database. During DQA visits the reports submitted are compared to what is the source documents to check for accuracy and completeness. - Some facilities continuously have challenges in timely submission of reports. Follow up is done at the provincial level by the TB/HIV coordinator to ensure that complete reports are submitted by all facilities. These are then validated and encoded at NDoH	- The surveillance forms are used by the health facility to summarise performance of the HIV/AIDS and STIs program. This information can be useful to improve service delivery - At the provincial level the reports are collated and the TB/HIV coordinators use the data to keep track of key program indicators for the province. Facilities that need support are identified and progress is monitored. Feedback is provided to health facilities to improve implementation - The data once captured at NDoH is used to analyse program performance on key indicators. Reports are generated and feedback is provided to the provinces, donors and other stakeholders
TB Database	- TB basic management units (BMUs) produce quarterly reports in triplicates. The health facility retains one copy which is filed and stored in lockable cabinet - One copy of the quarterly BMU report is submitted to the province. The TB/HIV Coordinator validates and files the reports from BMUS in the province and it is stored in a lockable cabinet - The last copy of the BMU report is sent by the province to the NTP. Here the reports are	- Data validation is done by the health facility manager and at the provincial level. All the errors identified are corrected by referring to the source document at the health facility - At the provincial level all the reports are validated and errors are corrected by following-up with the respective BMUs. - The provinces submit one copy of the validated BMU report to NDoH. The NTP also validates the report before	- The BMUs use the reports to review their performance for the quarter. They also take not of the challenges that they have and design local practical solutions. - The provincial level collate the reports and also use the data to review their performance and address challenges. Feedback is provided to the BMUs on areas that need to be improved.

	encoded into the TB database on a password protected computer and the reports are filed and stored in a locked cabinet for at least five years. A backup of the database is kept on a secure external hard drive.	encoding the report. Double entry is done to minimise data entry errors. The database is also verified by comparing what is on the report and what was captured. - Timely submission of BMU reports is major challenge in most provinces. The TB/HIV coordinator keeps track of all the BMUs that have submitted their reports and follows up on those that have not to ensure 100% reporting. BMUs that have not submitted their reports are also encouraged to do so and the reports are validated are then validated and encoded by the NTP	- At the NTP the data is analysed and program reports produced. The provinces and BMUs also get feedback from the NTP using various means.
KPMIS	- Health facilities that are managing KPs complete the KPMIS tool every month with support from the M&E officers from GFATM sub-recipients - The M&E officers enter the data in KPMIS using their unique password and login details. The encrypted data are stored on a cloud saver.	- Data validation for the data entered in KPMIS is done on a quarterly basis by the NDoH. - The NDoH HIV surveillance team keeps track of all facilities and SRs that have not submitted their reports on time. Follow up is done and support either remotely or onsite provided to ensure that there is 100% reporting. Late reports though not encouraged are accepted and they are validated and encoded.	- The GFATM SRs make use of the data reported in KPMIS to analyse their programmatic performance and give feedback to the facilities were KPs are accessing services - The NDoH use the data reported in KPMIS to monitor activities for KPs. - The data are also used by NACS to monitor and coordinate HIV prevention activities for KPs

2.5 Plan for integration of HIV/AIDS and STIs surveillance systems

The NDoH has expressed a strong desire to integrate the HIV/AIDS and STIs surveillance systems in the NHS. The eNHIS platform is the preferred choice to have all the HIV/AIDS, STIs and TB surveillance data. This will act as the national data repository or HIV Data hub. However, only five of the 22 provinces have the eNHIS installed and it still needs to be reviewed and updated before it is fully rolled out.

Over the lifetime of the NSIF, a phased approach will be used to initially review and update the eNHIS. This will be followed by capacity building of healthcare workers who are the end users to utilise the system to capture data on eNHIS and generate reports in the five provinces where eNHIS is in place. In the medium term, the updated eNHIS will be rolled out to all the high burden provinces for TB and HIV. By end of 2022 it is anticipated that eNHIS will have been rolled out to at least 90% of all facilities and will be used to capture and report on HIV/AIDS and STIs.

The scale up plan to integrate HIV/AIDS and STIs surveillance systems is a gradual process and very costly. Currently this plan has not received any commitment for funding by either domestic resources or development partners. As such, during the transition period, HIV Surveillance database and KPMIS will continue to be supported. Given the challenges of the paper-based reporting system and the need to continuously capture and report on data, decentralisation of the both the HIV Surveillance database and KPMIS which is already underway will continue. Once the eNHIS is fully up and running these two systems will be integrated into eNHIS.

The HIV surveillance database is currently being decentralised so that data entry is done at the provincial level. A pilot on the feasibility of decentralisation is currently underway in NCD. This will be followed by a nationwide rollout initially to the high burden provinces and ultimately the entire country by 2020.

The KPMIS is very important platform used to collect HIV/AIDS prevention, care and treatment interventions for KPs. Interventions for the KPs are being implemented by local NGOs and FBOs in close collaboration with the NDoH. In the immediate period, a review of the KPMIS pilot will be done. This will be followed by a review and updating of the KPMIS to address concerns identified in the pilot to improve reporting of activities conducted in during KP outreaches. Once this is addressed, KPMIS will be rolled out in all the provinces which are implementing the enhanced package and all NGOs and FBOs will use it as the sole platform to report KP activities. By 2022, it is anticipated that KPMIS will be fully integrated in eNHIS.

The HPDB is used to collect individual clinical information for PLHIV on ART longitudinally. This information is very specific to the day-to-day monitoring of PLHIV on ART by clinicians as well as addresses the needs of the HIV/AIDS and STIs program. The HPDB will be linked with eNHIS as the national data repository for the HIV program. The intention is to increase coverage to all the health facilities providing ART initially in high burden provinces and ultimately all provinces by 2022. Table 3 summaries the scale up plan for integrating HIV/AIDS and STIs surveillance systems.

Table 3: Plan to integrate HIV/AIDS and STIs surveillance systems

	eNHIS	**HIV Surveillance Database**	**KPMIS**	**HPDB**	**VLSM**
Current status	• Only five provinces have eNHIS installed • End-users lack capacity to use it • Reporting formats do not comply with needs of the HIV/AIDS and STIs surveillance	• All Surv1 and Surv2 forms currently being captured at NDoH • Pilot on feasibility of decentralisation to provinces underway in NCD	• Pilot underway in two locations in NCD	• Only 22 facilities reporting data on the HPDB	• Customized VLSM developed for PNG by CDC ILB/CDC PNG
Immediate activities (2018 -2019)	• Review reporting formats and build capacity for end users • Integrate reporting of Surv1, Surv2 and Surv4 forms • Integrate reporting of data captured on KPMIS • Review performance of the system in reporting HIV/AIDS and STIs surveillance data in the five provinces • Scale up eNHIS to cover all the high burden provinces • Integrate eNHIS with HPDB systems to feed aggregate patient level data near realtime	• Review of decentralisation pilot • Roll out decentralisation of data capturing to all high burden provinces • Integrate reporting on eNHIS	• Review of pilot • Updating of KPMIS • Capacity building of end-users • Roll-out of KPMIS to all the provinces implementing the enhanced package	• Roll out of the HPDB to all ART facilities in the high burden provinces • Development of HPDB National Datahub	• VLSM being configured and deployed at CPHL • Legacy VL data to be imported into VLSM • VLSM to be utilized at the central level to manage all VL testing Data
Midterm activities (2020 – 2021)	• Review reporting formats and build capacity for end users • Roll out eNHIS to all the provinces	• Roll out decentralisation of data capturing to all provinces on eNHIS	• Integrate reporting done on KPMIS on the eNHIS platform	• Roll out of HPDB to all ART facilities in the country • Integration of HPDB National Datahub with eNHIS	• VLSM Data to be integrated with eNHIS

Status by 2022	eNHIS is used to report information previously reported by HIV Surveillance database and KPMIS in at least 90% of all health facilities.	HIV Surveillance database fully integrated on eNHIS	KPMIS reporting replaced by eNHIS in all provinces implementing the enhanced package.	All ART facilities using HPDB	
Estimated total cost	TBA	TBA	TBA	TBA	TBA
Funding availability	Yes	Yes	No funding committed	Yes	Yes
Responsible organisation/agency	NDoH	NDoH, CDC and WHO	NDoH, CDC, GFATM and WHO	NDoH, CDC and WHO	NDoH, CPHL, CDC

3 DATA COLLECTION, ANALYSIS & REPORTING FOR KEY POPULATIONS

3.1 Services available for KPs

KPs are an important high risk group that drive the HIV epidemic in PNG. Unfortunately they are stigmatised by the communities they live in and find it difficult to access health services. A number of high burden provinces have been identified in the NHS that will receive the enhanced package. This includes specific interventions aimed at strengthening prevention, care and treatment of HIV/AIDS and STIs among KPs.

High burdened provinces are implementing the enhanced package of care. These are National Capital District, Enga, Jiwaka, Simbu, Western Highlands, Southern Highlands, Morobe and Madang. The remaining provinces are implementing the standard package. In the high burden districts KPs can access services in both the standard package and enhanced package. Table 2 is a list of services available to KPs for each package of care.

KPs are provided with a combination HIV prevention package that includes but is not limited to condom and lubricants distribution, risk reduction counselling, pre/post-exposure prophylaxis, STI treatment, HIV testing services and ART. There is no limit to the number of condoms and lubricants that a KP is given, they are encouraged to take as much as they need. HIV testing is done as recommended by national guidelines. Those who test positive are immediately linked to ART services in-line with the new test-and-treat national guideline. For those who test negative the intention is to ensure that they maintain their negative status for as long as possible. As such, peer counsellors (PCs) continuously provide them with risk reduction counselling. In addition, once every three months PCs encourage KPs to who tested negative to have a repeat test. This allows for the early identification of those who would have sero-converted to ensure they are started on ART earlier.

Table 4: HIV/AIDS and STI services accessed by KPs

Standard Package	**Enhanced Package**
• Condoms promoted and widely available in community • Condoms, lubricant, STI and HIV social and behavioural change information available at district and local level through existing health services and community organisations • HIV and TB awareness raising in community, integrated into NGO, church and community programmes, with a focus on connecting people with testing and treatment services • HIV testing and STI treatment to be available at district and local level through existing health services • HIV testing, emergency contraception, STI treatment and PEP available in all gender-based violence clinical care settings, with support for PEP adherence • HIV counselling and testing and STI treatment integrated into existing rural 'patrols' that take services into isolated populations • Early ART treatment for pregnant women with HIV, or HIV testing and initiating ART in labour or post-partum for mothers who have missed pre-natal testing. • HIV testing provided in ANC, STI and TB clinics and in paediatric inpatient clinics. • HIV treatment, care and support for PLHIV available in provincial capital (with point of care HIV viral load testing) and in selected district-level hospitals and clinics • PLHIV peer counsellors in services providing ART, with case management and adherence support reaching into community • Coordinated HIV and TB services, including provider-initiated HIV and TB testing and treatments support • Active case management and tracking of clients initiated on HIV and linking with TB programs to track clients and increase TB treatment success rates among clients with co-infections. • Advocacy at provincial and local level to strengthen the supportive environment for service access – with a particular focus on ensuring people from key populations have access to services and attention to police and justice issues.	• Peer-based outreach to key populations in urban areas and sites of particular risk and at times when populations can be best accessed, with a direct connection between outreach to clinical services • PLHIV case management (with adherence support) incorporated into outreach – combined HIV and TB treatment support • Mobile clinical services (including rapid HIV testing) operating in key environments of risk, at times when people from key populations can be accessed – HIV and STI testing, STI treatment, TB testing, peer counselling, condom access, with a direct connection back to clinics • Decentralisation of HIV and STI testing and HIV adherence support as far into rural health service levels as possible • Decentralising ART to district level and using community/outreach ART delivery approaches to increase access in remote districts with no road access to the provincial capital.

3.2 Data management process for KPs

Given the high levels of stigma against key populations in our setting, all information about KPs is kept private and confidential. In order to have an accurate record of who has had access to HIV/AIDS and STIs preventions, care and treatment, KPs reached are identified using a NUIC. The NDoH has developed a simple and standardised algorithm called the KP Decision tree that is used by peer counsellors (PC) during outreach activities (see Annex I). All the sub-recipients (SRs) that are implementing KP activities make use of this NUIC. The PC will then report to the M&E team of their respective SRs the KPs she has referred and provide them with their NUIC and referral health facility.

Once KPs are reached by outreach workers, they are referred for HIV/AIDS and STIs at static health facilities. The healthcare workers will then provide services which the KP has been referred for by the PC and retain the referral slip which shows the services provided. An M&E officer will collect the referral slips from the health facilities where the PC referred KPs. A successful referral is one in which the information provided by the PC matches what was collected by the healthcare worker. The PCs undergo continuous training, coaching and mentorship by the SRs to ensure that they accurately record and report all activities done during outreach activities. The NUIC is used to accurately identify the KP and ensure that there are no duplications. Figure 4 shows how data from community flows into KPMIS.

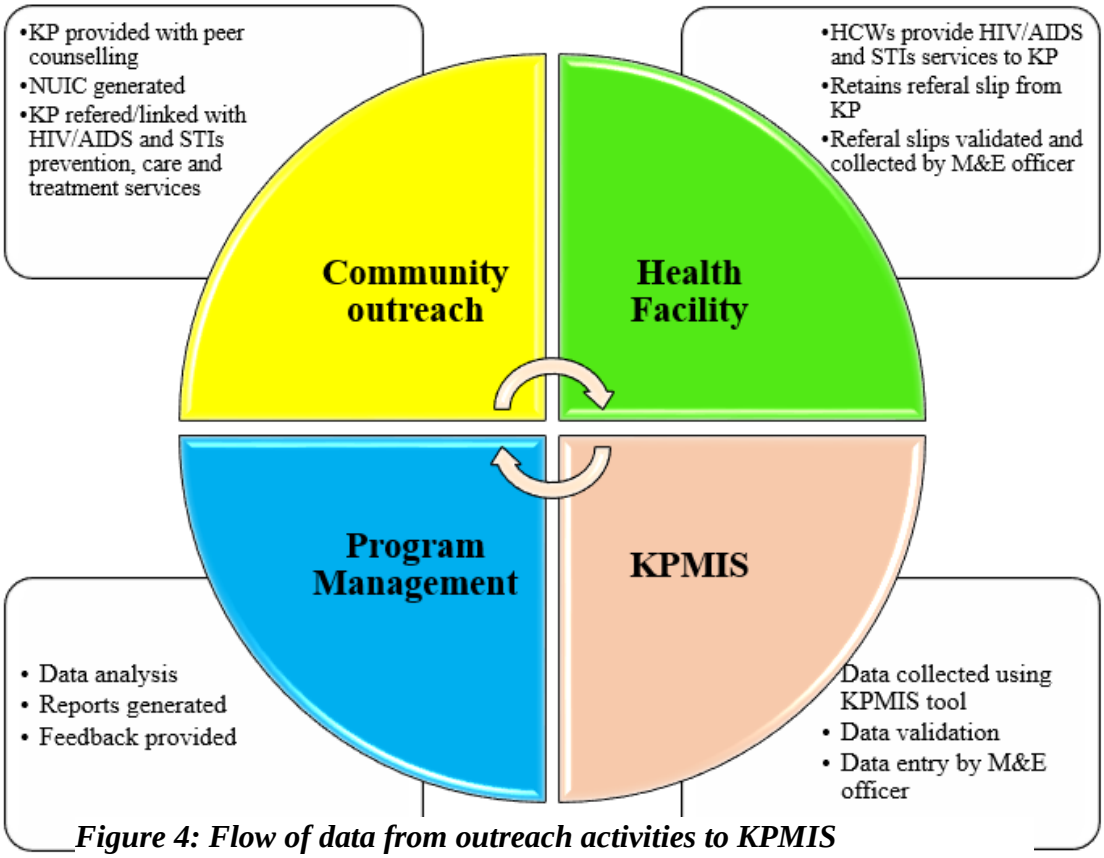


Figure 4: Flow of data from outreach activities to KPMIS

NDoH has developed a standardised KPMIS tool that is being used by all SRs to collect information on KPs that have been reached and linked with HIV/AIDS and STIs prevention, care and treatment services on a quarterly basis. Once completed, the KPMIS tools are then reviewed and validated before being entered on KPMIS. The information on KPMIS is then used to analyse progress made in implementing KP activities by the SRs. Reports on key indicators can be generated and used for decision making.

Data on the KPMIS is kept in a central server at NDoH. Different users have varying degrees of access rights depending on their need. The server is password protected and maintained by a KPMIS M&E officers at NDoH. There are three levels of log-in that have been created on KPMIS and these are;

- *KP site level:* Can enter the data and generate reports. Data entry is done only at site level.
- *Province level:* Can generate aggregated report for all KP sites for the province.
- *Intervention partner:* Can generate aggregated report for all provinces.

4 NATIONAL HIV/AIDS & STIs INDICATORS

The list of national indicators is limited to 40 core indicators that are essential for high-level monitoring of STI, HIV and AIDS epidemiology and PNG's national response.

Of the 40 national indicators, most are taken from the 2016 United Nations Political Declaration on HIV and AIDS. Others are taken from the NHSP 2018 – 2022 and the World Health Organization Consolidated Strategic Information Guidelines for HIV in the Health Sector and UNAIDS Global AIDS Monitoring 2017. Detailed information about the definitions of the national indicators is in the next section.

It should be noted that in addition to the suggested disaggregation levels for the national indicators, geographical disaggregation is also needed, usually at regional and provincial levels whenever possible.

Indicators related to specific projects or donor requirements may be found at Appendix C.

Table of National Strategy Indicators	Baseline 2017	Milestone 2020	Target 2022	Data source	Frequency of collection	Entity responsible
Goal 1: An efficiently managed, capable and well-resourced national, provincial and district response to STIs and HIV						
Stock outs of essential medicines	0	0	0	NDOH Logistic Reports	Quarterly	NDOH
Stock outs of essential test kits	0	0	0	NDOH Logistic Reports	Quarterly	NDOH
Stock outs of essential condoms	1	0	0	NDOH Logistic Reports	Quarterly	NDOH
Goal 2: A successful response to STIs and HIV and that is driven by accurate and up to date strategic information and research						
National HIV surveillance system is harmonised into eNHIS system	No harmonization	Harmonization process is underway	Harmonization is completed	SI Milestone Report	Annual	NDoH/SITWG
Establish STI surveillance system (WHO Global STI strategy goal 2020)	No STI surveillance system	STIs surveillance system in development	STIs surveillance system is established	SI Milestone Report	Annual	NDoH/SITWG
National HIV surveillance report submission rate	50%	70%	90%	SI Milestone Report	Semi-annual	NDoH/SITWG
National STI & HIV data quality audits conducted	None at present	Quarterly	Quarterly	Meeting reports	Annual	NDOH/WHO
High Priority Provinces STI & HIV data quality audits conducted	None at present	Annually	Annually	Meeting reports	Annual	NDOH/WHO
National STI & HIV Consolidated report prepared and circulated	Not at present	Annual	Annual	Final Report	Annual	NDOH/WHO

Table of National Strategy Indicators	Baseline 2017	Milestone 2020	Target 2022	Data source	Frequency of collection	Entity responsible
Goal 3: Minimized HIV and STI transmission and optimized health and well-being of PLHIV						
All elements of the Standard & Enhanced Service Package in place in all provinces (WHO Global HIV/STI Strategy 2020 milestones	No data	50% of provinces	All provinces	Mid-term/final evaluation	Mid-term and final	NDOH/PHAs/PHOs
HIV incidence GAM 3.1	2,765	<1500	<500	Spectrum EPP Analysis	Annually	NDOH/UNAIDS
Syphilis screening among pregnant women (WHO Global STI Strategy 2020 milestones) GAM 2.4	3.6%	50%	95%	Surveillance Database	Annually	NDOH
Syphilis-seropositive pregnant women treated with effective regimen (WHO Global STI Strategy 2020 milestones)	79%	85%	95%	Surveillance Database	Annually	NDOH
Men with urethral discharge GAM 10.4	5.2%	4.5%	3.5%	NHIS	Annually	NHOH
A country report on antimicrobial resistance in N. gonorrhoea is published (WHO Global STI Strategy 2020 milestones)	No report	Report published	No Report	Survey	Once	NDOH/WHO/IMR
HIV prevalence among key populations (by population) GAM 3.3	FSW 14.9% MSM/TG 8.9	FSW 14.9% MSM/TG 8.9	FSW 14.9% MSM/TG 8.9	BBS	Triennially	NDOH/IMR
Condom use among key populations (by population) (WHO/UNAIDS Global indicator) GAM 3.6	SW 49.5% MSM/TG 30.4%	SW 60% MSM/TG 50%	SW 80% MSM/TG 80%	BBS	Triennially	NDOH/IMR

