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Special Session on HIV/AIDS

Monitoring the Declaration of Commitment on HIV/AIDS

GUIDELINES ON CONSTRUCTION OF CORE INDICATORS

2008 Reporting



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Special Session on HIV/AIDS

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CORE INDICATORS**

2008 Reporting

*April 2007
Geneva, Switzerland*

Please submit your completed UNGASS Country Progress Report before 31 January 2008 by email to UNAIDS Evaluation Department at: ungassindicators@unaids.org

If the Country Response Information System (CRIS) is not used for submission of indicator data, please submit reports before 15 January 2008 to allow time for the manual entry of data into the Global Response Information Database in Geneva.

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For comments or enquiries please contact us via email at: ungassindicators@unaids.org

Foreword

To assist Member States in preparing and submitting Country Progress Reports, UNAIDS has prepared these guidelines for the monitoring of the Declaration of Commitment made at the 2001 General Assembly Special Session on HIV/AIDS. In the coming months UNAIDS will provide technical guidance and support to Member States for the preparation of national reports. This presents an opportunity to further strengthen national monitoring and evaluation systems, and UNAIDS looks forward to our continued collaboration with your government. The 2006-2007 round of progress reports from countries will be due on 31 January 2008.

Reports received by UNAIDS, on behalf of the Secretary-General, are used to prepare the *Report on the Global AIDS Epidemic*. The report from the 2004-2005 reporting round is available on the UNAIDS website at: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

The 2004-2005 report represents the most comprehensive data set on the global response to HIV ever available and was presented to the United Nations General Assembly in 2006. In response to the report, the Secretary-General noted that while remarkable progress has been made in certain areas of the global response, such as the provision of antiretroviral treatment, much remains to be done before we can claim to have reversed the HIV pandemic.

As the former Secretary-General, Kofi Annan, stated in the 2001 Special Session, "Maintaining the momentum and monitoring progress are essential". To this end, the Secretary-General requested UNAIDS to again report on progress in 2008. As with previous years, this report will be based on national reports prepared by Member States.

I would like to thank you for your efforts in strengthening your national system for the monitoring and evaluation of the response to HIV and AIDS, and wish you well in preparing your next Country Progress Report.



Dr Peter Piot
Executive Director
UNAIDS

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	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	Injecting Drug User(s)
ILO	International Labour Organization
MICS	Multiple Indicator Cluster Survey
NA	Not Applicable
NAC	National AIDS Committee(s)
NAP	National AIDS Programme
NAS	HIV/AIDS National Spending Assessment
NGO	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 Paper
SPA	Service Provision Assessment
STD	Sexually Transmitted Disease(s)
STI	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 a country's response to AIDS with essential information on core indicators that measure the effectiveness of the national response. These guidelines will also help ensure the consistency and transparency of the process used by national governments. In addition, this information can be used by UNAIDS to prepare regional and global progress reports on implementation of the United Nations General Assembly Special Session (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 targets in the Declaration of Commitment on HIV/AIDS. Given the dual purposes of the indicators, the guidelines in this document are designed to improve the quality and consistency of data collected at the country level, which will enhance the accuracy of conclusions drawn from the data at both national 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 UNGASS on HIV/AIDS in June 2001, 189 Member States adopted the Declaration of Commitment on HIV/AIDS. It reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the HIV epidemic by 2015.

Recognizing the need for multisectoral action on a range of fronts, the Declaration of Commitment on HIV/AIDS addresses global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. Although governments initially endorsed the Declaration of Commitment on HIV/AIDS, 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 on HIV/AIDS, success in the AIDS response is measured by the achievement of concrete, time-bound targets. They call for careful monitoring of progress in implementing agreed-on commitments and require the United Nations Secretary-General to issue progress reports annually. These reports are designed to identify problems and constraints and recommend action to accelerate achievement of the 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 on HIV/AIDS. 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 Evaluation Department established clear definitions for each indicator and mechanisms for collecting information on an ongoing basis.

In 2003, 103 Member States (55%) submitted Country Progress Reports to UNAIDS based on the core indicators. 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 were involved in just over half of them.

In 2005, 137 Member States (72%) submitted Country Progress Reports, representing a 33% increase in the number of countries reporting. Of these reports, 40 were from sub-Saharan Africa, 21 from Asia and the Pacific, 32 from Latin America and the Caribbean, 21 from Eastern Europe and Central Asia, 5 from North Africa and the Middle East and 18 from high-income countries.

The information provided by the country reports represents the most comprehensive set of standardized data on the status of the epidemic and progress on the response that has ever been made available. However, there were significant limitations to the data submitted in both 2003 and 2005 for the UNAIDS *Progress Report on the Global Response to the HIV/AIDS Epidemic* (henceforth referred to as the Global Progress Report 2003; 2006). In 2005, 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 adequately disaggregated, by sex or age, which impeded the ability to draw broader and more valid conclusions from the data (Global Progress Report 2006).

In June 2006, United Nations Member States met in the General Assembly to review progress and renew their commitments made in the 2001 UNGASS on HIV/AIDS, based on the findings of the Global Progress Report 2006. Following these deliberations and a review of the reporting process and indicator performance, some refinements and additions were made to the UNGASS indicators for the next round of reporting.

Changes Since the 2005 UNGASS Guidelines

In order to improve the comprehensiveness and quality of data to be submitted for the Global Progress Report 2008, refinements were made to the 2005 UNGASS indicators and accompanying guidelines, as described in this manual. Refinements were based on (i) input received from a variety of partners through an extensive debriefing process; (ii) an analysis of indicator performance in the 2005 reporting round; and (iii) new programmatic developments. These changes are summarized below and listed in detail in Appendix 1.

In all instances, every effort was taken to minimize changes, since clearly it is the consistency of indicators over time that allows for the assessment of trends and progress. Additionally, extra effort was taken to ensure that most countries would be able to collect the data required for the indicator or obtain it from existing sources.

Indicators that have been removed

The indicator relating to the quality of treatment provided to patients with sexually transmitted infections was removed from the UNGASS set. This decision was not intended to be a reflection on the programmatic importance of the management of sexually transmitted infections in national responses to HIV. UNAIDS maintains that prevention, detection and effective treatment of sexually transmitted infections is an important method of reducing vulnerability to HIV transmission. Rather, the decision reflects methodological concerns with the indicator as it was constructed. Refinements in the monitoring of sexually infected diseases and their treatment are currently being undertaken within the global health sector. When a suitably sensitive indicator is developed and demonstrated to produce valid data, it will be integrated into the set of indicators required for UNGASS reporting.

The indicator relating to workplace HIV programmes was removed and replaced with an element in the National Composite Policy Index (NCPI). This reflects difficulties countries experienced in collecting this data, and subsequently low reporting rates for this indicator. The inclusion of this issue in the NCPI will allow countries to qualitatively report on HIV-related activities undertaken in large workplaces without excluding those countries that could not undertake large quantitative workplace surveys as the previous methodology had required.

Indicators that have been added

Two new indicators were added to the UNGASS set. These relate to HIV testing in the adult population, measured through general population surveys such as the AIDS Indicator Survey, and tuberculosis treatment in AIDS patients receiving antiretroviral therapy, taken from patient records. The inclusion of these indicators reflects (i) the programmatic importance of adequate coverage of testing and counseling services in generalized epidemics; and (ii) the programmatic importance of adequate detection and treatment of HIV in tuberculosis patients.

These two indicators are currently in use by a number of development partners and national governments. They have been shown to reliably yield important information for monitoring the HIV response.

Indicators that have been revised

Revisions were made to the following indicators:

- Amount of national funds spent on the AIDS response
- The National Composite Policy Index
- Life skills education in schools
- Blood safety
- Higher-risk sex (multiple concurrent or sequential partners)
- Condom use in higher-risk sex
- Coverage of prevention of mother-to-child transmission (PMTCT) of HIV
- Coverage of HIV prevention programmes for most-at-risk populations
- Injecting practices and condom use of injecting drug users

In some cases these were relatively minor revisions to the wording of the guidance, in order to provide greater clarity. In others, following a consultative process led by the UNAIDS Monitoring and Evaluation Reference Group, the indicators were completely revised based on an assessment of new programme developments, response rates to this indicator and the quality of data reported. In all instances, every effort was made to harmonize any changes made with those indicators currently in use by national governments and other development partners. The consistency of indicators over time allows assessment of trends and progress.

In the previous round of reporting, the impact of prevention of mother-to-child transmission (PMTCT) was a national indicator, modelled on the PMTCT coverage indicator. In order to take into consideration a number of variables that influence the effectiveness of PMTCT services, such as differences in treatment protocols, this indicator will now be modelled at global level using UNAIDS methodologies and software, based on the PMTCT coverage data provided through national reporting.

Use of Additional Recommended Indicators to Monitor Country Progress

UNAIDS strongly recommends that the UNGASS indicators are used as the basis for the national monitoring and evaluation system. In accordance with their specific needs, and if resources allow, countries may wish to include additional indicators in their national monitoring plans.

At the global level, donors, multilateral organizations and the United Nations system are working closely with national governments to harmonize required monitoring indicators and reduce the reporting burden placed on countries. To this end, the UNAIDS Monitoring and Evaluation Reference Group has established a working group to harmonize the great variety of indicators that are currently recommended for programme monitoring or required for donor reporting. The product of this work will be a set of standardized additional indicators that are complimentary to the UNGASS indicators and supported by a range of partners.

Both the core set of UNGASS indicators and a recommended set of additional indicators will be available in an on-line Indicator Registry, which is soon to undergo beta-testing. UNAIDS will provide additional technical guidance to national governments on these indicators later in 2007.

Country Progress Report Format

In response to input received, we have provided more structure in the Country Progress Report format to ensure that similar information is received from each country and to encourage enhanced use by countries of the UNGASS data. This format and these guidelines are intended to facilitate more in-depth and focused analyses of the country's UNGASS data at the country level before submission to the global level. The UNGASS indicator data are considered an integral part of each country's UNGASS Country Progress Report submission. Hence, both the narrative part of the Country Progress Report and the UNGASS indicator data should be considered in the consultation and report preparation process as outlined in the section titled "Reporting" on page 16 of these guidelines.

Appendix 2 provides the full template for the Country Progress Report and detailed instructions for completion of the different sections included in it. It is highly recommended that the UNGASS indicator data are submitted through the Country Response Information System (CRIS) to enhance the completeness and quality of the data and to facilitate processing and analysis at both the country and global levels.

CRIS can provide a national monitoring infrastructure, having been designed to address many of the obstacles to collecting and reporting indicator data. For example, data exchange, appropriate technology and the analytic needs of national and international staff conducting monitoring and evaluation have been built into a system that is cost-effective compared to ad hoc or proprietary systems. For 2005 reporting, 62% of countries that reported by the deadline used CRIS and at least seventeen countries are currently using CRIS to collect data at the subnational level and produce local analyses that, in turn, result in improved data quality and programmatic decision-making. Work is also being done to integrate CRIS with antiretroviral therapy delivery systems to provide streamlined data flow from the facility to national and international levels, providing a more complete and accurate picture of coverage.

