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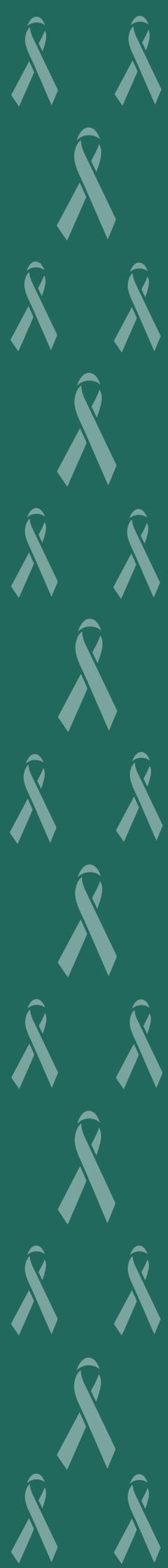
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## United Nations General Assembly Special Session on HIV/AIDS

### Monitoring the Declaration of Commitment on HIV/AIDS

# GUIDELINES ON CONSTRUCTION OF CORE INDICATORS

July 2005



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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC(s)	Antenatal Clinic(s)
API	AIDS Programme Effort Index
BSS	Behavioural Surveillance Survey
CCA	Common Country Assessment
CRIS	Country Response Information System
DAC	Development Assistance Committee
DHS	Demographic and Health Survey
EC	European Community
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IDU(s)	Injecting Drug User(s)
ILO	International Labour Organization
MICS	Multiple Indicator Cluster Survey
NA	Not Applicable
NAC(s)	National AIDS Committee(s)
NAP	National AIDS Programme
NAS	HIV/AIDS National Spending Assessment
NGO(s)	Nongovernmental Organization(s)
NIDI	Netherlands Interdisciplinary Demographic Institute
NSP	National Strategic Plan
OECD	Organisation for Economic Co-operation and Development
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Papers
SPA	Service Provision Assessment
STD(s)	Sexually Transmitted Disease(s)
STI(s)	Sexually Transmitted Infection(s)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

# Introduction

## Purpose

The primary purpose of this document is to provide key constituents, who are actively involved in an individual country's response to HIV and AIDS, with essential information on core indicators that measure the effectiveness of the national response. These guidelines will also help ensure the transparency of the process used by national governments and UNAIDS to prepare progress reports on implementation of the UNGASS *Declaration of Commitment on HIV/AIDS*.

Countries are strongly encouraged to integrate the core indicators into their ongoing monitoring and evaluation activities. These indicators are designed to help countries assess the current state of their national response while simultaneously contributing to a better understanding of the global response to the AIDS pandemic, including progress towards meeting the *Declaration of Commitment* targets. Given the parallel applications of the indicators, the guidelines in this document are designed to improve the quality and consistency of data collected at country level, which will enhance the accuracy of conclusions drawn from the data at both regional and global levels.

This document also includes an overview of global indicators that will be used by UNAIDS and its partners to assess key components of the response that are best measured on a worldwide basis.

## Background

At the close of the groundbreaking United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, 189 Member States adopted the *Declaration of Commitment on HIV/AIDS*. The *Declaration of Commitment* reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015.

Recognizing the need for multisectoral action on a range of fronts, the *Declaration of Commitment* addresses global, regional and country-level responses to prevent new HIV infections, expand health-care access and mitigate the epidemic's impact. Although it was governments that initially endorsed the *Declaration of Commitment*, the document's vision extends far beyond the governmental sector—to private industry and labour groups, faith-based organizations, nongovernmental organizations and other civil-society entities, including organizations of people living with HIV.

Under the terms of the *Declaration of Commitment*, success in the response to AIDS is measured by the achievement of concrete, time-bound targets. The *Declaration* calls for careful monitoring of progress in implementing agreed-on commitments and requires the United Nations Secretary-General to issue progress reports annually. These reports are designed to identify problems and constraints and recommend action to accelerate realization of the *Declaration's* targets.

In keeping with these mandates, in 2002 the UNAIDS Secretariat collaborated with UNAIDS Cosponsors and other partners to develop a series of core indicators to measure progress in implementing the *Declaration of Commitment*. The core indicators were grouped into four broad categories: (i) national commitment and action; (ii) national knowledge and behaviour; (iii) national impact; and (iv) global commitment and action. Once the indicators were developed, the UNAIDS Monitoring and Evaluation Unit established clear definitions for each indicator and mechanisms for collecting information on an ongoing basis.

In 2003, 103 Member States submitted national reports to UNAIDS based on the original core indicators. Of these reports, 29 were from sub-Saharan Africa, 17 from Asia and the Pacific, 21 from Latin America and the Caribbean, 14 from Eastern Europe and Central Asia, eight from North African and the Middle East and 14 from high-income countries. In most cases, National AIDS Committees or equivalent bodies oversaw compilation of the national report and more than three quarters of them included

input from three or more government ministries. Civil society was involved in the preparation of roughly two thirds of the reports and people living with HIV and AIDS were involved in just over half of them.

From a global perspective, there were serious limitations to the data submitted in 2003 for the UNAIDS *Progress Report on the Global Response to the HIV/AIDS Epidemic (Global Progress Report)*. For example, while almost all of the countries completed the National Composite Policy Index questionnaire, only 40% of the countries that submitted reports supplied information related to other national indicators. In addition, less than 20% of the national-level data submitted was disaggregated by gender, age, location, etc., which further complicated the ability to draw valid conclusions from the data. There was also an uneven level of reporting between regions, with the highest proportion of responding countries per region coming from sub-Saharan Africa and the lowest level of reporting from countries in North Africa and the Middle East.

## Core Indicators

This document focuses on the national-level indicators, although it does include basic information on the global indicators. In order to improve the quality of data that is submitted for the 2006 *Global Progress Report*, refinements were made to the national indicators and their accompanying guidelines. These refinements (reflected in this manual) also take into account input received from a variety of important stakeholders, including National AIDS Committees or their equivalents, civil-society organizations and people living with HIV and AIDS. In addition, the guidelines now address specific monitoring needs of countries with concentrated or low-prevalence epidemics.

For countries with a generalized epidemic, the refinements include minor revisions to four indicators and the addition of five core indicators. A separate set of nine core indicators has been developed specifically for countries with concentrated or low-prevalence epidemics. All of the refinements are an extension of the well-established list of core indicators developed in 2002 and they rely on many of the same measurement tools to avoid any confusion or complication (see a complete list of the core indicators on page 19).

### National Indicators: Overview

The national indicators are important for two reasons. First, they can help individual countries evaluate the effectiveness of their national response, which reinforces the value of including these indicators in national monitoring and evaluation frameworks. Second, when data from multiple countries is analysed collectively, the indicators can provide critical information on the effectiveness of the response at regional and global levels while simultaneously supplying countries with insights into the efforts of other national-level responses.

The core national-level indicators are divided into three categories.

- *National commitment and action.* These indicators focus on policy and the strategic and financial inputs for the prevention of the spread of HIV infection, the provision of care and support for people who are infected and the mitigation of the social and economic consequences of high levels of morbidity and mortality due to AIDS. They also capture programme outputs, coverage and outcomes; for example, the prevention of mother-to-child transmission and treatment with antiretroviral combination therapy.
- *National knowledge and behaviour.* These indicators cover a range of specific knowledge and behaviour outcomes, including accurate knowledge of HIV transmission, age at first sex, sexual behaviours and school attendance among orphans.
- *National-level programme impact.* These indicators focus on the extent to which the other national programme activities have succeeded in reducing rates of HIV infection and its impact on adults and children receiving antiretroviral therapy.

Most of these national indicators are **applicable** for all countries. However, certain indicators may not be appropriate in some countries because the data gathered might convey an inaccurate picture of a country's epidemic. For example, the new knowledge and behaviour indicators related to most-at-risk populations are mainly relevant in countries with concentrated epidemics, although countries with generalized epidemics should also collect data on those indicators if they have a concentrated sub-epidemic among a specific group. Conversely, countries with a concentrated epidemic are encouraged to collect data on broader activities such as life-skills education, sexual behaviours among young people and workplace programmes as a mechanism to track trends that could influence the nature of the national response.

Four of the national indicators are also **Millennium Development Indicators**. These indicators measure progress against the Millennium Development Goals, which are part of the Millennium Declaration that was adopted by all 189 Member States of the United Nations General Assembly in 2000. These four indicators relate to knowledge among young people about HIV, condom use, school attendance among orphans and the percentage of young people who are infected with HIV.

Four of the national indicators have an **additional indicator**, which can provide valuable supplemental data. For example, the core indicator on HIV treatment, which states, "percentage of people with advanced HIV infection receiving antiretroviral combination therapy," has an additional indicator to measure the "percentage of health facilities with the capacity to deliver appropriate care to people living with HIV/AIDS." If resources are available, countries are encouraged to collect and analyse data for these additional indicators in order to better understand their national response and to contribute to global knowledge about the epidemic. In most cases, the data for the additional indicators is already being collected for one or more of the core indicators.

#### National Indicators: Generalized, Concentrated or Low-Prevalence Epidemics

Since the *Global Progress Report* of 2003, new core indicators were developed to better understand the nature and scope of the response to HIV and AIDS at the national level. In addition, there are now recommendations for use of separate sets of indicators for countries with generalized epidemics and those with concentrated or low-prevalence epidemics.

For countries with generalized epidemics, there are five new core indicators (see Figure 1 below). A complete list of national-level indicators for generalized epidemics appears on page 19 of this manual. (It should be noted that one of the original national indicators—percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV—has been shifted to the set of indicators for countries with concentrated or low-prevalence epidemics.)

Figure 1

#### Five New Core Indicators for Generalized Epidemics

- Percentage of orphans and vulnerable children whose households received free basic external support in care for the child.
- Percentage of transfused blood units screened for HIV.
- Percentage of young women and men who have had sex before the age of 15.
- Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months.
- Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral treatment.

For countries with concentrated or low-prevalence epidemics, the set of nine priority indicators includes four indicators from the national commitment and action category, four from the knowledge and behaviour category and one from the impact category (see Figure 2 below).

Figure 2

### Nine Core Indicators for Concentrated or Low-Prevalence Epidemics

- Amount of national funds disbursed by governments in low- and middle-income countries.
- National Composite Policy Index.
- Percentage of [most-at-risk population(s)] who received HIV testing in the last 12 months and know the results.
- Percentage of [most-at-risk population(s)] reached with HIV/AIDS prevention programmes.
- Percentage of [most-at-risk population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- Percentage of female and male sex workers reporting the use of a condom with their most recent client.
- Percentage of men reporting use of a condom the last time they had anal sex with a male partner.
- Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who avoid using non-sterile injecting equipment and use condoms, in the last 12 months. (Applies only to countries where injecting drug use is an established mode of HIV transmission.)
- Percentage of [most-at-risk population(s)] who are HIV infected.

*Note: The term “most-at-risk populations” included in the above-mentioned indicators should be replaced with a defined segment of the population (e.g., sex workers, injecting drug users, men who have sex with men), which are being measured. In countries where there are multiple most-at-risk populations, the indicators should be reported for each population.*

### Global Indicators

The global indicators are designed to provide information on levels of international support for key elements of the global response and to identify trends in that support. The indicators measure donor funding for HIV and AIDS in low- and middle-income countries, the amount of public funds for research and development of vaccines and microbicides, and the percentage of transnational companies and international organizations with HIV/AIDS workplace policies/programmes. In light of the international requirements of the data collection process, UNAIDS and its partners are responsible for calculating the global indicators.

### Implementation at National Level

This section of the manual addresses issues related to gathering, analysing, interpreting and reporting data for the core national-level indicators. Countries needing additional information on implementation should seek technical assistance from their Expanded Theme Groups and monitoring and evaluation working groups. The evaluation unit at the UNAIDS Secretariat is also available to provide support and can be reached via email at [UNGASSindicators@unaids.org](mailto:UNGASSindicators@unaids.org).

### Indicator Construction

This manual includes detailed guidelines for the construction of each national indicator. These guidelines include the purpose of the indicator, its applicability in a given country, the frequency with which relevant data should be gathered, recommended measurement tools, recommended methods of measurement and a summary interpretation of the indicator. Where an additional indicator is suggested to supplement the core indicator, it is also described as part of the guidelines. However, detailed information on measurement tools, methods of measurement and interpretation for the additional indicators is not included in this manual (see Appendix 6, Bibliography).

**Targets** were specified for three core indicators in the *Declaration of Commitment*. The targets for “percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission” and the “percentage of HIV-infected infants born to HIV-infected mothers” are applicable for all countries. The target for the “percentage of young people aged 15–24 who are HIV-infected” applies only to countries that have high-prevalence epidemics for the year 2005 and to all countries for 2010. Individual countries may choose to establish targets for other indicators; in case they do so, it would be helpful if they would explain how and why a particular target was set when submitting any reports on those indicators.

### Measurement Tools and Data Sources

The primary measurement tools are: (i) nationally representative, population-based sample surveys such as Demographic and Health Surveys (DHS and DHS+), Multiple Indicator Cluster Surveys (MICS) and the AIDS Survey; (ii) school, health facility and workplace surveys; and (iii) specially-designed surveys and questionnaires, including surveys of specific population groups (e.g., targeted surveys of most-at-risk populations and specific service coverage surveys) and the National Composite Policy Index Questionnaire included in this manual. Existing monitoring resources, including records and programme reviews from health facilities and schools as well as specific information from HIV and sexually transmitted infection surveillance activities and control programmes, should supplement the primary measurement tools. Civil society organizations are also valuable sources of data for many indicators, especially those that relate to interventions where nongovernmental, faith-based and community-based organizations play an active role, including work with young people, most-at-risk populations and pregnant women.

In most countries, the bulk of the data required for the core national-level indicators may not be available from existing sources and is likely to require the adaptation of existing monitoring tools or the addition of specific surveys. Countries that conduct regular, nationally representative, population-based surveys such as the Demographic and Health Survey will collect important information, including behavioural data on young people. In countries where other types of population-based surveys are conducted, including those for purposes other than HIV/AIDS, it is possible to adapt these surveys to collect data for selected core indicators. In countries that already capture information from schools, health facilities and employers, the necessary HIV data requirements can be added to the ongoing data collection process.

In situations where nationally representative service **coverage data** is not available from monitoring systems, countries may use data collected from interviews of key informants. Although the data collected using this approach is less accurate than data collected by monitoring systems, the approach can be implemented quickly and relatively inexpensively. (See Appendix 4 for information on one alternative methodology for collecting coverage data.)

For countries with concentrated epidemics or sub-epidemics among most-at-risk populations—e.g., sex workers, injecting drug users and men who have sex with men—focused efforts must be made to collect data on each at-risk group. Because most-at-risk populations are typically marginalized and often mobile, it is challenging to monitor trends in behaviour and HIV prevalence and will require a greater level of effort to collect the critical data. In many cases, collaborating with civil society organizations that work directly with these populations will be the most effective way to collect the data. It should be noted that most-at-risk populations could be hidden or hard to reach; consequently, countries may need to use alternative methodologies and calculations to estimate the total size of a given population.

### Numerators and Denominators

The guidelines include detailed instructions on how to measure the national response against each core indicator. Most core national-level indicators use numerators and denominators to calculate the percentages that measure the current state of the national response.

Where numerators and denominators are used, the guidelines include precise definitions for each of them. For example, the numerator for the indicator related to antiretroviral combination therapy states: “Number of people with advanced HIV infection who receive antiretroviral combination therapy according to the

nationally approved treatment protocol.” The corresponding denominator states: “Number of people with advanced HIV infection.” Each of the numerators and denominators in this manual have equally detailed definitions and supporting instructions to ensure that countries understand exactly what information is needed to calculate a core indicator and how it should be used.

In most cases, countries are asked to disaggregate data for the numerators and denominators. For example, the numerator for the indicator on antiretroviral combination therapy disaggregates the data on several levels; see Figure 3 below. First, data is disaggregated by gender. Under gender, data is disaggregated by whether people are receiving antiretroviral therapy in the public or private health sector. The numerator is then further disaggregated by categories of information about the people receiving antiretroviral therapy, including categories about receiving treatment, starting it and discontinuing it due to death or other reasons.