Table of National Strategy Indicators	**Baseline 2017**	**Milestone 2020**	**Target 2022**	**Data source**	**Frequency of collection**	**Entity responsible**
Coverage of HIV prevention program among key populations (by population) (WHO Global HIV/STI Strategy 2020 milestones) GAM 3.7	SW 48.2% MSM 12% TG 18.8%	SW 60% MSM 25% TG 30%	SW 80% MSM 50% TG 60%	BBS	Triennially	NDOH/IMR
Knowledge of HIV status among key populations (by population) GAM 3.4	SW 38.9% MSM/TG 24.4%	SW 70% MSM/TG 70%	SW 85% MSM/TG 85%	BBS	Triennially	NDOH/IMR
Active syphilis among sex workers GAM 3.11	7.2%	5%	3%	BBS	Triennially	NDOH/IMR
Active syphilis among men who have sex with men GAM 3.12	4.0%	3.5%	3%	BBS	Triennially	NDOH/IMR
Viral hepatitis among key populations (by population) GAM 3.14	SW 9.3% MSM 11.7%	SW 7% MSM 9%	SW 5% MSM 7%	BBS	Triennially	NDOH/IMR
Percentage of people living with HIV who know their HIV status	75%	80%	90%	HPDB/EPP Spectrum	Annually	NDOH/UNAIDS/WHO
Mother-to-child transmission of HIV GAM 2.3	28.3%	20%	15%	CPHL EID Data	Annually	NDOH/CPHL
Preventing mother-to-child transmission of HIV GAM 2.3 (ART coverage among pregnant women)	32.5%	50%	80%	Surveillance Database/EPP Spectrum	Annually	NDOH/UNAIDS
HIV screening among pregnant women (WHO Global STI Strategy 2020 milestones)	21%	60%	90%	Surveillance Database/EPP Spectrum	Annually	NDOH/UNAIDS

Table of National Strategy Indicators	Baseline 2017	Milestone 2020	Target 2022	Data source	Frequency of collection	Entity responsible
People living with HIV on antiretroviral therapy (WHO/UNAIDS Global indicator) GAM 1.2	53.2%	70%	90%	HPDB	Annually	NDOH/WHO
Retention on antiretroviral therapy at 12 months (WHO/UNAIDS Global indicator) GAM 1.3	86.5%	90%	90%	HPDB	Annually	NDOH/WHO
People living with HIV who have suppressed viral loads (WHO/UNAIDS Global indicator) GAM 1.4	87.4%	90%	90%	CPHL/HPDB	Annually	NDOH/WHO/CPHL
AIDS-related deaths (WHO/UNAIDS Global indicator) GAM 1.7	1,062	750	<500	EPP Spectrum	Annually	NDOH/UNAIDS
Antiretroviral therapy coverage among people with HIV from key populations (by population) GAM 3.5	Not available	To be assigned	To be assigned	KPMIS	Annually	NDOH
Percentage of PLHIV in care who are screened for TB in HIV care or treatment settings	87%	100%	100%	HPDB	Annually	NDOH/WHO
Co-managing TB and HIV treatment GAM 10.1	65%	80%	90%	HPDB	Annually	NDOH/WHO
Proportion of people living with HIV newly enrolled in HIV care with active TB disease GAM 10.2	10%	10%	10%	HPDB	Annually	NDOH/WHO
Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy (IPT) GAM 10.3	10%	30%	60%	HPDB	Annually	NDOH/WHO
Goal 4: An environment that is safe and supportive of people's efforts to remain healthy						

Table of National Strategy Indicators	Baseline 2017	Milestone 2020	Target 2022	Data source	Frequency of collection	Entity responsible
Discriminatory attitudes towards people living with HIV GAM 4.1	No Data	No Data	Baseline Established	Survey	Once every three to five years	NACS
Avoidance of HIV services because of stigma and discrimination among key populations GAM 4.2	No Data	No Data	Baseline Established	BBS	Triennially	NDOH/WHO/IMR
Prevalence of recent intimate partner violence GAM 4.3	No Data	No Data	Baseline Established	Survey	Once every three to five years	NACS
Annual assessment of legal and policy environment using UNAIDS-NCPI (National Commitment and Policy Instruments)	No Assessment	Completion of Two Assessments	Completion of Two Assessments	Policy Analysis	Annual	NACS

4.1 Indicator Descriptions

4.1.1 Goal 1: An efficiently managed, capable and well-resourced national, provincial and district response to STIs and HIV

Indicator 38	Stock Out of Essential Drugs (Antiretroviral) and STI Drugs (Number of stock outs of essential medicines)
Description	Measures the availability of antiretroviral in country and for PLHIV
Milestones	0 (2018); 0 (2020); 0 (2022)
Responsible Entity	NDoH
Frequency	Quarterly
Data Collection Method or Source	NDoH Logistics Report
Disaggregation	By Drug
Numerator	NA
Denominator	NA
Calculation	Total Number of Stock Outs by Drug
Link	NHSP18-22 Goal 1

Indicator 39	Stock Out of Syphilis and HIV Test Kits (Number of stock outs of essential test kits)
Description	Measures the availability of Syphilis and HIV test kits
Milestones	0 (2018); 0 (2020); 0 (2022)
Responsible Entity	NDOH
Frequency	Quarterly
Data Collection Method or Source	NDOH Logistics Report
Disaggregation	By Test Kit
Numerator	NA
Denominator	NA
Calculation	Total Number of Stock Outs by Kit Type
Link	NHSP18-22 Goal 1

Indicator 40	Stock Out of Condoms (Number of stock outs of essential condoms)
Description	Measures the availability of condoms in country
Milestones	1 (2018); 0 (2020); 0 (2022)
Responsible Entity	NDoH
Frequency	Quarterly
Data Collection Method or Source	NDoH Logistics Report
Disaggregation	NA
Numerator	NA
Denominator	NA
Calculation	Total Number of Stock Outs of Condoms
Link	NHSP18-22 Goal 1

4.1.2 Goal 2: A successful response to STIs and HIV and that is driven by accurate and up to date strategic information and research

Indicator 1	National HIV Surveillance system is harmonized into eNHIS system
Description	Bring the range of existing HIV and STI databases and HIV/TB co-infection data into the harmonized eNHIS system, through a transition process that involves further improving the quality and comprehensiveness of the databases before integrating them
Milestones	No Harmonization (2018); Harmonization Process is underway (2020); Harmonization is completed (2022)
Responsible Entity	NDoH/SITWG
Frequency	Annual
Data Collection Method or Source	SI Milestone Report
Disaggregation	NA
Numerator	NA
Denominator	NA
Links	NHSP18-22 Goal 2

Indicator 2	Establish STI surveillance system (WHO Global STI strategy goal 2020)
Description	Develop new STI surveillance tools and incorporate tools into eNHIS system, through a transition process that involves further improving the quality and comprehensiveness of the databases before integrating them
Milestones	No STI Surveillance System (2018); STIs surveillance system in development (2020); STIs surveillance is established (2022)
Responsible Entity	NDoH/SITWG
Frequency	Annual
Data Collection Method or Source	SI Milestone Report
Disaggregation	NA
Numerator	NA
Denominator	NA
Links	NHSP18-22 Goal 2; WHO Global STI strategy Goal 2020

Indicator 3	National HIV surveillance report submission rate
Description	Monitor and evaluate submission rates for SURV 1, 2, 4 for all regions, provinces and facilities
Milestones	50% (2018); 70% (2020); 90% (2022)
Responsible Entity	NDoH/SITWG
Frequency	Semi-annual
Data Collection Method or Source	HIV Surveillance Database
Disaggregation	Region/Province/Facility/ Month/Year
Numerator	NA
Denominator	NA
Link	NHSP18-22 Goal 2

Indicator 3.1	Surveillance 1 Report – All Points Non-ANC
Description	Monitor and evaluate submission rates for SURV 1, All points, Non-ANC all regions, provinces and facilities
Milestones	50% (2018); 70% (2020); 90% (2022)
Responsible Entity	NDoH

Frequency	Semi-annual
Data Collection Method or Source	HIV Surveillance Database
Disaggregation	Region/Province/Facility/ Month/Year
Numerator	Number of Surveillance 1 Reports Received From all Non-ANC Testing Sites
Denominator	Total Number of NON-ANC Testing Facilities multiplied by 6 months (semi-annual) and 12 months (annual)
Link	NHSP18-22 Goal 2

Indicator 3.2	Surveillance 2 Report – All Points Non-ANC
Description	Monitor and evaluate submission rates for SURV 2, All points, Non-ANC all regions, provinces and facilities
Milestones	50% (2018); 70% (2020); 90% (2022)
Responsible Entity	NDoH
Frequency	Semi-annual
Data Collection Method or Source	HIV Surveillance Database
Disaggregation	Region/Province/Facility/ Month/Year
Numerator	Number of Surveillance 2 from Non-ANC ART Facilities Reports Received
Denominator	Total Number of Non-ANC ART Facilities multiplied by 6 months (semi-annual) and 12 months (annual
Link	NHSP18-22 Goal 2

Indicator 3.3	Surveillance 4 – All Points and ANC
Description	Monitor and evaluate submission rates for SURV 4 for all regions, provinces and facilities
Milestones	50% (2018); 70% (2020); 90% (2022)
Responsible Entity	NDoH
Frequency	Semi-annual
Data Collection Method or Source	HIV Surveillance Database
Disaggregation	Facility, district, province
Numerator	Number of Confirmed Positive Cases from Surveillance 1 Report (January 1 to June 30 and January 1 to December 31)

Denominator	Total Number of Case Reports Received (January 1 to June 30 and January 1 to December 31)
Link	NHSP18-22 Goal 2

Indicator 4	National STI & HIV data quality audits conducted
Description	Conduct routine data quality audits on all NDoH surveillance systems at NDoH
Milestones	None (2018); Quarterly (2020); Quarterly (2022)
Responsible Entity	NDoH
Frequency	Annual
Data Collection Method or Source	DQA Tools
Disaggregation	HIV Surveillance Database (1, 2, 4), HPDB, KPMIS
Numerator	NA
Denominator	NA
Link	NHSP18-22 Goal 2

Indicator 5	High Priority Provinces STI & HIV data quality audits conducted
Description	Provincial health authority conduct routine data quality audits on HIV and STI data collection tools
Milestones	None (2018); Annually (2020); Annually (2022)
Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	Audit Tools
Disaggregation	HIV Surveillance Reporting Tools (1, 2, 4), HPDB, KPMIS
Numerator	NA
Denominator	NA
Link	NHSP18-22 Goal 2

Indicator 6	National STI & HIV Consolidated report prepared and circulated
Description	Annual report to inform key partners and stakeholders about the HIV and STIs program results and the epidemiology of HIV and STIs in PNG
Milestones	None (2018); Annually (2020); Annually (2022)

Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	HIV Surveillance Database, NHIS, HPDB, KPMIS, eNHIS
Disaggregation	Region/Province/District/Year/POS/Sex/Age
Numerator	NA
Denominator	NA
Link	NHSP18-22 Goal 2

4.1.3 Goal 3: Minimised HIV and STI transmission and optimised health and well-being of PLHIV

Indicator 7	All elements of the Standard & Enhanced Service Packages in Place in all provinces
Description	The elements of the Standard Service Package are available across every province (with the Enhanced Package in higher-burden provinces), integrated into existing services wherever possible
Milestones	0% (2018); 50% of Provinces (2020); 100% of Provinces (2022)
Responsible Entity	NDoH/PHA/PHO
Frequency	Mid-term/Final Evaluation
Data Collection Method or Source	Mid-term/Final Evaluation
Disaggregation	Region/Province/Month/Year
Numerator	Number of Standard and Enhanced Packages Provided (mid-term/final)
Denominator	Total Target Population (mid-term/final)
Link	NHSP18-22 Goal 3.1; WHO Global HIV/STI Strategy 2020 milestones

Ensure that people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Indicator 8	People living with HIV who know their HIV status (Percentage of people living with HIV who know their HIV status at the end of the reporting period)
Description	Measures progress towards increasing the proportion of people living with HIV who know their HIV status and the efficacy of HIV testing interventions. People living with HIV who know their HIV status will be able to access the HIV care and treatment services required to live healthy, productive lives and to reduce the potential of transmitting HIV to other people. The most effective way to ensure that people living with HIV are aware of their HIV status is to offer HIV testing services at locations and among populations with the highest HIV burden. This measure is one of the 10 global indicators in the 2015 WHO consolidated strategic information guidelines for HIV in the health sector and helps to monitor the first 90 of the UNAIDS 90–90–90 target: that 90% of the people living with HIV know their HIV status by 2020.
Milestones	75% (2018); 85% (2020); 90% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	HPDB/EPP Spectrum
Disaggregation	Sex, Age: for HIV case report measures: 0–14, 15–49 and 50+ years; for survey-based measures: 0–14 and 15+ years, region and province
Numerator	Number of people living with HIV who know their HIV status
Denominator	Number of people living with HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 1.1

Indicator 10	People living with HIV on antiretroviral therapy (Percentage and number of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period)
Description	Measures progress towards providing antiretroviral therapy to all people living with HIV. Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among people living with HIV and to halt onward transmission of the virus. Studies also show that early initiation, regardless of a person's CD4 cell count, can enhance treatment benefits and save lives. WHO currently recommends test and treat.
Milestones	53.2% (2018); 70% (2020); 90% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually

Data Collection Method or Source	HPDB
Disaggregation	Sex, Age: 0–14, 15–49 and 50+ years; for survey-based measures: 0–14 and 15+ years, region and province
Numerator	Number of people on antiretroviral therapy at the end of the reporting period
Denominator	Estimated number of people living with HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 1.2

Indicator 11	Retention on antiretroviral therapy at 12 months (Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after initiation of ART)
Description	Measures progress in increasing survival among adults and children living with HIV by maintaining them on antiretroviral therapy. One goal of any antiretroviral therapy program is to increase survival among people living with HIV. As antiretroviral therapy is scaled up around the world, understanding why people drop out of treatment programs and how many do this is important. The data can be used to demonstrate the effectiveness of programs and highlight obstacles to expanding and improving them.
Milestones	86.5% (2018); 90% (2020); 90% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	HPDB Retention at 12 months after starting antiretroviral therapy is defined as the outcome. Those who have died since starting therapy, those who have stopped therapy and those lost to follow-up as of month 12 (or 24, 36, 48, 60, etc.) are included in the denominator but not in the numerator. For example, people who started antiretroviral therapy between 1 January and 31 December 2014 will have reached their 12-month outcomes for the reporting period 1 January to 31 December 2015. As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated. At facility level, patients who have transferred out will not be counted either in the numerator or denominator. Patients who have transferred in will be counted in both numerator and denominator. Survival over longer durations of treatment provide a better picture of the long-term effectiveness of ART.
Disaggregation	Sex, Age (0–14 and 15+ years), Pregnancy status when starting therapy, Breastfeeding status when starting therapy, region and province
Numerator	Number of adults and children who are still alive and receiving antiretroviral therapy 12 months after initiating treatment

Denominator	Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period (This includes those who have died since starting therapy, those who have stopped therapy and those lost to follow-up as of month 12)
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 1.3

Indicator 12	People living with HIV who have suppressed viral loads (Number and percentage of people living with HIV who have suppressed viral loads at the end of the reporting period)
Description	Measures individual-level viral load is the recommended measure of antiretroviral therapy efficacy and indicates treatment adherence and the risk of transmitting HIV. A viral load threshold of <1000 copies/mL defines treatment success according to the 2016 WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. People with viral load test results below the threshold should be considered as having suppressed viral loads. Viral suppression among people living with HIV is one of the 10 global indicators in the 2015 WHO consolidated strategic information guidelines for HIV in the health sector. This indicator also helps monitor the third 90 of the UNAIDS 90–90–90 target: that 90% of the people receiving antiretroviral therapy will have suppressed viral loads by 2020.
Milestones	87.4% (2018); 90% (2020); 90% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	HPDB/CPHL
Disaggregation	Sex (male and female), Age:0–14, 15+, <1 year, 1–4 years, 5–9, 10–14, 15–19, 20–24, 25–49 and 50+ years, region, province
Numerator	Number of people living with HIV in the reporting period with suppressed viral loads (≤1000 copies/mL)
Denominator	Estimated number of people living with HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 1.4

Indicator 13	AIDS mortality (Total number of people who have died from AIDS-related causes per 100 000 population)
Description	Measures impact of HIV prevention, care and treatment programs. Recent efforts to scale up access to life-saving antiretroviral therapy, including the 2016 WHO guidelines that recommend treatment for all, should significantly reduce the number of people dying from AIDS-related causes, if these services are accessible and delivered effectively. The impact of the HIV response should be assessed by monitoring changes in AIDS-related mortality over time. This indicator, modified as the total number of

	people who have died from AIDS-related causes in the reporting period divided by the population (per 100 000), is also included in the WHO consolidated strategic information guidelines for HIV in the health sector.
Milestones	1,062 (2018); 750 (2020); <500 (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	EPP Spectrum
Disaggregation	Sex (male and female), Age (<5, 5–14 and 15+ years), region, province
Numerator	Number of people dying from AIDS-related causes
Denominator	Total population regardless of HIV status
Calculation	Numerator/denominator multiplied by 100,000
Link	NHSP18-22 Goal 3; GAM 1.7

Eliminate new HIV infections among children by 2020 while ensuring that children have access to HIV treatment

Indicator 14	HIV Screening Among Pregnant Women (Percentage of pregnant women with known HIV status).
Description	Measures coverage of the first step of the PPTCT cascade. High coverage enables early initiation of care and treatment for HIV-infected mothers. The total number of identified HIV positive women provided the facility-specific number of pregnant women with HIV to start facility-based program PPTCT cascades.
Milestones	21% (2018); 60% (2020); 90% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	NHIS/HIV Surveillance Database/EPP Spectrum
Disaggregation	1) Known HIV infection at ANC entry; 2) Tested HIV positive at ANC during current pregnancy; 3) Tested HIV negative at ANC during current pregnancy; Total identified positive women = 1+2
Numerator	Number of pregnant women attending ANC and/or had facility based delivery who were tested for HIV during their pregnancy or already knew they were HIV positive.
Denominator	Number of pregnant women who delivered in the previous 12 months
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; MTCT.1 PMTCT; WHO Global HIV/STI Strategy 2020 milestones

Indicator 15	Mother-to-child transmission of HIV (Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months)
Description	Measures progress in providing women with antiretroviral medicines to reduce mother-to-child transmission of HIV. Efforts have been made to increase access to interventions that can significantly reduce mother-to-child transmission of HIV, including combining antiretroviral medicine prophylactic and treatment regimens and strengthening counselling on infant feeding. The impact of interventions for preventing mother-to-child transmission in reducing the number of children newly infected with HIV through mother-to-child transmission needs to be assessed. The percentage of children who are living with HIV should decrease as the coverage of interventions for preventing mother-to-child transmission and the use of more effective regimens increase.
Milestones	28.3% (2018); 15% (2020); 5% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	CPHL/HIV Surveillance Database/EPP Spectrum
Disaggregation	None
Numerator	Estimated number of children newly infected with HIV from mother-to-child transmission among children born in the previous 12 months to women living with HIV
Denominator	Estimated number of children delivered by women living with HIV who delivered in the previous 12 months
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 2.2

Indicator 16	Preventing the mother-to-child transmission of HIV (Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV)
Description	Measures progress in preventing mother-to-child transmission of HIV during pregnancy and delivery by providing antiretroviral medicine This indicator allows countries to monitor the coverage of provision of antiretroviral medicines to pregnant women living with HIV to reduce the risk of transmitting HIV to infants during pregnancy and delivery. When disaggregated by regimen, it can show increased access to more effective antiretroviral regimens for pregnant women living with HIV. Since the indicator usually measures the antiretroviral medicines dispensed and not those consumed, adherence to the regimen cannot be determined in most cases. Providing antiretroviral medicines (as lifelong therapy or as prophylaxis) for the mother during pregnancy and delivery can significantly reduce the risk of mother-to-child transmission. This entails antiretroviral medicine prophylaxis for the infant and antiretroviral medicines for the mother or child if breastfeeding and using safe delivery practices and safer infant feeding. The data will be used to track progress towards global

	and national goals of eliminating mother-to-child transmission; to inform policy and strategic planning; for advocacy; and for leveraging resources for accelerating scale-up. It will help measure the trends in the coverage of antiretroviral medicine prophylaxis and treatment and, when disaggregated by regimen type, will also assess progress in implementing more effective antiretroviral therapy regimens.
Milestones	32.5% (2018); 50% (2020); 80% (2022)
Responsible Entity	NDoH/UNAIDS/WHO
Frequency	Annually
Data Collection Method or Source	HIV Surveillance Database/EPP Spectrum
Disaggregation	The numerator should be disaggregated by the six general regimens, region and province
Numerator	Number of pregnant women living with HIV who delivered and received antiretroviral medicines during the past 12 months to reduce the risk of the mother-to-child transmission of HIV during pregnancy and delivery. Global reports summarizing the coverage of antiretroviral medicine for preventing mother-to-child transmission will exclude women who received single-dose nevirapine, since it is considered a suboptimal regimen. However, the country should report this.
Denominator	Estimated number of women living with HIV who delivered within the past 12 months
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 2.3