The use of CRIS for UNGASS reporting greatly facilitates the transfer of data from countries to the global level. CRIS supports each of the six United Nations languages, thereby eliminating the need for translation. Additionally, indicator data submitted via CRIS are seamlessly integrated into the global database, eliminating the necessity of entering data manually. These two features ensure that the data in the global set reflect exactly that submitted by countries and reduces the processing time needed at UNAIDS headquarters.

It is requested that the Country Progress Report be submitted as an email to ungassindicators@unaids.org with two attachments: a Microsoft Word file for the narrative section and a CRIS data file (or Microsoft Excel file, using the templates provided) before 31 January 2008.

If CRIS is not used for reporting, reports must be submitted by January 15 2008 to allow for the manual entry of data into the Global Response Information Database.

National Indicators: Overview

This document focuses on the national-level UNGASS indicators, although it also includes basic information on the global UNGASS indicators.

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 are analysed collectively, the indicators can provide critical information on the effectiveness of the response at regional and global levels while simultaneously supplying countries with comparative insights into the efforts of other national-level responses.

The national-level UNGASS 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, in preventing the transmission of HIV from mother to child, in providing treatment with antiretroviral therapy for those in need, and of services for orphans and vulnerable children.
- **National knowledge and behaviour** – These indicators cover a range of specific knowledge and behavioural outcomes, including accurate knowledge about HIV transmission, age at first sex, sexual behaviours and school attendance among orphans.
- **National-level programme impact** – These indicators, such as the percentage of young people infected with HIV, focus on the extent to which national programme activities have succeeded in reducing rates of HIV infection and its associated morbidity and mortality.

Most of the national indicators are applicable to **all** countries. For example, the new knowledge and behaviour indicators related to the most-at-risk populations are relevant in countries with concentrated epidemics as well as countries with generalized epidemics if they are aware they have a concentrated sub-epidemic occurring among a specific group. Similarly, countries with a concentrated epidemic are encouraged to collect data on general activities such as life skills education and sexual behaviours among young people as a means to track trends that could influence the nature of the national response in the future.

Four of the national indicators are also Millennium Development Goal 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.

National Indicators for High-income Countries

As signatories to the Declaration of Commitment on HIV/AIDS, high-income countries are also required to report on progress made in their national responses to HIV domestically (not internationally through development assistance or aid programmes). It is recognized that high-income countries often have a number of relatively complex information systems and a variety of data sources which can make the calculation of a single national indicator challenging. However, this does not obviate the need for data from high-income countries to monitor global progress towards the Declaration of Commitment on HIV/AIDS. High-income countries are encouraged to contact the UNAIDS Evaluation Department (ungassindicators@unaids.org) if they require further technical advice regarding reporting on their domestic programmes.

National Indicators for Generalized and Concentrated/Low Prevalence Epidemics

In the previous round of UNGASS reporting, indicators were grouped into two categories according to the nature of the epidemic. The distinction between a generalized epidemic indicator set and a Concentrated/Low Prevalence epidemic set has not been made for this round of reporting. This is due to the fact that epidemics do not fit neatly into simple dichotomous classifications.

In 2006, for example, some countries with a generalized epidemic and a relatively high prevalence recognized that sub-epidemics in most-at-risk populations were important in their epidemic and that prevention programmes for these populations were an essential element of their national response. Rightly, these countries chose to report on the indicators for these populations in addition to the generalized indicator set.

For this round of reporting, countries are expected to consider each indicator in light of the individual dynamics of their epidemic. When countries choose not to report on a particular indicator, they are asked to provide an explanation as to why they chose not to report. This will allow for an analysis that differentiates between an absence of data, and the inapplicability of particular indicators to particular country situations.

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 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 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.

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.

Universal Access Target Setting

The universal access initiative is complementary to the UNGASS Declaration of Commitment. Wherever possible, UNAIDS has encouraged the use of UNGASS indicators in the universal access target-setting process. Country Progress Reports submitted in the UNGASS monitoring process can therefore also be used to track progress towards achieving universal access. Further guidance on universal access, including additional indicators for use in target setting, have been provided in *Setting National Targets for Moving Towards Universal Access by 2010: Operational Guidance* (UNAIDS, 2006) and *Scaling Up Towards Universal Access: Considerations for Countries to Set their Own National Targets for HIV Prevention, Treatment and Care* (UNAIDS, 2006). Both are available on the UNAIDS website at:

<http://www.unaids.org/en/Coordination/Initiatives/Setting+national+targets.asp>.

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 UNAIDS Monitoring and Evaluation Advisers and monitoring and evaluation working groups. The Evaluation Department at the UNAIDS Secretariat is also available to provide support and can be reached via email at 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.

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 and the Demographic and Health Survey/AIDS Indicator Survey; (ii) school surveys; (iii) behavioural surveillance surveys; (iv) specially-designed surveys and questionnaires, including surveys of specific population groups (e.g. specific service coverage surveys); (v) patient tracking systems; (vi) health information systems; and (vii) the National Composite Policy Index questionnaire, included in this manual.

Existing data sources, including records and programme reviews from health facilities and schools as well as specific information from HIV surveillance activities and programmes, should supplement the primary measurement tools. Civil society organizations are 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/AIDS Indicator 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, 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 are not available from monitoring systems, countries may use data collected from interviews of key informants. Although the data collected using this approach are less accurate than data collected by monitoring systems, the approach can be implemented quickly and relatively inexpensively (see Appendix 3 for information on one alternative methodology for collecting coverage data).

For countries with concentrated epidemics or sub-epidemics among most-at-risk populations—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 it 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.

For a given indicator, it is important that the data collection period is consistent for all the information relevant to that indicator's numerator and denominator. If data are collected at different times for the numerator and denominator, 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 have been designed to facilitate the construction of global estimates from national-level data. While these methods can be applied at the subnational level, simpler, faster and more flexible approaches that 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. In such cases, a subnational approach using the methods in this manual would be appropriate.

Disaggregated Data: Essential Sex and Age Breakdowns

One of the key lessons learnt from previous rounds of reporting was the importance of obtaining disaggregated data, for example, breakdowns by sex and age. As mentioned previously, less than 20% of the data submitted for the 2005 report were disaggregated, which makes it difficult to draw valid conclusions from the information. Moving forward, it is vital that countries collect data in their component parts and not simply in summary form. Without 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 actual collection of the information. There is no question that collecting data in their component parts requires more effort. However, it is important to point out that much of the data collected at subnational levels are already disaggregated when they are first collected. It is known, for example, if information is collected from a male or a female. Unfortunately, the more detailed data are 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 remain disaggregated and are retained in this form moving from the local to the national to the global level. When only partially disaggregated data are available, consideration must be given to the representativeness of the data when determining the total value to report for that indicator. For example, reporting only data from males may not represent the total value for an entire population on a given indicator, such as percentage of the population tested for HIV or receiving antiretroviral therapy.

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

Sex and age disaggregation will allow more effective tracking of resources and the programmatic response. This will, in turn, improve the ability of national AIDS programmes and global monitoring efforts to know the degree of success of the HIV response for special populations such as women and youth, who are increasingly becoming two of the most affected populations in this pandemic.

This manual includes reporting forms that countries use to report on each of the national indicators. These forms clearly identify the disaggregated data that are required to accurately report on the numerator and denominator for each indicator (see the preceding subsection entitled Numerators and Denominators for additional information). In general, where appropriate all data are required disaggregated by sex and age. In acknowledgement of the difficulties faced in collecting disaggregated data, enhancements were made to the CRIS to facilitate entry of partial data, if necessary. This will allow time for capacity building surrounding data quality and for disaggregated data collection systems to be created.

In situations where disaggregated data are 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 Global Progress Report 2006 identified a number of valuable resources for data related to core indicators, which may be applicable in other countries.

Countries should seek technical assistance from UNAIDS and its partners at the 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.

Recency and Representativeness of Survey Data

For indicators that are based on surveys of the general population, the most recently available nationally representative survey should be used. It is recognized that in some cases this may mean that the data reported in this round will be the same as the data reported in 2005, since such surveys are generally undertaken at five year intervals.

Ensuring the representativeness of samples taken for surveys of most-at-risk populations is a great technical challenge. Methods are being developed to try to achieve representative sampling of these populations (e.g. respondent-driven sampling). While these are being refined, it is recognized that countries may not be able to attest to the representativeness of samples used for surveys of most-at-risk populations. As such, countries are advised to report data for these indicators using the most recent survey of most-at-risk populations that has been reviewed and endorsed by technical experts within the country, such as monitoring and evaluation technical working groups or national research councils.

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. This section is intended to provide further explanation that should help in interpreting each indicator and any potential issues related to it. They should also consider the points raised in the interpretation section before they finalize their Country Progress 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 Country Progress Reports. Other points in this section provide additional information on the value of a particular indicator. The section acknowledges that variations 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 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.

Selection of Indicators

As mentioned previously, a change from the 2005 round of reporting is that there are no longer two different sets of indicators for different epidemic types. Country Progress Reports received by UNAIDS showed that indicators were selected from both the generalized list and the concentrated/low prevalence list according to their relevance to each country's situation. As such, there is now one consolidated set of indicators.

Countries are expected to "know their epidemic" and to review all of the indicators in the light of this knowledge 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. young people's knowledge of HIV, higher-risk sex in women and men, and condom use during higher-risk sex), which are relevant in tracking the spread of HIV into the general population.

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

For each indicator that countries do not submit data for, countries are asked to indicate if (i) data are not available to answer that indicator, or (ii) the indicator is not considered to be applicable to the epidemic situation in the country.

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, 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 Country 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 Country Progress Report before it is finalized and submitted. 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 the 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 ensure the dissemination of reports, including, whenever possible, reports in national languages.

Shadow reports by civil society will be accepted by UNAIDS for the 2007 round of reporting, as they were in 2003 and 2005. UNAIDS will undertake a consultation with civil society regarding their participation in UNGASS reporting, which will address the issues of both civil society participation in the preparation and submission of official National Progress Reports and shadow reporting.

It must be noted that shadow reports are not intended as a parallel reporting process for civil society. Wherever possible UNAIDS encourages civil society integration into national reporting processes, as described above. Shadow reports are intended to provide an alternative perspective where it is strongly felt that civil society was not adequately included in the national reporting process, or where governments do not submit a Country Progress Report.

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 2) should be used for the report that is submitted to UNAIDS. The Country Progress Report should be submitted to the UNAIDS Evaluation Department in Geneva by 31 January 2008. Country Progress Reports should be emailed to ungassindicators@unaids.org as one message with two files attached: the narrative report as a Microsoft Word file and a second file containing the indicator data. Wherever possible the data should be submitted in a CRIS file. If CRIS cannot be used, please use the Microsoft Excel report forms provided. It is not necessary to use both CRIS and Excel files. Please note that countries that do not submit their indicator data via CRIS are asked to submit their reports by 15 January 2008 to allow time for the manual entry of data into the Global Response Information Database at UNAIDS Geneva.

To facilitate any follow-up that may be necessary, countries are requested to provide the name and contact details of the individual responsible for submitting the Country Progress Report. A form for this purpose is included as Appendix 4. Please note that it is not necessary to have this form or the Country Progress Report officially signed.

