

**FOLLOW-UP TO THE
DECLARATION OF COMMITMENT
ON HIV/AIDS (UNGASS)**

COUNTRY REPORT FORMAT
Reporting period: January-December 2002

PREAMBLE

The proposed generic reporting format is meant to assist National AIDS Councils (or equivalent) in drafting their national report to be submitted to the UN General Assembly on biennial basis as a follow-up to the Declaration of Commitment (DoC) signed in June 2001 at the UNGASS on HIV/AIDS

Countries should carefully review the *Guidelines on construction of core indicators – Monitoring the Declaration of Commitment on HIV/AIDS* (named hereinafter Guidelines) before embarking in any data collection exercise. As explained in the Guidelines, a total of 13 core indicators divided into three categories are supposed to be collected/reported on at national level to monitor the DoC on HIV/AIDS:

Category 1: Two indicators on national commitment and action

Category 2: Nine indicators on national programmes and behaviour trends

Category 3: Two indicators on impact.

The Guidelines provide countries with technical guidance on the definition of the core indicators, the measurement tools required for their construction and frequency of data collection. It is essential that countries follow those Guidelines to ensure quality of the reported information. Countries are also encouraged to report on additional nationally representative coverage indicators since this report will be used as baseline to monitor progress over time. While selecting data to be reported on, it is recommended to avoid anecdotal information.

For **2003** General Assembly Session, reporting is required for all three categories of indicators. In view of time constraints, the following is recommended to all countries:

Category 1: Collect information through desk reviews and survey on financial resource flows

Category 2: Compile existing data from (1) recent surveys such as DHS or MICS for those indicators requiring population-based information; (2) health facility, school-based, or workplace surveys for the other indicators. Countries are also encouraged to consult the following indicator database that contains data on some core indicators collected through household surveys: www.measuredhs.com/data.

Category 3: For HIV prevalence among young people, compile data from HIV sentinel surveillance (for countries with generalized epidemics) and recent specific surveys (for countries with concentrated or low epidemics). For HIV prevalence among infants, calculation of estimates needs to be done using programme coverage data.

<p style="text-align: center;">2003 General Assembly Session Target dates</p>
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<p>End of data collection: 10 March 2003 Reporting to Geneva: 31 March 2003.</p>
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For **2004** General Assembly Session, no reporting on national indicators is required.

For **2005** General Assembly Session, reporting is required for all three categories of indicators. This means that countries that have not yet planned any surveys for collecting information on the second category of indicators need to do so as soon as possible and latest early 2003.

**2005 General Assembly Session
Target dates**

End of data collection: 30 September 2004
Reporting to Geneva: 28 February 2005

A total of four annexes should be attached to the national report: (1) the consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS form; (2) the National Composite Policy Index Questionnaire; (3) the nine forms related to the National Programme and Behaviour Indicators; (4) the country M&E sheet.

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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

ANNEX 3: Nine national return forms national programme and behaviour indicators

ANNEX 4: Country M&E sheet

I. STATUS AT A GLANCE

NATIONAL COMMITMENT & ACTION

1. Since the approval of the National Strategic Plan 2002-2005 by Cabinet in September 11th 2002, activities have been ongoing to make the programme more effective in light of the new structure. Cabinet will meet again on April 9th 2003 to peruse the recommendations provided for the organization of the various committees identified under the new structure. While this aspect is being finalised the NAP is making necessary preparations for the National treatment of PLWHA by year-end under the initiative of the Clinton Foundation. A major workshop for health workers on clinical management of HIV infection was undertaken with the assistance of CAREC. This level of training is expected to continue at regular intervals and is a part of NAP initiative to sensitise and educate health workers on the use of antiretroviral. The session consisted of a broad selection of Doctors, Dentist, Pharmacist, Nurses and Lab technicians. The MTCT programme is likewise being evaluated for more effective management; among the considered changes will be the merging of VCT sites and the inclusion of rapid testing and Nevirapine into the protocol for emergency cases. The protocol for case management of commercial sex workers is also being evaluated and guidelines for structuring programmes for MSM is also being considered with the assistance of CAREC. Legal consultations are presently being undertaken for the inclusion of human rights indicators specific to HIV/AIDS in the legal code.
2. The budgeted funds **allocated** to health for 2002 were EC\$71 million. Of that figure the AIDS Secretariat was **allocated** EC\$689,000. Salaries represent 74 percent of the total. The AIDS Secretariat budget **called for** EC\$75,000 for medications, nutrition, clothing and other expenses incurred by HIV-positive persons.