Figure 3

<b>NUMERATOR:</b> Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	<b>Males</b>			<b>Females</b>			<b>Both sexes</b>		
	<b>Public</b>	<b>Private</b>	<b>Total</b>	<b>Public</b>	<b>Private</b>	<b>Total</b>	<b>Public</b>	<b>Private</b>	<b>Total</b>
1. Number of people receiving antiretroviral combination therapy at the beginning of the year									
2. Number of people who commenced treatment in the last 12 months									
3. Number of people receiving antiretroviral combination therapy at the start of the year who died during the year									
4. Number of people for whom treatment was discontinued for other reasons									
5. <i>Number of people receiving antiretroviral combination therapy at the end of the year</i>									
<b>Calculate line 5 by adding lines 1 and 2 and then subtracting lines 3 and 4.</b>									

The denominator for the same indicator also relies on disaggregated data; see Figure 4 below. In this case, the data is disaggregated first by gender and then by specific categories. Although the denominator data is less disaggregated than the numerator data, the disaggregation is equally important to the complete measurement of the indicator.

Figure 4

<b>DENOMINATOR:</b> Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	<b>Male</b>	<b>Female</b>	<b>Both sexes</b>
6. Number of people (adults and children) with HIV infection in the total population			
7. Percentage of people with HIV who are at an advanced stage of infection			
8. <i>Number of people with advanced HIV infection</i>			
<b>Calculate line 8 by multiplying line 6 and line 7 and dividing the product by 100.</b>			

For a given indicator, it is important that the data collection period is consistent for all the information relevant to that indicator’s numerators and denominators. For example, data should be reported consist-

ently from year to year, either by calendar year or by financial year. If data is collected at different times for the numerators and denominators, the accuracy and validity of that information will be compromised. Countries are strongly encouraged to pay close attention to the dates attached to specific data when calculating an indicator.

The methods described in these guidelines can be applied at the subnational level. However, for most countries, this will require detailed data that are less likely to be available and too expensive or less feasible to collect at the local level. Furthermore, the standardized methodology used in this manual has been designed to facilitate the construction of global estimates from national-level data. Simpler, faster and more flexible approaches, which are tailored to local conditions, may be more appropriate to guide decision-making below the national level. An important exception is in countries with large populations such as China, India, Indonesia and Nigeria where it is difficult to collect data at the national level and a subnational approach using the guidelines in this manual would be appropriate.

### Disaggregated Data

One of the key lessons learned from the 2003 *Global Progress Report* was the importance of obtaining disaggregated data; for example, breakdowns by gender, age, location and sector. As mentioned previously, less than 20% of the data submitted for the 2003 report was disaggregated, which makes it difficult to draw valid conclusions from the information. Moving forward, it is vital that countries collect data in its component parts and not simply in its summary form. Without this disaggregated data, it is difficult to monitor the breadth and depth of the response to the epidemic at either national or global levels. It is equally difficult to monitor access to activities, the equity of that access, the appropriateness of focusing on specific populations and meaningful change over time.

The fundamental challenge with disaggregated data is the collection of the information. There is no question that collecting data in its component parts requires more effort. However, it is important to point out that much of the data collected at subnational levels is disaggregated when it is first collected. Unfortunately, the more detailed data is often lost when the information is passed to the national level. The challenge for National AIDS Committees or their equivalents is to ensure that data remains disaggregated and is retained in this form as it moves from the local to the national level.

Countries are strongly encouraged to make the collection of disaggregated data one of the cornerstones of their monitoring and evaluation efforts. Key ministries should review their health-information systems, surveys and other instruments for collecting data to ensure that they capture disaggregated data at subnational levels, including facility and project levels. In addition, the private sector and/or civil society organizations involved in the country's response to HIV and AIDS must understand the importance of disaggregated data and the collection and dissemination of this data should be a priority in their ongoing operations.

This manual includes forms that countries use to report on each of the national indicators. These forms clearly identify the disaggregated data that is required to accurately report on the numerator and denominator for each indicator; see the preceding subsection on *Numerators and Denominators* for additional information on these factors. Data on these forms is disaggregated by a range of characteristics, depending on the specifics of the indicator. These characteristics include gender (male/female), age (<20/20+, <25/25+), location (urban/rural/national) and sector (public/private).

In situations where disaggregated data is not readily available for National AIDS Committees or their equivalents, it may be possible to extract the information needed for core indicators from larger data sets. Although the location of the data will vary from country to country, discussions with countries that participated in the 2003 *Global Progress Report* identified a number of valuable resources for data related to core indicators, which may be applicable in other countries. See Figure 5 for an indicative list of indicators cross-referenced with the relevant disaggregated data and sources for that data.

Countries should seek technical assistance from UNAIDS and its partners at country level if they are unsure how to access the disaggregated data needed to properly complete the measurements of core indicators. Governments are encouraged to look beyond their internal information resources to both collect and validate data. In many cases, civil-society organizations may be able to provide valuable primary and secondary data.

Figure 5

<b>Indicative list of indicators, disaggregated data, sources of information</b>		
<b>Indicator</b>	<b>Disaggregated Data</b>	<b>Data Source</b>
Schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	<ul style="list-style-type: none"> <li>• Primary/secondary/all schools</li> <li>• Urban/rural/national</li> </ul>	<ul style="list-style-type: none"> <li>▪ Education information systems (e.g., Ministries of Education, Ministries of Youth)</li> <li>▪ DHS/DHS+/MICS data sets</li> <li>▪ Targeted surveys</li> </ul>
Orphans and vulnerable children whose households received free basic external support in caring for the child	<ul style="list-style-type: none"> <li>• Gender</li> <li>• Age</li> </ul>	<ul style="list-style-type: none"> <li>▪ Education information systems (e.g., Ministries of Education, Ministries of Youth, Ministries of Social Welfare)</li> <li>▪ Health information systems (e.g., Ministries of Health, facility-based)</li> <li>▪ Coverage data from NGOs and other civil society organizations</li> <li>▪ Targeted surveys</li> </ul>
Sexually transmitted infection, prevention of mother-to-child transmission and antiretroviral-related indicators	<ul style="list-style-type: none"> <li>• Gender</li> <li>• Age</li> <li>• Public/Private sector</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clinical data from health information systems (e.g., Ministries of Health, facility-based)</li> <li>▪ Service delivery data from NGOs and other civil-society organizations</li> </ul>
Behaviour-related indicators, including young people and most-at-risk populations	<ul style="list-style-type: none"> <li>• Gender</li> <li>• Age</li> <li>• Urban/rural/national</li> </ul>	<ul style="list-style-type: none"> <li>▪ DHS/MICS/BSS data sets</li> <li>▪ Targeted surveys</li> </ul>

### Interpretation and Analysis

The guidelines in this manual include a section on interpretation for each of the core national-level indicators. Countries should carefully review this section before they begin collecting and analysing information for an individual indicator to help them understand the specific intent of that indicator and any potential issues related to it. They should also reconsider the points raised in the interpretation section before they finalize their national report in order to confirm the appropriateness of their findings for each indicator.

Many of the points raised in the interpretation section of the guidelines are designed to improve the accuracy and consistency of the data submitted to UNAIDS in the national progress reports. Other points in this section provide additional information on the value of a particular indicator. Points also acknowledge the variations that may occur from country to country on issues as diverse as the relationship of costs to local income, standards for quality and variations in treatment regimens.

Once countries have compiled their progress reports, they are strongly encouraged to continue analysing their findings as a way to better understand their national response and to identify opportunities to improve that response. Countries should be looking closely at the linkages between policy, implementation of HIV and AIDS programmes, verifiable behaviour change and HIV prevalence. For example, if a country has a policy on the reduction of mother-to-child transmission of HIV, does it also have field programmes that make prevention of mother-to-child transmission available to pregnant women? And if these field programmes are in place, are women using them in sufficient numbers to have an impact on the number of HIV-infected infants born in that country?

These types of linkages exist in every facet of a national response and many of the most important ones are reflected in the core national-level indicators included in this manual. To effectively analyse these linkages, countries must draw on the widest range of data available, including quantitative and qualitative information from both the public and private sectors. An over-reliance on data of any one type or from any one source is less likely to provide the perspective or insights required to understand the linkages and to identify any existing or emerging trends.

## Concentrated or Low-Prevalence Epidemics

Another important lesson learned from the 2003 *Global Progress Report* was the need for indicators that specifically addressed the situation in countries with concentrated or low-prevalence epidemics. As a direct result of feedback from participating countries, UNAIDS has developed a set of nine core indicators relevant for concentrated or low-prevalence epidemics, including early-stage epidemics.

These core indicators focus on most-at-risk populations, which include sex workers, injecting drug users and men who have sex with men. These populations are typically more vulnerable to HIV infection for two reasons: first, they engage in high-risk behaviours and, second, they are often marginalized from mainstream society, which decreases their access to information, products and services that could reduce their risk of infection.

In most cases, it is likely that countries with a concentrated or low-prevalence epidemic will find applicable indicators beyond the nine core indicators. It is also likely that these countries may not need to report on all of the core indicators. Consequently, countries with a concentrated or low-prevalence epidemic should review all of the indicators to determine which ones are applicable in their situation. For example, a country with a concentrated epidemic only among sex workers would not need to report on the core indicators related to injecting drug users. However, that same country would be well advised to calculate the specific indicators for sex workers as well as broader indicators (e.g., teachers trained in life-skills-based HIV/AIDS education; HIV/AIDS workplace policies and programmes; sexually transmitted infection diagnosis, treatment and counselling), which are relevant to preventing and tracking the spread of HIV into the general population.

Similarly, countries with a generalized epidemic should review the unique indicators for concentrated or low-prevalence epidemics to determine if any of them are applicable in their situation. For example, a country with a generalized epidemic may also have a concentrated sub-epidemic among injecting drug users and it would be valuable to also calculate and report on the indicators that relate to the most-at-risk population.

## Role of Civil Society

Civil society plays a key role in the response to the AIDS epidemic in countries around the world. The wide range of strategic and tactical expertise within civil-society organizations makes them ideal partners in the process of preparing national progress reports. Specifically, civil-society organizations are well positioned to provide quantitative and qualitative information to augment the data collected by governments. They can provide a valuable perspective on the issues included in the National Composite Policy Index. They are also equally well positioned to participate in the review and vetting process for progress reports.

National AIDS Committees or their equivalents should seek input from the full spectrum of civil society, including nongovernmental organizations, faith-based organizations, trade unions and community-based organizations, for their reports on the core national-level indicators underlying the *UNGASS Declaration of Commitment on HIV/AIDS*. The importance of securing input from the full spectrum of civil society, including people living with HIV and AIDS, cannot be overstated; civil society speaks with many voices and represents many different perspectives, all of which can be valuable in the monitoring and evaluation of a country's AIDS response.

In order to ensure a productive relationship with civil society during the preparation of their reports on the core indicators, National AIDS Committees or their equivalents should provide civil-society organizations with easy access to their plans for data collection as well as a straightforward mechanism for submitting and evaluating information for the national progress report. As part of this effort, these organizations should also be invited to participate in workshops at the national level to determine how they can best support the country's reporting process. In addition, civil society in every country should have sufficient opportunity to review and comment on the national progress report before it is finalized and submitted. And the report that is submitted to UNAIDS should be widely disseminated to ensure that civil society generally has ready access to it.

UNAIDS staff at country level are available to help facilitate input from civil society throughout the process. In particular, UNAIDS country-level staff are available to brief civil-society organizations on the indicators and the reporting process; provide technical assistance on gathering, analysing and reporting data, including focused support to people living with HIV and AIDS; and ensure the dissemination of reports, including, whenever possible, reports in national languages.

UNAIDS has also established a parallel process for civil society to submit data relevant to the core indicators directly to UNAIDS headquarters. For the 2006 *Global Progress Report*, UNAIDS will accept reports from civil society with a recommended focus on key thematic areas.

## Reporting

National governments, through their National AIDS Committees or equivalents, are responsible for reporting on the national-level indicators with support from UNAIDS and its partners. The procedures outlined in this manual should be followed to collect and calculate the necessary information for each indicator. The suggested report format (Appendix 5) should be used for the report that is submitted to UNAIDS. The report and completed national return forms (included in the next version of the Country Response Information System) should be returned to the UNAIDS Secretariat in Geneva by 31 December 2005.

The report should highlight successes as well as constraints and future national plans to improve performance, especially in areas where data indicate weaknesses in a country's response. This report should also include a short explanatory note for each indicator, stating how the numerator and denominator were calculated and assessing the accuracy of the composite and disaggregated data.

As discussed above and as required by the *Declaration of Commitment*, civil society, including people living with HIV and AIDS, should be involved in preparing the national progress report. The private sector at large should have a similar opportunity to participate in the reporting process. UNAIDS strongly recommends that national governments organize a workshop/forum to openly present and discuss the findings of the national progress report before it is submitted to UNAIDS; where appropriate, the final report should reflect the discussion at this event. UN Theme Groups and Expanded Theme Groups in country are available to facilitate this discussion process. Once submitted, all national reports will be made public on the UNAIDS website.

A reporting schedule for all indicators is found in Appendix 1. In 2006, countries are expected to report on each of the national indicators that are applicable to their response. Countries with concentrated or low-prevalence epidemics are advised to consult with UNAIDS to determine which indicators are appropriate for their particular situation.

In countries where the Country Response Information System (CRIS) is operational, this database will serve as the primary information system for national responses and should house all data obtained on core and additional indicators supporting the *Declaration of Commitment*. The system provides a structure for national-level information relative to the epidemic, the response and the impact, including epidemiological information; strategic planning, costing and coordination capacities; budget allocations to AIDS programming and other resource flows; and project implementation rates.

Local CRIS systems provide data to UNAIDS to be aggregated and presented on the upcoming UNAIDS Global Response Information Database website. This site will provide tools to facilitate the creation of reports and pursue more detailed analysis of global data from the three modules of the CRIS system (Indicator, Project Resource Tracking, and Research Inventory Database).

### *National-Level Reporting Framework*

Complete national-level reporting on the core indicators are essential if the 2006 *Progress Report on HIV/AIDS* is going to contribute to the global response to the epidemic. Countries are strongly encouraged to establish timetables and milestones for completing the necessary tasks. Listed below is a simple framework of the actions required in most countries to complete their national-level reports. Under the direction of the National AIDS Committee or its equivalent, countries should:

- identify data needs in line with the national strategic plan requirements;

- develop and disseminate a plan for data collection, analysis and report writing, including timelines and the roles of the National AIDS Committee or equivalent, other government agencies and civil society;
- identify relevant tools for data collection;
- secure required funding for the entire process of collecting, analysing and reporting the data;
- collect data, including coordination with partner organizations from government, civil society and the international community;
- analyse data, including coordination with partner organizations from government, civil society and the international community;
- complete the appropriate National Return Forms and draft the accompanying report;
- allow stakeholders, including government agencies and civil society, to comment on the draft report;
- enter data into CRIS or equivalent data management systems; and
- submit data and reports to UNAIDS Geneva by 31 December 2005.
- Final draft of the report will be presented at the UN General Assembly Special Session on AIDS in mid-2006. At that time, copies of country reports will also be placed on UNAIDS website.

Although National AIDS Committees or their equivalents have no direct role in reporting on the core global indicators, there is a similar process for collecting, analysing and reporting data, which is handled directly by UNAIDS and its partners. As part of that process, civil society organizations at the national level are able to provide input directly to UNAIDS, including the submission of data that is relevant to the core indicators and comments on the draft report.

### *Evidence-Based Advocacy*

Reporting on the core indicators for the *Progress Report* and UNGASS is an opportunity for countries to assess advocacy efforts to date and, more importantly, to define the agenda for future advocacy efforts at national and global levels. The central role of advocacy in policy development, resource allocation and programme implementation at both levels reinforces the importance of comprehensive national-level reporting, including disaggregated data and inputs from public and private sector organizations involved in the response to HIV and AIDS.

Advocacy is a strategic process designed to influence political, social, economic and cultural changes needed to improve the response to HIV and AIDS. Successful advocacy uses credible data to influence decision-makers and opinion-leaders and change the status quo. Countries that commit to gathering, analysing and reporting on the core indicators in this manual will have a wealth of data to use for both national and global advocacy, including answers to the following questions.