Printed copies of reports may be sent to:

Dr. Paul De Lay, Director, Evaluation Department
UNAIDS, 20 Avenue Appia
CH-1211 Geneva 27, Switzerland

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 mentioned previously, where countries do not submit data on an indicator, it is requested that countries indicate whether this was due to an absence of appropriate data or whether the indicator was not considered relevant to the epidemic. Country Progress Reports should therefore refer to each indicator in these guidelines, regardless of whether or not data are submitted on the indicator.

The full multi-year UNGASS reporting schedule for all indicators is found in Appendix 5. In 2008, countries are expected to provide a comprehensive report on all of the national indicators that are applicable to their response. If there are any questions, countries are advised to consult with UNAIDS locally or in Geneva at ungassindicators@unaids.org. Updated information on UNGASS reporting will be made available on the UNAIDS internet site at: <http://www.unaids.org>.

As discussed previously, and as required by the Declaration of Commitment on HIV/AIDS, civil society, including people living with HIV, should be involved in preparing the Country 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 or forum to openly present and discuss the findings of the Country Progress Report before it is submitted to UNAIDS. Where appropriate, the final report should reflect the discussion at this event. Joint UN Teams on AIDS are available in most countries to facilitate this discussion process. Once submitted, all Country Progress Reports will be made public on the UNAIDS website. It is therefore important that the report has been fully reviewed in the country and officially endorsed prior to submission to UNAIDS. Data submitted via CRIS must be validated against the narrative report and all data quality reviewed and checked prior to submission. There will be no time for UNAIDS to verify quality of data after submission to UNAIDS Geneva for global aggregation and analysis.

In countries where the 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 on HIV/AIDS. 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.

The National-Level Reporting Process: Some Necessary Actions

Complete reporting on the core indicators is essential if the Country Progress Report 2008 is 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 are necessary actions to facilitate completion of the report. Under the direction of the National AIDS Committee or its equivalent, countries need to:

- identify data needs in line with the national strategic plan requirements and these UNGASS guidelines;
- 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 and collate data in coordination with partner organizations from government, civil society and the international community;
- analyse data in coordination with partner organizations from government, civil society and the international community;
- complete the appropriate data forms and draft the accompanying Country Progress 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 validate it against the narrative; and
- submit (i) the narrative report and (ii) the indicator data by e-mail (*ungassindicators@unaid.org*) to UNAIDS Geneva before **31 January 2008**, or by **15 January 2008** for countries not submitting data via CRIS.

A checklist which may be used in the preparation and submission of the Country Progress Report is included as Appendix 8.

The Role of Monitoring Indicators in Evidence-based Advocacy

Reporting on the core indicators is a way of tracking a country's progress in achieving the Declaration of Commitment on HIV/AIDS. It is also 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 AIDS response.

Advocacy is a strategic process designed to influence political, social, economic and cultural changes needed to improve the AIDS response. 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 are not readily available, it highlights the need for advocacy to address the issue of improving the capacity of the monitoring and evaluation systems themselves.

Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS 2008 reporting

Indicators	Data Collection Frequency	Measurement Tool
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National Indicators

National Commitment and Action

1. Domestic and international AIDS spending by categories and financing sources	Ad hoc based on country request and financing, by calendar or fiscal year	National AIDS Spending Assessments, National Health Accounts or financial resource flow surveys
2. National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Every 2 years	Desk review and key informant interviews

National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)

3. Percentage of donated blood units screened for HIV in a quality assured manner	Annual	Programme monitoring
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Annual	Programme monitoring and estimates
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Annual	Programme monitoring and estimates
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Annual	Programme monitoring
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Every 4-5 years	Population-based survey
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Every 2 years	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV prevention programmes	Every 2 years	Behavioural surveys
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	Every 4-5 years	Population-based survey
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Every 2 years	School-based survey

Knowledge and Behaviour

12. Current school attendance among orphans and among non-orphans aged 10-14*	Every 4-5 years	Population-based survey
13. 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*	Every 4-5 years	Population-based survey
14. 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	Every 2 years	Behavioural surveys
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Every 4-5 years	Population-based survey

NATIONAL

16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Every 4–5 years	Population-based survey
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	Every 4–5 years	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Every 2 years	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Every 2 years	Behavioural surveys
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Every 2 years	Behavioural surveys
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Every 2 years	Behavioural surveys

Impact

22. Percentage of young women and men aged 15–24 who are HIV infected*	Annual	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	Annual	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Every two years	Programme monitoring
25. Percentage of infants born to HIV-infected mothers who are infected	(Modelled at UNAIDS Headquarters, based on programme coverage)	Treatment protocols and efficacy studies

Global Indicators

1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries	Annual	Donor reports
2. Amount of public funds for research and development of preventive HIV vaccines and microbicides	Annual	Donor reports
3. Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programmes	Annual	Desk review
4. Percentage of international organizations that have workplace HIV policies and programmes	Annual	Desk review

* Millennium Development Goals indicator

NATIONAL COMMITMENT AND ACTION INDICATORS

1. AIDS spending by categories and financing source

2. National Composite Policy Index (NCPI)

Part A (to be administered to government officials):

- Strategic plan
- Political support
- Prevention
- Treatment, care and support
- Monitoring and evaluation

Part B (to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations):

- Human rights
- Civil society involvement
- Prevention
- Treatment, care and support

1. AIDS Spending

As the national and international response to AIDS continues to scale up, it is increasingly important to accurately track in detail: i) how funds are spent at the national level and ii) where the funds originate. The data are used to measure national commitment and action, which is an important component of the UNGASS Declaration of Commitment on HIV/AIDS. In addition, the data help national-level decision-makers monitor the scope and effectiveness of their programmes. When aggregated across multiple countries, the data also help the international community evaluate the status of the global response. This piece of strategic information supports the coordination role of the National AIDS Authority in each country and provides the basis for resource allocation and improved strategic planning processes.

Since different countries can choose among different methodologies and tools to monitor the flow of AIDS funding – i.e. National AIDS Spending Assessments (NASA), AIDS sub-account of the National Health Accounts (NHA) and ad hoc Resource Flows Surveys – the National Funding Matrix includes a spreadsheet that allows financial data from any of these three methodologies to be easily entered, reviewed and reported. A “crosswalk” between NASA and NHA has been achieved for the AIDS health expenditures so there is now no difference between any of these tools to track AIDS-health expenditures; NASA simply provides more detail on expenditures on activities performed outside the health system, such as social mitigation, education, justice and other activities. A similar alignment process was undertaken for the UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute Resource Flows Project.

Domestic and international AIDS spending by categories and financing sources

PURPOSE	To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	2005, 2006 and 2007 calendar or fiscal year data (as available)
MEASUREMENT TOOLS	<p>Primary tool/method: National AIDS Spending Assessment (NASA)</p> <p>Alternative tools/methods:</p> <ol style="list-style-type: none"> 1) National Health Accounts - AIDS sub-accounts. The NASA guidelines include a section mapping the codes of the NHA and NASA for AIDS health expenditures and for selected activities performed outside the health system. Thus, there should not be any difference in the AIDS health spending measured by NASA or by the NHA sub-accounts. However, some activities performed outside the health system might not be included in National Health Accounts. 2) Resource Flows (RF) Survey. There has been an alignment process and countries that have been selected in the sample of this survey and have responded to the questionnaires may enter the information in the funding matrix at the aggregated level by main activities. Some activities performed outside the health system might not be included in this RF Survey. In addition, some population-related actions should be excluded from the total for AIDS. <p>The outputs from any of these measurement tools are to be used to complete the National Funding Matrix, which is to be submitted as part of the Country Progress Report (see Appendix 6).</p>

METHOD OF MEASUREMENT

Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources:

1. Prevention;
2. Care and treatment;
3. Orphans and vulnerable children¹;
4. Programme management and administration strengthening;
5. Incentives for human resources;
6. Social protection and social services (excluding orphans and vulnerable children);
7. Enabling environment and community development;
8. Research (excluding operations research included under programme management).

(There are multiple sub-categories in each AIDS Spending Category; see Appendix 6).

Three main groups of financing sources:

1. Domestic public;
2. International;
3. Domestic private (optional for UNGASS reporting).

(There are multiple sub-categories for each source; see Appendix 6)

INTERPRETATION

The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. For example, the diagnosis and treatment of opportunistic infections would require a special costing estimate to track the specific resources allocated to AIDS-related diagnosis and treatment. Similarly, prevention activities in schools may benefit from a detailed estimation to calculate actual expenditures on AIDS activities. The AIDS expenditures might occur outside the health system given the nature of expanded responses to AIDS.

Historically, there has been very limited information available on how AIDS financial resources are spent at the national level and where countries source that funding. Completing the National Funding Matrix will provide a more detailed picture of the situation at the country level, which is useful for both national and global decision-making.

REPORTING

The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix. Appendix 6 provides further instructions on how to submit the report of this indicator via the completed National Funding Matrix. The cover sheet as well as the information indicated in Appendix 6 needs to be submitted with the Country Progress Report.

FURTHER INFORMATION

For further information, please consult the following references and websites:

- Partners for Health Reform Plus/USAID (2004). *Methodological Guidelines for Conducting a National Health Accounts Sub-analysis for HIV/AIDS*. This publication can be found at: http://www.phrplus.org/Pubs/Tech044_fin.pdf

¹ In the context of resource needs estimates and AIDS Spending Assessments, vulnerable children are defined as those who have at least one parent who is alive but seriously ill (mainly because of HIV) and unable to take care of them.

- UNAIDS (2007). *Notebook to Produce National AIDS Spending Assessment*. This publication is available at: www.unaids.org/en/Coordination/FocusAreas/track-monitor-evaluate.asp
- UNAIDS (2007). *NASA-NHA Crosswalk*. This publication is available at www.unaids.org/en/Coordination/FocusAreas/track-monitor-evaluate.asp
- UNFPA/UNAIDS/NIDI. Details on Resource Flows Surveys, survey instruments, countries sampled and more details on this tool are available at: www.resourceflows.org
- World Bank/WHO/USAID (2003). *Guide to Producing National Health Accounts*. This publication and other tools for National Health Accounts and AIDS sub-accounts can be found at: www.who.int/nha

2. Government HIV and AIDS Policies

National Composite Policy Index

PURPOSE	To assess progress in the development and implementation of national-level HIV and AIDS policies and strategies
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	National Composite Policy Index (NCPI) questionnaire (see Appendix 7)
METHOD OF MEASUREMENT	The composite index covers the following broad areas of policy, strategy and programme implementation: <ul style="list-style-type: none"> Part A <ol style="list-style-type: none"> 1. Strategic plan 2. Political support 3. Prevention 4. Treatment, care and support 5. Monitoring and evaluation Part B <ol style="list-style-type: none"> 1. Human rights 2. Civil society involvement 3. Prevention 4. Treatment, care and support

INTERPRETATION

- It is important to analyse the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in (a) policy and strategy development and (b) implementation of policies and strategies, in order to tackle the country's HIV epidemic. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available².

