

Questions & Answers

**The UNGASS Report & Guidelines on the
Construction of the Declaration of Commitment
Core Indicators**

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1. The UNGASS Report

Q1. What is the history of the report?

A. The international community took a historic step forward in addressing the global HIV/AIDS epidemic with the adoption by 189 UN member states of the Declaration of Commitment (DoC) on HIV/AIDS at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001.

Over the next several months, a standardized set of 18 core indicators were developed for use by all countries to measure baselines and progress in key areas of the DoC. The indicators are:

- **Global-level indicators**, e.g., international spending, policies and advocacy efforts.
- **National commitment and action indicators**, e.g., domestic government spending, country-level policy development and implementation.
- **National programme and behaviour indicators**, e.g., access by vulnerable groups to key services – risk behaviour changes.
- **National impact indicators**, e.g., rate of new infections among young people, high-risk groups, and infants born to HIV-infected mothers.

The DoC contains numerous targets to measure progress. The first set of targets in the DoC, due in 2003, primarily focus on the establishment of national policy frameworks to enable and stimulate effective action against the epidemic. The targets for 2005 and 2010 focus on the rapid expansion of HIV prevention, care and impact alleviation programmes.

On 22 September, as mandated in the DoC, the UN General Assembly convened one day High Level Meeting to review progress in implementing the DoC over the last two years. During this meeting, the first reports on progress were released.

Q2. How was the information for the report obtained?

A. In addition to the national surveys that were sent to National AIDS Control Councils, data was also obtained from:

- Sero-prevalence data (WHO and other sources).
- Special analytical studies (e.g., HIV prevention in the workplace and IDU service coverage).
- Other reports, e.g., the Gates Report on Prevention.

Information was not included where there was no confidence about the quality or accuracy of the data.

Q3. To what extent was civil society involved in the compilation of the report?

A. There was involvement of civil society in the compilation of about two-thirds of country reports, and over half recorded the involvement of people living with HIV/AIDS. The highest level of civil society participation was in sub-Saharan Africa.

Q4. Which countries reported?

A. A total of 103 national reports were received and included in the Report, representing 90% of the people living with HIV/AIDS. Two national reports (Croatia and Mali) were submitted too late to be included in the Expanded Report. Countries with generalized epidemics over 1% that did not report included:

- Bahamas
- Estonia
- Trinidad and Tobago
- Panama
- Sudan

In sub-Saharan Africa countries with greater than 5% HIV prevalence rate that did not report included:

- Angola
- Central African Republic
- Congo Brazzaville

The lowest response rate was among “high income” countries, such as the Belgium, Italy, Japan, United Kingdom, and United States.

Q5. What is the different about this Report from other reports on HIV/AIDS?

A. In the past, most global reports have focused on HIV infection rates. It has been difficult to obtain coverage and risk reduction indicators in a standardized and comprehensive manner. This Report contains consistent, standardized data coming directly from countries. The response rate has been remarkable, 103 out 189 countries.

Q6. What is the key message of the Report?

A. The 2005 DoC targets will not be met, unless there is a significant increase in financial and political resources, increase in the pace of scaling up interventions, investment in the necessary human capital, and development of new technologies to both prevent new infections and treat those already infected.

Q7. What are the specific findings?

A. **National commitment:** there is good evidence of increasing national commitment for fighting the epidemic. Of the countries, 93% now have a comprehensive national strategy; many national AIDS councils are led by senior government official, especially

in Africa; in 2002, total domestic government spending in 58 low- and middle-income countries was estimated to be USD\$995, a doubling of the amount documented in 1999.

However:

- Most AIDS programmes are still centered on the health sector.
- The highest leaders are still disengaged, especially where epidemics are low at a level or concentrated among specific populations.

Policies: Nearly all countries surveyed have begun to establish policies for fighting the epidemic in the areas of concern-providing access to prevention.

However:

- Nearly 40% of countries with widespread epidemics do not have policies in place to provide appropriate care to AIDS orphans.
- Nearly one third of countries lack policies that ensure women's equal access to prevention and care services, despite women accounting for 50% of all people living with HIV/AIDS worldwide as of December 2002.
- Of countries with generalized epidemics, 39% have no national policy in place to provide essential support to children orphaned or made vulnerable by HIV/AIDS.
- In sub-Saharan Africa, 38% of countries have no policies to protect HIV infected persons from discrimination, and 64% have no policies to prohibit discrimination against vulnerable populations.