Indicator 17.1	Syphilis screening among pregnant women (Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated)
Description	Measures coverage of syphilis testing in women attending antenatal care services. Testing pregnant women for syphilis early in pregnancy is important for their health and that of the fetus. This contributes to monitoring the quality of antenatal care services and services to prevent HIV among pregnant women. It is also a process indicator for assessing the validation of eliminating the mother-to-child transmission of syphilis
Milestones	3.6% (2018); 50% (2020); 95% (2022)
Responsible Entity	NDoH/UNAIDS/CDC/WHO
Frequency	Annual
Data Collection Method or Source	HIV Surveillance Database Surv 1/ANC
Disaggregation	Tested at any visit, tested at first visit
Numerator	Number of women attending antenatal care services who were tested for syphilis

Denominator	Number of women attending antenatal care service
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 2.4a; WHO Global HIV/STI Strategy 2020 milestones

Indicator 17.2	Syphilis screening among pregnant women (Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated)
Description	Measures Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology. Syphilis infection in antenatal care attendees can be used to guide programs for preventing sexually transmitted infections and may provide early warning of potential changes in HIV transmission in the general population.
Milestones	5.3% (2018); 4.0% (2020); 2.0% (2022)
Responsible Entity	NDoH/UNAIDS/CDC/WHO
Frequency	Annual
Data Collection Method or Source	HIV Surveillance Database Surv 1/ANC
Disaggregation	Age (15–24 and 25+ years)
Numerator	Number of women attending antenatal care services who tested positive for syphilis
Denominator	Number of women attending antenatal care service who were tested for syphilis
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 2.4b; WHO Global HIV/STI Strategy 2020 milestones

Indicator 17.3	Syphilis screening among pregnant women (Percentage of women accessing antenatal care services who were tested for syphilis, tested positive and treated)
Description	Measures Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately. Treating antenatal care attendees who test positive for syphilis directly measures the program for eliminating the mother-to-child transmission of syphilis and efforts to strengthen primary HIV prevention. It is also a process indicator for validating the elimination of mother-to-child transmission of syphilis.
Milestones	79% (2018); 85% (2020); 95% (2022)
Responsible Entity	NDoH/UNAIDS/CDC/WHO
Frequency	Annual
Data Collection Method or Source	HIV Surveillance Database Surv 1/ANC

Disaggregation	None
Numerator	Number of antenatal care attendees with a positive syphilis test who received at least one dose of benzathine penicillin 2.4 mU intramuscularly
Denominator	Number of antenatal care attendees who tested positive for syphilis
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 2.4c; WHO Global HIV/STI Strategy 2020 milestones

Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients

Indicator 18	HIV Incidence (Number of people newly infected with HIV in the reporting period per 1000 uninfected population)
Description	Measures progress towards the AIDS epidemic. The overarching goal of the global AIDS response is to reduce the number of people newly infected to less than 200 000 in 2030. Monitoring the rate of people newly infected over time measures the progress towards achieving this goal. This indicator is one of the 10 global indicators in the WHO consolidated strategic information guidelines.
Milestones	2,765 (2018); <1500 (2020); <500 (2022)
Responsible Entity	NDoH/UNAIDS/CDC/WHO
Frequency	Annual
Data Collection Method or Source	HIV Surveillance Database Surv 1/ANC/EPP Spectrum Analysis
Disaggregation	Sex (male and female), Age (0–14, 15–24, 15–49 and 50+ years) Nationa1/Region/Province
Numerator	Number of people newly infected during the reporting period
Denominator	Total number of uninfected population (or person-years exposed)
Calculation	Rate: (Numerator x 1000)/denominator
Link	NHSP18-22 Goal 3; GAM 3.1

Indicator 19.1	HIV prevalence among sex workers (Percentage of sex workers living with HIV)
Description	Measures Progress on reducing HIV prevalence among key populations. Sex workers typically have higher HIV prevalence than the general population in both concentrated and generalized epidemics. In many cases, the prevalence among these populations can be more than twice the prevalence among the general population. Reducing the prevalence among sex workers is a critical measure of a national-level response to HIV.

Milestones	14.9% (2018); 14.9% (2020); 14.9% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of sex workers who test positive for HIV
Denominator	Number of sex workers tested for HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.3a

Indicator 19.2	HIV prevalence among MSM (Percentage of MSM living with HIV)
Description	Measures Progress on reducing HIV prevalence among key populations. Men who have sex with men typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, the prevalence among these populations can be more than twice the prevalence among the general population. Reducing the prevalence among men who have sex with men is a critical measure of a national-level response to HIV.
Milestones	8.9% (2018); 8.9% (2020); 8.9% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS Data from HIV tests conducted among respondents in the sentinel site(s) or participants in bio behavioural surveys
Disaggregation	Age (<25 and 25+ years), region, province
Numerator	Number of MSM who test positive for HIV
Denominator	Number of MSM tested for HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.3b

Indicator 19.3	HIV prevalence among TGs (Percentage of TGs who are living with HIV)
Description	Measures Progress on reducing HIV prevalence among key populations. Transgender communities often have higher HIV prevalence than the general population in many settings. In many cases, the prevalence is more than twice that of the general population.

	Reducing the prevalence among transgender people is an important measure for monitoring the national HIV response.
Milestones	8.9% (2018); 8.9% (2020); 8.9% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (transmen and transwomen), Age (<25 and 25+ years), region, province
Numerator	Percentage of TGs who are living with HIV
Denominator	Number of TGs tested for HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.3d

Indicator 20.1	Knowledge of HIV status among key populations (A, B, D) (Percentage of a key population who know their HIV status)
Description	Measures progress providing HIV testing services to members of key populations who are living with HIV and measuring against the first 90 of the 90–90–90 target: the percentage of people living with HIV who know their HIV status. Ensuring that people living with HIV receive the care and treatment required to live healthy, productive lives and reducing the chance of transmitting HIV require that they know their HIV status. In many countries, targeting testing and counselling at locations and populations with the highest HIV burden is the most efficient way to reach people living with HIV and ensure that they know their HIV status. This indicator captures the effectiveness of HIV testing interventions targeting populations at higher risk of HIV infection.
Milestones	FSW 38.9% (2018); 70% (2020); 85% (2022); MSM/TG 24.4% (2018); 70% (2020); 85% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of people in key populations who answered question A with “yes”
Denominator	Number of people in key populations who answered question A
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.4a; GAM 3.4b; GAM 3.4d

Indicator 20.2	Sex workers who know their HIV status (Percentage of sex workers that have received an HIV test during the reporting period and know their results)
Description	Measures progress providing HIV testing services to sex workers who may be living with HIV. This will help in achieving the first 90 of the 90–90–90 target. HIV counselling and testing becomes an entry point to HIV prevention or care and treatment for this important key population. Ensuring that people living with HIV receive the care and treatment required to live healthy, productive lives and reducing the chance of transmitting HIV requires that they know their HIV status. This indicator captures the coverage of HIV testing services in populations at higher risk of HIV infection.
Milestones	The annual targets will be 4,031 (2018); 7,064 (2019) and 10,811 (2020) hence the proportion of tested amongst FSW reached would be 50% (2018); 60% (2019) and 70% (2020)
Responsible Entity	NDoH
Frequency	Every six months
Data Collection Method or Source	KPMIS/ SR's KP database
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of sex workers who have been tested for HIV during the reporting period and who know their results
Denominator	Estimated number of sex workers in the targeted areas
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3;

Indicator 20.3	MSM who know their HIV status (Percentage of MSM that have received an HIV test during the reporting period and know their results)
Description	Measures progress providing HIV testing services to MSM who may be living with HIV. This will help in achieving the first 90 of the 90–90–90 target. HIV counselling and testing becomes an entry point to HIV prevention or care and treatment for this important key population. Ensuring that people living with HIV receive the care and treatment required to live healthy, productive lives and reducing the chance of transmitting HIV requires that they know their HIV status. This indicator captures the coverage of HIV testing services in populations at higher risk of HIV infection.
Milestones	The annual targets will be 1,806 (2018); 3,370 (2019) and 6,617 (2020) hence the proportion of tested amongst MSM/TG reached would be 50% (2018); 60% (2019) and 70% (2020). Using the estimated population as denominator however, the proportion will be 6% (2018); 11% (2019) and 21% in 2020
Responsible Entity	NDoH
Frequency	Every six months

Data Collection Method or Source	KPMIS/ SR's KP database
Disaggregation	Age (<25 and 25+ years), region, province
Numerator	Number of MSM who have been tested for HIV during the reporting period and who know their results
Denominator	Estimated number of MSM in the targeted areas
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3;

Indicator 20.3	TGs who know their HIV status (Percentage of TGs that have received an HIV test during the reporting period and know their results)
Description	Measures progress providing HIV testing services to TGs who may be living with HIV. This will help in achieving the first 90 of the 90–90–90 target. HIV counselling and testing becomes an entry point to HIV prevention or care and treatment for this important key population. Ensuring that people living with HIV receive the care and treatment required to live healthy, productive lives and reducing the chance of transmitting HIV requires that they know their HIV status. This indicator captures the coverage of HIV testing services in populations at higher risk of HIV infection.
Milestones	The annual targets will be 1,806 (2018); 3,370 (2019) and 6,617 (2020) hence the proportion of tested amongst MSM/TG reached would be 50% (2018); 60% (2019) and 70% (2020). Using the estimated population as denominator however, the proportion will be 6% (2018); 11% (2019) and 21% in 2020
Responsible Entity	NDoH
Frequency	Every six months
Data Collection Method or Source	KPMIS/ SR's KP database
Disaggregation	Sex (transmen or transwoman)Age (<25 and 25+ years), region, province
Numerator	Number of TGs who have been tested for HIV during the reporting period and who know their results
Denominator	Estimated number of TGs in the targeted areas
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3;

Indicator 21	Antiretroviral therapy coverage among people living with HIV in key populations (A, B, D) (Percentage of the people living with HIV in a key population receiving antiretroviral therapy in the past 12 months)
Description	Measures progress towards providing antiretroviral therapy to people living with HIV in key populations. Antiretroviral therapy has been shown to reduce HIV-related

	morbidity and mortality among people living with HIV and to reduce the transmission of HIV. People living with HIV in key populations should be able to access mainstream services that provide antiretroviral therapy without fear of facing stigma or discrimination and to be able to receive care from health-care workers who have the clinical knowledge to meet their specific needs. Ideally, all of these mainstream services should meet the standards for becoming sensitized to the need of key populations. Accordingly, antiretroviral therapy coverage is a crucial way of assessing access to mainstream services. In recent years, the guidelines on eligibility for antiretroviral therapy have changed several times. National guidelines do not always match global guidelines. As a result, antiretroviral therapy coverage has been reported using numerous definitions, including those based on global guidelines, or national guidelines, or both. When guidelines are modified to increase eligibility among people who are living with HIV, coverage estimates will decrease. To avoid multiple antiretroviral therapy coverage values, the number of key population members living with HIV receiving antiretroviral therapy will be presented in relation to the total number of key population members living with HIV. This indicator will be aligned with the indicator on antiretroviral therapy coverage among all people living with HIV.
Milestones	No Baseline (2018); Baseline Established (2020); Performance Indicator (2022)
Responsible Entity	NDoH
Frequency	Annually
Data Collection Method or Source	KPMIS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of respondents living with HIV who report receiving antiretroviral therapy in the past 12 months
Denominator	Number of respondents living with HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.5a; GAM 3.5b; GAM 3.5d

Indicator 22.1	Condom use among sex workers (Percentage of sex workers reporting using a condom with their most recent client)
Description	Measures progress in preventing exposure to HIV among sex workers through unprotected sex with clients. Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, by consistently and correctly using condoms.
Milestones	49.5% (2018); 60% (2020); 80% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially

Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of sex workers who reported using a condom with their last client
Denominator	Number of sex workers who reported having commercial sex in the past 12 months
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.6a

Indicator 22.2	Condom use among MSM (Percentage of men reporting using a condom the last time they had anal sex with a male partner)
Description	Measures progress in preventing exposure to HIV among MSM who have unprotected anal sex with a male partner. Condoms can substantially reduce the risk of sexually transmitting HIV. Consistently and correctly using condoms is therefore important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with the most recent male partner is considered a reliable indicator of longer-term behaviour.
Milestones	30.4% (2018); 60% (2020); 80% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Age (<25 and 25+ years), region, province
Numerator	Number of MSM who reported that a condom was used the last time they had anal sex with a male partner
Denominator	Number of MSM who reported having had anal sex with a male partner in the last six months
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.6b

Indicator 23.1	Coverage of HIV prevention programs among key populations (A, B and D) (Percentage of people in a key population reporting having received a combined set of HIV prevention interventions)
Description	Measures people in key populations who received at least two HIV prevention interventions in the past three months. Successfully confronting the HIV epidemic requires combining preventive behaviour and antiretroviral therapy. Coverage with

	evidence-informed prevention programming is a critical component of the response, the importance of which is reflected in the UNAIDS Strategy.
Milestones	FSW 48.2% (2018); 60% (2020); 80% (2022); MSM 12% (2018); 25% (2020); 50% (2022); TG 18.8% (2018); 30% (2020); 60% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of people in a key population who report receiving two or more of the prevention interventions listed
Denominator	Number of people in a key population responding
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; WHO Global HIV/STI Strategy 2020 milestones; GAM 3.7a; GAM 3.7b; GAM 3.7d

Indicator 23.2	Sex workers that access HIV prevention services (Percentage of sex workers reached with HIV prevention programs - defined package of services)
Description	Measures sex workers that are reached with a defined package of HIV prevention services. The minimum package of services includes interpersonal coordination (IPC), receiving condoms and lubricants, condom demonstration and referrals for STI & HIV testing.
Milestones	Annual target is 8,062 (2018); 11,773 (2019) and 15,444 (2020) hence the proportion would be 22% (2018); 31% (2019) and 40% (2020)
Responsible Entity	NDoH
Frequency	Every 6 months
Data Collection Method or Source	KPMIS/ SRs KP database If sex workers are reached with the minimum package of services at least once in six months they will be counted as reached once. Hence, individuals reached will be counted and not the number of times they have been reached. All key population have unique identification (UID) and can be counted individually therefore accumulation is not applicable.
Disaggregation	Sex (female, male and transgender), region, province
Numerator	Number of sex workers who have received a defined package of HIV prevention services
Denominator	Estimated number of sex workers in the targeted area

Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3;

Indicator 23.3	MSM that access HIV prevention services (Percentage of MSM reached with HIV prevention programs - defined package of services)
Description	Measures MSM that are reached with a defined package of HIV prevention services. The minimum package of services includes interpersonal coordination (IPC), receiving condoms and lubricants, condom demonstration and referrals for STI & HIV testing.
Milestones	The annual targets will be 3,611 (2018); 5,616 (2019) and 9,453 (2020) hence the proportion would be 12% (2018); 18% (2019) and 30% (2020).
Responsible Entity	NDoH
Frequency	Every 6 months
Data Collection Method or Source	KPMIS/ SRs KP database If MSM are reached with the minimum package of services at least once in six months they will be counted as reached once. Hence, individuals reached will be counted and not the number of times they have been reached. All key population have unique identification (UID) and can be counted individually therefore accumulation is not applicable.
Disaggregation	Region, province
Numerator	Number of MSM who have received a defined package of HIV prevention services
Denominator	Estimated number of MSM in the targeted area
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3;

Indicator 23.4	TGs that access HIV prevention services (Percentage of TGs reached with HIV prevention programs - defined package of services)
Description	Measures TGs that are reached with a defined package of HIV prevention services. The minimum package of services includes interpersonal coordination (IPC), receiving condoms and lubricants, condom demonstration and referrals for STI & HIV testing.
Milestones	The annual targets not available yet. The IBBS results will be used to set targets for the TGs
Responsible Entity	NDoH
Frequency	Every 6 months
Data Collection Method or Source	KPMIS/ SRs KP database

	If TGs are reached with the minimum package of services at least once in six months they will be counted as reached once. Hence, individuals reached will be counted and not the number of times they have been reached. All key population have unique identification (UID) and can be counted individually therefore accumulation is not applicable.
Disaggregation	Sex (Transmen or transwomen), Region, province
Numerator	Number of TGs who have received a defined package of HIV prevention services
Denominator	Estimated number of TGs in the targeted area
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3;

Indicator 24	Active syphilis among sex workers (Percentage of sex workers with active syphilis)
Description	Measures progress in decreasing high-risk sexual behaviour and intervention efforts to control syphilis among sex workers. Testing sex workers for syphilis is important for their health and for second-generation surveillance purposes.
Milestones	SW 7.2% (2018); 5% (2020); 3% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), region, province
Numerator	Number of sex workers who tested positive for active syphilis
Denominator	Number of sex workers who were tested for active syphilis
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.11

Indicator 25	Active syphilis among men who have sex with men (Percentage of men who have sex with men with active syphilis).
Description	Measures progress in decreasing high-risk sexual behaviour and intervention efforts to control syphilis among men who have sex with men. Testing of syphilis among men who have sex with men is important for their health and for second-generation surveillance purposes.
Milestones	MSM/TG 4.0% (2018); 3.5% (2020); 3% (2022)
Responsible Entity	NDoH/IMR

Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), region, province
Numerator	Number of men who have sex with men testing positive for active syphilis
Denominator	Number of men who have sex with men tested for active syphilis
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.12

Indicator 26	Viral hepatitis among key populations (Prevalence of hepatitis and coinfection with HIV among key populations)
Description	Measures comorbidity with HIV and potential need for appropriate treatment. Appreciation of hepatitis and HIV coinfection has improved recently. Many people living with HIV receiving antiretroviral therapy are dying from liver disease resulting from untreated viral hepatitis. HIV treatment regimens can be adjusted to treat chronic hepatitis B infection as well. Measuring the hepatitis burden among key populations living with HIV can help national planners determine the resources needed to address the syndrome.
Milestones	FSW 9.3% (2018); 7% (2020); 5% (2022); MSM/TG 11.7% (2018); 9% (2020); 7% (2022)
Responsible Entity	NDoH/IMR
Frequency	Triennially
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), Key population, region, province
Numerator	Number of people in a key population who test positive for hepatitis B surface antigen and; Number of people in a key population who also test positive for HIV together with one of the above
Denominator	Number of respondents tested for both HIV and hepatitis B
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 3.14

Taking HIV out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, gonorrhoea and hepatitis B

Indicator 27	The proportion of PLHIV including PPTCT who were screened for TB in an HIV care setting
Description	Gauges implementation of the recommendation that PLHIV be screened for TB at diagnosis and at every follow-up visit
Milestones	87% (2018); 100% (2020); 100% (2022)
Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	HPDB
Disaggregation	Sex (female, male and transgender), Age (0-4, 5-14 and 15+), Key population, pregnancy status, region, province
Numerator	Number of PLHIV enrolled in HIV care in the past 12 months whose TB status was assessed and recorded at their last visit during the reporting period
Denominator	Number of PLHIV enrolled in HIV care in the past 12 months
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; Global Indicator Link 5

Indicator 28.1	Percentage of registered new and relapse TB patients with documented HIV status
Description	Gauges implementation of the recommendation that all notified TB patients must be tested for HIV
Milestones	33% (2016); 91% (2020); 100% (2022)
Responsible Entity	NDoH - NTP
Frequency	Quarterly
Data Collection Method or Source	NTP database Review and consolidation of validated BMU reports submitted to NTP-NDOH by the provinces. The number of TB patients tested and with positive results will be obtained from the TB register of each health facility. The national guideline directs health staff to test all TB patients for HIV and results be recorded in the TB register.
Disaggregation	Province, Region
Numerator	Number of new and relapsed TB patients registered during the reporting period who had an HIV test result (whether positive or negative) recorded in the TB register.
Denominator	Number of new and relapsed TB patients registered in the TB register during the reporting period.
Calculation	Numerator/denominator
Link	NHSP18-22 Goal, NTP Strategy Objective 3

Indicator 28.2	ART Coverage for HIV positive TB patients (Percentage of HIV-positive new and relapse TB patients on ART during TB treatment)
Description	Measures progress in ensuring that all TB patients that are co-infected with HIV are initiated on ART early (between 2 – 8 weeks after starting TB treatment). TB is a leading cause of morbidity and mortality among people living with HIV, including those receiving antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines are essential to improve the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB patients that access appropriate treatment for their TB and HIV is important.
Milestones	85% (2016); 100% (2020); 100% (2022)
Responsible Entity	NDoH - NTP
Frequency	Quarterly
Data Collection Method or Source	NTP database
Disaggregation	Region, province
Numerator	Number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or who start on ART during TB treatment
Denominator	Number of HIV-positive new and relapsed TB patients registered during the reporting period
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; NTP Strategy Objective 3