² see *Guidelines on construction of core indicators*, UNAIDS 2002 and UNAIDS 2005, respectively, for the key questions in previous NCPI questionnaires

NATIONAL PROGRAMME INDICATORS

Programme areas: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphaned and vulnerable children, and education

3. Percentage of donated blood units screened for HIV in a quality-assured manner
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy
5. Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission
6. Percentage estimated HIV-positive incident TB cases that received treatment for TB and HIV
7. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results
9. Percentage of most-at-risk populations reached with HIV prevention programmes
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child
11. Percentage of schools that provided life skills-based HIV education within the last academic year

3. Blood Safety

Blood safety programmes aim to ensure that all blood units are screened for transfusion-transmissible infections, including HIV, and that only those units that are non-reactive on screening tests are released for clinical use. In many countries, blood units are not screened for all the major transfusion-transmissible infections. Often, even when screening does occur, the safety of blood is compromised by inaccurate test results due to the poor quality or incorrect storage of test kits. Furthermore, inadequate staff training or a lack of standard operating procedures may result in laboratory errors. This could lead to blood units being classified as safe even when they are infectious, posing a serious risk of transmission of HIV through unsafe blood.

Universal (100%) screening of donated blood for HIV and other transfusion-transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. In some countries, interruptions to supplies of test kits and reagents, or emergency situations, can result in the use of blood for transfusion without screening for transfusion-transmissible infections. The development of systems for reliable and regular supplies of low-cost, high-quality test kits and reagents and effective stock management are therefore essential to ensure universal quality screening of blood units.

Thus, it is crucial that all donated blood units be screened for HIV in a quality-assured manner. Two key components of quality assurance in screening are:

- 1) The use of documented and standardized procedures (standard operating procedures) for the screening of every blood unit:
- 2) Participation of the laboratories in an External Quality Assessment Scheme for HIV screening in which external assessment of the laboratory's performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.

Percentage of donated blood units screened for HIV in a quality-assured manner

PURPOSE	To assess progress in ensuring a safe blood supply
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	FRAME Tool (Framework for Assessment, Monitoring and Evaluation of blood transfusion services): a rapid assessment tool used by the WHO Global Database on Blood Safety
METHOD OF MEASUREMENT	<p>The information relates to data from the previous 12 months (January-December). This information should be available from the National Blood Transfusion Service or the National Blood Programme Manager in the Ministry of Health</p> <p>The following information is required to measure this indicator:</p> <ol style="list-style-type: none"> 1. What was the total number of blood units that were donated in the country? <p>For each blood centre and blood screening laboratory that screens donated blood for HIV:</p> <ol style="list-style-type: none"> 2. How many units of blood were donated in each blood centre/blood screening laboratory? 3. How many donated units were screened in the blood centre/blood screening laboratory?

4. Does the blood centre/blood screening laboratory follow documented standard operating procedures for HIV screening?
5. Does the blood centre/blood screening laboratory participate in an External Quality Assessment Scheme for HIV screening?

From this information, the indicator can be calculated.

Numerator:

Number of donated blood units screened for HIV in blood centres/ blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme

Denominator:

Total number of blood units donated

In this context, donation refers to any blood collected for the purposes of medical use. This includes all possible types of providers of blood, regardless of whether they receive remuneration or not. Examples of different categories of blood donors include:

- Voluntary non-remunerated blood donor: an altruistic donor who gives blood freely and voluntarily without receiving money or any other form of payment.
- Family/replacement blood donor: a donor who gives blood when it is required by a member of the patient's family or community. This may involve a hidden paid donation system in which the donor is paid by the patient's family.
- Paid donor: a donor who gives blood for money or other form of payment.
- Autologous donor: a patient who donates his/her blood to be stored and reinfused, if needed, during surgery.

Examples of the data needed to calculate this indicator are shown below:

Name of the blood centre or blood screening laboratory	Quality Assurance in HIV screening		Blood units		
	Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Screened blood	Blood screened in quality-assured manner
A	Yes	Yes	1000	1000	1000
B	Yes	No	800	450	0
C	No	Yes	150	50	0
D	No	No	50	0	0
Total	2	2	2000	1500	1000
	[number of facilities]		[number of blood units]		

Thus, the percentage of donated blood units screened for HIV in a quality-assured manner in the previous 12 months is: $1000 / 2000 = 50\%$.

INTERPRETATION

If the blood screening laboratory follows documented and standardized procedures for the screening of blood, this implies a certain level of uniformity, reliability and consistency of performance by staff trained to use the standard operating procedures. If a blood screening laboratory participates in an External Quality Assurance Scheme, this implies that the quality of HIV screening performed is being assessed at regular intervals. It is important to view the percentage of screened blood units in relation to these two basic components of quality as both are required to ensure the quality of procedures.

Countries provide data to the WHO Global Database on Blood Safety on this indicator annually. Locally, these data can be obtained by contacting the National Blood Transfusion Service, the National Blood Programme and/or the National AIDS Programme.

FURTHER INFORMATION

For further information, please consult the following websites:

- www.who.int/bloodsafety
- www.who.int/diagnostics_laboratory
- www.who.int/worldblooddonorday

4. HIV Treatment: Antiretroviral Therapy

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

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

PURPOSE	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting.
MEASUREMENT TOOL	For the numerator: facility ART registers and ART cohort analysis report forms, or programme monitoring tools. For the denominator: antenatal clinic surveillance or estimation models.
METHOD OF MEASUREMENT	ART registers, HIV surveillance systems
Numerator:	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period
Denominator:	Estimated number of adults and children with advanced HIV infection This indicator should be disaggregated by sex and age (<15, 15+) and percentages given for 2006 and 2007 to track annual trends in coverage.
Explanation of Numerator:	The numerator can be generated by counting the number of adults and children who received antiretroviral therapy at the end of the reporting period. The numerator should equal the number of adults and children with advanced HIV infection who ever started antiretroviral treatment minus those patients who are not currently on treatment prior to the end of the reporting period. Patients not currently on treatment at the end of the reporting period, in other words, those who are excluded from the numerator, are patients who died, stopped treatment or are lost to follow-up. Some patients pick up several months of antiretroviral drugs at one visit, which could include antiretroviral therapy received for the last months of the reporting period, but not be recorded as visits for the last months in the patient register. Efforts should be made to account for these patients, as they need to be included in the numerator.

Antiretroviral therapy taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-infected pregnant women who are eligible for and on antiretroviral drugs for their own treatment are included in this indicator.

The number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy can be obtained through data collected from drug supply management systems or facility-based antiretroviral treatment registers. These are then tallied and transferred to cross-sectional monthly or quarterly reports which can then be aggregated for national totals.

Patients receiving antiretroviral therapy in the private sector and public sector should be included in the numerator where data are available.

Explanation of Denominator: The denominator is generated by estimating the number of people with advanced HIV infection requiring (in need of/eligible for) antiretroviral therapy.

The denominator estimates are most often based on the latest data available from sentinel surveillance which can then follow UNAIDS/WHO Reference Group on Estimates, Modelling and Projections methodology.³

Need or eligibility for antiretroviral therapy should follow the WHO definitions for the diagnosis of advanced HIV (including AIDS) for adults and children.⁴

INTERPRETATION

This indicator permits monitoring 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 needing antiretroviral therapy varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral combination therapy among adults and children.

The degree of utilization of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, and perceptions of effectiveness and possible side effects of treatment.

³ http://www.unaids.org/en/HIV_data/Methodology/default.asp

⁴ <http://www.who.int/hiv/pub/guidelines/HIVstaging.pdf>

5. Prevention of Mother-to-Child Transmission

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 significantly reduced through the complementary approaches of antiretroviral prophylactic regimes 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 who received antiretrovirals to reduce the risk of mother-to-child transmission

PURPOSE	To assess progress in preventing vertical transmission of HIV
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly.
MEASUREMENT TOOL	For the numerator: programme monitoring tools. For the denominator: antenatal clinic surveillance or estimation model.
METHOD OF MEASUREMENT	The number of HIV-infected pregnant women who received antiretrovirals (ARVs) to reduce the risk of mother-to-child transmission during the last 12 months is obtained from programme monitoring records compiled from patient records and registers.
Numerator:	Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission
Denominator:	Estimated number of HIV-infected pregnant women in the last 12 months
Explanation of numerator:	<p>Data for this indicator should be provided for both 2006 and 2007 to track annual trends in coverage.</p> <p>There are four general antiretroviral treatment options that HIV-infected women can receive for the prevention of mother-to-child transmission (PMTCT):</p> <ol style="list-style-type: none"> 1. Single-dose Nevirapine 2. Prophylactic regimens using a combination of two ARVs 3. Prophylactic regimens using a combination of three ARVs 4. ART for HIV-positive pregnant women eligible for treatment <p>HIV-infected women receiving any of the four options meet the definition for the numerator. Countries should report as the numerator the total number of HIV-infected pregnant women who were provided with any of the antiretroviral treatment regimes in options one to four.</p> <p>In option number four, HIV-infected pregnant women who are eligible for antiretroviral treatment and receive a treatment regimen will also benefit from the prophylactic effect for prevention of mother-to-child transmission and thus are included in the numerator.</p> <p>Antiretroviral drugs can be provided to HIV-infected women during pregnancy, at labour and shortly after delivery, and provision can take place at a number of sites. Countries should focus on compiling data for the numerator from patient registers at antenatal clinics, delivery and care sites, and post-partum care service sites.</p>

Women receiving antiretroviral drugs in both the private sector and the public sector should be included in the numerator where data for both are available.

Explanation of Denominator: The denominator is generated by estimating the number of HIV-infected women who were pregnant in the last 12 months. This is based on surveillance data from antenatal clinics.

Two methods are possible for generating the estimate for the denominator:

1. Estimates generated by a projection model⁵ such as Spectrum;⁶ or
2. Multiplying:
 - (a) the total number of women who gave birth in the last 12 months, which can be obtained from the Central Statistics Office estimates of births, by
 - (b) the most recent national estimate of HIV prevalence in pregnant women, which can be derived from HIV sentinel surveillance antenatal clinic estimates.

INTERPRETATION

Countries are encouraged to track and report on the actual or estimated percent distribution of the various regimens provided so that the impact of antiretroviral drugs on mother-to-child-transmission can be modelled based on the efficacy of corresponding regimens. In 2006, international guidelines were updated to recommend more efficacious regimens for prevention of mother-to-child transmission, and countries may be at different phases in adopting the newer recommendations. Although countries may not have a system in place yet to collect and report coverage of antiretroviral drug provision for prevention of mother-to-child transmission by the various regimen possibilities, the goal should be towards setting up such a system.

This indicator permits monitoring trends in antiretroviral drug provision that addresses prevention of mother-to-child transmission. However, since countries provide different regimens of antiretroviral drugs for prevention of mother-to-child transmission, cross-country comparisons of aggregate estimates must be interpreted with caution and with reference to the regimens provided.

In addition to antiretroviral drugs for the mother, ARV regimens to reduce mother-to-child transmission should be accompanied by an appropriate regimen for the infant, and thus where possible, countries should track and report on whether the infant dose has been provided.

In some 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 drugs can be accessed via such services or where levels of stigma are particularly high. National estimates of HIV-infected pregnant women should be derived by adjusting surveillance data from antenatal clinic sentinel sites and other sources, taking into consideration characteristics such as rural/urban patterns of HIV prevalence that may affect the representation of surveillance sites.