Funding: There has been some positive progress over the past two years. Key has been the establishment of the Global Fund and the dramatic increase in resources since 1999. Funding for fighting HIV/AIDS in low- and middle-income countries has increased by 20% since 2002 to nearly USD\$5 billion. Funds for critical research have also increased – USD\$430-470 in 2001 for vaccines.

However:

- Only half of the USD\$10 billion required to effectively fight HIV/AIDS in 2005 has been secured.

Prevention: Public awareness of HIV/AIDS is increasing in many parts of the world – 88% of countries surveyed have invested in public education initiatives.

However:

- Only 1% of pregnant women in heavily affected countries (greater than 5% prevalence rate) have access to services aiming to prevent mother-to-child HIV transmission. This is almost four years after that this groundbreaking technology became available. The target for 2010 is that 80% of pregnant women would have access to these services.
- Only 25% of people at risk of infection are able to obtain basic information on HIV/AIDS.
- Fewer than 5% of IDUs receive recommended HIV prevention services.

- While HIV-related knowledge among young people has grown in many countries since 2000, overall basic knowledge remains disturbingly low, especially among young women.
- Of young people, 15-20% report having had sexual intercourse before the age of 15.

Care and treatment services: Of countries, 80% have introduced policies to assure access to antiretroviral (ARV) drugs.

However:

- Only 1% of people in sub-Saharan Africa who need ARV drugs are currently receiving them – 50,000 out of four million people. Most of these people are receiving treatment in the private sector. This number rises to 5% over all developing countries in all regions.
- Only one quarter of sub-Saharan African countries report that at least 50% of patients with sexually transmitted infections are appropriately diagnosed, counseled, and treated.

Q8. What are the conclusions?

A.

- Resources to address HIV/AIDS in low- and middle-income countries must be increased two-fold over current levels by 2005, and three-fold by 2007.
- Significant investments must be made in human resources, training, health systems, physical infrastructure, and access to critical commodities.
- Countries must take swift and high-level action to ensure that their HIV/AIDS policies and programmes comply with the DoC's basic HIV prevention and care targets for 2005.
- A greater number of political leaders must become directly involved in anti-AIDS efforts, especially in regions such as Asia where effective action is immediately needed in order to prevent a major expansion of the epidemic.
- Countries must implement a basic package of HIV prevention and services and guarantee access to vulnerable groups – particularly women and girls.
- National strategies must be devised to support the global community's target that three million people with HIV/AIDS receive ARV therapy by 2005. This would represent 30-40% of those in need, compared to the less than five percent who are receiving treatment today.
- As set out in the DoC, countries should adopt, implement and enforce national policies that prevent discrimination against and protect the human rights of people living with HIV/AIDS and vulnerable populations.
- All countries with generalized epidemics need to implement programmes to support orphans.
- Monitoring and evaluation systems must be strengthened.

Q9. For the 2005 Report, what will be different?

A. The 18 “core indicators” will be used again to ensure consistency and the ability to measure progress over time. However, after consultation with countries a limited number of indicators might be added for areas that are not adequately covered:

- Blood safety
- Decreasing possible transmission in health care settings
- Quality of treatment
- Revision of some of the behaviour/risk reduction indicators, e.g., IDU

2. Guidelines on the Construction of the Declaration of Commitment Core Indicators

A. General questions

Q1. What is the background of the guidelines?

A. The UNGASS DoC included a pledge on part of the United Nations General Assembly that it would devote at least one full day per annum to reviewing the progress achieved in realizing the DoC goals established. To facilitate this ongoing review process, UNAIDS and its partners have developed a set of core indicators that permit monitoring measurable aspects of the various international and national actions, national programme outcomes, and national impact objectives envisaged in the DoC.

Q2. What is the purpose of the guidelines?

A. The purpose of the current guidelines is to provide countries with technical guidance on the detailed specification of the indicators, on the information required and the basis of their construction, and on their interpretation.

Q3. What is the aim of the guidelines?

A. The guidelines aim to maximize the validity, internal consistency and comparability across countries and over time of the indicator estimated obtained, and to ensure consistency in the types of data and methods of calculation employed.

Q4. What categories of indicators are there?