- What is the status of the epidemic in the country?
- What are the basic trends in HIV transmission and service coverage?
- What are the main obstacles to accessing HIV prevention, care and treatment services?
- What is the quality of services being delivered?
- Are services being delivered equitably and effectively?
- What exacerbates these problems (e.g., policies, laws, resources, politics, customs, organizations, individuals)?
- Who can change this situation (e.g., elected leaders, bureaucrats, religious leaders, community leaders, traditional leaders, donors, international organizations, nongovernmental organizations)?
- What are these people currently doing to address the problems?

If the data required for the core indicators is not readily available, it highlights the need for advocacy to address the issue of monitoring and evaluation systems themselves.



# Core Indicators for the *Declaration of Commitment* Implementation

## 2006 reporting

Indicators

Reporting  
schedule

Method of data  
collection

### Generalized Epidemics

#### National Commitment and Action

Expenditures		
1. Amount of national funds disbursed by governments in low- and middle-income countries	Ad hoc based on country request and financing	HIV/AIDS National Spending Assessment Survey on financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index  <b>Areas covered:</b> prevention, care and support, human rights, civil society involvement, and monitoring and evaluation <b>Target groups:</b> people living with HIV and AIDS, women, youth, orphans, and most-at-risk populations	Biennial	Desk review and key informant interviews
National Programmes: education, workplace policies, STI case management, blood safety, prevention of mother-to-child transmission coverage, antiretroviral combination therapy coverage, and services for orphans and vulnerable children		
3. Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	Biennial	School-based survey and education programme review
4. Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	Biennial	Workplace survey
5. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	Biennial	Health-facility survey
6. Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Biennial	Programme monitoring and estimates
7. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	Biennial	Programme monitoring and estimates
8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Every 4–5 years	Population-based survey
9. Percentage of transfused blood units screened for HIV	Biennial	Programme monitoring/special survey

#### Knowledge and Behaviour

10. ** Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (Target: 90% by 2005; 95% by 2010)	Every 4–5 years	Population-based survey
11. Percentage of young women and men who have had sex before the age of 15		
12. Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months		
13. ** Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner		
14. ** Ratio of current school attendance among orphans to that among non-orphans, aged 10–14		

#### Impact

15. **Percentage of young women and men aged 15–24 who are HIV infected (Target: 25% in most-affected countries by 2005; 25% reduction globally by 2010)	Annual	HIV sentinel surveillance and population-based survey
16. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Biennial	Programme monitoring
17. Percentage of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010)	Biennial	Estimate based on programme coverage

\*\* Millennium Development Goals

NATIONAL

## Concentrated/low-prevalence Epidemics

### National Commitment and Action

Expenditures		
1. Amount of national funds disbursed by governments in low- and middle-income countries	Ad hoc based on country request and financing	HIV/AIDS National Spending Assessment Survey on financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index  <b>Areas covered:</b> prevention, care and support, human rights, civil society involvement, and monitoring and evaluation <b>Target groups:</b> most-at-risk populations	Biennial	Desk review and key informant interviews
National Programmes: HIV testing and prevention programmes for most-at-risk populations		
3. Percentage (most-at-risk populations) who received HIV testing in the last 12 months and who know the results	Biennial	Programme monitoring/special survey
4. Percentage (most-at-risk populations) reached by prevention programmes	Biennial	Programme monitoring/special survey

### Knowledge and Behaviour

5. Percentage of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Biennial	Special survey
6. Percentage of female and male sex workers reporting the use of a condom with their most recent client		
7. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		
8. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid using non-sterile injecting equipment and use condoms, in the last 12 months (for countries where injecting drug use is an established mode of HIV transmission)		

### Impact

9. Percentage of (most-at-risk population(s)) who are HIV infected	Annual	HIV sentinel surveillance
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## Global Commitment and Action

1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low and middle income countries	Annual	Survey on financial resource flows
2. Amount of public funds for Research and Development of preventive HIV vaccines and microbicides	Annual	Survey on financial resource flows
3. Percentage of transnational companies which are present in developing countries and which have HIV/AIDS workplace policies and programmes	Annual	Desk review
4. Percentage of international organizations which have workplace policies and programmes	Annual	Desk review

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# GENERALIZED EPIDEMICS

## NATIONAL COMMITMENT AND ACTION INDICATORS

1. Amount of national funds disbursed by governments.
2. National Composite Policy Index.
  - Strategic plan
  - Political support
  - Prevention
  - Care and support
  - Human rights
  - Civil society involvement
  - Monitoring and evaluation

## Government funding for HIV/AIDS

### Amount of national funds disbursed by governments in low- and middle-income countries

At present, there are two methodologies used to thoroughly monitor HIV/AIDS resources in low- and middle-income countries which are collectively termed as HIV/AIDS National Spending Assessments (NSAs).

1. National AIDS Accounts in the context of National Health Accounts.
2. Stand-alone National AIDS Accounts.

Efforts have been made to harmonize National AIDS Accounts in the context of National Health Accounts and the stand alone National AIDS Accounts. Any of these two approaches provide information on prevention and public health, care and treatment, mitigation, infrastructure and administration.

Other approaches, such as HIV/AIDS-budget analysis, have been limited to the description of budgets. Amendments will be made to ensure that expenditures are also accounted for. In the meantime, it might be a useful proxy measurement of the public expenditures as shown in the list on page 23.

There are also surveys on financial resource flows conducted by the Resource Flows Project (joint UNFPA/UNAIDS/NIDI project); however, these need to be thoroughly analysed to assess their completeness for HIV/AIDS since the major focus of such surveys is on reproductive health. Those reports might not be based on standard methodologies, meaning that they might not include estimates of public expenditures which are not clearly identified in the public budgets.

For countries that have access to information or databases on public budgets, careful attention is required in assessing that the budgets are actually spent using the same budget lines as described in the original budget. Also, it is essential to ensure the inclusion of expenditures which are not traditionally included within explicit budget lines (e.g., treatment of opportunistic infections is not a single budget item; yet it is usually paid for using public resources within hospital budgets).

Countries that do not have developed any of the tools described above (NSA, AIDS-budget analysis or special surveys on financial resource flows) may provide information on this indicator using the executed public budgets. However, again, they should supplement this information with the costing of other activities not included explicitly in budget items. In a number of countries, most of the expenditures might occur at the health facilities and not be clearly labelled as HIV/AIDS e.g., treatment of opportunistic infections in public hospitals, etc. To include these public expenditures as part of the indicator, there are no options but to cost the provision of these services and acknowledge the source of the funding to differentiate public and private expenditures.

It is also important to include in the total public expenditures relevant costs on non-health areas derived from budgets of different ministries. This indicator should not be limited to data from the National AIDS Commission or the National AIDS Programme within the Ministry of Health.

## Description of tools used for HIV/AIDS National Spending Assessments National AIDS Accounts<sup>1</sup>

<b>PURPOSE</b>	Comprehensive approach to monitoring HIV/AIDS spending across all sectors
<b>FREQUENCY</b>	Ad hoc based on country request
<b>MEASUREMENT TOOL</b>	Desk review
<b>METHOD OF MEASUREMENT</b>	<p>Examination of primary and secondary data sources from donors, public and private entities.</p> <ol style="list-style-type: none"> <li>1. Relevant government agencies.</li> <li>2. Employers.</li> <li>3. Households living with HIV/AIDS (free standing household survey; or service providers and patients based).</li> <li>4. Nongovernmental organizations.</li> <li>5. Donors.</li> <li>6. Insurance companies.</li> <li>7. Providers of HIV and AIDS services including hospitals, clinics, physician offices, pharmacies, and traditional healers.</li> </ol> <p><b>A. HIV/AIDS health-care expenditures</b>—expenditures on those activities that are:</p> <ol style="list-style-type: none"> <li>1. primarily intended to have impact on the health status of people living with HIV and AIDS in a given period of time; and</li> <li>2. intended to prevent the spread of HIV, which may target the population at large (e.g., recipients of condom distribution programmes intended to curb the spread of HIV).</li> </ol> <p><b>B. Direct health-care expenditures</b> – <i>‘expenses primarily or entirely associated with health care’</i></p> <ol style="list-style-type: none"> <li>1. HIV-prevention activities.</li> <li>2. Treatment and diagnostic services for HIV case management.</li> <li>3. Administration of HIV and AIDS services.</li> <li>4. Care and Support activities.</li> </ol> <p><b>C. Health-care related expenditures</b>—<i>expenses contributing to health but that are non-medical and/or intersect with other disciplines</i></p> <ol style="list-style-type: none"> <li>1. Mitigation.</li> <li>2. Training and support.</li> <li>3. Capital formation for provider institutions.</li> </ol> <p><b>D. Non health-care related expenditures</b>—<i>all other HIV/AIDS related expenditures in sectors outside of health</i></p> <ol style="list-style-type: none"> <li>1. Education and social sectors.</li> <li>2. Orphaned and vulnerable children.</li> <li>3. In-kind or monetary benefits to people living with HIV.</li> </ol>

<sup>1</sup> National AIDS Accounts implemented by the Regional AIDS Initiative for Latin America and the Caribbean and National AIDS Accounts in the context of National Health Accounts implemented by PHRPlus/Abt Associates

## INTERPRETATION

The methodology:

- allows for cross country, regional and international comparison of data;
- identifies how resources are being mobilized within a country:
  - a. Who pays?
  - b. Who finances?
  - c. Under what schemes?
- identifies how resources are being managed within a country;
- identifies who provides HIV/AIDS services and who benefits from these services;
- measures additionality; and
- provides possibility to conduct beneficiary analysis.

## HIV/AIDS-Budget Analysis<sup>2</sup>

### PURPOSE

1. To track national HIV/AIDS budget allocations and analyse the budget from an HIV/AIDS perspective.
2. To compare the amounts of state and donor funding to HIV/AIDS activities.
3. To use allocations in the national budget as indicators of human rights achievements or violations.

### FREQUENCY

Ad hoc based on country request.

### MEASUREMENT TOOL

1. Literature review.
2. Official budget documents (medium-term expenditure frameworks, expenditure records).
3. Face-to-face interviews with key officials and stakeholders.

### TERMINOLOGY USED

Budgetary allocation to health and HIV/AIDS.

### LIMITATIONS

1. Inaccessibility and unavailability of budget documentation, little disaggregation.
2. Varying budgetary and accounting systems—undermined comparability.
3. Lack of central database of donor funds.
4. Difficulty in ensuring quality and validity of data in country reports, especially if done by non-academic civil-society organizations.
5. Inability to measure allocations against actual expenditures, outputs according to programme indicators and impact of expenditure.

## INTERPRETATION

The methodology:

- develops a common framework for tracking HIV/AIDS-targeted allocations and expenditure in the national budget;
- provides an indication of the attainment of human rights—issues of equity and efficiency in resource allocation, if based on need;
- indicates prioritization of interventions; and
- provides an overview and recommendations to policy-makers on the effectiveness and efficiency of budgeting and funding mechanisms for governments' responses to HIV/AIDS.

<sup>2</sup> Implemented by the Institute for Democracy in South Africa in selected Sub-Saharan countries.

## Government HIV/AIDS policies

### National Composite Policy Index

<b>PURPOSE</b>	To assess progress in the development and implementation of national-level HIV/AIDS policies and strategies
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Country assessment questionnaire (see appendix 3)
<b>METHOD OF MEASUREMENT</b>	<p>The composite index covers the following broad areas of policy.</p> <p>Part A</p> <ol style="list-style-type: none"> <li>1. Strategic plan.</li> <li>2. Political support.</li> <li>3. Prevention.</li> <li>4. Care and support.</li> <li>5. Monitoring and Evaluation.</li> </ol> <p>Part B</p> <ol style="list-style-type: none"> <li>1. Human rights.</li> <li>2. Civil Society involvement.</li> <li>3. Prevention.</li> <li>4. Care and support.</li> </ol> <p>A number of specific policy indicators have been identified for each of these policy areas (see appendix 3).</p>

### INTERPRETATION

- The revised National Composite Policy Index attempts to assess both policy development and effectiveness using elements of the AIDS Programme Effort Index Survey conducted in selected countries by the Policy Project.



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## **NATIONAL PROGRAMMES:**

**education, workplace policies, sexually transmitted infection case management, blood safety, prevention of mother-to-child transmission coverage, antiretroviral combination therapy coverage, and services for orphaned and vulnerable children**

3. Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year.
4. Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes.
5. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled.
6. Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.
7. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy.
8. Percentage of orphaned and vulnerable children whose households received free basic external support in caring for the child.
9. Percentage of transfused blood units screened for HIV.

## Life-skills-based HIV education in schools

Life skills is an effective, education methodology, which uses participatory exercises to teach behaviours to young people that help them deal with the challenges and demands of everyday life. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach young people how to cope with their emotions and causes of stress. When adapted specifically for HIV education in schools, a life-skills approach helps young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. When properly implemented, it can have a positive impact on behaviours, including delay in sexual debut and reduction in number of sexual partners.

### Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year

<b>PURPOSE</b>	To assess progress towards implementation of life-skills based HIV education in all schools
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	School survey or education programme review
<b>METHOD OF MEASUREMENT</b>	<p>Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV education and then are asked the following questions.</p> <ol style="list-style-type: none"> <li>1. Does your school have at least one qualified teacher who has received training in participatory life-skills based HIV education in the last 5 years?</li> <li>2. <i>If the answer to question 1. is “yes”</i>: Did this person teach life-skills based HIV education on a regular basis to each grade in your school throughout the last academic year?</li> </ol> <p>The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes, and skills (e.g., interpersonal communication, negotiation, decision-making, critical thinking and coping strategies) that assist young people in maintaining safe lifestyles. Wherever possible, the teacher training should have been done in accordance with the latest UNICEF guidelines, which can be found at <a href="http://www.unicef.org/lifeskills/index_documents.html">http://www.unicef.org/lifeskills/index_documents.html</a>.</p> <p>For the purposes of calculating this indicator, at least 30 hours of tuition per year per grade of pupil is recommended if life-skills-based HIV education is to qualify as standard tuition. However, countries may adjust this number according to local contexts.</p>

**Numerator:** Number of schools with staff members trained in and regularly teaching life-skills-based HIV education.

**Denominator:** Number of schools surveyed.

Indicator scores are required for all schools combined and for primary and secondary schools separately each by private/public status and by urban/rural setting. Church schools should be treated as private schools for this purpose. If school provides both primary and secondary education, information should be collected and reported separately for both levels of education.

## INTERPRETATION

- It is important that life-skills-based HIV education is initiated in the early grades of primary school and then continued throughout schooling with contents and methods being adapted to the age and experience of the students. Where schools provide both primary and secondary education, at least one teacher should have been trained to teach life-skills-based HIV education at each of these levels.
- The indicator provides useful information on trends in the coverage of life-skills-based HIV education within schools. However, the substantial variations in the levels of school enrolment must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Consequently, primary and secondary school enrolment rates for the most recent academic year should be included in the supporting information provided for this indicator.
- Complementary strategies that address the needs of out-of-school youth will be particularly important in countries where school enrolment rates are low.
- The indicator is a measure of coverage. The quality of education provided may differ by country and over time.

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## ADDITIONAL INDICATOR

### Percentage of primary and secondary schools where life-skills-based HIV education is taught

<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	School survey or education programme review

## Workplace HIV/AIDS control

Formal-sector workers are central to the development efforts of low-income countries. Business productivity is being undermined by the AIDS epidemic through the detrimental effects of higher morbidity, and mortality on staff performance, absenteeism and turnover, skills shortages and low workforce morale. Individual workers frequently have large numbers of dependent relatives. Male workers, in particular, are often at high risk of acquiring and transmitting HIV especially where labour migration is common. Those infected may also suffer stigma and discrimination in the workplace. However, the workplace is often a highly convenient and conducive setting for HIV control activities and workplace-based interventions have proven to be effective.

### Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes

<b>PURPOSE</b>	To assess progress in implementing workplace policies and programmes to combat HIV/AIDS
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Survey a representative sample of major employers in both the public and private sectors. Public-sector employers should include the ministries of transport, labour, tourism, education and health at a minimum. Private-sector employers should be selected on the basis of the size of their labour force.
<b>METHOD OF MEASUREMENT</b>	<p>Employers are asked to state whether they are currently implementing personnel policies and programmes that cover, as a minimum, all of the following aspects.</p> <ol style="list-style-type: none"> <li>1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.</li> <li>2. Workplace-based HIV/AIDS prevention activities that cover: (a) the basic facts on HIV/AIDS; (b) specific work-related HIV-transmission hazards and safeguards; (c) condom promotion; (d) voluntary counselling and testing; (e) sexually transmitted infection diagnosis and treatment; and (f) provisions for HIV/AIDS-related drugs.</li> </ol> <p><b>Numerator:</b> Number of employers with HIV/AIDS policies and programmes that meet all of the above criteria.</p> <p><b>Denominator:</b> Number of employers surveyed.</p> <p>Copies of written personnel policies and regulations should be obtained and assessed wherever possible.</p> <p>Indicator scores are required for all employers combined and for the public and private sectors separately.</p> <p>Estimates of the total number of men and women in formal sector workforce should also be provided in the supporting information provided for this indicator.</p>

## **INTERPRETATION**

- People employed in small businesses and the informal sector often constitute a significant proportion of the workforce but are less likely to be reached by workplace HIV/AIDS programmes. Nevertheless, trends in this indicator will provide a useful guide to incremental improvements in national coverage.
- The indicator is useful even in countries where HIV prevalence is low because early action in educating workers on HIV prevention is essential if the likelihood of serious economic and social consequences from HIV and AIDS is going to be reduced.

## Sexually transmitted infections: comprehensive case management

The risk of HIV transmission is substantially increased when one or both partners in a sexual relationship have another sexually transmitted infection. Thus, the availability and utilization of services to treat and contain the spread of sexually transmitted infections can reduce the rate of HIV transmission within a population. One of the corner stones of sexually transmitted infection control is comprehensive case management of patients with symptomatic sexually transmitted infections.

### Percentage of women and men with sexually transmitted infections at health-care facilities who are appropriately diagnosed, treated and counselled

<b>PURPOSE</b>	To assess progress in implementing universally effective sexually transmitted infection diagnosis, treatment and counselling
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Health facility survey—based on the UNAIDS/MEASURE (2000) <i>National AIDS Programme: A guide to monitoring and evaluation</i>
<b>METHOD OF MEASUREMENT</b>	<p>Data are collected in observations of provider-client interaction at a sample of health care facilities offering sexually transmitted infection services. See reference on: <i>Evaluation of a national AIDS programme: A methods package</i> UNAIDS/WHO (1994) for details on how to select this sample. Providers are assessed on history taking, examination, proper diagnosis and treatment of patients, and effective counselling including counselling on partner notification, condom use and HIV testing.</p> <p>“Appropriate” diagnosis and treatment and counselling procedures in any given country, are those specified in national sexually transmitted infection service guidelines.</p> <p>A “health-care” facility is defined as any setting (i.e., including public, private, and church sectors) where health-care services are provided by one or more medically qualified personnel.</p> <p><b>Numerator:</b> Number of sexually transmitted infection patients for whom the correct procedures were followed on: (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) effective counselling on partner notification, condom use and HIV testing.</p> <p><b>Denominator:</b> Number of sexually transmitted infection patients for whom provider-client interactions were observed.</p> <p>Disaggregated indicator scores should be reported for men and women and for patients under and over 20 years of age.</p> <p>Scores for each component of the indicator (i.e., history-taking, examination, diagnosis and treatment, and counselling) must be reported as well as the overall indicator score.</p>

## INTERPRETATION

- This composite indicator reflects the competence of health-service providers to correctly identify and treat sexually transmitted infections, the availability of the necessary equipment, drugs and materials, and the provision of appropriate counselling to patients.
- The indicator reflects the quality of services provided but not the cost or accessibility of these services.
- The standard for “appropriate” care upon which the measurement of the indicator is based may vary between countries (or over time). Currently, syndromic management is seen as the most practical approach in high-prevalence, low-income countries since there are fewer bottlenecks in diagnosis.

## Prevention of mother-to-child transmission: antiretroviral prophylaxis

In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery or after delivery through breastfeeding. The risk of mother-to-child transmission can be reduced through the complementary approaches of antiretroviral prophylaxis for the mother with or without prophylaxis to the infant, implementation of safe delivery practices and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months.

### Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission

<b>PURPOSE</b>	To assess progress in preventing vertical transmission of HIV
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Programme monitoring and estimates
<b>METHOD OF MEASUREMENT</b>	<p>The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of mother-to-child transmission in the last 12 months is obtained from programme monitoring records. Only those women who completed the full course should be included.</p> <p>The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of mother-to-child transmission <i>could potentially have been given</i> is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates).</p> <p><b>Numerator:</b> Number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce mother-to-child transmission according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months.</p> <p><b>Denominator:</b> Estimated number of HIV-infected pregnant women.</p> <p>The decision as to whether or not to include women who receive treatment from private sector and nongovernmental organization clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. Private sector and nongovernmental organization clinics that provide prescriptions for antiretrovirals, but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of prevention of mother-to-child transmission services.</p>

The definition of a “full course” of antiretroviral prophylaxis will depend on the country’s policy on antiretroviral prophylaxis to reduce the risk of mother-to-child transmission and may or may not include a dose for newborns. Details of the definition used should be provided.

Separate estimates of the numbers of pregnant women provided with antiretroviral prophylaxis at public sector and private sector clinics should be given.

## INTERPRETATION

- In many countries, the estimate of HIV prevalence among pregnant women used in the calculation of this indicator will be based on antenatal clinic-based HIV surveillance data. In some of these countries, large numbers of pregnant women do not have access to antenatal clinic services or choose not to make use of them. Pregnant women with HIV may be more or less likely to use antenatal clinic services (or public rather than private antenatal clinic services) than those who are not infected, particularly where antiretroviral prophylaxis can be accessed via such services. In such circumstances, this indicator should be interpreted with reference to recent estimates of utilization of national antenatal clinic services.
- Voluntary testing and counselling for HIV and antiretroviral prophylaxis to reduce mother-to-child transmission can be made available but, ultimately, it is up to individual women to decide whether or not to make use of these services. Thus, a country’s score on this indicator will reflect the degree of interest in these services (partly a function of the way in which they are promoted) as well as the extent to which they are available.
- Countries will apply different definitions as to what constitutes a “full course” of antiretroviral prophylaxis. Thus, intercountry comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case.
- This indicator does not measure compliance with the antiretroviral treatment regime because it is not possible to monitor drug compliance, unless direct supervision is undertaken.

## HIV treatment: antiretroviral combination therapy

As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral combination therapy has been shown to reduce mortality amongst those infected and efforts are being made to make it more affordable even within less-developed countries. Antiretroviral combination therapy should be provided in conjunction with broader care and support services including counselling for family caregivers.

### Percentage of people with advanced HIV infection receiving antiretroviral combination therapy

<b>PURPOSE</b>	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Programme monitoring
<b>METHOD OF MEASUREMENT</b>	<p>The number of people with advanced HIV infection who are currently receiving antiretroviral combination therapy is obtained from programme monitoring records.</p> <p><b>Numerator:</b> Number of people with advanced HIV infection who receive antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards); it is calculated as follows: number of people receiving treatment at the start of the year, plus number of people who commenced treatment in the preceding 12 months, minus number of people for whom treatment was terminated in the preceding 12 months (including those who died).</p> <p><b>Denominator:</b> Number of people with known advanced HIV infection (i.e. those in need of antiretroviral combination therapy)</p> <p>The number of adults in need of antiretroviral combination therapy is calculated by adding the number of adults newly in need of therapy to the number who were on treatment in the previous year and survived to the current year.</p> <p>The number of adults newly in need of antiretroviral combination therapy is estimated as the number developing advanced HIV disease who are not yet on treatment. Since some of the adults projected to develop advanced HIV disease may already have started treatment in the previous year, the number newly in need of antiretroviral combination therapy is adjusted by subtracting people in this category. It is currently assumed that between 80% and 90% of adults on treatment will survive to the following year, depending on patients' adherence to treatment, resistance patterns, the quality of clinical management and other factors.</p>

The denominator is generated by estimating the number of people with advanced HIV infection requiring antiretroviral combination therapy, most frequently on the basis of the latest sentinel surveillance data. The provision of antiretroviral drugs in the private sector should be included in the calculation of the indicator wherever possible and the extent of such provision should be recorded separately.

The start and end dates of the period for which antiretroviral combination therapy is given should be stated. Overlaps between reporting periods should be avoided if possible.

## INTERPRETATION

- The indicator permits monitoring of trends in coverage, but does not attempt to distinguish between different forms of antiretroviral therapy, or to measure the cost, quality, or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.
- The proportion of people with advanced stages of HIV infection varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral combination therapy among adults and children.
- Dynamic prevalence affects the accuracy of the estimate of the eligible population. Changing estimates of prevalence are not reflected in current prevalence. This specifically affects the denominator.
- The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, perceptions of effectiveness and possible side effects of treatment etc.
- Preventative antiretroviral therapy for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator.

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## ADDITIONAL INDICATOR

### Percentage of health facilities with the capacity to deliver appropriate care to people living with HIV and AIDS

<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Health facility survey (UNAIDS/MEASURE (2000), <i>National AIDS Programmes: A Guide to Monitoring and Evaluation</i> )

## Support for children affected by HIV and AIDS

As the number of orphaned and vulnerable children continues to grow, adequate support to families and communities needs to be assured. In practice, care and support for orphaned children comes from families and communities. As a foundation for this support, it is important that households are connected to additional support from external sources.

### Percentage of orphaned and vulnerable children whose households received free basic external support in caring for the child

<b>PURPOSE</b>	To assess progress in providing support to households that are caring for orphaned and vulnerable children
<b>APPLICABILITY</b>	High HIV-prevalence countries
<b>FREQUENCY</b>	4–5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (DHS, MICS)
<b>METHOD OF MEASUREMENT</b>	<p>Household heads are asked the following four questions about the types and frequency of support received, and the primary source of the help for each orphan and vulnerable child.</p> <ol style="list-style-type: none"> <li>1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months?</li> <li>2. Has this household received school-related assistance, including school fees, within the last 12 months?</li> <li>3. Has this household received emotional/psychological support, including counselling from a trained counsellor and/or emotional/spiritual support/companionship, within the last three months?</li> <li>4. Has this household received other social support, including socioeconomic support (e.g., clothing, extra food, financial support, shelter) and/or instrumental support (e.g., help with household work, training for caregiver, childcare, legal services) within the last three months?</li> </ol> <p><b>Numerator:</b> Number of orphaned and vulnerable children who live in households that answered YES to at least one of questions 1, 2, 3 and 4.</p> <p><b>Denominator:</b> Total number of orphaned and vulnerable children.</p>

### INTERPRETATION

- External support is defined as free help coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization.
- This indicator should only be monitored in settings with high HIV prevalence.
- This indicator does not measure the needs of the household or the orphans and vulnerable children. Additional questions could be added to measure expressed needs of families caring for orphans. This indicator implicitly suggests that all households with orphans and vulnerable children need external support: some orphans and vulnerable children are more in need of external support than others. Therefore, it is important to disaggregate the information by other markers of vulnerability such as socioeconomic status of the household, dependency ratio, head of the household, etc.
- If sample sizes permit, the data should be tabulated by orphans versus other vulnerable children. It should also be disaggregated by age and duration of orphanhood as both play a key role in determining the type of support needed. For example, an orphan whose parent(s) died 10 years ago will need support of a different kind from one whose parent(s) died within the past year.

## Blood safety

Blood-safety programmes aim to ensure that the overwhelming majority (ideally 100%) of blood units are screened for HIV and those units that are included in the national blood supply are uninfected. In many countries, blood units are not screened at all; often, if they are screened, the testing is done by poorly-trained personnel or with outdated equipment or insufficient inputs, which could lead to blood units being classified as safe even when they are infected.

### Percentage of transfused blood units screened for HIV

<b>PURPOSE</b>	To assess progress in screening transfused blood units for HIV
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	MEASURE <i>Evaluation</i> blood safety protocol
<b>METHOD OF MEASUREMENT</b>	<p>Three pieces of information are needed for this indicator: the number of blood units transfused in the previous 12 months, the number of blood units screened for HIV in the previous 12 months, and among the units screened, the number screened up to WHO or national standards.</p> <p>The number of blood units transfused and the number screened for HIV should be available from national health information systems. Quality of screening may be determined from a special study that re-tests a sample of blood previously screened. In situations where this approach is not feasible, data on the percentage of facilities with good screening and transfusion records and no stockouts of test kits may be used to estimate adequately screened blood for this indicator.</p> <p><b>Numerator:</b> Number of blood units screened for HIV in the last 12 months up to WHO or national standards.</p> <p><b>Denominator:</b> Number of blood units transfused in the last 12 months.</p>

### INTERPRETATION

- Where health systems are decentralized, or where the private sector, including hospitals and clinics, is involved in blood screening and blood banking, it may be difficult to obtain enough accurate information to construct a robust indicator on a national scale. In this case, it will probably be necessary to select sentinel hospitals and laboratories in both the public and private sector for facility-based surveys of blood transfusion and screening quality.
- Countries may have different national standards for blood screening. If the standards are below those published by WHO, it is essential that details of the national standards be included in the report on this indicator.



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## KNOWLEDGE AND BEHAVIOUR

10. \*\* Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Target: 90% by 2005; 95% by 2010).
11. Percentage of young women and men who have had sex before the age of 15.
12. Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months.
13. \*\* Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner.
14. \*\* Ratio of current school attendance among orphans to that among non-orphans, aged 10–14.

## Young people: knowledge about HIV prevention

HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV and AIDS is an essential pre-requisite—albeit, often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

### Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

<b>PURPOSE</b>	To assess progress towards universal knowledge of the essential facts about HIV transmission
<b>APPLICABILITY</b>	All countries
<b>TARGETS</b>	2005 – 90% 2010 – 95%
<b>FREQUENCY</b>	Preferred: biennial Minimum: every 4–5 years
<b>MEASUREMENT TOOL</b>	Population-based survey such as DHS, MICS, BSS (youth section)
<b>METHOD OF MEASUREMENT</b>	<p>This indicator is constructed from responses to the following set of prompted questions.</p> <ol style="list-style-type: none"> <li>1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?</li> <li>2. Can the risk of HIV transmission be reduced by using condoms?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. Can a person get HIV from mosquito bites?</li> <li>5. Can a person get HIV by sharing a meal with someone who is infected?</li> </ol> <p><b>Numerator:</b> Number of respondents (aged 15–24 years) who gave the correct answers to all five questions.</p> <p><b>Denominator:</b> Number of respondents (15–24) who gave answers (i.e., including “don’t know”) to all five questions.</p> <p>Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.</p> <p>Indicator scores are required for all respondents aged 15–24 years and for males and females, separately, each by urban/rural residence.</p> <p>Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.</p>

### INTERPRETATION

- The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners.
- Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behaviour, while belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.
- This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it can be used to ensure that pre-existing high levels of knowledge are maintained.

## Sex before the age of 15

A major goal in many countries is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV. There is also evidence to suggest that a later age at first sex reduces susceptibility to infection per act of sex, at least for women.

### Percentage of young women and men who have had sex before the age of 15

<b>PURPOSE</b>	To assess progress in increasing the age at which young men and women aged 15–24 first have sex
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	4–5 years
<b>MEASUREMENT TOOL</b>	Population-based survey such as DHS, MICS, BSS (youth section)
<b>METHOD OF MEASUREMENT</b>	In household or special surveys focusing on young people, all respondents are asked whether or not they have ever had penetrative sex and, if applicable, to recall age at first sex.  The indicator should be presented as separate percentages for males and females, each by urban/rural residence, and should be disaggregated by the age groups 15–19 and 20–24 years.  <b>Numerator:</b> Number of respondents (aged 15–24 years) who report their age at sexual initiation as under 15 years.  <b>Denominator:</b> Number of respondents aged 15–24 years.