FURTHER INFORMATION

The prevention of mother-to-child transmission is a rapidly evolving programmatic area. Methods for monitoring coverage of this service are therefore also evolving. To access the most current information available please consult the following website:

- <http://www.who.int/hiv/pub/guidelines/pmtct/en/index.html>

⁵ Methodology described by UNAIDS/WHO Reference Group on Estimates Modelling and Projections: http://www.unaids.org/en/HIV_data/Methodology/default.asp

⁶ http://www.unaids.org/en/HIV_data/Epidemiology/episofware.asp

6. Co-management of Tuberculosis and HIV Treatment

Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

PURPOSE	To assess progress in detecting and treating TB in people living with HIV
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here.
MEASUREMENT TOOL	Facility ART registers and reports; programme monitoring tools and estimates
METHOD OF MEASUREMENT	Programme data and estimates of incident TB cases in people living with HIV
Numerator:	Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year
Denominator:	Estimated number of incident TB cases in people living with HIV Country-specific annual estimates of the number of incident TB cases in people living with HIV are calculated by WHO and are available at: http://www.who.int/tb/country/en Data for this indicator should be disaggregated by sex.

INTERPRETATION

Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. WHO provides annual estimates of the burden of TB among people living with HIV, based on the best available country estimates of HIV prevalence and TB incidence. All incident TB cases among people living with HIV should be started on TB treatment and, depending on country specific eligibility criteria. All or most people living with HIV who have TB should be on antiretroviral therapy, depending on local eligibility criteria. TB treatment should only be started in accordance with national TB programme guidelines.

This indicator provides a measure of the extent to which collaboration between the national TB and HIV programmes is ensuring that people with HIV and TB disease are able to access appropriate treatment for both diseases. However, this indicator will also be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral treatment, and poor access to TB diagnosis and treatment. Separate indicators exist for each of these factors and should be referred to when interpreting the results of this indicator.

It is important that those providing HIV care and antiretroviral treatment record TB diagnosis and treatment, as this information has important implications for antiretroviral treatment eligibility and choice of regimen. It is therefore recommended that the date of starting TB treatment is recorded in the antiretroviral treatment register.

If possible, the number of patients started on TB treatment among those in HIV care but not yet on antiretroviral treatment should also be reported. This would capture additional cases of TB that are detected and treated among people living with HIV.

FURTHER INFORMATION

For further information, please consult the following reference and website:

- World Health Organization (2007). *Global Tuberculosis Control: Surveillance, Planning, Financing. WHO Report 2007*. (WHO/HTM/TB/2007.376) Geneva: World Health Organization.
<http://www.who.int/tb/country/en>

7. HIV Testing in the General Population

In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results

PURPOSE	To assess progress in implementing HIV testing and counselling
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	<p>Respondents are asked:</p> <ol style="list-style-type: none"> 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? 2. If yes: I don't want to know the results, but did you get the results of that test?
Numerator:	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results
Denominator:	<p>Number of all respondents aged 15–49</p> <p>The indicator must be presented as percentages for males and females, and should be disaggregated by the age groups 15–19, 20–24 and 25–49.</p> <p>The denominator includes respondents who have never heard of HIV or AIDS.</p>

INTERPRETATION

In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

The introductory statement “I don't want to know the results, but...” allows for better reporting and reduces the risk of underreporting of HIV testing among people who do not wish to disclose their serostatus.

FURTHER INFORMATION

For further information, please consult the following website:

- <http://www.measuredhs.com/aboutsurveys/ais.cfm>

8. HIV Testing in Most-at-risk Populations

In order to protect themselves and to prevent infecting others, it is important for 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: sex workers, injecting drug users and 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, they should calculate and report this indicator for those populations.

Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results

PURPOSE	To assess progress in implementing HIV testing and counselling among most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Behavioural surveillance or other special surveys
METHOD OF MEASUREMENT	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Have you been tested for HIV in the last 12 months? <p>If yes:</p> <ol style="list-style-type: none"> 2. I don't want to know the results, but did you receive the results of that test?
Numerator:	Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results
Denominator:	<p>Number of most-at-risk population included in the sample</p> <p>Data for this indicator should be disaggregated by sex and age (<25/25+).</p> <p>Whenever possible, data for most-at-risk populations 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 are 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 and 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 and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

9. 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: 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, they should calculate and report this indicator for those populations.

Percentage of most-at-risk populations reached with HIV prevention programmes

PURPOSE	To assess progress in implementing HIV prevention programmes for most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Behavioural surveillance or other special surveys
METHOD OF MEASUREMENT	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic) <p>Injecting drug users (IDUs) should be asked the following additional question:</p> <ol style="list-style-type: none"> 3. In the last twelve months, have you been given sterile needles and syringes? (e.g. by an outreach worker, a peer educator or from a needle exchange programme)
Numerator:	Number of most-at-risk population respondents who replied “yes” to both (all three for IDUs) questions
Denominator:	<p>Total number of respondents surveyed</p> <p>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>Data collected for this indicator should be reported separately for each most-at-risk population and disaggregated by sex and age (<25/25+).</p> <p>Whenever possible, data for most-at-risk populations 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 are 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 and reliability of the data, and any related issues should be included in the report submitted with this indicator.

The inclusion of these indicators for reporting purposes should not be interpreted to mean that these services alone are sufficient for HIV prevention programmes for these populations. The set of key interventions described above should be part of a comprehensive HIV prevention programme, which also includes elements such as provision of HIV prevention messages (e.g. through outreach programmes and peer education), and opioid substitution therapy for injecting drug users.

Since the Global Progress Report in 2006, it has been recommended that the issue of quality and intensity of reported services among most-at-risk populations be addressed more explicitly in terms of criteria for the measurement of the components of provided services. Taking into account the complexity of this element of measurement, particularly within the context of most-at-risk populations, the development of such criteria requires an intensive process of information gathering, synthesis and recommendations formulation. This was difficult to address between the reporting processes of 2005 and 2007. However, the process has been initiated and is expected to have recommendations for the next reporting round. In the meantime, it is recommended that the guidelines mentioned below be referred to as reference documents that can facilitate interpretation of the collected data from a quality and intensity perspective.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

10. 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 aged 0–17 whose households received free basic external support in caring for the child

PURPOSE	To assess progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17
APPLICABILITY	High HIV-prevalence countries
DATA COLLECTION FREQUENCY	Every 4–5 years
MEASUREMENT TOOL	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	<p>After all orphaned and vulnerable children aged 0–17 in the house have been identified, the household heads are asked the following four questions about the types and frequency of support received, and the primary source of the help for <i>each</i> orphan and vulnerable child. Each question is to be asked for each child.</p> <ol style="list-style-type: none"> 1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months? 2. Has this household received school-related assistance, including school fees, within the last 12 months? (This question is to be asked only of children aged 5–17.) 3. Has this household received emotional/psychological support, including counselling from a trained counsellor and/or emotional/spiritual support or companionship within the last three months? 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 caregivers, childcare, legal services) within the last three months? <p>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.</p>
Numerator:	Number of orphaned and vulnerable children aged 0–17 who live in households that received at least one of the four types of support for each child (answered “yes” to at least one of questions 1, 2, 3 and 4)
Denominator:	Total number of orphaned and vulnerable children aged 0–17
	For the purposes of this indicator, an orphan is defined as a child below the age of 18 that has lost both parents.

A child made vulnerable by HIV is below the age of 18 and:

- i.) has lost one or both parents; or
- ii.) has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or
- iii.) lives in a household where, in the last 12 months, at least one adult died and was sick for three of the four months before he or she died; or
- iv.) lives in a household where at least one adult was seriously ill for at least three of the past 12 months.

INTERPRETATION

This indicator should only be monitored in settings with high HIV prevalence (5% or greater). The 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. The 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, it may be useful for programmatic purposes to investigate differences between values for this indicator for orphans versus other vulnerable children. It may also be useful to look at data 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.

When considering the four types of support separately, data for school-related assistance should be limited to children aged 5-17.

FURTHER INFORMATION

For further information, please consult the following website:

- http://www.unicef.org/aids/index_documents.html

11. Life Skills-based HIV Education in Schools

Life skills-based education is an effective methodology that 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-based 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 effect on behaviours, including delay in sexual debut and reduction in number of sexual partners.

Percentage of schools that provided life skills-based HIV education in the last academic year.

PURPOSE	To assess progress towards implementation of life skills-based HIV education in all schools
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	School survey or education programme review
METHOD OF MEASUREMENT	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 question: Within the last academic year, did your school provide at least 30 hours of life skills training to each grade?
Numerator:	Number of schools that provided life skills-based HIV education in the last academic year
Denominator:	Number of schools surveyed Indicator scores are required for all schools combined and for primary and secondary schools separately. If the 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.

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.

FURTHER INFORMATION

For further information, please consult the following websites:

- http://www.unicef.org/lifeskills/index_hiv_aids.html
- http://www.unicef.org/aids/index_documents.html

KNOWLEDGE AND BEHAVIOUR INDICATORS

12. Current school attendance among orphans and non-orphans aged 10–14*
13. 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*
14. 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
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
17. Percentage of women and men aged 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

* Millennium Development Goals indicator

12. 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.

Current school attendance among orphans and non-orphans aged 10–14

PURPOSE	To assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Preferred: Every two years Minimum: every 4–5 years
MEASUREMENT TOOL	Population-based survey (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	For every child aged 10–14 living in a household, a household member is asked: <ol style="list-style-type: none"> 1. Is this child's natural mother still alive? If yes, does she live in the household? 2. Is this child's natural father still alive? If yes, does he live in the household? 3. Did this child attend school at any time during the school year? <p>Part A: Current school attendance rate of orphans aged 10–14</p> <p>Numerator: Number of children who have lost both parents and who attend school</p> <p>Denominator: Number of children who have lost both parents</p> <p>Part B: Current school attendance rate of children aged 10–14 both of whose parents are alive and who live with at least one parent</p> <p>Numerator: Number of children both of whose parents are alive, who are living with at least one parent and who attend school</p> <p>Denominator: Number of children both of whose parents are alive who are living with at least one parent</p> <p>This indicator should be reported disaggregated by sex.</p>

INTERPRETATION

The intent of this indicator is to compare school attendance among the most vulnerable children (double orphans) to school attendance among the least vulnerable children (those with both parents still alive and who are living with at least one parent).

The definitions of orphan/non-orphan used here—i.e. child aged 10–14 years as of the 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 often been HIV-infected for less time) and older children are more likely to have left school.

Typically, the data used to measure this indicator are 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.

This 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.

FURTHER INFORMATION

For further information, please consult the following website:

- http://www.unicef.org/aids/index_documents.html

13. 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 is an essential pre-requisite—albeit, often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

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

PURPOSE	To assess progress towards universal knowledge of the essential facts about HIV transmission
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Preferred: every two years; minimum: every 4–5 years
MEASUREMENT TOOL	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	<p>This indicator is constructed from responses to the following set of prompted questions:</p> <ol style="list-style-type: none"> 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?
Numerator:	Number of respondents aged 15–24 years who gave the correct answer to all five questions
Denominator:	<p>Number of all respondents aged 15–24</p> <p>The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: “Can a person get HIV by hugging or shaking hands with a person who is infected?” and “Can a person get HIV through supernatural means?”</p> <p>Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of “don’t know” should be recorded as an incorrect answer.</p> <p>The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15–19 and 20–24 years.</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 HIV.

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.