A. The indicators are divided into two sub-groups: global and national indicators.

Q5. What is the purpose of the global indicators?

A. The global indicators comprise a combination of five indicators that provide information on levels and trends in international commitment to HIV/AIDS control. UNAIDS and its partners are responsible for calculating the global-level indicators.

Q6. What categories of national indicators can be identified and what is the purpose of each category?

A. (i). *Indicators of national commitment and action.* These indicators focus on policy, strategic and financial inputs for the prevention and spread of HIV infection, to provide care and support to those who are infected, and to mitigate the social and economic consequences of high morbidity and mortality.

(ii). *Indicators of national programme and behaviour.* These indicators focus primarily on programme outputs, coverage and outcomes (e.g. increased knowledge about HIV/AIDS or altered behaviour).

(iii). *Indicators of national programme impact.* These indicators measure the extent to which programme activities have succeeded in reducing rates of HIV infection.

Q7. What does a high or low score on an indicator imply?

A. For national commitment and action, and national programme and behaviour indicators, a higher score on an indicator implies better or improved performance. However, for indicators on national-level programme impact, higher scores on the indicators imply higher prevalence of HIV/AIDS.

Q8. What is the linkage between indicators developed for the UNGASS DoC and the MDGs?

A. Four of the national indicators are also Millennium Development Indicators, established to monitor progress in achieving the goals and targets set in the Millennium Declaration. As far as possible, national indicators have been built on those that have previously been recommended for use in monitoring and evaluation of HIV/AIDS programmes.

Q9. Is each indicator applicable to all countries?

A. Yes, with the exception of the indicator covering injecting drug use (IDUs). This indicator is applicable to countries where injecting drug use is an established mode of HIV transmission. Similarly, countries with low and concentrated epidemics should report on an alternative indicator of HIV prevalence among high-risk-behaviour groups, as opposed prevalence among young people obtained from antenatal clinic sentinel surveillance. It is recommended that countries with generalized epidemics also report on this indicator to track the epidemic among all key high-risk-behaviour groups.

Q10. What is the purpose of having additional indicators?

A. A number of additional indicators have been suggested in the guidelines that could complement or serve to elucidate the information obtained using the relevant core indicator in some settings.

Q11. When should an additional indicator be reported on?

A. An additional indicator might be calculated, utilized and reported on by a country to provide useful interim information in circumstances where calculation of the core indicators awaits the collection of specialist survey data.

Q12. Especially which additional indicators should countries report on?

A. It is recommended that countries report on especially those additional indicators on median age at first sex; number of non-regular sexual partners in the last year; and condom use during last commercial sex.

Q13. How should indicators where the DoC requires a specific focus on the 15-24-age-year-old age group be approached?

A. It is recommended that data be obtained for the whole 15-49-year-old age range, with separate indicator scores being reported by gender for the 15-19, 20-24 and 25-49-year-old age groups.

Q14. For which indicators is the DoC listing specific targets to be achieved by 2005 and 2010.

A. Specific targets by 2005 and 2010 are listed for 3 out the 13 national indicators: knowledge about HIV/AIDS among young people; prevalence of HIV among young people; and prevalence of HIV among newborns.

Q15. Do the targets set in the DoC apply to all countries?

A. Some of the targets set in the DoC apply only to those countries that are most affected by the HIV/AIDS pandemic. These and other indicators may be less relevant in countries that currently have low overall levels of HIV prevalence, in which cases they may be reported on less frequently. Even so, it is important to recognize that relatively small changes in behaviour have the potential to trigger rapid epidemics in these countries. To ensure that this potential is not realized, careful epidemiological surveillance and appropriate and effective HIV prevention must be maintained.

Q16. Are the indicators for monitoring the DoC final?

A. No, the indicators will need to be revised from time to time to reflect experiences in their use and changes in the course of the HIV/AIDS epidemics and in approaches to

HIV control. Thus, the identity specification and method of construction of the core, alternative and additional indicators will be reviewed on a regular basis by UNAIDS and its partners and revisions will be made when necessary. Subsequent updates of the guidelines will be made available on the UNAIDS website at: www.unaids.org

Q17. When are targets given for indicators and are countries to set their own targets?

A. Targets are given for indicators only where these have been specified in the DoC. Individual countries may, of course, set and monitor progress against their own internal targets if they wish to do so.

B. Technical questions

Q1. What measurement tools are required to collect data on the indicators?