### INTERPRETATION

- Countries where very few young people have sex before the age of 15 might opt to use an alternative indicator: “Percentage of young women and men aged 20–24 who report their age at sexual initiation as under 18 years.”
- The advantage of using the reported age at sexual initiation (in comparison with the median age at first sex) is that calculation is simple and allows easy comparison over time. The denominator is easily defined because all members of the survey sample contribute to this measure.
- It is difficult to monitor change in this indicator over a short period because only individuals entering the group, i.e. those aged under 15 at the beginning of the period for which the trends are to be assessed can influence the numerator. If the indicator is assessed every two to three years, it may be better to focus on changes in the levels for the 15–17 age group. If it is assessed every five years, the possibility exists of looking at the 15–19 age group.
- In countries where HIV-prevention programmes encourage delaying first sex or virginity, young people’s responses to survey questions on this issue may be biased, including a deliberate misreporting of age at first sex.

### ADDITIONAL INDICATOR

#### Median age at first sex

<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	4–5 years
<b>MEASUREMENT TOOL</b>	Population-based survey (UNAIDS/MEASURE (2000), <i>National AIDS Programmes: A Guide to monitoring and evaluation</i> ; BMJ Journals Sexually transmitted infections (December 2004 Volume 80 Suppl II) Measurement of sexual behaviour, pages 28–35).

## Higher-risk sex among young women and men

The spread of HIV depends upon unprotected sex among people with high number of partnerships. Partners who do not live together are those who are most likely to have other partners over the course of a year. These partnerships, therefore, carry a higher risk of HIV transmission than partnerships that do not link into a wider sexual network.

### Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months

<b>PURPOSE</b>	To assess progress in reducing the percentage of young people aged 15–24 who have higher risk sex
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	4–5 years
<b>MEASUREMENT TOOL</b>	Population-based survey such as DHS, MICS, BSS (youth section)
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked about their marital status and the last three sexual partners within the last 12 months. For each partner, details are taken of cohabiting status as well as duration of the relationship, condom use and other factors.</p> <p><b>Numerator:</b> Number of respondents aged 15–24 who have had sex with a non-marital, non-cohabiting partner in the last 12 months.</p> <p><b>Denominator:</b> Number of respondents aged 15–24 who report sexual activity in the last 12 months.</p>

### INTERPRETATION

- This indicator gives a picture of levels of higher-risk sex. If people stop having sex with all of their non-cohabiting partners, the change will be captured by changes in this indicator. However, if people simply decrease from seven non-cohabiting partners to one, for example, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a programme success.

## Young people: condom use with non-regular partners

Consistent correct use of condoms within non-regular sexual partnerships substantially reduces the risk of sexual HIV transmission. This is especially important for young people who often experience the highest rates of HIV acquisition because they have low prior exposure to infection and (typically) relatively high numbers of non-regular sexual partnerships. Consistent condom use with non-regular sexual partners is important even in countries where HIV prevalence is low because it can prevent the spread of HIV in circumstances where non-regular relationships are common. Condom use is one measure of protection against HIV: delaying age at first sex, reducing the number of non-regular sex partners, and being faithful to one non-infected partners are equally important.

### Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sex partner

<b>PURPOSE</b>	To assess progress towards preventing early-age exposure to HIV through unprotected sex with non-regular partners
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Preferred: biennial Minimum: every 4-5 years
<b>MEASUREMENT TOOL</b>	Population-based survey such as DHS, MICS, BSS (youth)
<b>METHOD OF MEASUREMENT</b>	<p>Survey respondents aged 15–24 years are asked whether they have commenced sexual activity (or otherwise this is inferred from responses to a question on age at first sex). Those who report sexual activity (whether currently married or unmarried) are then asked the following questions.</p> <ol style="list-style-type: none"> <li>1. In the last 12 months, have you had sexual intercourse with a non-regular partner who was neither your spouse nor someone you were living with?</li> <li>2. <b>If the answer to question 1 is “yes”:</b> How many non-regular partners have you had sex with in the 12 months?</li> <li>3. <b>If the answer to question 1. is “yes”:</b> Did you (or your partner) use a condom the last time you last had sex with your most recent non-regular partner?</li> </ol> <p><b>Numerator:</b> Number of the respondents (aged 15–24) who reported having had a non-regular (i.e., non-marital and non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.</p> <p><b>Denominator:</b> Number of respondents (15–24) who reported having had a non-regular sexual partner in the last 12 months</p> <p>Indicator scores are required for all respondents aged 15–24 years and for males and females, separately, each by urban/rural residence.</p> <p>The percentage of young people who said they had started sex and the percentage of these who had had a non-regular partner in the last 12 months should be stated.</p>

## **INTERPRETATION**

- This indicator shows the extent to which condoms are used by young people who engage in non-regular sexual relationships. However, the broader significance of any given indicator score will depend upon the extent to which young people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on percentages of young people who have started sex and (of these) that have engaged in a non-regular partnership within the last year.
- The maximum protective effect of condoms in non-regular sexual intercourse is achieved when their use is consistent rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms were always/sometimes/never used in sexual encounters with non-regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sex act with a non-regular partner will generally reflect the trend in consistent condom use with such partners.

## Orphans: school attendance

AIDS is claiming ever growing numbers of adults just at the time in their lives when they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly uncertain future. Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can further jeopardize children's chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important therefore to monitor the extent to which AIDS-support programmes succeed in securing the educational opportunities of orphaned children.

### Ratio of current school attendance among orphans to that among non-orphans aged 10–14

<b>PURPOSE</b>	To assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Preferred: biennial Minimum: every 4–5 years
<b>MEASUREMENT TOOL</b>	Population-based survey such as DHS, MICS or other representative survey
<b>METHOD OF MEASUREMENT</b>	Ratio of the current school attendance rate of children aged 10–14 both of whose <b>biological</b> parents have died to the current school attendance rate of children aged 10–14 both of whose parents are still alive and who currently live with at least one biological parent.
Orphan school attendance (1)	<b>Numerator:</b> Number of children who have lost both parents and are still in school. <b>Denominator:</b> Number of children who have lost both parents.
Non-orphan school attendance (2)	<b>Numerator:</b> Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school. <b>Denominator:</b> Number of children both of whose parents are still alive and who live with at least one parent.
Calculate the ratio of (1) to (2).	Indicator scores are required for all children aged 10–14 years and for boys and girls, separately. Where possible, the indicator should also be calculated by single year of age (see section on interpretation).  The minimum number of orphaned 10–14 year-old children needed to calculate this indicator is 50 (see section on interpretation).

### INTERPRETATION

- The definitions of orphan/non-orphan used here i.e., child aged 10–14 years at last birthday both of whose parents have died/are still alive—are chosen so that the maximum effect of disadvantage resulting from orphanhood can be identified and tracked over time. The age-range 10–14 years is used because younger orphans are more likely to have lost their parents recently so any detrimental effect on their education will have had little time to materialize. However, orphaned children are typically older than non-orphaned children—because the parents of younger children have had less

time to die—and older children are more likely to have left school. Thus, the value of this indicator will tend to be slightly greater than one, even when orphans suffer no relative disadvantage.

- Typically, the data used to measure this indicator will be taken from household-based surveys. Children not recorded in such surveys—e.g., those living in institutions or on the street—generally, are more disadvantaged and are more likely to be orphans. Thus, the indicator will tend to understate the relative disadvantage in educational attendance experienced by orphaned children.
- The indicator does not distinguish children who lost their parents due to AIDS from those whose parents died of other causes. In countries with smaller epidemics or in the early stages of epidemics, most orphans will have lost their parents due to non-HIV-related causes. Any differences in the treatment of orphans according to the known or suspected cause of death of their parents could influence trends in the indicator. However, to date, there is little evidence that such differences in treatment are common.
- The indicator provides no information on actual numbers of orphaned children. The restrictions to double orphans and to 10–14 year-olds mean that estimates may be based on small numbers in countries with small or nascent epidemics.

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## ADDITIONAL INDICATOR

### Percentage of children aged less than 15 years who are orphans

This indicator provides information on trends in the extent of the orphan burden within a population. Loss of the father, of the mother or of both parents may have different implications. Similarly, orphanhood at different ages is liable to carry different consequences. Ideally, therefore, data should be collected by types of orphanhood (maternal, paternal and double) and by five-year age-group as well as by gender of child.

<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	4–5 years
<b>MEASUREMENT TOOL</b>	Population-based survey (UNAIDS/MEASURE (2000), <i>National AIDS Programmes: A Guide to Monitoring and Evaluation</i> )

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## IMPACT

15. \*\* Percentage of young women and men aged 15–24 who are HIV infected (**target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010**).
16. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy.
17. Percentage of infants born to HIV infected mothers who are infected (**target: 20% reduction by 2005; 50% reduction by 2010**).

## Reduction in HIV prevalence

The goal in the response to HIV is to reduce HIV infection. As the highest rates of new HIV infections typically occur at young adult ages, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people—25% reduction in the most affected countries by 2005 and 25% reduction globally by 2010.

### Percentage of young people aged 15–24 who are HIV infected

<b>PURPOSE</b>	To assess progress towards reducing HIV infection
<b>APPLICABILITY</b>	Countries with generalized epidemics
<b>TARGETS</b>	2005 – 25% reduction (in the most affected countries) 2010 – 25% reduction (globally)
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	<i>UNAIDS/WHO Guidelines for Second Generation HIV Surveillance, and Guidelines for Conducting HIV serosurveys among pregnant women and other groups.</i>
<b>METHOD OF MEASUREMENT</b>	<p>This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites <i>in the capital city</i>, other urban areas and rural areas.</p> <p><b>Numerator:</b> Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive</p> <p><b>Denominator:</b> Number of antenatal clinic attendees (15–24) tested for their HIV infection status</p> <p>Median figures should be used for other urban and rural areas.</p> <p>Indicator scores should be given for the whole age range (15–24 years) and disaggregated by 5-year age-group (i.e., 15–19 years and 20–24 years).</p> <p>The proportion of the total female population aged 15–24 living in the capital city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.</p>

### INTERPRETATION

- HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in HIV prevalence figures for the 15–19 year age group. Where available, parallel behavioural surveillance data should be used to aid interpretation of trends in HIV prevalence.
- In countries where age at first sexual intercourse is late and/or levels of contraception are high, HIV prevalence among pregnant women in the age group 15–24 years will differ from that among all women in the age group.

- This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV-epidemic trends in locations where most infections are concentrated in most-at-risk populations.
- To supplement data from sentinel surveillance, an increasing number of countries are implementing HIV testing as part of the population-based survey. This approach is recommended in countries with high HIV prevalence. Wherever available, results of the survey should be included in the report submitted with this indicator.

## HIV treatment: survival after 12 months on antiretroviral therapy

One of the goals of any antiretroviral therapy programme is to increase survival among infected individuals. As antiretroviral therapy is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. This data can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

### Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy

<b>PURPOSE</b>	To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy
<b>APPLICABILITY</b>	All countries
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Programme monitoring
<b>METHOD OF MEASUREMENT</b>	<p>Information on survival can be obtained from patient registers (HMIS) by tallying results for several monthly cohorts, each tabulated when on antiretroviral therapy for 12 months.</p> <p>For a comprehensive understanding of survival, the following data must be collected.</p> <ul style="list-style-type: none"> <li>• Number of adults and children initiating antiretroviral therapy and the start date.</li> <li>• Number of adults and children continuously on antiretroviral therapy at 12 months after initiating treatment.</li> <li>• Number of people who have stopped antiretroviral therapy, including those who have transferred out, those lost to follow-up and those who have died.</li> </ul> <p>A proportion of people who have stopped treatment or were lost to follow-up may still be alive. However, since they are not continuously on treatment, they should not be included in the numerator.</p> <p>People who transfer between antiretroviral therapy programmes and for whom a start date of treatment exists should be counted as continuously on treatment.</p> <p><b>Numerator:</b> Number of adults and children continuously on antiretroviral therapy at 12 months after initiating treatment.</p> <p><b>Denominator:</b> (a) Minimum survival: Total number of adults and children who initiated antiretroviral therapy in the therapy start-up group 12 months earlier, including those who have stopped antiretroviral therapy, those who have transferred out, and people lost to follow-up.</p> <p>(b) Maximum survival: Total number of adults and children who initiated antiretroviral therapy in the therapy start-up group 12 months earlier, excluding those who have stopped antiretroviral therapy, those who have transferred out, and people lost to follow-up.</p>

## **INTERPRETATION**

- In most countries, data for this indicator can only be obtained from a limited number of care/referral facilities and/or designated cohort studies while national health-information systems are scaled up. When these systems become fully operational, data should be even more accessible and comprehensive.
- Patient records may not include mobile populations or the status of the duration of their therapy.

## Reduction in mother-to-child transmission

In high-income countries, strategies such as antiretroviral treatment during pregnancy and following birth, and the use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In developing countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using voluntary counselling and testing services, reproductive health and maternal and child health services, which have integrated prevention of mother-to-child transmission interventions including breast milk substitute (where this is part of the country's policy on prevention of mother-to-child transmission). Nevertheless, substantial reductions in mother-to-child transmission can be achieved through approaches such as short-course antiretroviral prophylaxis.

### Percentage of infants born to HIV infected mothers who are infected

<b>PURPOSE</b>	To assess progress towards eliminating mother-to-child HIV transmission
<b>APPLICABILITY</b>	All countries
<b>TARGETS</b>	2005 – 20% reduction 2010 – 50% reduction
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Estimates based on programme coverage
<b>METHOD OF MEASUREMENT</b>	<p>The indicator can be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving antiretroviral; the weights being the proportions of women receiving and not receiving antiretroviral, respectively. Expressed as a simple mathematical formula:</p> <p><b>Indicator score</b> = <math>\{ T*(1-e) + (1-T) \} * v</math></p> <p>where:</p> <p><b>T</b> = proportion of HIV-positive pregnant women provided with antiretroviral treatment</p> <p><b>v</b> = mother-to-child transmission rate in the absence of any treatment</p> <p><b>e</b> = efficacy of treatment provided</p> <p><b>T</b> is simply national indicator #6. Default values of 25% and 50%, respectively, can be used for v and e. However, where scientific estimates of the efficacy of the specific forms of antiretroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded.</p> <p>The most common forms of treatment provided during the last 12 months should be noted.</p>

### INTERPRETATION

- This indicator focuses on prevention of mother-to-child transmission of HIV through increased provision of antiretroviral drugs. Thus, the effect of breastfeeding on mother-to-child transmission of HIV is ignored and the indicator may yield underestimates of true rates of mother-to-child transmission in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of mother-to-child transmission of HIV (e.g., caesarean section) are widely practised, the indicator will typically provide overestimates of mother-to-child transmission. For these reasons, trends in this indicator may not reflect overall trends in mother-to-child transmission of HIV.
- National Indicator # 6 may provide a poor estimate for T in circumstances where usage of antenatal clinic services is low.

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# CONCENTRATED/LOW-PREVALENCE EPIDEMICS

## NATIONAL COMMITMENT AND ACTION

### Expenditures and policy development and implementation status

1. Amount of national funds disbursed by governments.
2. National Composite Policy Index:
  - Strategic plan
  - Political support
  - Prevention
  - Care and support
  - Human rights
  - Civil society involvement
  - Monitoring and evaluation

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For national Indicators 1 and 2 on expenditures, and policy development and implementation status, see pages 22–25.

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## **NATIONAL PROGRAMMES:**

### **HIV testing and prevention programmes for most-at-risk populations**

3. Percentage of (most-at-risk populations) who received HIV testing in the last 12 months and who know the results.
4. Percentage of (most-at-risk populations) reached by prevention programmes.

## Most-at-risk populations: HIV testing

In order to protect themselves and to prevent infecting others, it is important for members of most-at-risk populations to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. *This indicator should be calculated separately for each population that is considered most-at-risk in a given country e.g., sex workers, injecting drug users, men who have sex with men.*

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, it would be valuable for them to calculate and report on this indicator for those populations.