Table below shows the major categories of expenditures in 2002 for HIV/AIDS prevention, care and treatment. Funding comes from a variety of departments including Holberton Hospital, the Ministry of Health, and the AIDS Secretariat.

Category	2002
Medications	\$75,000
Inpatient medical care*	\$193,258
Laboratory services	\$65,000
Prevention and education	\$490,503
Program support	\$64,396
Total Expenses	\$888,156

*Inpatient medical care is based on the average cost of a hospital day, multiplied by the number of inpatient days for persons with a primary or secondary diagnosis of HIV/AIDS.

Please note: In reality only a 1/3 fraction of the allocated funds were actually received, for e.g. only \$25,000 of the allocated \$75,000 was received for medications.

NATIONAL PROGRAMME & BEHAVIOUR

Prevention

3. % of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year.
4. % large enterprises/companies that have HIV/AIDS workplace policies and programmes
5. Over the period 2000 – 2002 over 50% of the pregnant women receiving prenatal care at the antenatal clinic consented to an HIV test. Of those tested a small number representing a prevalence rate less than 1% tested positive and as a result consented to be admitted into the programme. In 2000, 70% of the HIV+ pregnant women received a complete course of ARV prophylaxis to reduce the risk of MTCT. In 2001 80% of those tested + received a complete course of ARV and in 2002 there was 100% uptake.

See table below

YEAR	NO. OF WOMEN TESTED	NO. OF WOMEN HIV+	% COMPLETED COURSE OF ARV PROPHYLAXIS
2000	1326 (51%)	10	70
2001	1078 (56%)	5	80
2002	985 (57%)	2	100

Care/Treatment

6. Information gathered suggest that on average 90% of patients diagnosed with sexually transmitted infections at the STI clinic were appropriately diagnosed, treated and counselled. Some patients would have been referred from the antenatal clinic but still underwent examination and counselling at the STI Clinic. Partners' testing is also done. For 2002, 254 patients were seen at the STI clinic, 73 patients were diagnosed and treated for STI and only four opted not to have an HIV test done.
7. Because of the unavailability ARV on a national level, approximately 42% of persons known to have advance HIV infection receive ARV combination therapy from a private physician/private source.

Knowledge/Behaviour – Information unavailable

8. % of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention **(Target: 90% by 2005; 95% by 2010)**
9. % of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner
10. % of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*)

Impact alleviation

11. Presently all orphaned children 10-14 years of age are attending school.

IMPACT

12. Statistical data gathered suggest that from 1992 to 30.09.02, 17% of all HIV notifications represented young people aged 15-24 years of age. **(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)**
13. % of infants born to HIV infected mothers who are infected **(Our records suggest that this occurrence is very minimal, percentage unavailable)** **(Target: 20% reduction by 2005; 50% reduction by 2010)**

II. Overview of the HIV/AIDS epidemic

This section should cover the status of the HIV prevalence in the country during the period January-December 2002 based on sentinel surveillance and specific studies (if any) for Indicator 1 (HIV prevalence among young people) and estimates for Indicator 2 (HIV prevalence among infants).

HIV prevalence at a glance

Of the 31 known HIV + cases for the period January to September 02, 23% represents young people between 15-24 years of age.

Since the intervention of the PMTCT program the risk of infants born to HIV infected mothers being infected has reduced significantly. For the period indicated our records do not show any infant being born to HIV infected mothers who are likewise infected.