A. The principal measurement tools required to provide the necessary data are nationally-representative population-based surveys; schools, health facility and employer surveys; and specially designed targeted surveys of marginalized groups. Other data requirements should be met from existing routine programme monitoring sources. It is envisaged that these will typically include education and health service records as well as specific HIV/AIDS or sexually transmitted infections (STIs) control programme and surveillance records.

Q2. Are there specific additional data collection efforts requirements?

A. The one indicators for which a significant additional data collection effort may be required is that covering injecting drug users.

Q3. How can countries obtain technical support to report on the DoC indicators?

A. Where necessary, technical support will be available through the Expanded UN Theme Groups at country level. In addition, assistance can be sought from the monitoring and evaluation unit at the UNAIDS Secretariat at: UNGASSindicators@unaids.org

Q4. How should data on indicators be calculated?

A. Calculation of a number of the indicators entails the initial computation of a numerator and a denominator for a percentage calculation. Where this is the case, precise definitions are given both for the numerator and the denominator. Some indicators summarize information collected on several interrelated topics. Where this is the case, information on each of the component topics must be provided. In most instances, information is required disaggregated by gender, urban-rural residence etc., so that most comparisons of indicator scores between population subgroups can be made. Finally,

supplementary information is needed to aid interpretation of some indicators. Requirements for such information are noted in the guidelines, as appropriate.

Q5. How should data be recorded?

A. Where data are extracted from routine programme records, these should be recorded on a consistent basis from year to year, preferably either by calendar year or by financial year. Similarly, data for specific time points should always be presented using the same reference date – i.e., calendar or financial year end. Details of these dates and periods used when extracting such data should be specified in the indicator return forms. It is particularly important to check the dates and periods used in initial reports before compiling subsequent returns.

Q6. How should the data be collected?

A. The data to be applied in these calculations should, whenever possible, be collected using the standard forms of questions specified in the guidelines. This will help to ensure minimization of reporting bias, particularly where cross-country comparisons are made.

Q7. How should bias be avoided when calculating indicators?

A. Notes are provided at the end of each guideline on any significant assumptions that are made in the calculation of the indicator and on any factors that may tend to introduce bias into the estimates. Particular attention is paid to highlighting factors that can cause distortion in temporal trends or cross-country comparisons of the indicators, because these may lead to incorrect conclusions being drawn as to the absolute and relative effectiveness of alternative programmes.

C. Reporting

Q1. Where does the responsibility lay for compiling the national-level indicators?

A. National governments, through their National AIDS Councils (NACs) or equivalent, with support from UNAIDS and its partners are responsible for compiling the national-level indicators.

Q2. Who are responsible for ensuring that the necessary data are collated and submitted (using standard forms) in a timely fashion?

A. NACs or equivalent are responsible in this area. They however may delegate or contact out some, or all of this work to appropriately qualified individuals or academic institutions.

Q3. To whom should completed indicator forms be submitted and along with what additional information?

A. Completed forms should be submitted to UNAIDS Secretariat in Geneva. The completed form should be accompanied by a narrative report highlighting success, as well as constraints and future national plans of action to improve performance, specifically in areas where data indicate weakness against national targets.

Q4. Who should the government involve in the preparation and dissemination of the report and how?

A. All levels of society, including civil society organizations and the private sector should be involved. UNAIDS strongly recommends that national governments organize a national workshop and/or a broad consultation forum to discuss the major findings of the national report prior to submitting it to UNAIDS.

Q5. What is the role of the Country Response Information System (CRIS) with regards to the DoC indicators?

A. CRIS will serve as an information system for national responses and will house all data obtained on core and additional indicators for use in monitoring implementation of the DoC.

Q6. What is the required reporting frequency?

A. Varying preferred and minimum frequencies of reporting have been determined for the different indicators. These reflect likely differences in the availability of the data needed to calculate the various indicators. The reporting schedule for the indicators is set out in Appendix 1 of the Guidelines.

Q7. Should the methods described in the Guidelines also be applied to the sub-national level?

A. In principle, yes. However, they 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 described in the Guidelines had been designed to facilitate the construction of global estimates from national-level data and to make it possible to conduct cross-country comparisons. Simpler, faster and more flexible approaches, tailored to local conditions, may therefore be more appropriate to guide decisions making at, for example, the district level.