Indicator 28.3	Co-management of tuberculosis and HIV treatment (Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV)
Description	Measures progress in detecting and treating TB among people living with HIV. TB is a leading cause of morbidity and mortality among people living with HIV, including those receiving antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines are essential to improve the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB patients that access appropriate treatment for their TB and HIV is important.
Milestones	65% (2018); 80% (2020); 90% (2022)
Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	HPDB

Indicator 29	Proportion of people living with HIV newly enrolled in HIV care with active TB disease (Total number of people living with HIV with active TB expressed as a percentage of those who are newly enrolled in HIV care (pre–antiretroviral therapy or antiretroviral therapy) during the reporting period)
Description	Measures the burden of active TB among people living with HIV who are newly enrolled in HIV care. It also indirectly measures efforts to detect HIV-associated TB early. The primary aims of intensified TB case-finding in HIV care settings and provider-initiated HIV testing and counselling for in TB patients are early detection of HIV-associated TB and prompt provision of antiretroviral therapy and TB treatment. Although intensified TB case-finding should be implemented among all people living with HIV at each visit to HIV care and treatment facilities, it is particularly important at the time of enrolment, since the risk of undetected TB is higher among newly enrolled patients than among those already receiving antiretroviral therapy. Further, newly enrolled people living with HIV may be less aware of TB symptoms and the importance of early detection and treatment and may not seek care for general or specific TB symptoms. Intensified TB case-finding offers an opportunity to educate people living with HIV and to detect TB early. All people living with HIV detected with TB disease should start anti-TB treatment immediately and antiretroviral therapy within eight weeks if they are not already receiving antiretroviral medicines.
Milestones	10% (2018); 10% (2020); 10% (2022)
Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	HPDB
Disaggregation	None
Numerator	Total number of people who have active TB disease during the reporting period of those newly enrolled in HIV care
Denominator	Total number of people newly enrolled in HIV care during the reporting period (pre–antiretroviral therapy plus antiretroviral therapy)
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 10.2
Disaggregation	Sex (female, male and transgender), Age (<15 and 15+), Key population, region, province
Numerator	Number of HIV-positive new and relapse TB patients started on TB treatment during the reporting period who were already on antiretroviral therapy or started on antiretroviral therapy during TB treatment within the reporting year
Denominator	Estimated number of incident TB cases in people living with HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 10.1

Indicator 30	Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy (Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period)
Description	Measures the extent to which people living with HIV newly registered in HIV care start treatment for latent TB infection. All people in HIV care should be screened for TB at every visit, using a clinical algorithm recommended by WHO. Adults and adolescents living with HIV who do not report any of the symptoms—current cough, fever, weight loss or night sweats—are unlikely to have active TB and should be offered TB preventive therapy: that is, treatment for latent TB infection. Similarly, children who do not have poor weight gain, fever or current cough should be offered TB preventive therapy to reduce the risk of developing active TB, both those receiving antiretroviral therapy and those who do not.
Milestones	10% (2018); 30% (2020); 60% (2022)
Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	HPDB
Disaggregation	None
Numerator	Total number of people living with HIV newly enrolled in HIV care who start treatment for latent TB infection during the reporting period
Denominator	Total number of people newly enrolled in HIV care: that is, registered for pre–antiretroviral therapy or antiretroviral therapy during the reporting period
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 10.3

Indicator 31	Men with urethral discharge (Number of men reporting urethral discharge in the past 12 months)
Description	Measures progress in reducing unprotected sex among men. Urethral discharge among men is a sexually transmitted infection syndrome generally most commonly caused by *Neisseria gonorrhoeae* or *Chlamydia trachomatis*. Presentation with an acute sexually transmitted infection syndrome, such as urethral discharge, is a marker of unprotected sexual intercourse, and urethral discharge facilitates HIV transmission and acquisition. Surveillance for urethral discharge therefore contributes to second-generation HIV surveillance by providing early warning of the epidemic potential of HIV from sexual transmission and ongoing high-risk sexual activity that may require more aggressive program interventions to reduce the risk. Untreated urethral discharge can result in infertility, blindness and disseminated disease. Increasing resistance to the recommended treatment options for *Neisseria gonorrhoeae* may render this infection untreatable.
Milestones	5.2% (2018); 4.5% (2020); 3.5% (2022)

Responsible Entity	NDoH/WHO/IMR
Frequency	Annual
Data Collection Method or Source	NHIS
Disaggregation	None
Numerator	Number of men reported with urethral discharge during the reporting period
Denominator	Number of men 15 years and older
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 10.4

Indicator 32	Hepatitis B testing (Proportion of people starting antiretroviral therapy who were tested for hepatitis B)
Description	It monitors trends in hepatitis B testing among people starting antiretroviral therapy, a critical intervention to ensure that they receive a drug combination that treats hepatitis B. The presence of hepatitis B surface antigen indicates chronic infection with hepatitis B virus (HBV). Knowing people's HIV and hepatitis B status enables antiretroviral medicines to be prescribed that are effective against HBV and HIV infection. Testing for hepatitis B identifies coinfection to adapt treatment
Milestones	11% (2018); 50% (2020); 80% (2022)
Responsible Entity	NDoH/WHO
Frequency	Annually
Data Collection Method or Source	HPDB
Disaggregation	Sex, Age (<15 and 15+ years)
Numerator	Number of people started on antiretroviral therapy who were tested for hepatitis B during the reporting period using hepatitis B surface antigen tests
Denominator	Number of people starting antiretroviral therapy during the reporting period
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 3; GAM 10.6

Indicator 33	A country report on anti-microbial resistance to N. gonorrhoea
Description	Develops a baseline epidemiological profile to determine if anti-microbial resistance to N. gonorrhoea is occurring in PNG.
Milestones	No Report (2018); Report Published (2020); No report (2022)

Responsible Entity	NDoH/WHO/IMR
Frequency	Once
Data Collection Method or Source	Survey
Disaggregation	Sex (female, male and transgender), region, province
Numerator	NA
Denominator	NA
Calculation	NA
Link	NHSP18-22 Goal 3; WHO Global HIV/STI Strategy 2020 milestones

4.1.4 Goal 4: An environment that is safe and supportive of people's efforts to remain healthy

Indicator 35	Discriminatory attitudes towards people living with HIV (Percentage of women and men 15–49 years old who report discriminatory attitudes towards people living with HIV)
Description	Measures progress towards reducing discriminatory attitudes and support for discriminatory policies. Discrimination is a human rights violation prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or an omission) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fuelling the HIV epidemic. This indicator does not directly measure discrimination but rather measures discriminatory attitudes that may result in discriminatory acts (or omissions). One item in the indicator measures the potential support by respondents for discrimination that takes place at an institution and the other measures social distancing or behavioural expressions of prejudice. The composite indicator can be monitored as a measure of a key manifestation of HIV-related stigma and the potential for HIV-related discrimination within the general population. This indicator could provide further understanding and improve interventions in HIV discrimination by: showing change over time in the percentage of people with discriminatory attitudes; allowing comparisons between national, provincial, state and more local administrations; and indicating priority areas for action.
Milestones	No Data (2018); No Data (2020); Baseline Established (2022)
Responsible Entity	NACS/NDoH
Frequency	Once Every Five Years
Data Collection Method or Source	Survey
Disaggregation	Age (15–19, 20–24 and 25–49 years); Sex (female, male and transgender)

Numerator	Number of respondents (15–49 years old) who respond no to either of the two questions
Denominator	Number of all respondents (15–49 years old) who have heard of HIV
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 4; GAM 4.1

Indicator 36	Avoidance of HIV services because of stigma and discrimination among key populations (A, B, D) (Avoidance of HIV services because of stigma and discrimination among key populations)
Description	Measures progress towards reducing discriminatory attitudes and support for discriminatory policies. Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or failing to act) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fuelling the HIV epidemic. HIV-related stigma refers to negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people. This indicator directly measures fear of or experienced stigma or discrimination. This indicator could provide further understanding and improve interventions in reducing HIV stigma and discrimination by: (1) showing change over time in the percentage of people perceiving or experiencing stigma, (2) enabling comparisons between national, provincial, state and more local administrations and (3) indicating priority areas for action
Milestones	No Data (2018); No Data (2020); Baseline Established (2022)
Responsible Entity	NDOH/IMR/WHO
Frequency	Triennial
Data Collection Method or Source	BBS
Disaggregation	Sex (female, male and transgender), Age (<25 and 25+ years), region, province
Numerator	Number of respondents who answer yes to one of the following: Why did you not seek HIV testing/prevention/treatment services? 1. Fear of or concern about stigma by staff or neighbours. 2. Fear of or concern about or experienced violence. 3. Fear of or concern about or experienced police harassment or arrest
Denominator	Number of respondents
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 4; GAM 4.2

Indicator 37	Prevalence of recent intimate partner violence (Proportion of ever-married or partnered women 15–49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months)
Description	Measures progress in reducing the prevalence of intimate partner violence against women, as an outcome itself and as a proxy for gender inequality. An intimate partner is defined as a cohabiting partner, whether or not they were married at the time. The violence could have occurred after they separated. Globally, especially in sub-Saharan Africa, high rates of HIV infection among women have brought into sharp focus the problem of violence against women. There is growing recognition that deep-rooted, pervasive gender inequalities, especially violence against women and girls, shape their risk of and vulnerability to HIV infection. Violence and HIV have been linked through direct and indirect pathways. Studies in many countries indicate that many women have experienced violence in some form or another at some point in their life. WHO estimates that one in three women globally has experienced intimate partner violence and/or non-partner sexual violence.
Milestones	No Data(2018); No Data (2020); Baseline Established (2022)
Responsible Entity	NDOH/NACS
Frequency	Once Every Five Years
Data Collection Method or Source	Survey
Disaggregation	Age (15–19, 20–24 and 25–49 years); HIV status is available
Numerator	Women 15–49 years old who have or have ever had an intimate partner and report experiencing physical or sexual violence from at least one of these partners in the past 12 months. See the numerator explanation below for the specific acts of physical or sexual violence to include.
Denominator	Total number of women 15–49 years old surveyed who currently have or have had an intimate partner
Calculation	Numerator/denominator
Link	NHSP18-22 Goal 4; GAM 4.3

5 SURVEILLANCE AND M&E ACTIVITIES

To ensure that the actions laid out in the M&E and Surveillance plan are achievable, it is critical that structural and human resource improvements are made at NDoH. To that end, this plan calls to strengthen the strategic information systems and develop human resource capacity at national and provincial levels which are described below. Appendix A provides as detailed work plan.

5.1 Strengthen Strategic Information Systems

The NSIF 2018 – 2022 plan strengthens data processes and systems at all levels. This effort requires national staff to engage directly with provincial stakeholders to ensure timely submission, data accuracy and feedback. Routine data quality assessments at provincial and large facilities will be conducted to ensure collected data are reliable and valid. These visits are critical for addressing data collection errors as well as developing relationships between the national program and provincial and community stakeholders. Figure 2 illustrates the NHS proposed data flows for prevention, facility, laboratory, provincial and national levels.

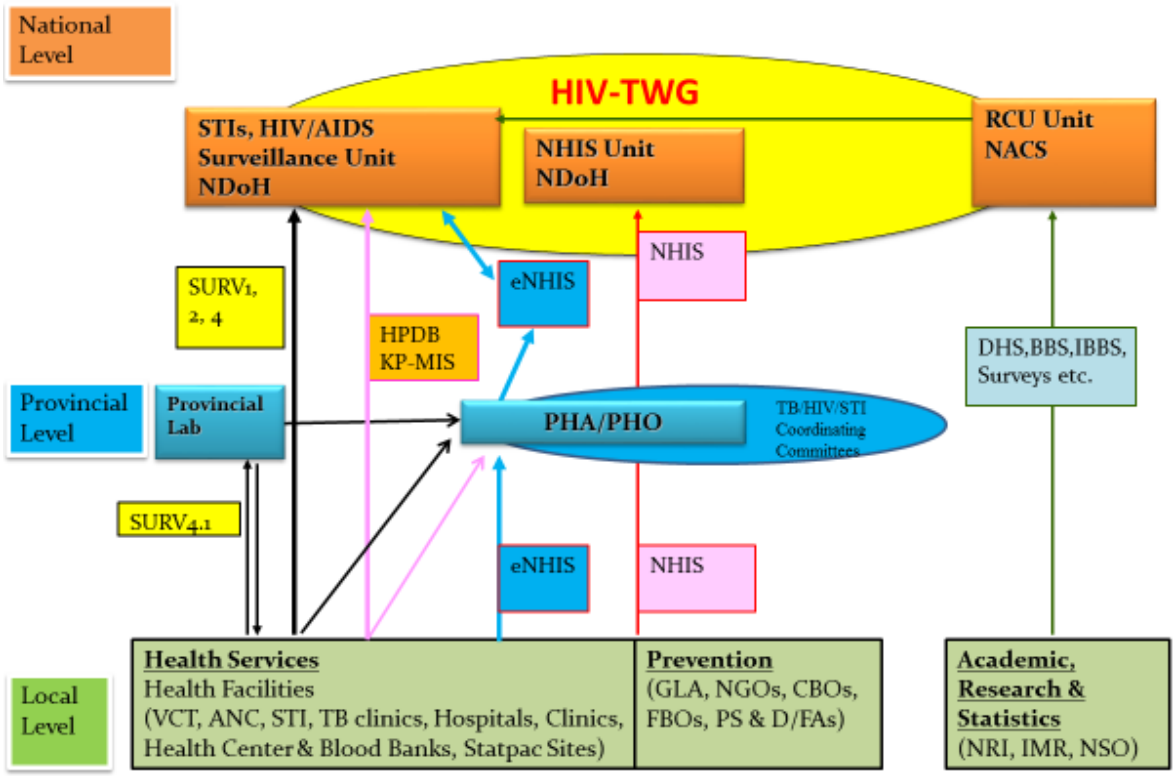


Figure 5: Proposed data flows of HIV/AIDS and STI data

5.1.1 eNHIS

Over the five years the surveillance plan and in alignment of the NHS, considerable efforts will be made to integrate surveillance data into the eNHIS.

i. Primary data repository for HIV, STI and TB data.
ii. Collection of SURV 1, 2 and 4 data
iii. Incorporate early infant diagnosis lab data into eNHIS
iv. Incorporate auto-generated NUIC within eNHIS
v. Sentinel Surveillance Data Collection
vi. KPMIS Data Collection
vii. Geo-spatial Mapping

5.1.2 HIV Surveillance Database

i. Connect database to NDoH server to support multi-entry and archival capabilities
ii. Connect server to cloud service for external data entry
iii. Examine opportunities for public health authority level data entry
iv. Develop and implement data control and quality protocol for SURV database
v. Schedule data quality assessments at national and provincial levels
vi. Conduct routine supervisory visits of reporting sites

5.1.3 HPDB

i. Continued support of HPDB data flows from facility to national system
ii. Develop and implement data control and quality protocol for HPDB system
iii. Schedule data quality assessments at national and provincial levels
iv. Conduct routine supervisory visits of reporting sites
v. Create database manual for end users.
vi. Conduct role specific database training for end users.
vii. Expand access of HPDB to HIV surveillance team.

5.1.4 KPMIS

i. Increase capacity for KPMIS data flows from facility and prevention levels to national systems
ii. Develop and implement data control and quality protocol for KPMIS system
iii. Schedule data quality assessments at national and provincial levels
iv. Conduct routine supervisory visits of reporting sites
v. Convert KPMIS to SQL server
vi. Integrate KPMIS to eNHIS

5.2 M&E and Surveillance Data Collection Activities

5.2.1 Routine Activities

i. **HIV Surveillance:** The SURV database is the primary system to assess testing rates, positivity rates, and ART treatment by demographic indicators, and the demographics of newly diagnosed individuals. The data from this system provides basic but very important epidemiological data which are used to inform program activities, as well as quarterly and annual reports.

ii. **Case Based Surveillance:** Case-based surveillance is conducted through the HPDB which represents approximately 76% of PLHIV on ART. The system contains information on key populations, TB infections, drug resistance, biological markers, behavioural data, risk indicators, lab values (CD4 and viral load) drug adherence, medical visit history, LTFU and several other key indicators. The HPDB lacks mortality information, lab data and is not connected to any other system. Despite this, the tool provides the most comprehensive data of PLHIV on ART. Data from the HPDB is incorporated into quarterly and annual surveillance reports, and inform program activities.

Viral load testing 90-90-90 is the target set by UNAIDS that by 2020 in all countries 90% of the people who are HIV infected are tested and know their status, 90% of those infected are on ART and 90% of those on ART have suppressed viral loads. The Surveillance 1 report captures reactive positive tests (via the confirmatory test) and Surveillance 2 report provides the number of individuals initiated on ART. To meet the requirements of the last 90%, viral load testing must be implemented in PNG. Viral load data are available at a few HIV care and treatment sites in NCD and are captured in the HPDB. In 2018, it is planned through the Global Fund Grant to expand viral load testing using GeneXpert. The machine is pre-qualified for viral load testing. To meet the last 90, the program in cooperation with its partners to will expand GeneXpert to high burden provinces. Sites

iii. **Estimate HIV Prevalence:** Population size estimate is conducted annually between January and March using the previous year's data. This activity is done jointly with UNAIDS. HIV testing is routine for antenatal care thus, it is considered the most representative sample of the general population. The data abstracted the SURV database (Surveillance 1 form) are used to calculate the size estimates at the provincial and national levels.

The prevalence estimate must be used with caution as it may under-represent the true burden of disease. The vast majority of women in PNG do not receive antenatal care services or deliver at a healthcare facility. It has been estimated that between 60 and 70 percent of women do present at antenatal care and only 21% are routinely tested (NDoH

2017). Furthermore, many facilities have not reported a full year's worth of data when the estimation exercise occurs, meaning that it is normal that 30 to 40 percent of the prior year's data has not been received by the NDoH surveillance team and thus, not used in the calculation. Data from the exercise will be incorporated into quarterly and annual surveillance reports, and inform program activities.

iv. **TB and HIV Co-infection Surveillance:** The HPDB is used to co-infected patient management and treatment adherence. Data from this system are incorporated into quarterly and annual surveillance reports, and inform program activities.

v. **TB and HIV Testing Surveillance:** The SURV and TB databases are used to examine trends in HIV testing rates at BMUs. The HPDB is used to explore the number of PLHIV registered into care who have been tested for TB. Data from all sources are incorporated into quarterly and annual surveillance reports, and inform program activities.

vi. **STI Surveillance:** The SURV database is used to examine trends in HIV testing in STI facilities and syphilis testing in the ANC, and the HPDB is maintains testing data for Hepatitis B and syphilis co-infected patient management and treatment adherence. STI data from the NHIS is used to examine syndromic disease trends. Data from all sources are incorporated into quarterly and annual surveillance reports, and inform program activities.

vii. **Key Population Management Information System:** KPMIS focuses efforts on populations most at risk for HIV infection and transmission. Efforts have been made to reach key populations within PNG including the adoption of standardized definitions for female sex workers (FSW), men who have sex with men (MSM) and transgender (TG) key populations. Data collection for key populations commenced in 2014 with the Global Fund requirement to gather key population data. Accordingly, through the Global Fund recipients selected eight sites in six provinces to collect key population data through a system of peer networks. The SURV database houses some behavioural risk factors for HIV. The KPMIS tool gather data in the aggregate but fails to identify behaviours at the individual level, and cannot be used to establish risk behaviours. The HPDB has been modified to capture key population data and will be used within the program for key population surveillance. Data from all three systems are incorporated into quarterly and annual surveillance reports, and inform program activities.

viii. **Support and supervisory visits:** Both TB and HIV programs for the NDoH and PHAs conduct regular support and supervisory visits to monitor program implementation. Standard supervisory checklists has been developed and are used by both the NDoH and PHAs (see Annex C).

The TB and HIV supervisory visits will be integrated in line with the national vision laid out in the NHS. Feedback is provided to the health facilities implementing HIV/AIDS

and STIs prevention, care and treatment during the visits. The support and supervisory visits also provide an opportunity to provide face-to-face coaching and mentorship to healthcare workers who are providing services including improving documentation. Reports are also generated for each visit and shared with managers at the health facilities and the PHAs. On subsequent visits recommendations of the previous visit are reviewed and progress in their implementation is assessed as part of continuous improvement.