### Percentage of [most-at-risk population(s)] who received HIV testing in the last 12 months and who know the results

<b>PURPOSE</b>	To assess progress in implementing HIV testing and counselling among most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	A. Special surveys such as the FHI BSS B. Programme monitoring
<b>METHOD OF MEASUREMENT</b>	<p>A. Surveys: respondents are asked the following questions.</p> <ol style="list-style-type: none"> <li>1. Have you been tested for HIV in the last 12 months?</li> <li>2. If the answer to question 1 is "yes:" Do you know the results of that test?</li> </ol> <p>B. Programme monitoring: the proportion of the population accessing HIV testing and counselling services is calculated from data collected by service providers.</p> <p><b>Numerator:</b> Number of [most-at-risk population] respondents who have been tested for HIV during the last 12 months and who know the results of their test</p> <p><b>Denominator:</b> Number of [most-at-risk population] included in the sample (A) or prevalence estimation methods for the size of the most-at-risk population for the denominator (B).</p> <p>Data for this indicator should be disaggregated by gender and age (&lt;25/25+).</p> <p>Whenever possible, data for [most-at-risk population] should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

### INTERPRETATION

- Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national [most-at-risk population] being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.
- Tracking most-at-risk populations over time to measure progress may be difficult due to mobility.

## Most-at-risk populations: prevention programmes

Most-at-risk populations are often difficult to reach with HIV-prevention programmes. However, in order to prevent the spread of HIV among these populations as well as into the general population, it is important that they access these services. *This indicator should be calculated separately for each population that is considered most-at-risk in a given country, e.g., sex workers, injecting drug users, men who have sex with men.*

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, it would be valuable for them to calculate and report on this indicator for those populations.

### Percentage of [most-at-risk population(s)] reached with HIV-prevention programmes

<b>PURPOSE</b>	To assess progress in implementing HIV prevention programmes for most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	A. Special surveys such as the FHI BSS B. Programme monitoring
<b>METHOD OF MEASUREMENT</b>	<p>A. Surveys: Respondents are asked a series of questions about the exposure/use of key HIV-prevention services. Depending on local contexts, the list would include: (1) outreach and peer education; (2) exposure to targeted mass media; (3) sexually transmitted infection screening and/or treatment; (4) HIV counselling and testing; (5) substitution therapy and safer injection practices for injecting drug users.</p> <p>B. Programme monitoring: records of programmes providing the above-mentioned services are compiled and aggregated to obtain an overall measure of the reach of prevention programmes.</p> <p><b>Numerator:</b> Number of [most-at-risk population] respondents who have been reached by at least one HIV-prevention programme during the last 12 months.</p> <p><b>Denominator:</b> Number of [most-at-risk population] included in the sample (A) or prevalence estimation methods for the size of the most-at-risk population for the denominator (B).</p> <p>Data collected for this indicator should be disaggregated by gender and age (&lt;25/25+).</p> <p>Whenever possible, data for [most-at-risk population] should be collected through civil-society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

## **INTERPRETATION**

- Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national [most-at-risk population] being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.
- Different types of services will all count the same in estimating overall service coverage.
- In case the indicator is based on programme data, an attempt to address the issue of double counting during the reference period should be made. There is a need to ensure that clients served (as opposed to clients-visits) for the same service or across services are counted.

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## KNOWLEDGE AND BEHAVIOUR

5. Percentage of (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
6. Percentage of female and male sex workers reporting the use of a condom with their most recent client.
7. Percentage of men reporting the use of a condom the last time they had sex with a male partner.
8. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV i.e., who avoid using non-sterile injecting equipment and use condoms in the last month.

## Most-at-risk populations: knowledge about HIV prevention

Concentrated epidemics are generally driven by sexual transmission or use of contaminated injecting equipment. Sound knowledge about HIV and AIDS is an essential prerequisite if people are going to adopt behaviours that reduce their risk of infection. *This indicator should be calculated separately for each population that is considered most-at-risk in a given country e.g., sex workers, injecting drug users, men who have sex with men.*

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, it would be valuable for them to calculate and report on this indicator for those populations.

### Percentage of [most-at-risk population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

<b>PURPOSE</b>	To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Special surveys such as the FHI BSS
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following five questions.</p> <ol style="list-style-type: none"> <li>1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?</li> <li>2. Can using condoms reduce the risk of HIV transmission?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. Can a person get HIV from mosquito bites?</li> <li>5. Can a person get HIV by sharing a meal with someone who is infected?</li> </ol> <p><b>Numerator:</b> Number of [most-at-risk population] respondents who gave the correct answers to <i>all</i> five questions.</p> <p><b>Denominator:</b> Number of [most-at-risk population] respondents who gave answers, including “don’t know,” to all five questions.</p> <p>Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator.</p> <p>Indicator scores are required for all respondents and should be disaggregated by gender and location of residence (urban/rural). Whenever possible, data for [most-at-risk population] should be collected through civil-society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

## INTERPRETATION

- The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners.
- Correct knowledge about false beliefs of possible modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behaviour, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.
- This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained.
- Surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national [most-at-risk population] being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.

## Sex workers: condom use

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, through consistent and correct condom use.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among sex workers. If so, it would be valuable for them to calculate and report on this indicator for this population.

### Percentage of female and male sex workers reporting the use of a condom with their most recent client

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
<b>APPLICABILITY</b>	Countries with concentrated or low prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Special surveys including the FHI BSS for sex workers
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following question:</p> <p>Did you use a condom with your most recent client in the last 12 months?</p> <p><b>Numerator:</b> Number of respondents who reported that a condom was used with their last client in the last 12 months</p> <p><b>Denominator:</b> Number of respondents who reported having commercial sex in the last 12 months.</p> <p>Data for this indicator should be disaggregated by gender and location of residence (urban/rural).</p> <p>Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

### INTERPRETATION

- Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.
- Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample of the national sex worker population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.

## Men who have sex with men: condom use

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is 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 their most recent male partner is considered a reliable indicator of longer-term behaviour.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among men who have sex with men. If so, it would be valuable for them to calculate and report on this indicator for this population.

### Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Special surveys including the FHI BSS for men who have sex with men
<b>METHOD OF MEASUREMENT</b>	<p>In a behavioural survey in a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships, and about condom use at last anal sex.</p> <p><b>Numerator:</b> Number of respondents who reported that a condom was used the last time they had anal sex.</p> <p><b>Denominator:</b> Number of respondents who reported having had anal sex with a male partner in the last 6 months.</p> <p>Data for this indicator should be disaggregated by age (&lt;25/25+) and location of residence (urban/rural).</p> <p>Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

### INTERPRETATION

- Condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in populations surveyed.
- This indicator does not give any idea of risk behaviour in sex with women, among men who have sex with both men and women. In countries where men in the sub-population surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for male and female partners.
- Surveying men who have sex with men can be challenging. Consequently, data obtained may not be based on a representative sample of the national population of men who have sex with men. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.

## Injecting drug users: safe injecting and sexual practices

Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) injecting drug users can spread HIV (e.g., through sexual transmission) to the wider population.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among injecting drug users. If so, it would be valuable for them to calculate and report on this indicator for this population.

### Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoided using non-sterile injecting equipment and used condoms in the last month

<b>PURPOSE</b>	To assess progress in preventing injecting drug use-associated HIV transmission
<b>APPLICABILITY</b>	Countries where injecting drug use is an established mode of HIV transmission
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Special surveys including the FHI BSS for injecting drug users
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following sequence of questions:</p> <ol style="list-style-type: none"> <li>1. Have you injected drugs at any time in the last month?</li> <li>2. If the answer to question 1 is “yes:” Have you used non-sterile injecting equipment at any time in the last month?</li> <li>3. Have you had sexual intercourse in the last month?</li> <li>4. If the answers to questions 1 and 3 are both “yes:” Did you or your partner use a condom when you last had sex?</li> </ol> <p><b>Numerator:</b> Number of respondents who report having never used non-sterile injecting equipment during the last month and who also reported that a condom was used the last time they had sex.</p> <p><b>Denominator:</b> Number of respondents who report injecting drugs and having had sexual intercourse in the last month.</p> <p>Indicator scores are required for all respondents and should be disaggregated by gender and age (&lt;25/25+).</p> <p>Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

## INTERPRETATION

- Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.
- The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which injecting drug users use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among injecting drug users and between injecting drug users and the wider population. This indicator provides information on the third factor and partial information on the fourth factor.



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# IMPACT

9. Percentage of (most-at-risk populations) who are HIV infected.

## Most-at-risk populations: reduction in HIV prevalence

Most-at-risk populations typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among most-at-risk populations is a critical measure of a national-level response to HIV. *This indicator should be calculated separately for each population that is considered most-at-risk in a given country, e.g., sex workers, injecting drug users, men who have sex with men.*

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk population. If so, it would be valuable for them to calculate and report on this indicator for those populations.

### Percentage of [most-at-risk population(s)] who are HIV-infected

<b>PURPOSE</b>	To assess progress on reducing HIV prevalence among most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, where routine surveillance among pregnant women is not recommended; also includes countries with concentrated sub-epidemics within a generalized epidemic
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	<i>Annual UNAIDS/WHO Guidelines for Second Generation HIV Surveillance</i> ; FHI guidelines on sampling in population groups
<b>METHOD OF MEASUREMENT</b>	<p>This indicator is calculated using data from HIV tests conducted among members of [most-at-risk population] groups in the capital city:</p> <p><b>Numerator:</b> Number of members of [most-at-risk population] who test positive for HIV.</p> <p><b>Denominator:</b> Number of members of [most-at-risk population] tested for HIV.</p> <p>To avoid biases in trends over time, this indicator should be reported for the capital city only. In recent years, many countries have expanded the number of sentinel sites to include more rural ones, leading to biased trends resulting from aggregation of data from these sites.</p>

### INTERPRETATION

- Due to difficulties in accessing most-at-risk populations, biases in serosurveillance data are likely to be far more significant than in data from a more generalized population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in its interpretation.
- An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator.
- The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.
- Trends in HIV prevalence among most-at-risk populations in the capital city will provide a useful indication of HIV-prevention programme performance in that city. However, it will not be representative of the situation in the country as a whole.

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## GLOBAL COMMITMENT AND ACTION

1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries.
2. Amount of public funds for Research and Development of preventive HIV vaccines and microbicides.
3. Percentage of transnational companies which are present in developing countries and which have HIV/AIDS workplace policies and programmes.
4. Percentage of international organizations which have workplace policies and programmes.

## Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries

<b>PURPOSE</b>	To monitor financial flows (commitments and disbursements) from DAC member countries and multilateral agencies (the Global Fund to Fight AIDS, TB and Malaria, the UN System and selected Development Banks) to low- and middle-income countries <sup>3</sup> .
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Annual questionnaire by the Organisation for Economic Co-operation and Development (OECD) Development Co-operation Directorate (DCD).
<b>METHOD OF MEASUREMENT</b>	<ol style="list-style-type: none"> <li>1. Sexually transmitted infection control including HIV—all activities related to sexually transmitted diseases and HIV control (Creditor Reporting System code 13040).</li> <li>2. Official Development Assistance (ODA) and their Official Aid (OA) to low- and middle-income countries.</li> </ol>

### INTERPRETATION

- The indicator permits cross donor comparability of data.
- This indicator reflects statistical data on donor assistance to HIV control. It does not capture the private sector flows (international nongovernmental organizations and foundations, and corporate)
- At present the code is limited to interventions within the health sector. Efforts are currently being made to introduce one additional code to account for non-health related donor assistance to HIV/AIDS and to identify HIV/AIDS components in wider programmes. (see footnote)
- The indicator does not distinguish between resources devoted to HIV and AIDS prevention, treatment and care, social mitigation and support.
- Trends have shown that some donors include funding for Research and Development in their reporting to the OECD/DAC under the current HIV/AIDS definition, this however is not unique to all donors.

For these reasons, the indicator is likely to be an under-estimate of total donor assistance to HIV/AIDS and fluctuations in the indicator will reflect variations in response to the survey due to refinement of the current methodology<sup>4</sup>.

<sup>3</sup> Four funding streams support the financing of AIDS programmes – bilateral, multilateral, private and domestic flows. Bilateral multilateral and private flows are referred to as International flows.

<sup>4</sup> One additional CRS code covering social mitigation of HIV/AIDS (provision of social and legal assistance to people living with HIV/AIDS: special programmes to address social consequences of HIV/AIDS) is presently under consideration with the OECD, Development Co-operation Directorate (DCD), DAC – Working Party on Statistics. The Working Party is also discussing a multiple purpose code system. This would allow for the identification of HIV/AIDS related activities within wider health and other programmes.

## Amount of public funds for Research and Development of preventive HIV vaccines and microbicides

<b>PURPOSE</b>	To track public sector funding for research and development (R&D) for preventive HIV vaccines and microbicides.
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Survey of financial resource flows <sup>5</sup> to relevant Governments (Government research bodies, development assistance governments, multilateral organizations) funding preventive HIV vaccine and microbicide research and development.
<b>METHOD OF MEASUREMENT</b>	<p>Information on annual investment levels are collected from the national/federal departments and multilateral organizations identified who provide funding for preventive HIV vaccine and microbicide research and development. Information is collected on funds disbursed each year on a range of activities including: vaccine related basic science; pre-clinical research; clinical trials; support for clinical trial preparation; and advocacy and policy efforts directed at accelerating the development of these technologies and their eventual use. The estimates, however, do not include:</p> <ul style="list-style-type: none"> <li>• Research and development expenditures/investments for vaccines with primarily therapeutic applications;</li> <li>• Research not directed primarily at preventive HIV vaccines and/or microbicides but that may have benefits or links to either of these products (e.g., platform technologies).</li> </ul>

### INTERPRETATION

- This indicator provides data on annual public sector funding for preventive HIV vaccine and microbicides research and development that can be used to monitor current levels of effort and trends in investment, spending and research focus over time.
- The indicator provides only a partial picture of global funding for HIV vaccines and microbicides as it does not include philanthropic and private sector funding.

<sup>5</sup> Implemented and analysed by the HIV Vaccines and Microbicides Resource Tracking Working Group – AIDS Vaccine Advocacy Coalition, Alliance for Microbicide Development, International AIDS Vaccine Initiative, UNAIDS

## Workplace HIV/AIDS control: transnational companies

### Percentage of transnational companies which are present in developing countries and which have HIV/AIDS workplace policies and programmes

<b>PURPOSE</b>	To assess progress in implementing workplace policies and programmes to combat HIV/AIDS in transnational companies
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Desk review and key informant interviews
<b>METHOD OF MEASUREMENT</b>	<p>The United Nations Conference on Trade and Development (UNCTAD) list of 100 largest transnational companies ranked by foreign assets plus an addition 10 transnationals in mining and tourism sectors are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, <b>all</b> of the following aspects.</p> <ol style="list-style-type: none"> <li>1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.</li> <li>2. Workplace-based HIV-prevention activities that cover: (a) the basic facts on HIV and AIDS; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) confidential voluntary counselling and testing; (e) sexually transmitted infection diagnosis and treatment; and (f) provisions for HIV- and AIDS-related drugs.</li> </ol> <p><b>Numerator:</b> Number of employers with HIV/AIDS policies and programmes that meet all of the above criteria.</p> <p><b>Denominator:</b> Number of employers surveyed (110).</p> <p>Copies of written personnel policies and regulations should be obtained and assessed wherever possible.</p>

## Workplace HIV/AIDS control: international organizations

### Percentage of international organizations which have workplace policies and programmes

<b>PURPOSE</b>	To assess progress in implementing workplace policies and programmes to respond to HIV and AIDS in international organizations
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Desk review and key informant interviews
<b>METHOD OF MEASUREMENT</b>	<p>Major international organizations—UN, EC, bilaterals and other international organizations with global coverage and a development, humanitarian, or emergency mandate—are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, all of the following aspects.</p> <ol style="list-style-type: none"> <li>1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.</li> <li>2. Workplace-based HIV prevention activities that cover: (a) the basic facts on HIV and AIDS; (b) specific work-related HIV-transmission hazards and safeguards; (c) condom promotion; (d) confidential voluntary counselling and testing; (e) sexually transmitted infection diagnosis and treatment; and (f) provisions for HIV- and AIDS-related drugs.</li> <li>3. Training for HIV/AIDS control in conflict, emergency and disaster situations<sup>6</sup>.</li> </ol> <p><b>Numerator:</b> Number of major international organizations with HIV/AIDS policies and programmes that meet <b>all</b> of the above criteria.</p> <p><b>Denominator:</b> Number of major international organizations for which policies and programmes were reviewed.</p> <p>A core list of major international organizations that fulfil the necessary criteria for global coverage and a development, humanitarian or emergency-relief mandate for the purposes of calculating this indicator will be maintained by UNAIDS.</p> <p>Copies of written personnel policies and regulations should be obtained and assessed wherever possible.</p>

### INTERPRETATION

- This indicator does not specifically address international peacekeeping forces: it is expected that national governments will train their peacekeepers as part of their national strategy that addresses HIV and AIDS among national uniformed services including armed forces and civil defence forces.