14. 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 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: 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 populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

PURPOSE	To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special behavioural surveys such as the Family Health International Behavioural Surveillance Survey for most-at-risk populations
METHOD OF MEASUREMENT	<p>Respondents are asked the following five questions:</p> <ol style="list-style-type: none"> 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected?
Numerator:	Number of most-at-risk population respondents who gave the correct answers to all five questions
Denominator:	<p>Number of most-at-risk population respondents who gave answers, including “don’t know”, to all five questions</p> <p>Indicator scores are required for all respondents and should be disaggregated by sex and age (<25; 25+).</p> <p>The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the country.</p> <p>Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.</p>

Scores for each of the individual questions—based on the same denominator—are required in addition to the score for the composite indicator.

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

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 are 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 and reliability of the data, and any related issues should be included in the report submitted with this indicator.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

15. 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 first having sex at a later age reduces susceptibility to infection per act of sex, at least for women.

Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

PURPOSE	To assess progress in increasing the age at which young women and men aged 15–24 first have sex
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	4–5 years
MEASUREMENT TOOL	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: How old were you when you first had sexual intercourse for the first time?
Numerator:	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
Denominator:	Number of all respondents aged 15–24 years
	The indicator should be presented as separate percentages for males and females, and should be disaggregated by the age groups 15–19 and 20–24 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 which young people first had sexual intercourse (as opposed to the median age) is that the 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 virginity or delaying of first sex, young people's responses to survey questions on this issue may be biased, including a deliberate misreporting of age at which they first had sex.

16. Higher-risk Sex

The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners (concurrently or sequentially) have a higher risk of HIV transmission than individuals that do not link into a wider sexual network.

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

PURPOSE	To assess progress in reducing the percentage of people who have higher-risk sex
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	4–5 years
MEASUREMENT TOOL	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	<p>Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked:</p> <p>In the last 12 months, how many different people have you had sexual intercourse with?</p>
Numerator:	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	<p>Number of all respondents aged 15–49</p> <p>The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15–19, 20–24 and 25–49 years.</p>

INTERPRETATION

This indicator gives a picture of levels of higher-risk sex. If people have only one sexual partner, the change will be captured by changes in this indicator. However, if people simply decrease the number of sexual partners they have, 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. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.

17. Condom Use During Higher-risk Sex

Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners.

Percentage of women and men aged 15–49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse

PURPOSE	To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Preferred: Every two years Minimum: every 4–5 years
MEASUREMENT TOOL	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
METHOD OF MEASUREMENT	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: <ol style="list-style-type: none"> 1. In the last 12 months, how many different people have you had sexual intercourse with? <p>If more than one, the respondent is asked:</p> <ol style="list-style-type: none"> 2. Did you or your partner use a condom the last time you had sexual intercourse?
Numerator:	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
Denominator:	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months <p>The indicator should be presented as separate percentages for males and females, and should be disaggregated by the age groups 15–19, 20–24 and 25–49 years.</p>

INTERPRETATION

This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly). However, the broader significance of any given indicator value will depend upon the extent to which people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on the percentages of people that have had more than one sexual partner within the last year.

The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide 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 during the most recent sex act will generally reflect the trend in consistent condom use.

18. 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

PURPOSE	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special surveys, including the Family Health International Behaviour Surveillance Survey for sex workers
METHOD OF MEASUREMENT	Respondents are asked the following question: Did you use a condom with your most recent client?
Numerator:	Number of respondents who reported that a condom was used with their last client
Denominator:	Number of respondents who reported having commercial sex in the last 12 months
	Data for this indicator should be disaggregated by sex and age (<25; 25+).
	Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field.
	Access to survey respondents as well as the data collected from them must remain confidential.

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, most-at-risk population being surveyed. If there are concerns that the data are 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 and reliability of the data, and any related issues should be included in the report submitted with this indicator.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.

19. 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

PURPOSE	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special surveys including the Family Health International Behavioural Surveillance Survey for men who have sex with men
METHOD OF MEASUREMENT	In a behavioural survey of 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 when they last had anal sex.
Numerator:	Number of respondents who reported that a condom was used the last time they had anal sex
Denominator:	Number of respondents who reported having had anal sex with a male partner in the last six months
	Data for this indicator should be disaggregated by age (<25/25+).
	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.
	Access to survey respondents as well as the data collected from them must remain confidential.

INTERPRETATION

For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. This indicator does not give any idea of risk behaviour in sex with women among men who have sex with both women and men. 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 female and male 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, most-at-risk population being surveyed. If there are concerns that the data are 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 and reliability of the data, and any related issues should be included in the report submitted with this indicator.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.

20. Injecting Drug Users: Condom Use

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 reporting the use of a condom the last time they had sexual intercourse

PURPOSE	To assess progress in preventing sexual transmission of HIV
APPLICABILITY	Countries where injecting drug use is an established mode of HIV transmission
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special surveys including the Family Health International Behavioural Surveillance Survey for injecting drug users
METHOD OF MEASUREMENT	<p>Respondents are asked the following sequence of questions:</p> <ol style="list-style-type: none"> 1. Have you injected drugs at any time in the last month? 2. If yes: Have you had sexual intercourse in the last month? 3. If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse?
Numerator:	Number of respondents who reported that a condom was used the last time they had sex
Denominator:	<p>Number of respondents who report having had sexual intercourse in the last month</p> <p>Indicator scores are required for all respondents and should be disaggregated by sex and age (<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 are 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 and 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 partial information on the fourth factor.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

21. Injecting Drug Users: Safe Injecting 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 reporting the use of sterile injecting equipment the last time they injected

PURPOSE	To assess progress in preventing injecting drug use-associated HIV transmission
APPLICABILITY	Countries where injecting drug use is an established mode of HIV transmission
DATA COLLECTION FREQUENCY	Every two years
MEASUREMENT TOOL	Special surveys including the Family Health International Behaviour Surveillance Survey for injecting drug users
METHOD OF MEASUREMENT	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Have you injected drugs at any time in the last month? 2. If yes: The last time you injected drugs, did you use a sterile needle and syringe?
Numerator:	Number of respondents who report using sterile injecting equipment the last time they injected drugs
Denominator:	<p>Number of respondents who report injecting drugs in the last month</p> <p>Indicator scores are required for all respondents and should be disaggregated by sex and age (<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 are 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 and 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.

FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2006). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*.
- UNAIDS (2006). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.
- WHO (2006). *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

IMPACT INDICATORS

22. Percentage of young women and men aged 15–24 who are HIV-infected*
23. Percentage of most-at-risk populations who are HIV-infected
24. Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy
25. Percentage of infants born to HIV-infected mothers who are infected

* Millennium Development Goals

22. 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 in young adults, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people—a 25% reduction in the most affected countries by 2005 and a 25% reduction globally by 2010.

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

PURPOSE	To assess progress towards reducing HIV infection
APPLICABILITY	Countries with generalized epidemics
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	WHO guidelines for HIV sentinel surveillance
METHOD OF MEASUREMENT	This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas.
Numerator:	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive
Denominator:	Number of antenatal clinic attendees (15–24) tested for their HIV infection status
	Indicator scores should be given for the whole age range (15–24 years) and disaggregated by five-year age-group (i.e. 15–19 years and 20–24 years).
	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.

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 15–19-year-olds. Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence.

In countries where the age at which young people first have sexual intercourse is late and/or levels of contraception use are high, HIV prevalence among pregnant women of 15–24 years of age 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 remain temporarily confined to most-at-risk populations.

To supplement data from antenatal clinics, an increasing number of countries are implementing HIV testing as part of the population-based survey. Wherever available, the results of the survey should be included in the report submitted with this indicator.

FURTHER INFORMATION

For further information, please consult the following website:

- http://www.unaids.org/en/HIV_data/Methodology/default.asp

23. 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: 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 populations who are HIV-infected

PURPOSE	To assess progress on reducing HIV prevalence among most-at-risk populations
APPLICABILITY	Countries with Concentrated/Low Prevalence epidemics, where routine surveillance among pregnant women is not recommended; also includes countries with concentrated sub-epidemics within a generalized epidemic
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	UNAIDS/WHO <i>Second Generation Surveillance Guidelines</i> ; Family Health International guidelines on sampling in population groups
METHOD OF MEASUREMENT	This indicator is calculated using data from HIV tests conducted among members of most-at-risk population groups in the capital city
Numerator:	Number of members of the most-at-risk population who test positive for HIV.
Denominator:	Number of members of the most-at-risk population tested for HIV. Prevalence estimates should be disaggregated by sex and age (<25/25+). 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.

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available. In analyzing prevalence data of most-at-risk-populations for the assessment of prevention programme impact, it is desirable not to restrict analysis to young people but to report on those persons who are newly initiated to behaviours that put them at risk for infection (e.g. by restricting the analysis to people who have initiated injecting drug use within the last year or participated in sex work for less than one year, etc.) This type of restricted analysis will also have the advantage of not being affected by the effect of antiretroviral treatment in increasing survival and thereby increasing prevalence. In the Country Progress Report, it is imperative to indicate whether this type of analysis is used to allow for meaningful global analysis.

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 general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the 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.

FURTHER INFORMATION

For further information, please consult the following website:

- http://www.unaids.org/en/HIV_data/Methodology/default.asp

24. HIV Treatment: Survival After 12 Months on Antiretroviral Therapy

One of the goals of any ART programme is to increase survival among infected individuals. As ART is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. These 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 known to be on treatment 12 months after initiation of antiretroviral therapy

PURPOSE	To assess progress in increasing survival among infected adults and children by maintaining them on ART
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	As patients start ART, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated.
MEASUREMENT TOOL	Programme monitoring tools; cohort/group analysis forms
METHOD OF MEASUREMENT	ART registers
Numerator:	Number of adults and children who are still alive and on ART at 12 months after initiating treatment
Denominator:	Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.
Definitions:	<p>This indicator should be disaggregated by sex and age (<15, 15+).</p> <p>The reporting period is defined as any continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. The pre-defined number of months can be determined by national reporting requirements. If the reporting period is 1 January to 31 December 2007, countries will calculate this indicator by using all patients who started antiretroviral therapy any time during the 12-month period from 1 January to 31 December 2006. If the reporting period is 1 July 2006 to 30 June 2007, countries will include patients who started antiretroviral therapy from 1 July 2005 to 30 June 2006.</p> <p>A 12-month outcome is defined as the outcome (i.e. whether the patient is still alive and on antiretroviral therapy, dead or lost to follow-up) at 12 months after starting. For example, patients who started antiretroviral therapy during the 12-month period from 1 January to 31 December 2006 will have reached their 12-month outcomes for the reporting period of 1 January to 31 December 2007.</p>

Explanation of Numerator: The numerator requires that adult and child patients must be alive and on antiretroviral therapy at 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected:

- http://www.unaids.org/en/HIV_data/Methodology/default.asp
Number of adults and children in the antiretroviral therapy start-up groups initiating antiretroviral therapy at least 12 months prior to the end of the reporting period;
- Number of adults and children still alive and on antiretroviral therapy at 12 months after initiating treatment.

The numerator does not require patients to have been on antiretroviral therapy continuously for the 12-month period. Patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment during the 12 months since initiating treatment but are recorded as still being on treatment at month 12 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 12 months since starting treatment are not included in the numerator.