NDoH TB and HIV programs are expected to carry out supervisory visits to provinces at least twice a year. The PHAs are expected to visit each ART facility/BMU at least once a quarter.

ix. Data quality audits: These are done quarterly to randomly selected provinces and health facility as way of ensuring that data being captured from the source documents to the reporting forms is accurate. They are also used to assess the accuracy of extracting the data from the reporting forms to the database. A standardised Data Quality Assessment (DQA) tool has been developed and is used by NDoH during these visits (see Annex D). Feedback is given to the respective health facilities and PHAs so that high quality recording and reporting of HIV/AIDS and STIs surveillance data is maintained.

x. National and provincial program review meetings: The provincial teams conduct meetings once every quarter with health facilities providing TB, HIV/AIDS and STIs prevention, care and treatment. These meetings are coordinated by the PHAs to review progress of each facility in implementation and provide feedback on programmatic performance. They are also platforms where facilities share best practices and information is shared to improve programmatic performance.

At least twice a year the NDoH TB and HIV programs conduct national review meetings with all the provinces. These meetings are also attended by NGOs, FBOs and other development partners supporting the two programs. These meetings are very crucial in that they provide a platform to take stock of the performance of the each province for each semester and provide feedback. Challenges and best practices are shared with the view of continuously improving programmatic performance and meet the national targets.

xi. **Annual Surveillance reports:** The primary object of the annual M&E and surveillance report is to interpret and describe the HIV epidemic in PNG. The annual surveillance report is written and published by June 30 of each year. The report includes five-year trend (where available) for general population statistics, key population statistics and sentinel surveillance activities. In addition, comparative analyses are performed by large facility, region and province. Finally, outcomes of special projects/initiatives are presented. Reports are generated in collaboration with the surveillance program and key stakeholders. The Strategic Information Technical Working Group oversees the content of the reports, prior presenting to the HIV Technical Working Group for review and approval. The

epidemiologist and/or HIV program coordinator are primarily responsible for data analysis and report writing.

5.2.2 Non-Routine Activities

i. **Bio-Behavioural Survey:** The Integrated Bio-Behavioural Survey was conducted 2016 to 2017 in Lae, NCD and Hagen. The survey provides biological and behavioural data on several key indicators including viral loads, drug resistance, medical adherence, key population demographics and risk behaviours, and prevalence of TB, HIV and STIs within key populations. The surveillance plan call for a scaled version of the IBBS to be conducted every three years, at the same three locations and 250-300 participant per KP clinic.

ii. **Sentinel Surveillance:** The purpose of sentinel surveillance is to collect data for HIV prevalence, behavioural and demographic variable among selected groups such as antenatal mothers, and STI and TB clients. Sentinel surveillance activities in PNG have not been conducted since 2010. Thus, to increase understanding of HIV and STI epidemic it is critical that STI and HIV sentinel surveillance is reinstated at basic management units (BMU), antenatal care clinics and STI clinics.

   a. Reinstate annual sentinel surveillance for BMU, ANC and STI high volume facilities.
   b. Sentinel surveillance data will be entered directly into the eNHIS system.
   c. Sentinel Surveillance Periods:
      i. May 1 to July 31 — BMU and STI clinics
      ii. August 1 to October 31 — ANC

iii. **Annual Geo-Spatial Surveillance**: Mapping is a critical tool to clearly identify the location of the epidemic, areas that are at risk or are high risk, key population hotspots and HIV healthcare and support services. The map provides the surveillance team with a high-level overview of the epidemic and to develop hypotheses as to why certain areas are prone to HIV transmission and infection.

iv. **External program reviews:** A mid-term and end of term external program review will be carried out during the lifetime of the NSIF 2018 – 2022. These important reviews provide important feedback on the progress the country is making in meeting the targets of the NHS. A critical review of the program is done by international consultants and recommendations provided on how to improve implementation. These reviews provide important feedback that will be used in prioritising the limited resources available to support the program.

6 HUMAN RESOURCES

With the given human resource limitation, the HIV Program continually works to strengthen its M&E and surveillance system. For better coordination and efficient use of the human resources at the national level and for coordinated reporting, TB and HIV M&E and surveillance unit is organized as one headed by the Epidemiology Advisor for TB, HIV/AIDS and STIs (international post). He/she has oversight on the TB and HIV M&E coordinators who are specific to each programs. The HIV program has three surveillance officers for KPs, HIV/AIDS and STIs as well as three data entry clerks respectively who report to the coordinator. The TB program has one M&E Officer who reports to the coordinator and supervises two data entry clerks as shown in figure 6. There are currently two vacant positions in the structure that will be filled by the government of PNG (GoPNG).

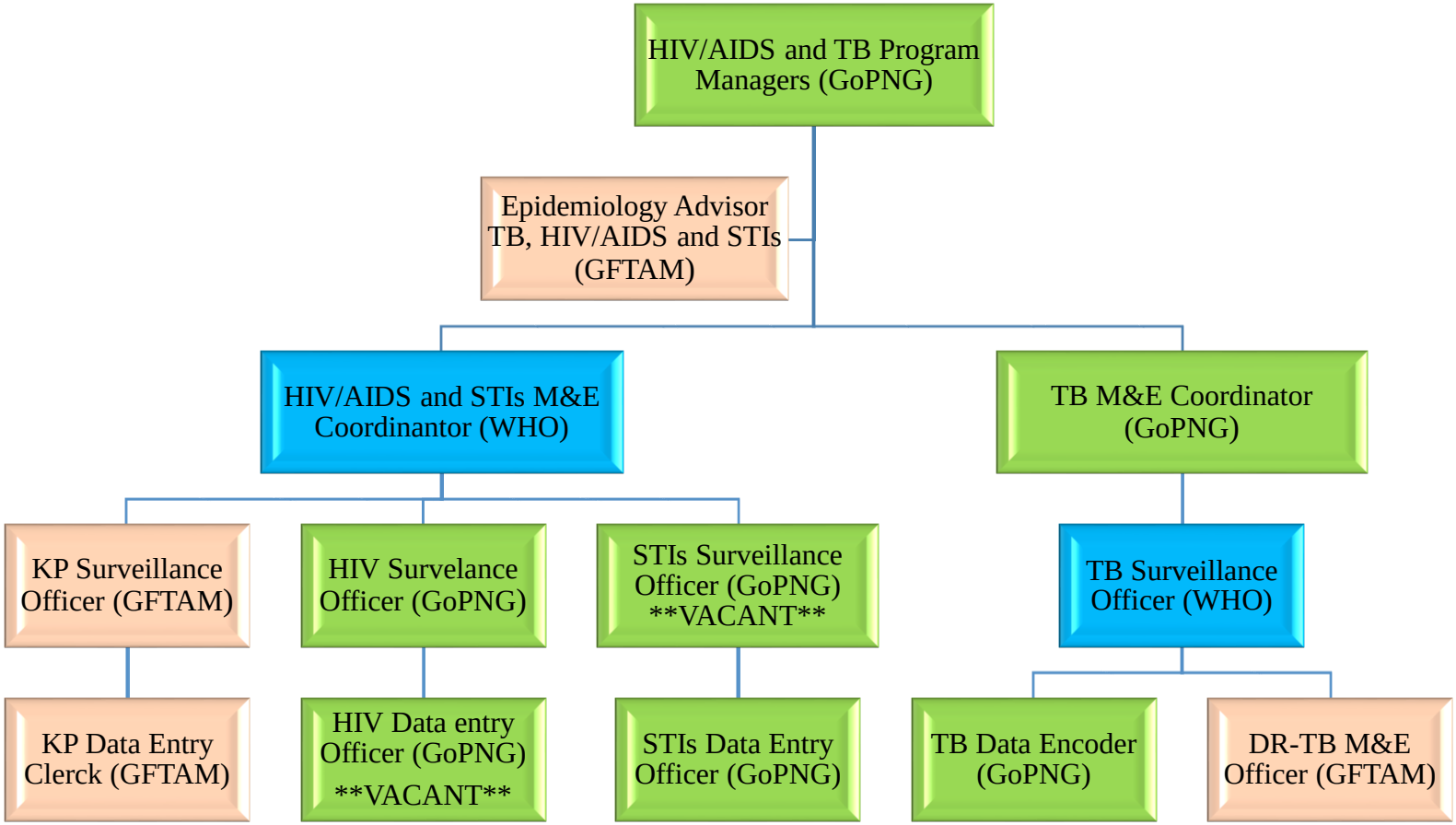


Figure 6: Structure of the M&E Unit for TB&HIV programs

6.1 M&E Human Resources and Terms of reference

6.1.1 International Epidemiology Advisor TB.HIV/AIDS and STIs

- Strengthen the National Surveillance system for TB and HIV
- Report to TB & HIV/TWG and senior staff of best practices for M&E and surveillance systems
- Oversee the integration and harmonisation of surveillance systems
- Conduct routine reviews of surveillance data collection tools to determine effectiveness at collecting required indicator data
- Oversee the global reporting process for TB and HIV
- Provide oversight and support related to all TB and HIV data management collection, collation, validation, encoding, analysis and interpretation
- Mentor and build the capacity of B and HIV M&E unit staff through formal and informal opportunities
- Ensure timely availability of the TB and HIV data and analysis for use at the provincial and national level
- Provide feedback report in timely manner to all provinces
- Lead the national progress review of the National Strategy for TB and HIV related to M&E data
- Assist the team for effective supportive supervision from the national level
- Supervise the coordinator in the production of TB and HIV annual surveillance reports
- Present TB and HIV data to TWG every quarter
- Supervise the coordinator in the production of periodic reports and other reports to the NDoH and partners
- Facilitate national-level trainings and workshops related to TB and HIV M&E
- Provide Data for Global reports for TB and HIV in discussion with NTP and NAP
- Build the capacity of National Coordinator to ensure all deliverables within the specialist position can be assumed by the coordinator at the end of the grant period

6.1.2 National TB & HIV M&E Coordinators

- Oversee the National Surveillance system for TB and HIV
- Organize and coordinate provincial level trainings/workshops
- Develop protocols and processes for data security, handling, dissemination, administration and management.
- Oversee annual EPP Spectrum data collection activities and ensure data meets submission deadlines and requirements
- Formalize data protocols and ensure implementation.
- Oversee and track all report submission for TB and HIV from all designated centres
- Ensure timely availability of the TB and HIV data and analysis for use at the provincial and national level
- Guide timely submission from the reporting centres of TB and HIV

- Conduct first level validation of all TB and HIV data
- Coordinate all surveillance activities
- Conduct data cleaning and produce output tables
- Analyse data for reporting purposes
- Feed back to the provinces in discussion with the M&E advisor
- Summarize findings of the supervisory visits by the national teams as well as the Provincial team and present to the TWG
- Produce quarterly reports to TB and HIV for provincial level
- Assist the M& E specialist on reports
- Conduct weekly surveillance staff meetings
- Assist the national progress review of the National Strategy for TB and HIV
- Prepare activity design for the TB and HIV M&E related activities
- Track progress of the M&E activities
- Mentor the Focal person and surveillance officers

6.1.3 National TB Surveillance Officer

- Communicate to provinces for data rectification
- Supervise and help the data encoders for their
- Provide TB report status to the NTP
- Conduct first level review of the data encoded by the encoders
- Provide weekly feed back to the M&E coordinator
- Upload TB data in the TBMIS
- Assist M&E coordinator for data cleaning and basic report production

6.1.4 TB Data Encoder

- Ensure and track data submission using the tracking form
- Review submitted data for completeness
- Rectify incorrect data
- Provide weekly feed back to the supervisor
- Encode TB data as reports are being submitted from the BMUs
- Do data back up and filing of paper based reports
- Follow up with the BMUS on timely submission of the Reports

6.1.5 HIV Surveillance Officer

- Oversee the National surveillance system for HIV
- Implement and ensure that data administration and management protocols and processes are adhered.

- Administer database and conduct daily back-up process of the all databases
- Communicate to provinces for data rectification
- Supervise and mentor surveillance officers and Data encoders
- Provide HIV report status to the NAP
- Conduct data quality reviews of data entered into all systems level review of the data entered by the officers
- Upload the data in the national HIV SQL system as required
- Conduct basic data analysis
- Assist M&E coordinator for report development
- Attend weekly meetings with specialist and coordinator
- Conduct daily staff meetings
- Maintain meeting documents and minutes
- Oversee the surveillance data collection tool logistics to include the procurement and dispensing of tools with the assistance of surveillance officers

6.1.6 KP and STIs Surveillance Officers

- Review submitted data for completeness
- Rectify incorrect data
- Enter the data into the national SQL system
- Analyze the data and assist the HIV surveillance unit with the development of reports, and submission of global indicator reports
- Contribute to the PUDR process of providing data
- Ensure that all previous year data has been entered by February 1 in with EPP Spectrum annual data activities
- Run different reports for NDoH use and reporting obligations
- Identify data entry errors and conduct cross verification
- Conduct area specific DQA and assist with provincial level DQA as needed
- Train and mentor provincial level staff on data collection tools
- Maintain data system as needed
- Do data back up and filing of paper-based reports, as needed
- Attend daily and weekly staff meetings and provide data reports as required/requested
- Assist with data entry as needed

6.1.7 Data Entry Officers (3)

- Enter surv 1, 2 and 4 data as well as KPMIS
- Check data for inconsistencies and verify data with surveillance officers
- Run daily data entry tracking reports
- Maintain paper-based filing system

- Assist with the calling of sites or focal people to track missing reports
- Check inbox daily for new surveillance reports
- Attend weekly and daily meetings

6.2 Human Resource Capacity

Successful and reliable surveillance systems require individuals with the skills and knowledge to ensure data quality, reliability and validity. Moreover, surveillance officers are required to analyse data to inform several key areas of the STI and HIV program including drug, test kits and condom procurement, spikes in prevalence, identifying new risk groups and reporting data to key stakeholders.

a. **NDoH:** Seven surveillance officers are responsible for monitoring and evaluating respective core surveillance programs (STI, KPMIS, core surveillance, sentinel surveillance and case-based reporting) through regular data analysis and reporting, performing data audits and mentoring provincial and facility counterparts. The KPMIS designate surveillance officer oversees the IBBS activities.

   All officers will also increase their capacities to collect and analyse TB data in conjunction with HIV data. The NDoH surveillance team will provide provincial M&E officers with training to ensure that data collection, quality assurance and reporting protocols are successfully implemented.

b. **Provincial and Facility Level:** Provincial M&E officers will assume data collection oversight responsibilities for all HIV and STI healthcare facilities including the installation of electronic data collection systems in key facilities and the submission of timely data to NDoH. Provincial M&E officers will provide training and support to district and facility level staff, as well as conduct routine data audits.

7 ANNEXURE

7.1 Annex A: M&E Plan

Year	NHS Strategic Result	M&E Indicators/ Surveillance Focus Area	Activity	Frequency	Timeline	Responsible Entity
2018	2.1	Focus Area 1	Hire appropriate personnel for vacant M&E and surveillance positions	Annual	2nd Quarter	NDoH
2018	2.1	Focus Area 1	Identify critical gaps in knowledge for new and existing personnel	Annual	2nd Quarter	NDoH
2018	2.1	Focus Area 1	Train new and existing personnel regarding gaps in capacity	Annual	4th Quarter	NDoH/WHO/CDC
2018	2.1	Focus Areas 1 and 3, Indicator 5	M&E and Surveillance Training for national staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology; Project management, identified gaps in knowledge and; other program requirements)	Annual	1st Quarter	NDOH/WHO/CDC
2018	2.1	Focus Areas 1 and 3, Indicator 5 and 6	M&E and Surveillance Training for provincial staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	NDOH/WHO/CDC
2018	2.1	Focus Areas 1 and 3, Indicator 6	M&E and Surveillance Training for facility staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	PHO/PHA
2018	2.2. 1.2	Focus Area 3, Indicators 3, 3.1, 3.2, 4, 4.1, 4.2, 338. 39. 40	Develop and implement documented process for tracking received and outstanding surveillance and logistic reports, KPMIS and HPDB data submissions. Conduct monthly reviews of outstanding data.	Once and Annual Review	1st Quarter	NDOH/WHO/CDC

2018	2.2	Focus Areas 1, 3 and 4, Indicators 1 and 2	Develop STI surveillance tools to be integrated into eNHIS	Once	2nd Quarter	NDOH/WHO/CDC/NACS
2018	2.2, 3.4	Indicators 9, 13, 14, 15, 16, 18, 19	Participate and provide data for Estimated Population Projection Activities	Annual	1st and 2nd Quarters	NDOH/UNAIDS/WHO
2018	2.3, 3.4	Indicators 9, 10, 11, 12, 14, 15, 16, 17.1, 17.2, 17.3, 28, 29, 30	Produce cascades for HIV, Syphilis and HIV ANC, and TB and HIV	Annual	1st and 2nd Quarters	NDOH/UNAIDS/WHO
2018	2.2	Focus Area 3, Indicator 5	Develop documented data quality assurance (DQA) audit process and internal, provincial and facility audit schedule.	Once	1st Quarter	NDOH/WHO/CDC
2018	2.2, 3.4	Focus Area 3, Indicators 5 and 6	DQA: April and September conduct internal audit; May and October conduct provincial audit; Two provinces per region; One province with report completion rate above 75% and; One province with report completion rate below 75%. Focus on ANC and; Three HPDB sites per region.	Annual	2nd, 3rd and 4th Quarters	NDOH/WHO/CDC
2018	2.1	Focus Area 1, Indicator 1	Improve access to HIV data for M&E and surveillance staff; HPDB accessible via the internet, KPMIS and; HIV database integrated with the NDoH IT platform	Once	4th Quarter	NDOH/CDC
2018	2.1	Focus Areas 1, 2 and 4, Indicator 1 and 2	Collaborate with eNHIS to determine feasibility of using eNHIS as the data system for the HIV surveillance program, NUIC and access STI and TB data. Develop timeline for data mapping and integration; Develop process for testing the eNHIS system; Execute testing and; Conduct DQA.	On-going	On-going	NDOH/CDC
2018	2.3, 3.3, 3.4	Focus Area 2	Conduct Annual HIV Mapping Exercise: Create HIV surveillance map including HIV healthcare and support services, TB and STI sites, low ANC testing (syphilis and HIV), high burden areas, hotspots, partner funded sites and other indicators as determined. Timeline: January to March and April 1 disseminate Map to external partners, RMO and PDCO.	Annual	1st Quarter	NDOH/CDC/PHO

2018	2.3	Focus Area 4 and Indicator 7	Develop quarterly reporting templates for surveillance data, and produce and disseminate surveillance quarterly reports. Timeline: Report time period October 1 to September 30. Content: National, regional and provincial level comparisons. Distribution cycle: March 15 (October 1 to December 31), June 15 (January 1 to March 31), September 15 (April 1 to June 30), December 15 (July 1 to September 30). Distribution: External partners, RMO and PDCO.	Quarterly	1st, 2nd, 3rd and 4th Quarters	NDOH/NACS/ WHO
2018	2.3	Focus Area 4 and Indicator 7	Produce and disseminate annual STIs, HIV/AIDS M&E and surveillance report to include three-year trend (January 1 to December 31). Provide national, regional and provincial level comparisons with a specific focus on high burden provinces. Timeline and distribution: Finalized and disseminated by July 15 to external partners, RMO and PDCO.	Annual	3rd Quarter	NDOH/NACS/ WHO
2018	2.2	Focus Area 3	Create 2019 detailed work plan (July 1, 2018 completion date)	Annual	3rd Quarter	NDOH/NACS/ WHO
2018	2.1, 2.2	Focus Areas 1 and 3, Indicator 1	Review all M&E and surveillance data collection instruments for modifications, usability.	Annual	2nd Quarter	NDOH/NACS
2018	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E Mentoring Visits to High Priority Provinces: Visits are geared for provincial level mentorship to increase M&E and Surveillance capacity.	Annual	2nd, 3rd and 4th Quarters	NDOH/PHO
2018	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E and surveillance officers' collaborative meetings with provincial partners from STI, HIV/AIDS and TB sectors.	Semi-Annual	2nd and 4th Quarters	NDOH/PHO
2019	2.2	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2	Annual M&E and surveillance plan assessment; Review M&E and surveillance work completed in prior year and adjust current work plan as needed.	Annual	1st Quarter	NDOH/NACS
2019	2.1	Focus Areas 1and 3, Indicator 5	M&E and Surveillance Training for national staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology; Project management, identified gaps in knowledge and; other program requirements)	Annual	1st Quarter	NDOH/WHO/CDC
2019	2.1	Focus Areas 1 and 3, Indicators 5 and 6	M&E and Surveillance Training for provincial staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	NDOH/WHO/CDC