<sup>6</sup> This aspect only applies to organizations with staff working in conflict, emergency and disaster situations.



# Appendices

## Reporting Schedule for Core Indicators for the Implementation of the *Declaration of Commitment on HIV/AIDS*

	<b>Global commitment and action</b>	<b>National commitment and action</b>	<b>National knowledge and behaviour</b>	<b>Impact</b>
2003 <sup>7</sup>				
2004	<i>No report</i>			
2005	<i>Interim report based on sub-set of indicators</i>			
2006				
2007	<i>No report</i>			
2008				
2009	<i>No report</i>			
2010				

<sup>7</sup> The 2003 data will be used as baseline estimates in the monitoring process.

## Consultation/preparation process for the National Report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS*

- 1) Which institutions/entities were responsible for filling out the indicator forms?
- |                               |     |    |
|-------------------------------|-----|----|
| a) NAC or equivalent          | Yes | No |
| b) NAP                        | Yes | No |
| c) Others<br>(please specify) | Yes | No |
- 2) With inputs from
- |                              |     |    |
|------------------------------|-----|----|
| Ministries:                  |     |    |
| Education                    | Yes | No |
| Health                       | Yes | No |
| Labour                       | Yes | No |
| Foreign Affairs              | Yes | No |
| Others<br>(please specify)   | Yes | No |
| Civil society organizations  | Yes | No |
| People living with HIV/AIDS  | Yes | No |
| Private sector               | Yes | No |
| United Nations organizations | Yes | No |
| Bilaterals                   | Yes | No |
| International NGOs           | Yes | No |
| Others<br>(please specify)   | Yes | No |
- 3) Was the report discussed in a large forum?      Yes      No
- 4) Are the survey results stored centrally?      Yes      No
- 5) Are data available for public consultation?      Yes      No

Name / title: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

## National composite policy index – 2006

Country:

Name of the National AIDS Committee officer in charge:

Signed by: Name and title

Address:

TEL:

FAX:

E-MAIL:

DATE:

# Instructions

## Background

The following instrument measures the second UNGASS *national commitment and action* indicator, a composite policy index designed to assess progress in the development and implementation of national level HIV/AIDS policies and strategies. It is an integral part of the list of core indicators, to be completed as part of UNGASS country reports 2006. The instrument supplements the previous one used in 2003, which serves as the baseline for comparable questions (see National Composite Policy Index in *Guidelines on construction of core indicators*, UNAIDS, Geneva, 2002).

This revised National Composite Policy Index is more detailed than the previous one and puts more emphasis on progress made in policy implementation. It also aims to estimate the amount of effort put into national HIV and AIDS programmes by national level government, nongovernmental organizations and by international organizations. It intends to measure the strength of effort for programme inputs and outputs, to complement data on programme outcomes, such as behaviour change or decline in HIV prevalence that are reported on under “National behaviour and impact indicators”. To the extent possible, this instrument has integrated many items of another survey, the “AIDS Programme Index effort” conducted in many countries by UNAIDS, USAID and the Policy project. It is hoped that this streamlined process of collecting data will help countries identify gaps as well as prioritize programme activities.

## Structure of the questionnaire

The National Composite Policy Index (NCPI) is divided into two parts.

**Part A to be administered to governments’ officials** (National AIDS Committees or equivalent). This part covers five broad areas:

1. Strategic plan
2. Political support (*new section*)
3. Prevention
4. Care and support
5. Monitoring and evaluation (*new section*)

In sections 1, 3 and 4, there are similar questions on policy development to those found in the 2003 NCPI. However, more detailed items related to the *content* of policies and programmes have been added for 2006 reporting. Most sections also contain summary questions that ask for opinions about the overall level of effort in that area both in 2003 and 2005 to assess changes over time.

**Part B administered to representatives from the governments’ primary partners including** nongovernmental organizations, bilateral agencies, and UN-system organizations. This part covers four broad areas with a particular focus on policy *implementation* for the last topic:

1. Human rights
2. Civil society involvement (*new section*)
3. Prevention
4. Care and support

The section on civil-society participation has been developed based on lessons learnt from 2003 reporting. It was felt that the full involvement and participation of civil society in the design, planning, implementation and evaluation of HIV and AIDS programmes was not sufficiently assessed in the previous reporting.

The overall responsibility for collecting information related to the National Composite Policy Index lies with National governments, through their National AIDS Committees (NAC) or equivalent, with support from UNAIDS and partners.

Responses to most questionnaires' categories often require more explanation than just a yes or no. There is a space in the questionnaire, under "*comment*", that should be selectively used to shortly explain why, for example, a particular policy has not been implemented, or if it has been implemented what difficulties there have been in particular areas. For example, if sex work HIV prevention education is given in re-education camps, it will be important information to be mentioned. Qualitative analysis of the comments will be performed. If a section or question is *not relevant* for a specific country, the response "non applicable" should be used and explanation provided (when appropriate).

The 2006 NCPI asks respondents to provide both a score for 2003 and 2005 to be able to measure change over time. Such comparison is required for the specific questions on implementation and for the overall rating.

## PROPOSED STEPS FOR DATA GATHERING

### 1. Designation of two technical coordinators for the study (one for each part)

Technical coordinators (preferably from the NAC (or equivalent) for Part A and a person outside the government for Part B) should be given responsibility to undertake the desk review and carry out specific interviews for this indicator. This person should ideally have a monitoring and evaluation background and may request the assistance of a national consultant with a similar background. It is strongly recommended that civil society representatives be part of the survey team for Part B.

### 2. Designation of a technical working group led by the NAC or equivalent (four to six members)

Composition: representatives from the government (key line ministries and officials at subnational level), nongovernmental organizations, UN and bilateral agencies.

Role: agree on (i) the process and timeline; (ii) the selection of best respondents for each section; and (iii) the final results from both parts.

### 3. Selection of key informants for each section

- *Strategic Plan and Political Support*: the Director or Deputy Director of the National AIDS Programme or National AIDS Council.
- *Monitoring and Evaluation*: officers of the National AIDS Committee or equivalent, Ministry of Health and HIV focal points of other ministries.
- *Human rights*: experts such as the Ministry of Justice officials, human rights commissioners, and representatives of human rights nongovernmental organizations or legal aid centres/institutions.
- *Civil society participation*: representative sample of major civil-society organizations working in the area of HIV and AIDS.
- *Prevention and care and support sections*: major implementing agencies in those areas.

### 4. Data gathering

Each section should be completed by desk review and by interviewing the two or three people most knowledgeable about that topic.

### 5. Data entry, analysis and interpretation

Once both sections are filled out, the technical coordinators need to carefully review similar questions and check whether there are any discrepancies between the government and other counterparts' responses. If such is the case, a meeting with members of the working group should be organized to discuss and address those issues before the final consensus meeting on the UNGASS national report. This stage may require additional selected consultations and more documents to review. Validated data are entered into the CRIS, and analysis and interpretation done by both coordinators.

### 6. Consensus workshop organized by the NAC (or equivalent)

UNAIDS secretariat strongly recommends that NAC or equivalent organize a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS national report, including this section on policy development and implementation.

# National composite policy index questionnaire part A

## I. Strategic plan

### 1. Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?

(Multisectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below.)

<b>Yes</b>	<b>No</b>	<b>Not Applicable (N/A)</b>	<b>Period covered:</b>
------------	-----------	-----------------------------	------------------------

1.1 *IF YES*, which sectors are included?

Sectors included	Strategy/Action framework		Focal point/Responsible	
	Yes	No	Yes	No
Health	Yes	No	Yes	No
Education	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Military	Yes	No	Yes	No
Women	Yes	No	Yes	No
Youth	Yes	No	Yes	No
Others to specify <sup>8</sup>	Yes	No	Yes	No

*Comments:*

1.2 *IF YES*, does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (*Yes/ No*)

<p><b>Programme</b></p> <p>a. Voluntary counselling and testing?</p> <p>b. Condom promotion and distribution?</p> <p>c. Sexually transmitted infection prevention and treatment?</p> <p>d. Blood safety?</p> <p>e. Prevention of mother-to-child transmission?</p> <p>f. Breastfeeding?</p> <p>g. Care and treatment?</p> <p>h. Migration?</p> <p><b>Target populations</b></p> <p>i. Women and girls?</p> <p>j. Youth?</p> <p>k. Most-at-risk populations<sup>9</sup>?</p> <p>l. Orphans and other vulnerable children?</p>	<p>a. _____</p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p> <p>e. _____</p> <p>f. _____</p> <p>g. _____</p> <p>h. _____</p> <p>i. _____</p> <p>j. _____</p> <p>k. _____</p> <p>l. _____</p>
--	---

<sup>8</sup> Any of the following: Agriculture, Finance, Human Resources, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

<sup>9</sup> Most-at-risk populations are groups that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, commercial sex workers, moto-taxi drivers etc.).

<b>Cross-cutting issues</b>	
m. HIV/AIDS and poverty?	m. _____
n. Human rights?	n. _____
o. PLHA involvement?	o. _____

1.3 *IF YES*, does it include an operational plan?

<b>Yes</b>	<b>No</b>
------------	-----------

1.4 *IF YES*, does the strategy/operational plan include:

<b>Yes</b>	<b>No</b>
------------	-----------

a. formal programme goals?

<b>Yes</b>	<b>No</b>
------------	-----------

b. detailed budget of costs?

<b>Yes</b>	<b>No</b>
------------	-----------

c. indications of funding sources?

<b>Yes</b>	<b>No</b>
------------	-----------

1.5 Has your country ensured “full involvement and participation” of civil society in the planning phase?

<b>Yes</b>	<b>No</b>
------------	-----------

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

<b>Yes</b>	<b>No</b>
------------	-----------

*Comments:*

**2. Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, and d) Common Country Assessments)?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

2.1 *IF YES*, in which development plan? a)\_\_\_\_ b)\_\_\_\_ c)\_\_\_\_ other

Covering which of the following aspects? (*Yes/No*)

	a)	b)	c)
HIV Prevention			
Care and support			
HIV/AIDS impact alleviation			
Reduction of gender inequalities as relates to HIV/AIDS prevention/care			
Reduction of income inequalities as relates to HIV prevention/care			
Others:			

**3. Has your country evaluated the impact of HIV and AIDS on its economic development for planning purposes?**

Yes	No	N/A
-----	----	-----

3.1 *IF YES*, how much has it informed resource allocation decisions? (*Low to High*)

<b>Low</b>												<b>High</b>
	0	1	2	3	4	5	6	7	8	9	10	

*Comments:*

**4. Does your country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police?**

Yes	No	N/A
-----	----	-----

4.1 *IF YES*, which of the following have been implemented?

HIV Prevention	Yes	No
Care and support	Yes	No
Voluntary HIV testing and counselling	Yes	No
Mandatory HIV testing and counselling		
Others to specify:	Yes	No

*Comments:*

<b>Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes?</b>												
2005	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												

## II. Political support

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

- 1. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?**

Head of government	Yes	No
Other high officials	Yes	No

- 2. Does your country have a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)\***

Yes	No	N/A
-----	----	-----

2.1 *IF YES*, when was it created? Year:

2.2 Does it include?

Terms of reference	Yes	No
Defined membership	Yes	No
Including civil society	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
Action plan	Yes	No
Functional Secretariat	Yes	No
Date of last meeting of the Secretariat	Date:	

*Comments:*

- 3. Does your country have a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes?**

Yes	No	N/A
-----	----	-----

3.1 *IF YES*, does it include?

Terms of reference	<b>Yes</b>	<b>No</b>
Defined membership	<b>Yes</b>	<b>No</b>
Action plan	<b>Yes</b>	<b>No</b>
Functional Secretariat	<b>Yes</b>	<b>No</b>
Date of last meeting	<b>Date:</b>	

*Comments:*

**4. Does your country have a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

4.1 *IF YES*, does it include?

Terms of reference	<b>Yes</b>	<b>No</b>
Defined membership	<b>Yes</b>	<b>No</b>
Action plan	<b>Yes</b>	<b>No</b>
Functional Secretariat	<b>Yes</b>	<b>No</b>
Date of last meeting	<b>Date:</b>	

*Comments:*

<b>Overall, how would you rate the political support for the HIV/AIDS programme?</b>											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

### III. Prevention<sup>10</sup>

- 1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population?**

Yes	No	N/A
-----	----	-----

- 1.1 In the last year, did you implement an active programme to promote accurate HIV and AIDS reporting by the media?

Yes	No
-----	----

*Comments:*

- 2. Does your country have a policy or strategy promoting HIV and AIDS-related reproductive and sexual health education for young people?**

Yes	No	N/A
-----	----	-----

- 2.1 Is HIV education part of the curriculum in:

primary schools?

Yes	No
-----	----

secondary schools?

Yes	No
-----	----

- 2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No
-----	----

*Comments:*

- 3. Does your country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations?**

Yes	No	N/A
-----	----	-----

<sup>10</sup> Strategies/policies discussed under Prevention may be included in the national strategy/action framework discussed in I.1 or separate.

## 3.1 Does your country have a policy or strategy for these most-at-risk populations?

Injecting drug users, including:	<b>Yes</b>	<b>No</b>	<b>N/A</b>
- Risk reduction information, education and counselling?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
- Needle and syringe programmes?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
- Treatment services?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
- If yes, drug substitution treatment?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Men who have sex with men?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Sex workers?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Prison inmates?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Cross-border migrants, mobile populations	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Refugees and/or displaced populations?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
Other most-at-risk populations? <i>Please specify</i>	<b>Yes</b>	<b>No</b>	<b>N/A</b>

Comments:

**4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

## 4.1 Do you have programmes in support of the policy or strategy?

A social-marketing programme for condoms?	<b>Yes</b>	<b>No</b>
A blood-safety programme?	<b>Yes</b>	<b>No</b>
A programme to ensure safe injections in health care settings?	<b>Yes</b>	<b>No</b>
A programme on antenatal syphilis screening	<b>Yes</b>	<b>No</b>
Other programmes? <i>Please specify</i>	<b>Yes</b>	<b>No</b>

Comments:

Overall, how would you rate policy efforts in support of prevention?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

**5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?**

*(Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations).*

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media.	a. _____	a. _____
b. A social-marketing programme for condoms	b. _____	b. _____
c. School-based AIDS education for youth	c. _____	c. _____
d. Behaviour-change communications	d. _____	d. _____
e. Voluntary counselling and testing	e. _____	e. _____
f. Programmes for sex workers	f. _____	f. _____
g. Programmes for men who have sex with men	g. _____	g. _____
h. Programmes for injecting drug users, if applicable	h. _____	h. _____
i. Programmes for other most-at-risk populations	i. _____	i. _____
j. Blood safety	j. _____	j. _____
k. Programmes to prevent mother-to-child transmission of HIV	k. _____	k. _____
l. Programmes to ensure universal precautions in health care settings	l. _____	l. _____
m. Other: <i>(please specify)</i>	m. _____	m. _____

<b>Overall, how would you rate the efforts in the implementation of HIV prevention programmes?</b>												
2005		Poor									Good	
		0	1	2	3	4	5	6	7	8	9	10
2003		Poor									Good	
		0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												

## IV. Care and support<sup>11</sup>

1. Does your country have a policy or strategy to promote comprehensive HIV and AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, confidential voluntary counselling and testing, psychosocial care, access to medicines, and home and community-based care.)