Source: AIDS SECRETARIAT/Holberton Hospital 2002

III. National response to the HIV/AIDS epidemic

1. National commitment and action

This sub-section should reflect the change in commitment made by national stakeholders in the fight against HIV/AIDS during the period January-December 2002. Commitment covers increased resources, expanded partnerships and multi-sectoral policy development.

National commitment at a glance

One of the major expansions occurring in the NAP last year and continuing into this year has been the partnership formed with the Clinton Foundation. This synergy has added a positive dimension in the program by opening the possibility of providing care and treatment to all known PLWHA on a national level. Of notable interest is also the work undertaken in the Tourist sector, which gives recognition to the link between HIV/AIDS and the Tourism industry. This development facilitated by CAREC allowed for the training of personnel in that industry, who in turn would train their colleagues.

Though government's spending has not increased significantly over the period indicated there has however been a vow of renewed commitment to the NAP as witness through the launch of the National Strategic Plan.

Source: AIDS SECRETARIAT 2002

2. National programmes and behaviour

This sub-section should cover progress made during the period January-December 2002 in specific HIV/AIDS programmes broken down by prevention and care/treatment.

National programmes at a glance

Prevention

% of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year (**Programme to be implemented September 2003**)

% large enterprises/companies that have HIV/AIDS workplace policies and programmes (Information unavailable)

Approximately 80% of HIV+ pregnant women receive a complete course of ARV prophylaxis to reduce the risk of MTCT

Care/Treatment

Approximately 90% of patients with sexually transmitted infections at the STI health clinic are appropriately diagnosed, treated and counselled.

Approximately 42% of people with advanced HIV infection receive ARV combination therapy.

Source AIDS SECRETARIAT/ STI Clinic 2002

This section should also reflect any changes in behaviour as a result of programmes' activities.

National behaviours at a glance (information unavailable)

% of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention

% of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner

% of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*)

Indicate Source

Finally, this section should address national efforts in impact alleviation, with a focus on orphans.

Impact alleviation at a glance

Currently there are 11 children known to have lost at least one parent to HIV/AIDS; 10 their mothers, 1 his father and 1 both parents. Six of these orphans are between the highlighted age of 10-14 years and they all attend school (3 males and 3 females). Only one orphaned is known to be HIV positive.

Source: AIDS SECRETARIAT 2002

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

The most difficult challenge faced throughout this data collection exercise has been the variations in indicators used at a national level to assess its programmed and those implemented by UNAIDS. Because of this, pertinent information collected locally was denied a voice in the annexes provided. Another significant factor impacting on this report has been time limitation, which did not allow for meeting with all resource person for data collection or the setting up of a forum/committee to address the indicators on a broader basis. It is important to gather the opinion of affected parties or for some sort of established synergy to be undertaken with key players when information of this nature is required, time limitation did not allow this.

This section should also provide information on the country's data collection plan for 2005 reporting (see Table below).

Data collection plan (2005 reporting)	2003	2004	2005
Household surveys			Knowledge, Attitude & Behaviour Study on HIV
Health facility surveys	End of year assessment on knowledge of procedures and protocol.	End of year assessment on knowledge of procedures and protocol.	End of year assessment on knowledge of procedures and protocol.
School-based surveys		Knowledge, Attitude and Behaviour study on HIV and safer sex practises (primary school).	
Workplace surveys	Study of stigma & discrimination		
Desk review	Development of recording format parallel to that used by donor agencies.		

V. Support required from country's development partners

Technical and financial assistance to design identified surveys, training in conducting and analysing information along established core indicators paralleled to that used by donor agencies. Accessing user-friendly programme is also an essential need; software that allows for flexibility similar to SPSS would be ideal. Upscale Epidemiological surveillance is also of utmost importance.

Cost for these activities are currently unavailable.

VI. Monitoring and evaluation environment

The section should provide an overview of the current M&E system in the country based on a country sheet to be filled out and included as an annex (see Annex 4), and highlight – where appropriate – the needs for M&E technical assistance and capacity building to meet the 2005 requirements.