2019	2.1	Focus Areas 1 and 3, Indicator 6	M&E and Surveillance Training for facility staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	PHO/PHA
2019	2.3, 3.3, 3.4	Focus Area 2	Conduct Annual HIV Mapping Exercise: Create HIV surveillance map including HIV healthcare and support services, TB and STI sites, low ANC testing (syphilis and HIV), high burden areas, hotspots, partner funded sites and other indicators as determined. Timeline: January to March and April 1 disseminate Map to external partners, RMO and PDCO.	Annual	1st Quarter	NDOH/CDC/PHO
2019	2.3	Focus Area 4 and Indicator 7	Produce and disseminate surveillance quarterly reports. Timeline: Report time period October 1 to September 30. Content: National, regional and provincial level comparisons. Distribution cycle: March 15 (October 1 to December 31), June 15 (January 1 to March 31), September 15 (April 1 to June 30), December 15 (July 1 to September 30). Distribution: External partners, RMO and PDCO.	Quarterly	1st, 2nd, 3rd and 4th Quarters	NDOH/NACS/ WHO
2019	2.2	Focus Areas 3 and 4	Conduct Regional HPDB workshops to increase the capacity of facility staff to use the data to assess patient population and quality of healthcare services delivered.	Bi-Annual	2nd and 3rd Quarters	NDOH/CDC/WHO
2019	2.2, 3.4	Indicators 9, 13, 14, 15, 16, 18, 19	Participate and provide data for Estimated Population Projection Activities	Annual	1st and 2nd Quarters	NDOH/UNAIDS /WHO
2019	2.3, 3.4	Indicators 9, 10, 11, 12, 14, 15, 16, 17.1, 17.2, 17.3, 28, 29, 30	Produce cascades for HIV, Syphilis and HIV ANC, and TB and HIV	Annual	1st and 2nd Quarters	NDOH/UNAIDS /WHO
2019	2.3	Focus Area 4 and Indicator 7	Produce and disseminate annual STIs, HIV/AIDS M&E and surveillance report to include three-year trend (January 1 to December 31). Provide national, regional and provincial level comparisons with a specific focus on high burden provinces. Timeline and distribution: Finalized and disseminated by July 15 to external partners, RMO and PDCO.	Annual	3rd Quarter	NDOH/NACS/ WHO
2019	2.3, 3.4, 1.3	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2, 38, 39, 40	Monthly review of surveillance and logistic stock reports, KPMIS and HPDB data submissions	Monthly	Last Week of the Month	NDOH/PHO/KP Sites

2019	2.2	Focus Area 3, Indicators 5 and 6	Develop internal, provincial and facility DQA schedule.	Annual	1st Quarter	NDOH/WHO/CDC
2019	2.2, 3.4	Focus Area 3, Indicators 5 and 6	DQA: April and September conduct internal audit; May and October conduct provincial audit; Two provinces per region; One province with report completion rate above 75% and; One province with report completion rate below 75%. Focus on ANC and; Three HPDB sites per region.	Annual	2nd, 3rd and 4th Quarters	NDOH/WHO/CDC
2019	2.1	Focus Areas 1, 2 and 4, Indicators 1 and 2	Collaborate with eNHIS to expand HIV surveillance data to include HPDB, KPMIS, sentinel surveillance and BBS determine feasibility of using eNHIS as the data system for the HIV surveillance program, NUIC and access STI and TB data. Develop timeline for data mapping and integration; Develop process for testing the eNHIS system; Execute testing and; Conduct DQA.	On-going	On-going	NDOH/WHO/CDC
2019	2.1	Focus Area 2	Develop sentinel surveillance protocol (Completed draft due August 15, 2019 and; Protocol approved October 15, 2019	Once	3rd and 4th Quarters	NDOH/WHO/NACS/IMR
2019	2.1, 2.2	Focus Area 2	Conduct sentinel surveillance training prior to December 1, 2019)	Once	4th Quarter	NDOH/WHO/NACS/IMR
2019	2.1, 2.2	Focus Area 3	Create 2020 detailed work plan (July 1, 2019 completion date)	Annual	3rd Quarter	NDOH/NACS/WHO
2019	2.1, 2.2	Focus Areas 1 and 3, Indicator 1	Review all M&E and surveillance data collection instruments for modifications, usability.	Annual	2nd Quarter	NDOH/NACS
2019	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E Mentoring Visits to High Priority Provinces: Visits are geared for provincial level mentorship to increase M&E and Surveillance capacity.	Annual	2nd, 3rd and 4th Quarters	NDOH/PHO
2019	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E and surveillance officers' collaborative meetings with provincial partners from STI, HIV/AIDS and TB sectors.	Semi-Annual	2nd and 4th Quarters	NDOH/PHO
2020	2.2	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2	Annual M&E and surveillance plan assessment; Review M&E and surveillance work completed in prior year and adjust current work plan as needed.	Annual	1st Quarter	NDOH/NACS

2020	2.1	Focus Areas 1 and 3, Indicator 5	M&E and Surveillance Training for national staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology; Project management, identified gaps in knowledge and; other program requirements)	Annual	1st Quarter	NDOH/WHO/CDC
2020	2.1	Focus Areas 1 and 3, Indicators 5 and 6	M&E and Surveillance Training for provincial staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	NDOH/WHO/CDC
2020	2.1	Focus Areas 1 and 3, Indicator 6	M&E and Surveillance Training for facility staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	PHO/PHA
2020	2.3, 3.3, 3.4	Focus Area 4	Conduct Annual HIV Mapping Exercise: Create HIV surveillance map including HIV healthcare and support services, TB and STI sites, low ANC testing (syphilis and HIV), high burden areas, hotspots, partner funded sites and other indicators as determined. Timeline: January to March and April 1 disseminate Map to external partners, RMO and PDCO.	Annual	1st Quarter	NDOH/CDC/PHO
2020	2.3	Focus Area 4 and Indicator 7	Produce and disseminate surveillance quarterly reports. Timeline: Report time period October 1 to September 30. Content: National, regional and provincial level comparisons. Distribution cycle: March 15 (October 1 to December 31), June 15 (January 1 to March 31), September 15 (April 1 to June 30), December 15 (July 1 to September 30). Distribution: External partners, RMO and PDCO.	Quarterly	1st, 2nd, 3rd and 4th Quarters	NDOH/NACS/WHO
2020	2.3	Focus Area 4 and Indicator 7	Produce and disseminate annual STIs, HIV/AIDS M&E and surveillance report to include three-year trend (January 1 to December 31). Provide national, regional and provincial level comparisons with a specific focus on high burden provinces. Timeline and distribution: Finalized and disseminated by July 15 to external partners, RMO and PDCO.	Annual	3rd Quarter	NDOH/NACS/WHO
2020	2.2, 3.4	Indicators 9, 13, 14, 15, 16, 18, 19	Participate and provide data for Estimated Population Projection Activities	Annual	1st and 2nd Quarters	NDOH/UNAIDS/WHO

2020	2.3,3.4	Indicators 9, 10, 11, 12, 14, 15, 16, 17.1, 17.2, 17.3, 28, 29, 30	Produce cascades for HIV, Syphilis and HIV ANC, and TB and HIV	Annual	1st and 2nd Quarters	NDOH/UNAIDS /WHO
2020	2.3, 3.4, 1.3	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2, 38, 39, 40	Monthly review of surveillance and logistic stock reports, KPMIS and HPDB data submissions	Monthly	Last Week of the Month	NDOH/PHO/KP Sites
2020	2.2	Focus Area 3, Indicators 5 and 6	Develop internal, provincial and facility DQA schedule.	Annual	1st Quarter	NDOH/WHO/C DC
2020	2.2, 3.4	Focus Area 3, Indicators 5 and 6	DQA: April and September conduct internal audit; May and October conduct provincial audit; Two provinces per region; One province with report completion rate above 75% and; One province with report completion rate below 75%. Focus on ANC and; Three HPDB sites per region.	Annual	2nd, 3rd and 4th Quarters	NDOH/WHO/C DC
2020	2.2, 3.4, 3.5, 4.2	Focus Area 1, Indicator 37	Conduct Sentinel Surveillance: June 1 to August 31: Blood Banks and TB Sites and September 1 to November 30: ANC and STI Facilities. Report findings in 2021 annual report.	Annual	June 1 to August 31: Blood Banks and TB Sites and September 1 to November 30: ANC and STI Facilities.	NDOH/WHO/P HO/NACS/CPH L
2020	2.2, 3.3, 4.1, 4.3	Focus Areas 1 and 4, Indicators 19.1, 19.2, 20, 22.1, 22.2, 23, 24, 25, 26, 36,37	Conduct triennial BBS to capture key population behavioral and biological data and incorporate using eNHIS.	Triennial	January 1-December 31, 2020	NDOH/IMR/CD C/WHO/NACS
2020	2.1, 2.2	Focus Area 3	Create 2021 detailed work plan (July 1, 2020 completion date)	Annual	3rd Quarter	NDOH/NACS/ WHO
2020	2.1, 2.2	Focus Areas 1 and 3, Indicator 1	Review all M&E and surveillance data collection instruments for modifications, usability.	Annual	2nd Quarter	NDOH/NACS
2020	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E Mentoring Visits to High Priority Provinces: Visits are geared for provincial level mentorship to increase M&E and Surveillance capacity.	Annual	2nd, 3rd and 4th Quarters	NDOH/PHO

2020	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E and surveillance officers' collaborative meetings with provincial partners from STI, HIV/AIDS and TB sectors.	Semi-Annual	2nd and 4th Quarters	NDOH/PHO
2021	2.2	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2	Annual M&E and surveillance plan assessment; Review M&E and surveillance work completed in prior year and adjust current work plan as needed.	Annual	1st Quarter	NDOH/NACS
2021	2.1	Focus Areas 1 and 3, Indicator 5	M&E and Surveillance Training for national staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology; Project management, identified gaps in knowledge and; other program requirements)	Annual	1st Quarter	NDOH/WHO/CDC
2021	2.1	Focus Areas 1 and 3, Indicators 5 and 6	M&E and Surveillance Training for provincial staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	NDOH/WHO/CDC
2021	2.1	Focus Areas 1 and 3, Indicator 6	M&E and Surveillance Training for facility staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	PHO/PHA
2021	2.3, 3.3, 3.4	Focus Area 4	Conduct Annual HIV Mapping Exercise: Create HIV surveillance map including HIV healthcare and support services, TB and STI sites, low ANC testing (syphilis and HIV), high burden areas, hotspots, partner funded sites and other indicators as determined. Timeline: January to March and April 1 disseminate Map to external partners, RMO and PDCO.	Annual	1st Quarter	NDOH/CDC/PHO
2021	2.2, 3.4	Indicators 9, 13, 14, 15, 16, 18, 19	Participate and provide data for Estimated Population Projection Activities	Annual	1st and 2nd Quarters	NDOH/UNAIDS/WHO
2021	2.3, 3.4	Indicators 9, 10, 11, 12, 14, 15, 16, 17.1, 17.2, 17.3, 28, 29, 30	Produce cascades for HIV, Syphilis and HIV ANC, and TB and HIV	Annual	1st and 2nd Quarters	NDOH/UNAIDS/WHO

2021	2.3	Focus Area 4 and Indicator 7	Produce and disseminate surveillance quarterly reports. Timeline: Report time period October 1 to September 30. Content: National, regional and provincial level comparisons. Distribution cycle: March 15 (October 1 to December 31), June 15 (January 1 to March 31), September 15 (April 1 to June 30), December 15 (July 1 to September 30). Distribution: External partners, RMO and PDCO.	Quarterly	1st, 2nd, 3rd and 4th Quarters	NDOH/NACS/ WHO
2021	2.3	Focus Area 4 and Indicator 7	Produce and disseminate annual STIs, HIV/AIDS M&E and surveillance report to include three-year trend (January 1 to December 31). Provide national, regional and provincial level comparisons with a specific focus on high burden provinces. Timeline and distribution: Finalized and disseminated by July 15 to external partners, RMO and PDCO.	Annual	3rd Quarter	NDOH/NACS/ WHO
2021	2.3, 3.4, 1.3	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2, 38, 39, 40	Monthly review of surveillance and logistic stock reports, KPMIS and HPDB data submissions	Monthly	Last Week of the Month	NDOH/PHO/KP Sites
2021	2.2	Focus Area 3, Indicators 5 and 6	Develop internal, provincial and facility DQA schedule.	Annual	1st Quarter	NDOH/WHO/C DC
2021	2.2, 3.4	Focus Area 3, Indicators 5 and 6	DQA: April and September conduct internal audit; May and October conduct provincial audit; Two provinces per region; One province with report completion rate above 75% and; One province with report completion rate below 75%. Focus on ANC and; Three HPDB sites per region.	Annual	2nd, 3rd and 4th Quarters	NDOH/WHO/C DC
2021	2.2, 3.4, 3.5, 4.2	Focus Area 1, Indicator 37	Conduct Sentinel Surveillance: June 1 to August 31: Blood Banks and TB Sites and September 1 to November 30: ANC and STI Facilities. Report findings in 2022 annual report.	Annual	June 1 to August 31: Blood Banks and TB Sites and September 1 to November 30: ANC and STI Facilities.	NDOH/WHO/P HO/NACS/CPH L
2021	2.1, 2.2	Focus Area 3	Create 2022 detailed work plan (July 1, 2021 completion date)	Annual	3rd Quarter	NDOH/NACS/ WHO
2021	2.1, 2.2	Focus Areas 1 and 3, Indicator 1	Review all M&E and surveillance data collection instruments for modifications, usability.	Annual	2nd Quarter	NDOH/NACS

2021	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E Mentoring Visits to High Priority Provinces: Visits are geared for provincial level mentorship to increase M&E and Surveillance capacity.	Annual	2nd, 3rd and 4th Quarters	NDOH/PHO
2021	2.1, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E and surveillance officers' collaborative meetings with provincial partners from STI, HIV/AIDS and TB sectors.	Semi-Annual	2nd and 4th Quarters	NDOH/PHO
2021	2.2	Focus Areas 3 and 4	Conduct Regional HPDB workshops to increase the capacity of facility staff to use the data to assess patient population and quality of healthcare services delivered.	Bi-Annual	2nd and 3rd Quarters	NDOH/CDC/WHO
2022	2.2	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2	Annual M&E and surveillance plan assessment; Review M&E and surveillance work completed in prior year and adjust current work plan as needed.	Annual	1st Quarter	NDOH/NACS
2022	2.2	Focus Areas 1 and 3, Indicator 5	M&E and Surveillance Training for national staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology; Project management, identified gaps in knowledge and; other program requirements)	Annual	1st Quarter	NDOH/WHO/CDC
2022	2.1	Focus Areas 1 and 3, Indicators 5 and 6	M&E and Surveillance Training for provincial staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	NDOH/WHO/CDC
2022	2.1	Focus Areas 1 and 3, Indicator 6	M&E and Surveillance Training for facility staff ((M&E and Surveillance tools, and data collection; DQA; Reporting requirements; Data management and security; Data analysis; Public health methodology and; Project management)	Annual	2nd Quarter	PHO/PHA
2022	2.1	Focus Area 4	Conduct Annual HIV Mapping Exercise: Create HIV surveillance map including HIV healthcare and support services, TB and STI sites, low ANC testing (syphilis and HIV), high burden areas, hotspots, partner funded sites and other indicators as determined. Timeline: January to March and April 1 disseminate Map to external partners, RMO and PDCO.	Annual	1st Quarter	NDOH/CDC/PHO

2022	2.3, 3.3, 3.4	Focus Area 4 and Indicator 7	Produce and disseminate surveillance quarterly reports. Timeline: Report time period October 1 to September 30. Content: National, regional and provincial level comparisons. Distribution cycle: March 15 (October 1 to December 31), June 15 (January 1 to March 31), September 15 (April 1 to June 30), December 15 (July 1 to September 30). Distribution: External partners, RMO and PDCO.	Quarterly	1st, 2nd, 3rd and 4th Quarters.	NDOH/NACS/ WHO
2022	2.3	Focus Area 4 and Indicator 7	Produce and disseminate annual STIs, HIV/AIDS M&E and surveillance report to include three-year trend (January 1 to December 31). Provide national, regional and provincial level comparisons with a specific focus on high burden provinces. Timeline and distribution: Finalized and disseminated by July 15 to external partners, RMO and PDCO.	Annual	3rd Quarter	NDOH/NACS/ WHO
2022	2.3	Indicators 9, 13, 14, 15, 16, 18, 19	Participate and provide data for Estimated Population Projection Activities	Annual	1st and 2nd Quarters	NDOH/UNAIDS /WHO
2022	2.2, 3.4	Indicators 9, 10, 11, 12, 14, 15, 16, 17.1, 17.2, 17.3, 28, 29, 30	Produce cascades for HIV, Syphilis and HIV ANC, and TB and HIV	Annual	1st and 2nd Quarters	NDOH/UNAIDS /WHO
2022	2.3, 3.4, 1.3	Focus Area 3, Indicators 3, 3.1, 3.2, 3.3, 4, 4.1, 4.2, 38, 39, 40	Monthly review of surveillance and logistic stock reports, KPMIS and HPDB data submissions	Monthly	Last Week of the Month	NDOH/PHO/KP Sites
2022	2.2	Focus Area 3, Indicators 5 and 6	Develop internal, provincial and facility DQA schedule.	Annual	1st Quarter	NDOH/WHO/C DC
2022	2.2	Focus Area 3, Indicators 5 and 6	DQA: April and September conduct internal audit; May and October conduct provincial audit; Two provinces per region; One province with report completion rate above 75% and; One province with report completion rate below 75%. Focus on ANC and; Three HPDB sites per region.	Annual	2nd, 3rd and 4th Quarters	NDOH/WHO/C DC

2022	2.2, 3.4, 3.5, 4.2	Focus Area 1, Indicator 37	Conduct Sentinel Surveillance: June 1 to August 31: Blood Banks and TB Sites and September 1 to November 30: ANC and STI Facilities. Report findings in 2022 annual report.	Annual	June 1 to August 31: Blood Banks and TB Sites and September 1 to November 30: ANC and STI Facilities.	NDOH/WHO/PHO/NACS/CPHL
2022	2.2, 3.1, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	Review all M&E and surveillance data collection instruments for modifications, usability.	Annual	2nd Quarter	NDOH/NACS
2022	2.1, 2.2	Focus Areas 1 and 3, Indicator 1	M&E Mentoring Visits to High Priority Provinces: Visits are geared for provincial level mentorship to increase M&E and Surveillance capacity.	Annual	2nd, 3rd and 4th Quarters	NDOH/PHO
2022	1.2, 3.1, 3.3, 3.4, 3.5	Focus Areas 1 and 3, Indicator 1	M&E and surveillance officers' collaborative meetings with provincial partners from STI, HIV/AIDS and TB sectors.	Semi-Annual	2nd and 4th Quarters	NDOH/PHO
2022	1.2, 3.1, 3.3, 3.4, 3.5	Focus Area 3	Produce 2023-2028 National STIs, HIV/AIDS Strategic Information Framework: To include outline and schedule of key surveillance activities and Costed work plan. Due by July 2022.	Once	2nd Quarter	NDOH/WHO/PHO/NACS
2022	2.1, 2.2	Focus Area 3	Create 2023 detailed work plan (July 1, 2022 completion date)	Annual	3rd Quarter	NDOH/NACS/WHO

7.2 Annex B: Costed M&E and Surveillance Work Plan 2018 – 2022

costed M&E plan benji final editing.xl

7.3 Annex C: Integrated HIV/AIDS & STIs Program Support and Supervision Checklist

DEPARTMENT OF HEALTH

INTEGRATED HIV & STI PROGRAM SUPPORT AND SUPERVISION CHECKLIST

FACILITY NAME: …… DATE:…./…../20…..

DISTRICT:…… PROVINCE:…….

Health services available/accessed at the health facility *(tick all appropriate)*

☐HIV Screening ☐HIV confirmation ☐ART satellite ☐ART parent

☐ Pediatric ART ☐ANC/Maternity/PNC ☐CD4 PIMA ☐CD4 Lab

☐STI Clinic ☐B Clinic (BMU) ☐GeneXpert/DSM ☐Viral Load

Names of the support and supervision team:

Full Name	Designation/tittle	Organization

INSTRUCTIONS

General instructions

This integrated support and supervision checklist is intended for use by all levels during health facility visits to assess implementation of the HIV/AIDS and STIs program. Although it provides a guide on the most critical issues that should be functional for the program to be a success it is not exhaustive. Regular support supervisory visits (at least once a quarter) are encouraged to improve the quality of HIV/AIDS and STIs service provision at health facilities.

Support and supervision is not a witch-hunting exercise. The overall goal is to help the health facilities deliver quality HIV/AIDS and STIs services to their patients. Engage the healthcare workers at the facility as much as possible and discuss how they can make improvements in their service delivery. Give clear information on recommendations of the national guideline so take time to familiarize yourself with it before the visit.

Completing the checklist

This checklist should be completed in triplicates. One copy is supposed to remain at the health facility visited. The other copy is kept at the provincial level while the last one is sent to NDoH HIV Surveillance Unit. Before filling out the checklist ask the officer responsible for HIV/AIDS and STIs at the health facility to provide you with all the registers, stock take booklets, HIV kits & laboratory commodities and reporting forms. In addition get copies of checklists completed in the previous support and supervision visits.