For example, for those patients who started antiretroviral therapy in May 2005, if at any point during the period May 2005 to May 2006 these patients die, are lost to follow-up (and do not return), or stop treatment (and do not restart), then at month 12 (May 2006), they are not on antiretroviral therapy, and not included in the numerator. Conversely, a patient who started antiretroviral therapy in May 2005 and who missed an appointment in June 2005, but is recorded as on ART in May 2006 (at month 12) is on ART and will be included in the numerator. What is important is that the patient who has started antiretroviral therapy in May 2005 is recorded as being alive and on ART after 12 months, regardless of what happens from May 2005 to May 2006.

Explanation of Denominator: The denominator is the total number of adults and children in the antiretroviral therapy start-up groups who initiated antiretroviral therapy at any point during the 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome. For example, for the reporting period 1 January to 31 December 2007, this will include all patients who started antiretroviral therapy during the 12-month period from 1 January to 31 December 2006. This includes all patients, both those on antiretroviral therapy as well as those who are dead, have stopped treatment or are lost to follow-up at month 12.

INTERPRETATION

At the facility level, the number of adults and children on antiretroviral therapy at 12 months includes patients who have transferred in at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. In other words, at the facility level, patients who have transferred out will not be counted either in the numerator or the denominator. Similarly, patients who have transferred in will be counted in both the numerator and denominator. At the national level, the number of transferred-in patients should match the number of transferred-out patients. Therefore, the net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior.

Using this denominator may underestimate true “survival”, since a proportion of those lost to follow-up are alive. The number of people alive and on antiretroviral therapy (i.e. retention on ART) in a treatment cohort is captured here.

Priority reporting is for aggregate survival reporting. If comprehensive cohort patient registries are available then it is encouraged for countries to track survival at 24, 36, and 48 months. This will enable comparison over time of survival on antiretroviral therapy. As it stands, it is possible to identify whether survival at 12 months increases or decreases over time. However, it is not possible to attribute cause to these changes. For example, if survival at 12 months increases over time, this may reflect an improvement in care and treatment practices or earlier initiation of antiretroviral therapy. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term success of antiretroviral therapy.

FURTHER INFORMATION

For further information, please consult the following website:

- <http://www.who.int/hiv/pub/me/en/nparv.pdf>

25. Reduction in Mother-to-child Transmission

In high-income countries, strategies such as antiretroviral therapy during pregnancy and following birth, and the use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In low-income 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 (PMTCT) interventions, including breast milk substitute (where this is part of the country's policy on PMTCT). 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

Countries are not required to submit any data for this indicator. The indicator will be modelled at UNAIDS Headquarters, using data submitted in Country Progress Reports for the coverage of services to prevent mother-to-child transmission indicator (page 35).

PURPOSE	To assess progress towards eliminating mother-to-child HIV transmission
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	Statistical modelling based on programme coverage and efficacy studies
METHOD OF MEASUREMENT	The indicator will be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving HIV prophylaxis, the weights being the proportions of women receiving and not receiving various prophylactic regimes.

INTERPRETATION

This indicator focuses on the 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.

GLOBAL COMMITMENT AND ACTION INDICATORS

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 that are present in developing countries and that have HIV workplace policies and programmes
4. Percentage of international organizations that have HIV workplace policies and programmes

1. Bilateral and Multilateral Financial Flows

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

PURPOSE	To monitor financial flows (commitments and disbursements) from Development Assistance Committee (DAC) member countries and multilateral agencies (The Global Fund to Fight AIDS, Tuberculosis and Malaria, the UN system and selected development banks) to low- and middle-income countries ⁷
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	Annual questionnaire by the Organisation for Economic Co-operation and Development's Development Cooperation Directorate (OECD/DCD); direct survey to donor countries for real-time estimates
METHOD OF MEASUREMENT	<p>Official Development Assistance/OECD:</p> <ol style="list-style-type: none"> 1. All activities related to the prevention, treatment and care of sexually transmitted infections, including HIV (OECD/DAC Creditor Reporting System code 13040) 2. Social mitigation of HIV—provision of social and legal assistance to people living with HIV: special programmes to address social consequences of HIV (OECD/DAC Creditor Reporting System code 16064) 3. Estimates including part of multipurpose aid codes⁸ <p>Real-time estimates from direct surveys to donor countries, including Official Development Assistance and Official Aid to low- and middle-income countries as direct bilateral aid or through different multilateral channels or through private sector flows (e.g. international nongovernmental organizations, foundations and corporate funds)</p>

INTERPRETATION

This indicator permits cross-donor comparability of data. The indicator also reflects statistical data on donor assistance to HIV control.

At present the OECD/DAC Creditor Reporting System codes are limited to interventions within the health sector. Efforts are being made to introduce an additional code to account for non-health related donor assistance to HIV and to identify HIV components in wider programmes (see Footnote 7). For these reasons, the indicator is likely to produce a low estimate of total donor aid for AIDS. Fluctuations in the indicator will reflect variations in response to the survey due to refinement of the current methodology.⁹

The real-time indicator for total commitments and disbursements for AIDS activities might be a higher estimate because of the broader contents included. The data are usually available by June each year after the fiscal years from donor countries have ended, which can be much sooner than the official reports. These data are not disaggregated by type of activity or purpose of the aid funds.

⁷ 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.

⁸ The OECD, Development Co-operation Directorate (DCD), DAC – Working Party on Statistics is discussing a multiple purpose code system. This would allow for the identification of HIV/AIDS-related activities within wider health and other programmes. At present, there is a text search option to identify projects for which there are parts dedicated to HIV or AIDS.

⁹ There is a proposal to test for quarterly reports from donor countries to OECD/DAC, which would allow for real-time official reports.

2. Public Funds for Research and Development

Amount of public funds for research and development of preventive HIV vaccines and microbicides

PURPOSE	To track public sector funding for research and development for preventive HIV vaccines and microbicides
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	Survey of financial resource flows ¹⁰ to relevant governments (governmental research bodies, development assistance governments, multilateral organizations) funding preventive HIV vaccine and microbicide research and development
METHOD OF MEASUREMENT	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 research and development expenditures/investments for vaccines with primarily therapeutic applications; or 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).

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.

¹⁰ Implemented and analysed by the HIV Vaccines and Microbicides Resource Tracking Working Group, comprising the AIDS Vaccine Advocacy Coalition, the Alliance for Microbicide Development, the International AIDS Vaccine Initiative and UNAIDS

3. Workplace HIV Control: Transnational Companies

Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programmes

PURPOSE	To assess progress in implementing workplace policies and programmes to combat HIV in transnational companies
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	Desk review and key informant interviews
METHOD OF MEASUREMENT	<p>The United Nations Conference on Trade and Development (UNCTAD) list of the 100 largest transnational companies ranked by foreign assets plus an additional 10 transnationals in the mining and tourism sectors 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"> 1. Prevention of stigmatization and discrimination on the basis of HIV status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits. 2. Workplace-based HIV prevention activities that cover: (a) the basic facts on HIV; (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 AIDS-related drugs.
Numerator:	Number of employers with HIV policies and regulations that meet all of the above criteria.
Denominator:	<p>Number of employers surveyed (110)</p> <p>Copies of written personnel policies and regulations should be obtained and assessed wherever possible.</p>

4. Workplace HIV Control: International Organizations

Percentage of international organizations that have workplace HIV policies and programmes

PURPOSE	To assess progress in implementing workplace policies and programmes to respond to HIV in international organizations
DATA COLLECTION FREQUENCY	Annual
MEASUREMENT TOOL	Desk review and key informant interviews
METHOD OF MEASUREMENT	Major international organizations—UN, European Community, 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: <ol style="list-style-type: none"> 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. 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 AIDS-related drugs. 3. Training for HIV/AIDS control in conflict, emergency and disaster situations.¹¹
Numerator:	Number of major international organizations with HIV policies and regulations that meet all of the above criteria (except number 3, which applies only to the relevant organizations).
Denominator:	Number of major international organizations 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. Copies of written personnel policies and regulations should be obtained and assessed wherever possible.

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 to address HIV among national uniformed services, including armed forces and civil defence forces.

¹¹ This aspect only applies to organizations with staff working in conflict, emergency and disaster situations.

Appendices

Appendix 1. Changes to core indicators for implementation of the Declaration of Commitment on HIV/AIDS

2005	2007	Comments on changes
National Commitment and Action Indicators		
Amount of national funds disbursed by governments in low- and middle-income countries	AIDS spending, by categories and financing source	Definition changed
National Composite Policy Index	National Composite Policy Index	Questions added
National Programme Indicators		
Percentage of transfused blood units screened for HIV	Percentage of donated blood units screened for HIV in a quality-assured manner	Changed from transfused blood to donated blood. Added a second part to the indicator on the proportion of blood screened according to standard operating procedures and quality assurance
Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Included children
Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Definition changed
	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Indicator added to core list
	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results	Indicator added to core list
Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results	Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No changes
Percentage of most-at-risk populations reached by prevention programmes	Percentage of most-at-risk populations reached with HIV prevention programmes	Definition changed
Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	No changes

Percentage of schools with teachers who have been trained in life skills-based HIV education and who taught it during the last academic year	Percentage of schools that provided life skills-based HIV education in the last academic year	Definition changed
Percentage of large enterprises/companies that have HIV workplace policies and programmes		Removed from the core indicator list; incorporated in the NCPI
Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled		Removed from the core indicator list; under revision for 2010 reporting
Knowledge and Behaviour Indicators		
Ratio of current school attendance among orphans to that among non-orphans, aged 10–14	Current school attendance among orphans and non-orphans aged 10–14	Ratio calculation no longer required
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	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	Suggest the replacement of the two misconception questions with local versions, where appropriate
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	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	Suggest the replacement of the two misconception questions with local versions, where appropriate
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 sexual intercourse before the age of 15	Age range expanded
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	Percentage of women and men aged 15–49 who have had sex with more than one partner in the last 12 months	Age range expanded, definition changed
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	Percentage of women and men aged 15–49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	Age range expanded, definition changed
Percentage of female and male sex workers reporting the use of a condom with their most recent client	Percentage of female and male sex workers reporting the use of a condom with their most recent client	No changes
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No changes

Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e. who both avoid sharing equipment and use condoms, in the last 12 months (for countries where injecting drug use is an established mode of HIV transmission)	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Composite indicator divided into component indicators (part 1)
	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Composite indicator divided into component indicators (part 2)
Impact indicators		
Percentage of young women and men aged 15–24 who are HIV infected	Percentage of young women and men aged 15–24 who are HIV infected	No changes
Percentage of most-at-risk populations who are HIV infected	Percentage of most-at-risk populations who are HIV infected	No changes
Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Definition changed
Percentage of infants born to HIV-infected mothers who are infected	Percentage of infants born to HIV-infected mothers who are infected	Remains in core set but calculated at UNAIDS/Geneva

Global Commitment and Action Indicators		
Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries	Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries	No changes
Amount of public funds for research and development of preventive HIV vaccines and microbicides	Amount of public funds for research and development of preventive HIV vaccines and microbicides	No changes
Percentage of transnational companies that are present in developing countries and that have HIV workplace policies and programmes	Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programmes	No changes
Percentage of international organizations that have workplace policies and programmes	Percentage of international organizations that have workplace HIV policies and programmes	No changes

Appendix 2. Country Progress Report template

The following provides the full template of the narrative part of the Country Progress Report and detailed instructions for completion of the different sections included in it. It is highly recommended that the UNGASS indicator data are submitted through the Country Response Information System (CRIS) to enhance the completeness and quality of the data and to facilitate trend analysis. A data file is required to be sent at the same time as the file containing the narrative Country Progress Report.