Yes	No	N/A
-----	----	-----

2. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

	2003	2005
a. HIV screening of blood transfusion	a. _____	a. _____
b. Universal precautions	b. _____	b. _____
c. Treatment of opportunistic infections (OI)	c. _____	c. _____
d. Antiretroviral therapy (ART)	d. _____	d. _____
e. Nutritional care	e. _____	e. _____
f. Sexually transmitted infection care	f. _____	f. _____
g. Family planning services	g. _____	g. _____
h. Psychosocial support for people living with HIV and their families	h. _____	h. _____
i. Home-based care	i. _____	i. _____
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	j. _____	j. _____
k. Cotrimoxazole prophylaxis among HIV-infected people	k. _____	k. _____
l. Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. _____	l. _____
m. Other: ( <i>please specify</i> )	m. _____	m. _____

Comments:

Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

<sup>11</sup> Strategies/policies discussed under Care and Support may be included in the national strategy/action framework discussed in I.1 or separate.

**3. Does your country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

3.1 *IF YES*, Is there an operational definition for orphans and other vulnerable children in the country?

<b>Yes</b>	<b>No</b>
------------	-----------

*IF YES*, please provide definition: \_\_\_\_\_

3.2 Which of the following activities have been implemented under orphan and vulnerable children programmes?

	<b>2003</b>	<b>2005</b>
School fees for orphans and vulnerable children		
Community programmes		
Other: <i>(please specify)</i>		

*Comments:*

<b>Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?</b>											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

## V. Monitoring and Evaluation

### 1. Does your country have one national Monitoring and Evaluation (M & E) plan?

Yes	No	In progress	Years covered:
-----	----	-------------	----------------

1.1 *IF YES*, was it endorsed by key partners in evaluation?

Yes	No
-----	----

*Comments:*

1.2 Was the Monitoring and Evaluation plan developed in consultation with civil society, people living with HIV?

Yes	No
-----	----

### 2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes	No
well defined standardized set of indicators	Yes	No
guidelines on tools for data collection	Yes	No
a strategy for assessing quality and accuracy of data	Yes	No
a data dissemination and use strategy	Yes	No

### 3. Is there a budget for the Monitoring and Evaluation plan?

Yes	No	In progress	Years covered:
-----	----	-------------	----------------

3.1 *IF YES*, has funding been secured?

Yes	No
-----	----

### 4. Is there a Monitoring and Evaluation functional Unit or Department?

Yes	No	In progress
-----	----	-------------

*IF YES,*

Based in NAC or equivalent?

Yes	No
-----	----

Based in Ministry of Health?

Yes	No
-----	----

Elsewhere? *Please specify*

--	--

4.1 If yes, are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department?

Yes	No
-----	----

*Comments:*

4.2 Is there a full-time officer responsible for monitoring and evaluation activities of the national programme?

Yes full time	Yes part-time	No Monitoring and Evaluation Officer
---------------	---------------	--------------------------------------

4.3 IF YES, since when? : Year \_\_\_\_\_

5. Is there a committee or working group that meets regularly coordinating Monitoring and Evaluation activities?

Yes regular	Yes irregular	No	Date last meeting:
-------------	---------------	----	--------------------

5.1 Does it include representation from civil society, people living with HIV?

Yes	No
-----	----

6. Have individual agency programmes been reviewed to harmonize Monitoring and Evaluation indicators with those of your country?

Yes	No	N/A
-----	----	-----

7. To what degree (*Low to High*) are UN, bi-laterals, other institutions sharing Monitoring and Evaluation results?

Low	High
0	10
1	9
2	8
3	7
4	6
5	5
6	4
7	3
8	2
9	1

Comments:

8. Does the Monitoring and Evaluation Unit manage a central national database?

Yes	No	N/A
-----	----	-----

8.1 IF YES, what type is it? \_\_\_\_\_

9. Is there a functional\* Health Information System?

National level

Yes	No
Yes	No

Subnational\*

(\*reporting regularly data from health facilities aggregated at district level and sent to national level, analysed, and used at different levels)

Comments:

**10. Is there a functional Education Information System?**

National level	<b>Yes</b>	<b>No</b>
Subnational*	<b>Yes</b>	<b>No</b>

\* If yes, please specify the level, i.e., district

**11. Does your country publish at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports?**

<b>Yes</b>	<b>No</b>	<b>N/A</b>
------------	-----------	------------

**12. To what extent strategic information is used in planning and implementation?**

*Comments:*

**13. In the last year, was training in Monitoring and Evaluation conducted**

At national level?	<b>Yes</b>	<b>No</b>
At subnational level?	<b>Yes</b>	<b>No</b>
Including civil society?	<b>Yes</b>	<b>No</b>

<b>Overall, how would you rate the monitoring and evaluation efforts of the HIV and AIDS programme?</b>											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

## National composite policy index questionnaire part B

### I. Human rights

1. Does your country have laws and regulations that protect people living with HIV and AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?

Yes	No	N/A
-----	----	-----

*Comments:*

2. Does your country have non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination (i.e., groups such as injecting drug users, men who have sex with men, sex workers, youth, mobile populations, and prison inmates)?

Yes	No	N/A
-----	----	-----

*IF YES, please list groups:*

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

Yes	No	N/A
-----	----	-----

*IF YES, please list groups:*

4. Is the promotion and protection of human rights explicitly mentioned in any HIV and AIDS policy/strategy?

Yes	No	N/A
-----	----	-----

*Comments:*

5. Has the Government, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation?

Yes	No	N/A
-----	----	-----

*IF YES, please list groups:*

- 6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?**

Yes	No	N/A
-----	----	-----

*Comments:*

- 7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?**

Yes	No	N/A
-----	----	-----

*Comments:*

- 8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?**

Yes	No	N/A
-----	----	-----

- 9. Does your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?**

Yes	No	N/A
-----	----	-----

9.1 *IF YES*, does the ethical review committee include civil society and people living with HIV?

Yes	No	N/A
-----	----	-----

*Comments:*

- 10. Does your country have the following monitoring and enforcement mechanisms?**

Collection of information on human rights and HIV and AIDS issues and use of this information in policy and programme development reform	Yes	No
Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV- and AIDS-related issues within their work	Yes	No

Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses	Yes	No
Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts	Yes	No

**11. Have members of the judiciary been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?**

Yes	No	N/A
-----	----	-----

**12. Are the following legal support services available in your country?**

Legal aid systems for HIV and AIDS casework	Yes	No
State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV and AIDS in areas such as discrimination	Yes	No
Programmes to educate, raise awareness among people living with HIV and AIDS concerning their rights		

**13. Are there programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance?**

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

Overall, how would you rate the effort to enforce the existing policies, laws and regulations?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

## II. Civil society participation

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

Low										High
0	1	2	3	4	5	6	7	8	9	10

2. To what extent civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low										High
0	1	2	3	4	5	6	7	8	9	10

3. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?

Low										High
0	1	2	3	4	5	6	7	8	9	10

4. Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in:

Yes	No	N/A
-----	----	-----

Month \_\_\_\_\_ Year \_\_\_\_\_

5. To what extent your country have a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which people living with HIV and caregivers participate?*

Low										High
0	1	2	3	4	5	6	7	8	9	10

Overall, how would you rate the efforts to increase civil-society participation?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

### III. Prevention

#### 1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).

	2003	2005
a. A programme to promote accurate HIV and AIDS reporting by the media.	a. _____	a. _____
b. A social-marketing programme for condoms	b. _____	b. _____
c. School-based AIDS education for youth	c. _____	c. _____
d. Behaviour-change communications	d. _____	d. _____
e. Voluntary counselling and testing	e. _____	e. _____
f. Programmes for sex workers	f. _____	f. _____
g. Programmes for men who have sex with men	g. _____	g. _____
h. Programmes for injecting drug users, if applicable	h. _____	h. _____
i. Programmes for other most-at-risk populations <sup>12</sup>	i. _____	i. _____
j. Blood safety	j. _____	j. _____
k. Programmes to prevent mother-to-child transmission of HIV	k. _____	k. _____
l. Programmes to ensure safe injections in health care settings	l. _____	l. _____
m. Other: (please specify)	m. _____	m. _____

Overall, how would you rate the efforts in the implementation of HIV-prevention programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

<sup>12</sup> Please define

## IV. Care and support

### 1. Which of the following activities have been implemented under the care and treatment of HIV and AIDS programmes?

	2003	2005
a. HIV screening of blood transfusion	a. _____	a. _____
b. Universal precautions	b. _____	b. _____
c. Treatment of opportunistic infections (OI)	c. _____	c. _____
d. Antiretroviral therapy (ART)	d. _____	d. _____
e. Nutritional care	e. _____	e. _____
f. Sexually transmitted infection care	f. _____	f. _____
g. Family planning services	g. _____	g. _____
h. Psychosocial support for people living with HIV and their families	h. _____	h. _____
i. Home-based care	i. _____	i. _____
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	j. _____	j. _____
k. Cotrimoxazole prophylaxis among HIV-infected people	k. _____	k. _____
l. Post exposure prophylaxis (e.g., occupational exposures to HIV, rape)	l. _____	l. _____
m. Other: <i>(please specify)</i>	m. _____	m. _____

Overall, how would you rate the care and treatment efforts of the HIV and AIDS programme?												
2005	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2003	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												

### 2. Does your country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes	No	N/A
-----	----	-----

2.1 Which of the following activities have been implemented under the orphan and other vulnerable children programmes?

	<b>2003</b>	<b>2005</b>
School fees for orphans and vulnerable children		
Community programmes		
Other: <i>(please specify)</i>		

*Comments:*

<b>Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?</b>											
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

## Methodology used for the coverage of selected services for HIV and AIDS prevention, care and support survey

In situations where nationally representative coverage data cannot be obtained, countries may have to rely on data collected from interviews of key informants. One example of a successful application of this methodology is a study undertaken by UNAIDS, WHO, UNICEF, USAID and the Policy Project entitled *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*<sup>13</sup>. This study collected data from 73 low- and middle-income countries, representing 88% of all people living with HIV and AIDS in the developing world at that time. In the report, the fundamental methodology is described as follows:

*“In each country the information was collected through national consultants. The consultants identified knowledgeable respondents for each service. Respondents were asked to provide statistics on the number of people receiving the service in the last year if this information was available. We also asked the respondents to estimate the percentage of the population needing the service that had access to the service. Respondents estimated access separately for the capital city, other urban areas and rural areas. These judgments are used only as a check on the coverage calculations and are not used in the coverage estimates reported here. The consultants used a standard questionnaire which is available from the authors upon request.*

*“Once the consultants had collected all the required information the results were presented and reviewed at a national consensus workshop. These workshops brought together 15–30 national experts to review the results, suggest additional sources of information, and agree on the final figures to be included in this report. Sixty of the 73 reporting countries held these national consensus workshops.*

*“The approach used here is relatively inexpensive and can be implemented quickly. Since it relies on service statistics and expert assessment, the information collected measures coverage less accurately than national surveys, and assessing the uncertainty associated with each estimate is difficult. Previous efforts to use expert opinion to estimate program coverage have shown mixed results. The Family Planning Program Effort Index, which relies on a small number of national and international experts, has shown consistency over time and good intercountry comparability. The 2003 round of the AIDS Program Effort Index, which relied on key respondents in each component of program effort produced useful profiles of effort within countries surveyed and allows comparison across countries but relies on expert judgment to assess the level of effort. This study attempted to avoid these problems by contacting only the most knowledgeable people in each country and focusing on quantitative information that does not require assessing the quality or effectiveness of services. The respondents were asked to provide a limited amount of information, for most interventions just the number of people served and the number of sites offering each service.”*

<sup>13</sup> The full text of this report can be downloaded at [www.futuresgroup.com/abstract.cfm/1953](http://www.futuresgroup.com/abstract.cfm/1953).

## **COUNTRY REPORTING FORMAT**

***Reporting period: January 2003–December 2005***

### TABLE OF CONTENTS

- I. Status at a glance
- II. Overview of the AIDS epidemic
- III. National response to the AIDS epidemic
- IV. Major challenges faced and actions needed to achieve the UNGASS goals/targets
- V. Support required from country's development partners
- VI. Monitoring and evaluation environment

### ANNEXES

ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS*

ANNEX 2: National Composite Policy Index Questionnaire (through CRIS)

ANNEX 3: National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)

***PLEASE SEND THE UNGASS NATIONAL REPORT TO UNAIDS GENEVA, EVALUATION UNIT  
BY E-MAIL: [UNGASSindicators@unaids.org](mailto:UNGASSindicators@unaids.org)***

## **I. Status at a glance**

This section should provide the reader with a summary of the status of the epidemic and the response. It is recommended to insert a table showing data on UNGASS core indicators selected by the country.

## **II. Overview of the AIDS epidemic**

This section should cover the status of the HIV prevalence in the country during the period January 2003–December 2005 based on sentinel surveillance and specific studies (if any) for the impact indicators. It is strongly recommended to include the source of information for all data provided in the report.

## **III. National response to the AIDS epidemic**

This section should reflect the change made in national commitment and programme implementation broken down by prevention, care/treatment and support, knowledge and behaviour change, and impact alleviation during the period January 2003–December 2005.

Countries should be looking closely at the *linkages* between policy, implementation of HIV and AIDS programmes, verifiable behaviour change and HIV prevalence.

Whenever relevant and as indicated in the introduction of the Guidelines, indicator scores should be reported by area of residence (urban/rural), gender, and the following age groups: 15–19, 20–24, 25–49. Countries are encouraged to report on additional indicators that contribute to an expanded national response.

## **IV. Major challenges faced and actions needed to achieve the goals/targets**

This section should focus on key challenges faced throughout the reporting period that hindered the national response and remedial actions envisaged to ensure achievements of agreed UNGASS targets.

## **V. Support required from country's development partners**

This section should focus on key actions that need to be taken by development partners to assist countries in achieving their goals/targets.

## **VI. Monitoring and evaluation environment**

The section should provide an overview of the current Monitoring and Evaluation system in the country based on the national composite policy index (see Appendix 3, Part A-V), and highlight—where appropriate—the needs for Monitoring and Evaluation technical assistance and capacity building to meet the UNGASS targets.

## Selected bibliography

UNAIDS/WHO (1999) *Evaluation of a National AIDS Programme: A Methods Package – Prevention of HIV Infection*. Geneva: UNAIDS

UNAIDS/MEASURE (2000) *National AIDS Programmes: A guide to monitoring and evaluation*. Geneva: UNAIDS. <http://www.cpc.unc.edu/measure/guide.html>

UNAIDS (2000) *Protocol for the Identification of Discrimination against People Living with AIDS*. Geneva: UNAIDS

Family Health International (2000) *Behavioural Surveillance Surveys: Guidelines for Repeated Behavioural Surveys in Populations at Risk of HIV*. Arlington, U.S.A: Family Health International

WHO/UNAIDS (2004) *Guide to monitoring and evaluating national HIV/AIDS prevention programmes for young people*. Geneva: WHO

WHO/UNAIDS (2004) *National AIDS Programmes: A guide to monitoring and evaluating HIV/AIDS care and support*. Geneva: WHO

UNAIDS/WHO (2004) *National guide to monitoring and evaluating programmes for the prevention of HIV in infants and young children*. Geneva: WHO

UNICEF/UNAIDS (2005) *Guide to Monitoring and Evaluation of the national response for Children Orphaned and Made Vulnerable by HIV/AIDS*. New York: UNICEF

WHO/UNAIDS (2005) *National AIDS Programmes: A Guide to Monitoring and Evaluating Antiretroviral Programmes*. Geneva: WHO

[www.measuredhs.com/data](http://www.measuredhs.com/data)

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

Produced with environment-friendly materials

The purpose of these guidelines is to provide National AIDS Councils (or equivalent) with technical guidance on how to measure the revised list of core indicators for the implementation of the Declaration of Commitment on HIV/AIDS, adopted by Member States of the United Nations during the United Nations General Assembly Special Session on HIV/AIDS in June 2001. These guidelines provide technical guidance on the detailed specifications of the core indicators, on the information required and the basis of their construction, and on their interpretation. The guidelines also aim to maximize the validity, internal consistency and comparability across countries and over time of the indicator estimates obtained. In particular, the guidelines aim to ensure consistency in the types of data and methods of calculation employed.



Joint United Nations Programme on HIV/AIDS

**UNAIDS**

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