The checklist has various sections. If you are a big team, divide yourselves into smaller teams depending on your area of expertise or interest. Address the questions in the checklist and tick the most appropriate response. Put a comment where necessary to give more details on your response. Remember the main purpose of these questions is to guide you the supervisor on important issues that you must pay attention to. **DON'T RUSH TO JUST TICK THE BOXES.**

Once completed, fill the reports in triplicates and discuss your main findings and recommendations with the management and healthcare workers implementing the HIV/AIDS and STIs program. **DO NOT LEAVE THE FACILITY WITHOUT PROVIDING FEEDBACK.**

REVIEW OF RECOMMENDATIONS FROM THE PREVIOUS VISIT

Date of last visit:…../……./20…..

Recommendation	**Status** *(tick appropriate box)*	**Comments**
	☐Done ☐Partially Done ☐Not Done	
	☐Done ☐Partially Done ☐Not Done	
	☐Done ☐Partially Done ☐Not Done	
	☐Done ☐Partially Done ☐Not Done	
	☐Done ☐Partially Done ☐Not Done	

SECTION 1: HIV TESTING SERVICES

Objectives

1. To determine if healthcare workers are complying with the national guidelines for HCT
2. To assess the quality of HIV testing and linkage to care at the facility
3. To assess the stock status and supply chain issues for HIV testing commodities

Question	**Status** *(tick appropriate box)*	**Comment**
1. Does the counsellor provide adequate information to the client regarding the test process and obtain informed consent?	☐**Yes** ☐**No**	
2. Is confidentiality and privacy maintained?	☐**Yes** ☐**No**	
3. Is the client adequately counselled and prepared before and after receiving the HIV result?	☐**Yes** ☐**No**	
4. Does the counsellor provide adequate information on HIV prevention and risk reduction for a HIV NEGATIVE client?	☐**Yes** ☐**No** ☐**N/A**	
5. Does the counsellor provide adequate information and link/refer the HIV POSITIVE client to HIV confirmation, care and treatment services?	☐**Yes** ☐**No** ☐**N/A**	
6. Did the technician adhere to the recommended HIV testing procedure and properly label/document the test?	☐**Yes** ☐**No**	
7. Was due care taken by the technician and adequate infection control measures maintained during testing?	☐**Yes** ☐**No**	
8. Are complete and accurate records and registers for HCT maintained and updated at the facility?	☐**Yes** ☐**No**	

9. Does the facility have printed guidelines, job-aides and SOPs for HCT? Are HIV testing and PEP algorithm displayed?	☐**Yes** ☐**No**	
10. Was a monthly stock status for HIV testing commodities done? ****Inspect the booklet.***	☐**Yes** ☐**No**	

Additional comments:

SECTION 2: SEXUALLY TRANSMITED INFECTIONS

Objectives

1. To determine if healthcare workers are complying to the national STI management guidelines
2. To determine if the health facility maintains adequate stocks of laboratory and pharmaceutical supplies for management of STIs

Question	**Status** *(tick appropriate box)*	**Comment**
11. Is confidentiality and privacy maintained during treatment of STIs?	☐**Yes** ☐**No**	
12. Does the staff demonstrate awareness of STIs and their syndromic management including provision of key messages on safe sex practices/ condoms?	☐**Yes** ☐**No**	
13. Does the facility have the latest STI treatment guidelines, job-aides and SOPs? Are relevant posters displayed and pamphlets available?	☐**Yes** ☐**No**	
14. Is adequate counselling provided and contact tracing and partner treatment practiced?	☐**Yes** ☐**No** ☐**N/A**	
15. Are adequate infection prevention and control measures maintained in the STI clinic?	☐**Yes** ☐**No** ☐**N/A**	
16. Does the health facility have the monthly stock take report of drugs to treat STIs? ****check the stock status report booklet***	☐**Yes** ☐**No**	
17. Does the health facility maintain accurate and complete STI records? Are monthly reports (Surv-3) compiled and submitted on time?	☐**Yes** ☐**No**	

SECTIN 3: PREVENTION OF PARENT TO CHILD TRANSMISION OF HIV (PPTCT)

Objectives

1. To determine if the healthcare workers are complying with the national PPTCT guidelines of "Test-and-Treat" for pregnant and breastfeeding mothers.
2. To determine if healthcare workers are complying with the national guidelines for early infant diagnosis and ART prophylaxis in the exposed infant clinic.

Question	**Status** *(tick appropriate box)*	**Comment**
18. Do healthcare workers demonstrate correct knowledge and understanding of PPTCT to pregnant and breastfeeding women as recommended by the national guidelines?	☐**Yes** ☐**No**	
19. Are all pregnant and breastfeeding mothers being offered and tested for HIV (including repeat testing)?	☐**Yes** ☐**No**	
20. Are all pregnant and breastfeeding mothers who test HIV POSITIVE started on ART (Test-and-Treat) as per national protocol?	☐**Yes** ☐**No**	
21. Are all pregnant and breastfeeding mothers being screened and treated for STIs (syphilis etc.)?	☐**Yes** ☐**No**	
22. Are all HIV exposed infants having DBS collected and sent to the laboratory for EID?	☐**Yes** ☐**No**	
23. Are all HIV exposed infants being provided with ARV prophylaxis?	☐**Yes** ☐**No** ☐**N/A**	
24. Does the health facility have the sufficient stocks of pediatric HIV commodities (DBS for IED, ARVs and OI drugs)? Are	☐**Yes** ☐**No**	

month stock status reports done? ***check the stoke take booklet***		
25. Does the health facility have adequate supplies of laboratory commodities to screen for STIs?	☐**Yes** ☐**No** ☐**N/A**	
26. Does the health facility maintain accurate and complete PPTCT records? Are monthly reports compiled and submitted on time?	☐**Yes** ☐**No**	

Additional comments:

SECTION 4: HIV CARE AND TREATMENT

Objectives

1. To determine if healthcare workers are complying with national ART guidelines in the care and treatment of both adults and children living with HIV.
2. To assess how PLHIV on ART are being monitored and supported during treatment
3. To evaluate how TB/HIV collaborative activities are being implemented at the health facility
4. To determine how ARV and OI drugs and supplies are being managed at the health facility

Question	**Status** *(tick appropriate box)*	**Comment**
27. Do healthcare workers demonstrate correct knowledge and understanding of how to start ADULTS on first line ART regimen as recommended by the national guidelines?	☐**Yes** ☐**No**	
28. Do healthcare workers demonstrate correct knowledge and understanding of how to start PEDIATRICS on first line ART regimen as recommended by the national guidelines?	☐**Yes** ☐**No** ☐**N/A**	
29. Are all PLHIV being put on co-trimoxazole prophylaxis	☐**Yes** ☐**No**	
30. Are the healthcare workers able to identify the common adverse drug reactions (ADRs) associated with first line ART drugs and how to manage them? Are the ADRs being reported?	☐**Yes** ☐**No**	
31. Are the healthcare workers documenting correctly in both the clinic book and registers in the ART clinic?	☐**Yes** ☐**No**	
32. Are patients on ART being monitored adequately with routine CD4 count and/or Viral Load as recommended by the national guideline?	☐**Yes** ☐**No**	

33. Are measures in place to identify patients that lost to follow up/missing appointments early?	☐**Yes** ☐**No**	
34. Is the enhanced adherence package being provided to patients that have poor adherence and/or failing on ART?	☐**Yes** ☐**No**	
35. Are patients that have failed on first line ART being switched to second line ART as recommended by the national guideline?	☐**Yes** ☐**No**	
36. Are ART services provided in a friendly patient-centered environment where human rights are respected and guarantees patient privacy plus confidentiality?	☐**Yes** ☐**No**	
37. Are all PLHIV screened for TB using the symptom based screening tool at every contact with a HCW?	☐**Yes** ☐**No**	
38. Are all eligible newly registered PLHIV being initiated on INH prophylaxis as per national guideline?	☐**Yes** ☐**No**	
39. Does the health facility maintain sufficient stocks for all HIV commodities? Are monthly stock update done regularly? ****check the stock update booklet***	☐**Yes** ☐**No**	

Additional Comments

……

……

……

……

……

SECTION 5: INTERVENTIONS FOR KEY POPULATIONS

Objectives

1. To assess the quality of TB, HIV/AIDS and STIs prevention, care and treatment services available for key populations (FSW, MSW, TG and MSM) at the health facility
2. To determine how interventions for key populations at the health facility are being recorded and reported

Question	Status *(tick appropriate box)*	Comment
40. Does the health facility provide the enhanced package service for key populations? Are condoms and lubricants being distributed at the health facility? ***If NO or NA move to section 6***	☐**Yes** ☐**No** ☐**N/A**	
41. Are KPs being screened for TB and those negative provided with TB preventive therapy (IPT)?	☐**Yes** ☐**No**	
42. Are KPs being screened and treated for STIs?	☐**Yes** ☐**No**	
43. Are the services for KPs provided in an environment that respects human rights, minimizes stigma and discrimination as well as guarantee patient privacy and confidentiality?	☐**Yes** ☐**No**	
44. Are interventions for KPs being recorded appropriately (using NUIC) in registers/log books and reported in the KPMIS? ***Verify that the data is available and up to date on KPMIS.***	☐**Yes** ☐**No**	

*****COMPLETE ANNEX A FOR KEY POPULATIONS*****

Annex A_Key Pupulations Data.xls

SECTION 6: HIV/STIs LABORATORY QUALITY MANAGEMENT

Objectives

1. To determine if appropriate high quality HIV and STI laboratory tests are being provided at the health facility.
2. To assess the quality assurance measures that are in place at the laboratory
3. To determine if there are any supply chain issues for laboratory commodities for HIV, TB and STIs

Question	**Status** *(tick appropriate box)*	**Comment**
45. Are stock cards for rapid HIV test kits maintained? Does the facility have adequate rapid HIV test kits available and stored appropriately?	☐**Yes** ☐**No**	
46. Does the health facility have adequate supplies of laboratory commodities for STIs?	☐**Yes** ☐**No** ☐**N/A**	
47. Has the laboratory at the facility recently participated in an External Quality Assurance and performed adequately?	☐**Yes** ☐**No** ☐**N/A**	
48. Does the facility have access to a functional CD4 count machine?	☐**Yes** ☐**No**	
49. Are patients at the facility having viral loads done (DBS/ Whole blood/GeneXpert etc.)?	☐**Yes** ☐**No**	
50. Does the facility have access (on-site/using a courier) to a functional microscopy center and/or GeneXpert for the diagnosis of TB?	☐**Yes** ☐**No**	
51. Are appropriate laboratory procedures being adhered to when any tests for TB and/or HIV are being done?	☐**Yes** ☐**No**	

SECTION 7: QUALITY ASSUARNCE

Objectives

1. To determine if the health facility is implementing any quality improvement activities in their service provision

Activity	**Score** *(Rate the facility between 1 – 5)*
52. To what extent does clinic/hospital management create an environment that supports a focus on improving the quality HIV and STI services provided at the facility?	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**
53. To what extent does the health facility have an effective quality improvement committee to oversee, guide, assess and improve the quality of services?	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**
54. To what degree does the health facility have a comprehensive quality improvement (QI) plan that is actively utilized to oversee QI activities?	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**
55. To what extent are clinicians and staff routinely implementing QI activities and provided training to enhance knowledge, skills and approaches needed to fully implement QI work on an ongoing basis?	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**
56. To what extent dose the health facility routinely measure performance and use of data for improvement?	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**
57. To what extent are patients effectively engaged and involved in the HIV Quality Management Plan?	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**
58. To what extend does the HIV program monitor patient outcomes and utilize data to improve Patient care.	☐**1** ☐ **2** ☐**3** ☐**4** ☐**5**

Additional Comments

……

……

……

……

……

……

……

……

SECTION 8: MONITORING AND EVALUATION

Objectives

1. To make an assessment of the recording and timely reporting of data on HIV and STIs to the NDoH
2. To determine the performance health facility on key coverage indicators for GF
3. To mentor the facility on how to complete the reporting forms and submit then on time.

Question	**Status** *(tick appropriate box)*	**Comment**
59. Is documentation in the health facility registers being done completely and accurately?	☐**Yes** ☐**No** ☐**N/A**	
60. Does the health facility manager review and discuss the report before submitting it?	☐**Yes** ☐**No**	
61. Does the facility properly compile monthly reports (Surv-1, Surv-2, Surv-3 and Surv-4) and submit them on time?	☐**Yes** ☐**No** ☐**N/A**	
62. Does the facility have sufficient recording and reporting tools?	☐**Yes** ☐**No**	

*****Go through all the recording and reporting forms with the health staff and show them how to complete them correctly. Remind them of the deadlines for submission and how they should send them. Also remind them about the importance of reporting on time.***

******COMPLETE THE DQA TOOL ANNEX B*****

Annex B_Data Quality Audit Tool.xl

Further comments:

.....

.....

.....

.....

.....

.....

TRAINING NEEDS ASSESSMENT

Please indicate the relevant training needs for the respective healthcare workers

	# Total in post currently	**PICT**	**PPTCT**	**EID/ DBS**	**IMAI**	**STI**	**Logistics and Supply Chain training**	**GeneXpert**	**STI/HIV & Care & Treatment Refresher**	**Surveillance M&E**	**TB/HIV**
Doctors											
HEOs											
Nursing Officers											
CHWs upskilled to in maternity care											
CHWs											
Counsellors											
Laboratory staff											

Additional comments on training needs/gaps/challenges identified:

……

……

……

……

……

……

RECOMMENDATIONS AND WAY FORWARD

RECOMMENDATION	RESPONSIBLE PERSON	TIMELINE

7.4 Annex D: TB Program Support and Supervision checklist

Instruction to fill the Supervisory Check List for TB Control Programme (NDOH)

- Every health center delivering TB services should be supervised regularly (every quarter)
- A copy of the supervisory check list from the previous quarter should be carried along for every visit
- A copy of the latest quarterly report of the health center that was submitted to the NTP if available should be carried- *but not mandatory if unavailable*
- This Supervisory checklist has **X(Ten)** Sections
- The completed checklist needs to have three copies;
    - *One for the BMU*
    - *One copy for the PDCO*
    - *One copy for the NTP*
- **Before filling up the check list ask the officer responsible for TB at the health center for:**
    1. *TB Suspect/ Presumptive TB Register*
    2. *Laboratory Register*
    3. *TB Register*
    4. *TB Treatment Cards*
    5. *MDR-TB Register*
    6. *MDR-TB Treatment Cards*
- **Section I: Case finding and diagnosis:**
- *Review TB suspect/ presumptive TB register, laboratory register, TB register and triangulate the data in these documents*
- *For bigger health centers, choose random one month data from last quarter to triangulate the data*
- *For smaller health centers with low caseloads, use last quarter data for the triangulation*
- **Section II: Contact tracing and IPT initiation:**
- *Review initial contact tracing form and IPT register and review all last quarter data*
- **Section III: Treatment initiation and follow up:**
- *Review TB register and treatment card*
- *For bigger health centers, choose random one month data from last quarter for comparison*
- *For smaller health centers with low caseloads, use last quarter data for comparison*
- *Choose minimum 10 random treatment cards for assessing diagnosis and treatment delays, DOT and sputum follow ups*
- **Section IV: DRTB diagnosis and management:**
- *Review presumptive TB register, laboratory register, MDR Register and the MDR treatment cards*
- *Use all last quarter data for the MDR-TB*
- **Section V: TB/HIV collaborative activities:**
- *Visit the HIV unit usually called the white house at the provincial level or equivalent at the BMUs for HIV/TB data*
- *Check treatment cards tally with the same records on TB register for TB/HIV co-infection and management in the last quarter*

- **Section VI: Infection control:**
  - *Observe environment at the OPD, TB and MDR-TB wards, DOTS chambers and laboratory*

- **Section VII: Supplies:**
  - *Visit the drug store and physically count all the FLD and paediatric TB medicine **patient boxes** and **SLD doses** and compare with number of all types of patients (DS-TB adult, paediatric cases and MDR TB cases from the TB/MDR registers and TB/MDR treatment cards*
- **Section VIII: Patient follow up and retrieval:**
  - *Choose 20 random treatment form the last quarter treatment card lot and check missed doses and retrieval activities*
  - *Describe the loss to follow up (LTFU) tracing mechanism*
- **Section IX: Staff Positions and Training for TB-Related Activities:**
  - *This section needs to be filled every year OR whenever there is an update in TB related staff position and training*
- **Section X: Observation, problem identification and recommendations:**
  - *Write in clear bullet points key observation (strength), identified main problems and their causes and recommendations*

- **Before starting to fill up the Supervisory check list, note the following:**

No. of visits by NDoH NTP unit in last year (dates if available): ……

No. of visits by Provincial TB team (PDCO or TB coordinator) in last six months:……

Is there a copy of the quarterly report that is just submitted (share a copy)……..

Priority issues from the last supervisory visit: *(this could be filled up from the previous report prior to the visit)*
Status of follow up on the issues from the last visit:

Supervisory Checklist for TB Unit, NDOH

Name of Centre: _____

Name of district: _____Name of Province: _____

Is this only BMU: ☐ or BMU–with-Microscopy Centre ☐

Name of OIC of health facility _____

Catchment population: _____

Average monthly AOPD (adult outpatient attendance): _____

I.	**Case finding and diagnosis:** *Review TB suspect (Presumptive TB register) and TB laboratory Register*	**Y**	**N**
I (a)	***Case Finding:***		
1	Is there OPD register maintained at the health center?		
2	If yes, number of adult (15 yrs or more) population recorded for the last quarter? (a)		
3	Is a presumptive TB register (TB suspect register) maintained at the facility?		
4	If yes, number of presumptive TB registered in the previous quarter? (b)		
5	Are all presumptive TB case mentioned in the presumptive TB register tested for sputum microscopy or GeneXpert as indicated?		
6	Are the results of the sputum smear microscopy/GeneXpert written in the presumptive TB register?		
7	Does the patient record in the presumptive TB register and the Laboratory register match?		
8	*Choose random 10 smear positive cases from laboratory register and compare with the presumptive TB register and check the diagnosis turnaround time:* Sum of number of days taken from the time of sending sample till the reported date /10		
9	**Comments:**		
I (b)	***Diagnosis:***		
1	*Do other BMUs refer samples to this BMU with Microscopy? If yes, how many?*		
2	If the BMU does not have laboratory, where are the samples sent?		
3	***Describe sample transport and result tracking mechanism followed:***		
4	Number of microscopes?		
5	Are/ Is the microscope/s functioning well and serviced on time?		
6	Is there GeneXpert machine in the health center? How many?		

7	Is the laboratory register filled with correct information as required?		
8	Number of presumptive TB case examined by Microscopy in the last quarter? (c)		
9	Number of presumptive TB case examined by GeneXpert in the last quarter? (d)		
10	Number of presumptive TB cases registered and tested in the laboratory? (e) = (c+d)		
11	Number of not tested for bacteriology (f)		
12	Number of Smear-positive cases among tested? (g)		
13	Number of Genexpert-positive cases among tested? (h)		
14	Number of bacteriologically confirmed cases among the tested? (i)= (g+h)		
15	Total number of positive slides in the last quarter (j)		
16	Total number of slides examined in the last quarter (k)		
17	How many of the above (d) are MTB detected by GeneXpert (T)?		
18	How many of the above (d) are R- resistant by GeneXpert (RR)?		
19	Number of R-resistant samples sent to CPHL for shipment for DST?		
20	What is the average CDST turnaround time of results from the SRL? *No.* of weeks taken X *all samples sent for CDST* / total samples sent in the last six months		
21	Are slides sent for external quality control according to national guidelines?		
22	Was there regular supervisory visit from the (CPHL) undertaken? if so, how often?		
23	Any feedback from the CPHL with the last date of feedback?		
24	Frequency of panel testing by the CPHL?		
25	Date of last panel test/ EQA and result?		
	Comments:		
II.	**Contact tracing and IPT initiation:**		
1	Is contact tracing being done in the health center for all contacts of bacteriologically confirmed cases?		
2	Is the initial contact investigation register maintained at the health center?		
3	Is the IPT register maintained at the health center?		
4	Number of contacts identified in the last quarter?		
5	Number of contacts traced in the last quarter?		
6	Number of contacts under 5 yrs traced in the last quarter?		
7	Number of adult TB cases identified among the contacts in the last quarter?		
8	Number of children under 5 yrs TB cases identified among the contacts in the last quarter?		

9	Number of children under 5 yrs eligible for IPT? (l)		
10	Number of children under 5 yrs put on IPT in the last quarter? (m)		
11	Are there any relevant IEC materials with TB information available and displayed?		
12	How many TB advocacy or education campaign carried out in the last quarter?		
	Comments:		
III.	**Treatment initiation and follow up:** *Review TB register and treatment cards of the quarter that just completed*		
1	Are all TB cases registered in the TB register with appropriate details		
2	Does each registered TB patient have a treatment card?		
3	Is each patient on correct treatment regimen as per national standard?		
4	*Compare TB laboratory register with the treatment card:* Has the sputum results been correctly recorded in the TB register as well as in the treatment card?		
5	Number of Bacteriologically confirmed cases (smear positives plus GeneXpert positive cases) registered for treatment in the last quarter		
6	Number of clinically diagnosed pulmonary cases registered in the last quarter?		
7	Number of Extra-Pulmonary cases registered in the last quarter?		
8	Number of paediatric cases (<= 14 years) registered in the last quarter?		
9	Total number of all forms TB cases under DOT by the health center or DOT provider? (n)		
10	Total number of all forms TB registered and started on treatment in the last quarter? (o)		
11	*Choose 10 random treatment cards and check the following:*		
12	*Compare date of diagnosis and date of start of treatment for each patient and calculate average delay in start of treatment after diagnosis in no. of days:* Sum of delay in number of days/10		
13	Is DOT on each treatment card recorded correctly every day/ monthly for the quarter that just completed?		
14	*See 10-20 random treatment cards from the same quarter of the previous year and check the following:* Are smear positive patients undergoing sputum examination at 2 months?		
15	Are smear positive patients undergoing sputum examination at 5 months?		

16	Are smear positive patients undergoing sputum examination at the end of treatment?		
17	For each patient who has completed treatment, is the information on treatment card sufficient to determine appropriate treatment outcome?		
	Comments:		
IV.	**DRTB diagnosis and management:** *Check the presumptive TB register, laboratory register, TB register, MDR eligibility register MDR TB register and MDR TB treatment card*:		
1	Are previously treated patients receiving GeneXpert as a preferred diagnostic?		
2	Are patients smear positive at 3 or 5 months of treatment receiving GeneXpert?		
3	Are all contacts of DR TB receiving GeneXpert as preferred diagnostics?		
4	Total Number of DR-TB (RR) cases identified by GeneXpert in the last quarter? (p)		
5	Total number of MDR TB cases confirmed by C/DST in the last quarter? (q)		
6	Total number of DR TB on treatment currently?		
7	Total number of XDR TB currently?		
8	Total number of DR TB cases enrolled on SLD treatment in the last quarter?(r)		
9	Are all DR TB cases put on DR regimen as per National Standard?		
10	Are all DR TB cases registered in the MDR register?		
11	Is DOT for DR TB cases provided and recorded on the treatment card appropriately?		
12	Are sputum follow up for TB done regularly as per schedule reflected in Treatment card and register?		
13	Is adverse drug reaction identified, recorded, managed and reported on time		
	Comments:		
V.	**TB/HIV collaborative activities:**		
1	*Visit the HIV unit (white house or equivalent) and find:*		

	Number of registered HIV cases?		
2	Are all HIV cases receiving TB screening as a part of HIV service package?		
3	Are all HIV cases who are screened and not found to have TB receiving six months IPT as HIV service package?		
4	*Check TB treatment cards and tally with the same records on TB register for the last quarter* Have all TB patients been tested for HIV?		
5	Number of TB cases tested for HIV in the last quarter? (s)		
6	Number of TB cases who are tested (s) and found to be HIV positive? (t)		
7	Number of TB/HIV co infected cases (t) on CPT?		
8	Number of TB/HIV co infected cases on (t) ART? (u)		
	Comments:		
VI.	**Infection control:** *Observe the following at the OPD and wards:*		
1	At the entrance to OPD, is there signs asking adults with cough to inform nurse or doctor?		
2	Is there a triage system to identify patients with cough to be seen at the earliest?		
3	Do patient with cough wait outside in a separate area from other patients?		
4	Is there good ventilation (open windows, exhaust fan, etc) in the patient waiting area?		
5	Is the ventilation good in the OPD and DOTS chambers?		
6	Is the sputum collection area outside with good ventilation and away from crowd?		
7	Are N95 masks being used by staff and visitors of the MDR areas including MDR TB wards?		
8	*Observe the Laboratory environment*: Does the laboratory have a good air flow with cross ventilation?		
9.	Are the work areas, slides and supplies well organized and cleaned regularly?		
10	Are used sputum containers and other used supplies managed according to appropriate biosafety and safe hazardous-waste disposal procedures?		
	Comments:		
VII.	**Supplies:**		
VII(a)	***Anti-TB Medicines:*** *Check drug store and check the following:*		

1	Are the anti-TB medicines stored in cool place with temperature control?		
2	Availability of cupboard for storage of TB medicines?		
3	Is FEFO (First-Expired, First-Out) being followed?		
4	*Count the number of patient under treatment currently (no. of treatment cards) and compare with the number of patient drug boxes:* Are patient boxes of anti-TB medicines adequate for number of patients under treatment (FLD)?		
5	Number of available buffer stock patient boxes?		
6	Number of available patient boxes for pediatric cases? Does it match the registered pediatric cases?		
7	Number of patient doses for MDR TB patients?		
8	Buffer stock available? How many patient boxes for DS-TB and peads. TB and how many doses of 2nd line treatment buffers available?		
9	Any stock out of anti-TB medicines in the last one month? (v)		
10	Any expired drugs in the center if so- how much?		
VII(b)	***Laboratory Reagents:***		
1	Are all laboratory reagents available currently		
2	Any stock out of laboratory reagents in the last one month? (w)		
3	Number of Xpert cartridge available at the center?		
	Comments:		
VIII.	**Patient follow up and retrieval:** *Choose 20 random treatment cards and check:*		
1	Number of patients have missed doses during last month (did not turn up for DOT or failed to collect supplies)		
2	Number of patients who were given non-supervised TB medicines?		
3	Number of community DOT providers who work for this BMU? (l)		
4	Number of community DOT providers (l) who have received training/ orientation on NTP guidelines?		
5	Number of defaulters retrieved at this BMU during last month?		
6	***Describe the defaulter/ Loss to follow up (LTFU) tracing mechanism in bullet points :***		

IX. Staff Positions and Training for TB-Related Activities (*Fill this only once a year or when there are changes in staffing pattern only)*

Category of staff involved in NTP activities	No. of positions sanctioned (a)	Of them (a), number of positions filled	Of them (a), number trained in NTP in the	Total trained in NTP in the previous 3 years	Remarks/Notes

			previous 12 months		

Any comments on the HR issues:

X. Observation, problem identification and recommendations:

Observations (strengths) from this supervisory visit: (three to 5 bullet points as per priority)

Describe problems identified during this visit: (three to 5 bullet points as per priority)
Actions and recommendations: (five to 7 bullet points as per priority)

_____

Signature of facility in-charge

Name: _____

Designation: _____

Place: _____

Date: _____

_____

Signature of visiting officer

Name of officer filling this _____

Designation: _____

Place: _____

Date: _____

7.5 Annex E: Data Quality Audit tool

DQA Tool.xls

7.6 Annex F: KPMIS reporting tool

KPMIS tool_v1.0.xls

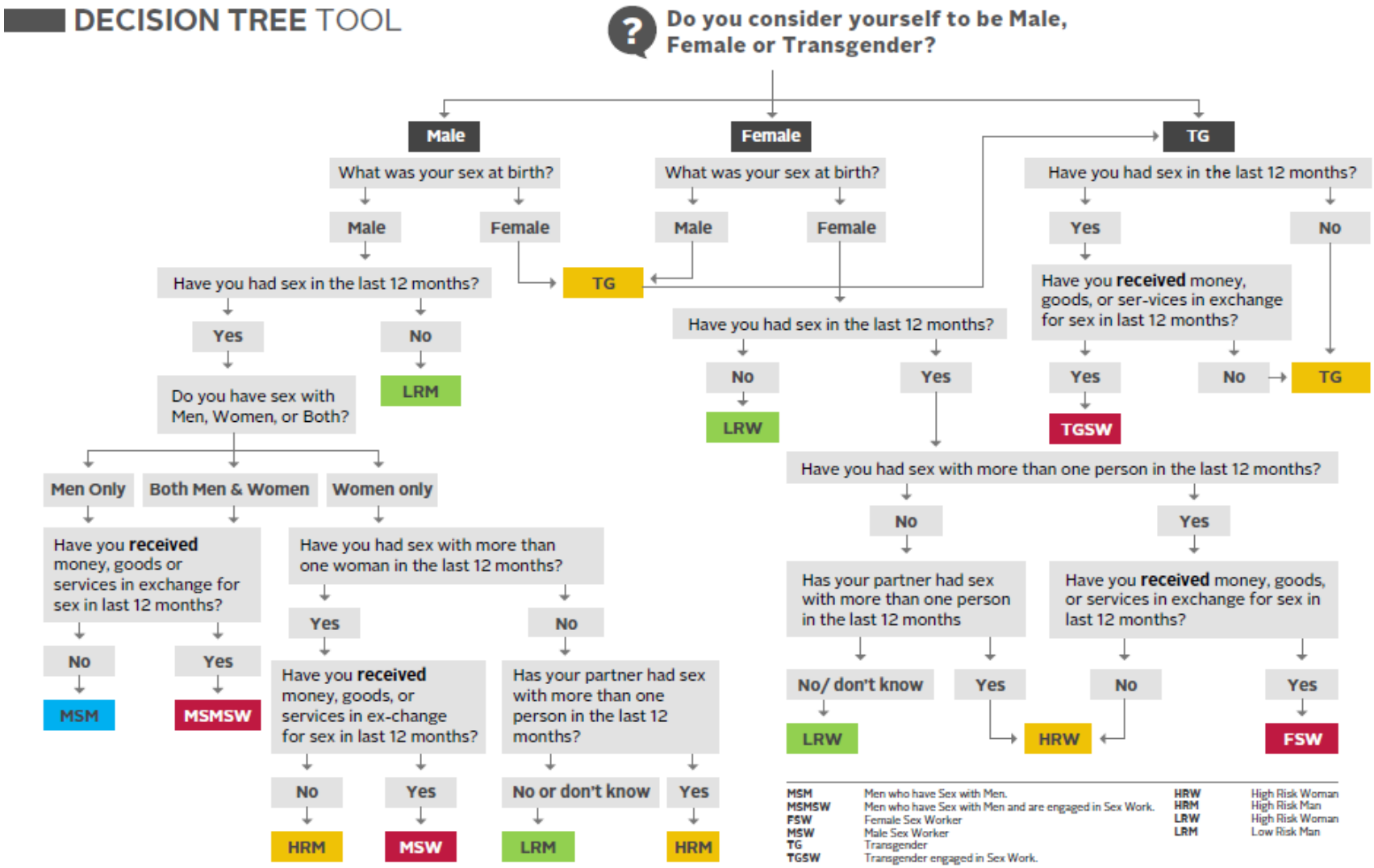
7.7 Annex G: Surv1 form

SURV 1_revised_final.xlsx

7.8 Annex H: Surv2 Form

Surv 2 Revised_final.xlsx

7.9 Annex I: Key Population Decision tree



7.10 Annex J: National Key Population types and Definitions

NAME	DEFINITION
Sex worker	Sex workers include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services on a regular or occasional basis. Sex work is consensual between adults, can take many forms, and varies in the degree to which it is formal and organised and the degree to which it is criminalised or is tolerated despite being illegal.
Men who have Sex with Men	Refers to all men who engage in sexual and/ or romantic relations with other men. The words "Men" and "sex" are interpreted differently in different cultures and societies and by the individuals involved. This term encompasses the wide variety of settings and contexts in which male to male sex takes place, regardless of the motivation for engaging in sex, self -determined sexual and gender identity, and identification with specific communities or social groups.
Transgender	Transgender is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender male, transwomen or transmen, transsexual or in specific cultures, as palopa, mahu, fa'a fafine and Fakaleiti (Pacific) or one of the may transgender identities. They may express their gender in a variety of masculine, feminine, and /or androgynous ways.
Minimum Service Package	MSP is defined as a package of minimum three services including: **i.** HIV and STI awareness, and BCC **ii.** Male/female condom promotion, demonstration or negotiation skills; **plus:** **iii.** Referrals or follow up for HTC and/or STIs treatment; **or** **iv.** Referral for or follow up or ART adherence counselling.
Beneficiary	KP client registered with a National Unique Identification code (NUIC).
In-Active client	KP client registered with NUIC but not delivered any service by PE for 6 successive attempts over the past 6 months.
Active client	KP client registered with NUIC excluding those whose status is dead, moved or inactive.
Re-active client	An inactive client returned to active status by the PE and verified by the Junior Project Officer.
New client	A new client identified by the PE and verified by the Junior Project Officer.

7.11 Annex K: KP Dictionary

Data element name	Definition	Disaggregation	Calculation of data element	Data source	Reporting Tool
Number of key populations reached with two contacts. (Include KP definitions/KP1/2 category) – refer to WHO doc	**Numerator:** Number of registered people from key populations (as identified by NUIC) contacted **at least once a fortnight** (**equivalent to 2 times a month**) and provided with a Minimum service package. Count only who received a minimum service package(MSP)	Sex: Male, Female and TG KP type: SW, MSM, TG or PLHIV	Direct count from data source	Daily Diary, Referral slips, NUIC database	Outreach monthly report, Output indicator report
Number of key populations contacted with MSP once in a month	**Numerator:** Number of registered people from key populations (as identified by NUIC**) contacted at least once a month** and reached with any three of the following services (including i and ii plus either iii or iv) delivered at the time of contact, during the reporting period. Count only who received a minimum of three services (MSP)	Sex: Male, Female and TG KP type: SW, MSM, TG or PLHIV	Direct count from data source	Daily Diary, Referral slips, NUIC database	Outreach monthly report, Output indicator report
Number of key population referred for HIV testing and counselling	**Numerator:** Number of people from KPs referred for HIV counselling and testing services during the reporting period Count all those who were issued referral slips for HIV counselling and testing whether or not the referral was successful.	Sex: Male, Female and TG KP type: SW, MSM.TG or PLHIV	Direct count from data source	Daily Diary, Referral slips, NUIC Database	Outreach monthly report, Output indicator report
Number of people from key populations successfully referred for HIV testing.	**Numerator:** Number of people from KPs completed referral for HIV counselling and testing services during the reporting period. Count only those who (i) accessed pre-test counselling OR (ii) accessed pre-test counselling and received HIV testing services OR	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Direct count from data source and verification of referral slips	Daily Diary, Referral slips, NUIC Database	Outreach monthly report, Output indicator report

	(iii) accessed pre-test counselling and received HIV testing services and post- test counselling				
Number of people from key populations tested for HIV and know their status.	**Numerator:** Number of people from KPs who received HIV counselling and testing and know their test results during the reporting period. Count only those that accessed pre-test counselling, testing and post-test counselling services. Including referrals and walk in clients.	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Merging of prevention and Health database using NUIC Direct count from data source	National/Clinic HCT log book Clinic Monthly summary forms	National Surveillance form SURV 1&SURV 4, Output indicator report
Number of people from key populations referred for ART	**Numerator:** Number of HIV positive KPs who were referred for Antiretroviral Therapy (ART) services. **ART** refers to long-term therapy with ARV triple regimen primarily to improve the health status of the individual on treatment according to national guidelines. Count all HIV positive KP individuals who were issued referral slips for ART whether or not the referral was successful (i.e. completed the referral by accessing the service). Count all those who received HIV testing and are to be followed up for ART initiation.	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Merging of prevention and Health database using NUIC	Daily Diary, NUIC database Clinic monthly summary forms	Outreach monthly report, Output indicator report
Number of HIV positive KPs referred for resumption of ART during the reporting period.	Count all those defaulted, missed the appointments and loss to follow up cases issued referral slips for return to ART services.		Direct count from the referral slips and clinic records.	Daily Diary, NUIC database Clinic monthly summary forms	
Number of people from key populations receiving ART at your facility (applicable to DFAT supported clinics)	**Numerator:** Number of registered HIV positive individuals who are alive and still active on (receiving) ART at the end of the reporting period. Count all PLHIV who are still receiving ARVs irrespective of when they started ART excluding those who have stopped treatment for any reason, dead, loss to follow up	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Merging of prevention and Health database using NUIC	National/Clinic ART register Clinic monthly	National Surveillance form SURV 2, Output indicator report

	or transferred out to another ART clinic. The count should include those who transferred from other clinics to continue ART in the reporting clinic.			summary forms	
Number of people from key populations referred to STI services.	**Numerator:** Number of people from KPs referred for STI related services during the reporting period. STI (Sexually transmitted Infections) services include screening, diagnosis and treatment or follow up. Count all those who were issued referral slips for STI services, whether or not the referral was successful (i.e. completed the referral by accessing any of the STI related services). KPs referred for HCT should not be counted here unless they also received referral for STI services.	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Merging of prevention and Health database using NNUIC	Daily Diary, Referral slips, NUIC Database Clinic summary forms	
Number of people from key populations successfully referred to STI services.	**Numerator:** Number of people from KPs referred for STI services who accessed services during the reporting period. Count all those who accessed STI (Sexually Transmissible Infections) services (i)screening, (ii) diagnosis, (iii) treatment Follow up. KPs tested HCT should not be counted here unless they also received STI testing.	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Merging of prevention and Health database using NUIC	Clinic STI register Clinic summary forms	
Number of people from key populations provided with counselling for sexual assault.	**Numerator:** Number of people from KPs who received counselling support following Sexual Assault during the reporting period. **Sexual Assault** (a subcategory of sexual violence) refers to the use of physical or other force to obtain or attempt sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object.	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Direct count from data source	Counselling service provider register. Occurrence form Daily diaries	Output indicator report

	Count only KPs who were referred and received counselling from the Gender Based Violence counselling service provider.				
Number of people from key populations provided with PEP for sexual assault/violence and other purposes	**Numerator:** Number of people from KPs who received post exposure prophylaxis (PEP) for HIV following potential exposure to HIV through sexual violence. Count only people from KPs initiated on PEP following an incident of sexual violence. Others include occupational hazard other related risks	Sex: Male, Female and TG KP: SW, MSM.TG or PLHIV	Direct count from data source	PEP Register/FSC service register. Occurrence Form Daily diaries	Output indicator report
Number of people from key populations referred to police for GBV	**Numerator:** Number of people from KPs referred to Police during the reporting period following GBV. **GBV** is an umbrella term for any harmful act that is perpetrated against a person's will based on socially ascribed (gender) differences between males and females. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices, including forced, early marriage. Count all KPs who were referred to the police following an incidence of GBV, whether or not the referral was successful (i.e. completed the referral by lodging a complaint with the police).	Sex: Male, Female and TG	Direct count from data source	Family Sexual Violence Unit (FSVU) services register. Occurrence Form Daily diaries	Output indicator report
Number of people from key populations referred to legal assistance for GBV	**Numerator:** Number of people from KPs referred to PNGDLA or any other authorised agency for Legal assistance following GBV during the reporting period. Count all people from KPs who were referred to the police following an incidence of GBV, whether or not the referral was successful (i.e. completed the referral by contacting a legal services unit).	Sex: Male, Female and TG	Direct count from data source	FSC service register/Legal services register/ PNGDLA	Output indicator report

Number of HIV testing sites	**Numerator:** Number of accredited clinics providing HCT services to KPs according to National Guidelines and HIV testing algorithm. Count only clinics that have received accreditation from the NDoH to provide HTC services.	Not applicable	Simple	Facility list of register.	Output indicator report
Number of STI treatment sites	**Numerator:** Number of accredited clinics providing STI services to KPs according to National STI Guidelines. Count only clinics that have received accreditation from the NDoH of Health to provide STI services.	Not applicable	Simple count of facilities that met the criteria.	Facility list of register.	Output indicator report
Number of lubricants distributed to KPs	Numerator; Count all lubricants distributed by peers in one to one contact during outreach with registered beneficiaries and at condom outlets set up at hotspots. Exclude condoms distributed at one to group awareness sessions.	lubricants	Direct count from data source	Daily Diary, NUIC database	
Number of condoms distributed to KPs	**Numerator**: Count all condoms distributed by peers in one to one contact during outreach with registered beneficiaries and at condom outlets set up at hotspots. Exclude condoms distributed at one to group awareness sessions	Type of condoms: Male and female	Direct count from data source	Daily Diary, NUIC database	Output indicator report
Number of condoms distributed to general population	**Numerator:** Number of male and female condoms distributed during one to group awareness sessions to general population. Include condoms distributed through condom outlet at clinics.	Type of condoms: Male and female	Direct count from data source	Condom distribution report	Output indicator report
Number of condom demonstrations for KPs	**Numerator:** Number of condom demonstration sessions conducted by Peer Educators during one to one contact.	Type of condoms: Male and female	Direct count from data source	Daily Diary, NUIC database	Output indicator report