UNGASS COUNTRY PROGRESS REPORT

[Country Name]

Reporting period: January 2006–December 2007

Submission date: [fill in the date of the formal submission of the country report to UNAIDS by e-mail]

I. Table of Contents

[Instructions: Fill in]

II. Status at a glance

[Instructions: This section should provide the reader with a brief summary of

- (a) the inclusiveness of the stakeholders in the report writing process;
- (b) the status of the epidemic;
- (c) the policy and programmatic response; and
- (d) UNGASS indicator data in an overview table.]

III. Overview of the AIDS epidemic

[Instructions: This section should cover the detailed status of the HIV prevalence in the country during the period January 2006–December 2007 based on sentinel surveillance and specific studies (if any) for the UNGASS impact indicators. The source of information for all data provided should be included.]

IV. National response to the AIDS epidemic

[Instructions: 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 2006–December 2007.

Countries should specifically address the linkages between the existing policy environment, implementation of HIV programmes, verifiable behaviour change and HIV prevalence as supported by the UNGASS indicator data. Where relevant, these data should also be presented and analysed by sex and age groups (15–19, 20–24, 25–49). Countries should also use the National Composite Policy Index data (see Appendix 7) to describe progress made in policy/strategy development and implementation, and include a trend analysis on the key NCPI data since 2003, where available. Countries are encouraged to report on additional data to support their analysis and interpretation of the UNGASS data.]

V. Best practices

[Instructions: This section should cover detailed examples of what is considered a best practice in-country in one or more of the key areas (such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation, capacity-building; infrastructure development. The purpose of this section is to share lessons learnt with other countries.]

VI. Major challenges and remedial actions

[Instructions: This section should focus on:

- (a) progress made on key challenges reported in the 2005 UNGASS Country Progress Report, if any;
- (b) challenges faced throughout the reporting period (2006–2007) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular; and,
- (c) concrete remedial actions that are planned to ensure achievement of agreed UNGASS targets.]

VII. Support from the country's development partners

[Instructions: This section should focus on (a) key support received from and (b) actions that need to be taken by development partners to ensure achievement of the UNGASS targets.]

VIII. Monitoring and evaluation environment

[Instructions: This section should provide (a) an overview of the current monitoring and evaluation (M&E) system; (b) challenges faced in the implementation of a comprehensive M&E system; and (c) remedial actions planned to overcome the challenges, and (d) highlight, where relevant, the need for M&E technical assistance and capacity-building. Countries should base this section on the National Composite Policy Index (see Appendix 5).]

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

ANNEX 2: National Composite Policy Index questionnaire

*Please email your complete UNGASS Country Progress Report **before 31 January 2008** to UNAIDS Evaluation Department at: ungassindicators@unaid.org.*

If the Country Response Information System (CRIS) is not used for submission of indicator data, please submit reports by 15 January 2008 to allow time for the manual entry of data into the Global Response Information Database in Geneva.

Printed copies may be posted to:

Dr. Paul De Lay, Director, Evaluation Department
UNAIDS 20 Avenue Appia
CH-1211 Geneva 27 Switzerland

Appendix 3. Methodology used for the coverage of selected services for HIV 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*. This study collected data from 73 low- and middle-income countries, representing 88% of all people living with HIV 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 programme coverage have shown mixed results. The Family Planning Programme Effort Index, which relies on a small number of national and international experts, has shown consistency over time and good inter-country comparability. The 2003 round of the AIDS Programme Effort Index, which relied on key respondents in each component of programme 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.”

In 2005 this survey was repeated and useful data were again obtained. Some of these data were utilized in the Global Progress Report 2006.

For further information, please refer to the publications below, available at <http://www.constellafutures.com/publications>:

- USAID/PEPFAR/UNAIDS/WHO/UNICEF (2006). *Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low- and Middle-income Countries in 2005*.
- USAID/PEPFAR/UNAIDS/WHO/UNICEF (2004). *Coverage of Selected Services for HIV/AIDS Prevention, Care and Support in Low- and Middle-income Countries in 2003*.

Appendix 4. Consultation/preparation process for the Country Progress 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
(please specify) | Yes | No |
- 2) With inputs from
- Ministries:
- | | | |
|----------------------------|-----|----|
| Education | Yes | No |
| Health | Yes | No |
| Labour | Yes | No |
| Foreign Affairs | Yes | No |
| Others
(please specify) | Yes | No |
- | | | |
|------------------------------|-----|----|
| Civil society organizations | Yes | No |
| People living with HIV | Yes | No |
| Private sector | Yes | No |
| United Nations organizations | Yes | No |
| Bilaterals | Yes | No |
| International NGOs | Yes | No |
| Others
(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
- 6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: _____

Date: _____

Signature: _____

Please provide full contact information:

Address: _____

Email: _____

Telephone: _____

Appendix 5. Reporting schedule for core indicators for the implementation of the Declaration of Commitment on HIV/AIDS

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

Appendix 6. National Funding Matrix — 2007

Cover Sheet

Please provide the following information when submitting the completed National Funding Matrix.

Country: _____

Contact Person at the National AIDS Authority/Committee (or equivalent):

Name: _____ Title: _____

Contact Information for the National AIDS Authority/Committee (or equivalent):

Address: _____ Email: _____

Telephone: _____ Fax: _____

Reporting Cycle: 2006 calendar year _____ or fiscal year _____

For a fiscal year reporting cycle, please provide the start and end month/year: ___ / ___ to ___ / ___

Local Currency: _____

Average exchange rate with US dollars during the reporting cycle: _____

Methodology:

(Please confirm which methodology – National AIDS Spending Assessments, National Health Accounts or Resource Flows Surveys – supplied the data for the National Funding Matrix. In addition, please provide information on how and where to access the full report from whichever methodology was used to collect the data.)

Unaccounted Expenditures:

(Please specify if there were expenditures for activities in any of the AIDS Spending Categories or sub-categories that are not included in the National Funding Matrix and explain why these expenditures were not included.)

Budget Support: Is budget support from an international source (e.g. a bilateral donor) included under the Central/National and/or Subnational sub-categories under Public Sources of financing?

___ Yes ___ No

National Funding Matrix — 2008

Background

The National Funding Matrix is used to measure the first UNGASS indicator on National Commitment and Action: AIDS Spending by Funding Source. The matrix is a spreadsheet that enables countries to record AIDS spending within eight categories across three funding sources. This indicator provides critical information that is valuable at both national and global levels of the AIDS response. The National Funding Matrix has been designed to be compatible with different data collection and tracking systems, i.e. National AIDS Spending Assessments (NASA), National Health Accounts¹² and Resource Flows Surveys, so as to transfer information from these tools to the matrix. For countries using the NASA, the matrix is one of the outputs of this tool. (Countries interested in implementing the NASA are encouraged to contact UNAIDS for additional information on this tool.)

Structure of the matrix

The National Funding Matrix has two basic components:

- AIDS Spending Categories (How funds allocated to the national response are spent)
- Financing Sources (Where funds allocated to the national response are obtained)

There are eight AIDS Spending Categories: Prevention; Care and Treatment; Orphans and Vulnerable Children; Programme Management and Administration Strengthening; Incentives for Human Resources; Social Protection and Social Services (excluding Orphans and Vulnerable Children); Enabling Environment and Community Development; and Research

Each spending category includes multiple sub-categories. Across the eight spending categories there are a total of 77 sub-categories. It is important to note that all of the spending categories and sub-categories are AIDS-specific; for example, expenditures listed under Enabling Environment and Community Development should only be those that are directly attributable to the AIDS response.

Prevention is the largest category with 22 sub-categories, ranging from voluntary counselling and testing to condom social marketing to blood safety; seven of the remaining eight spending categories have fewer than 10 sub-categories each. The purpose of the categories and sub-categories is to help national governments break out their spending as rationally and consistently as possible. As mentioned above, the matrix was designed to be compatible with common data collection and tracking systems in order to reduce the burden of reporting on national governments.

There are three major groups of Financing Sources: Domestic Public; International and Domestic Private (optional for UNGASS reporting).

Similar to the spending categories, each financing source has multiple sub-categories. Public Sources has four sub-categories: Central/National, Subnational, Development Bank Reimbursable (loans) and All Other Public. International Sources has five subcategories: Bilaterals, UN Agencies, Global Fund, Development Bank Grants (Non-reimbursable) and All Other International. Private Sources has two sub-categories: Corporations and Consumer/Out-of-Pocket. *(Note: The data on Private Sources are optional for UNGASS reporting. However, countries are strongly encouraged to collect and report available data in this area because they can be useful in managing the national response to the epidemic.)*

Instructions

- The National AIDS Authority/Committee or equivalent should designate a technical coordinator to manage the collection and input of relevant data for the National Funding Matrix. It is recommended that this coordinator have good knowledge of tools and methodologies currently in use

¹² If a country has a National Health Accounts program, it should refer to the NASA comprehensive guide from UNAIDS that offers guidance on how to map NHA matrices to match outputs from that program to the National Funding matrix. Added technical support on implementing the cross-walk may be obtained from the UNAIDS M&E advisers in their UNAIDS country office or from the Resource Tracking Unit at UNAIDS headquarters in Geneva.

in the country for collecting this type of financial data (i.e. National AIDS Spending Assessment, National Health Accounts, Resource Flows Survey). Also, it is encouraged that the coordinator contact other national resource tracking point persons, such as those in the Ministry of Health, who have been involved in reporting expenditures for HIV. The purpose of their involvement is to engender agreement on the national estimate for HIV expenditures and to avoid duplicate initiatives.

- Countries are requested to include as much detail in the National Funding Matrix as possible, including breakdowns by all applicable AIDS Spending and Funding Source Categories and sub-categories. Any categories or sub-categories that are not applicable in a country should be clearly identified; explanations for categories or sub-categories that do not include estimates for any other reason should be provided as part of the cover sheet to the matrix.
- The financial data in the matrix must be actual expenditures. They should not include budget figures that have not been validated as actual expenditures nor should the data reflect commitment or obligation figures.
- The total for each line item should include funding from all sources listed for that item. In addition, there should be a sub-total for each of the eight AIDS Spending Categories, which captures all funding from all sources for all sub-categories in a given category.
- Amounts in each category or sub-category should be reported in local currency. However, it is also important to report the average exchange rate to US dollars for the 2006 calendar or fiscal year being reported; see the National Funding Matrix cover sheet on page 92.
- Spending categories and sub-categories are designed to be self-explanatory. Expenditures that do not clearly fit a specific sub-category should be listed in the Other/Not Classified Elsewhere sub-category that appears in each of the eight AIDS Spending Categories. (Detailed descriptions of the categories and sub-categories are available in the UNAIDS-published *Notebook to Produce National Spending Assessments*; see reference below.)
- Expenditures should only be counted in a single category or sub-category; they should never be double counted. For example, expenditures on activities for Orphans and Vulnerable Children should not be listed again under Social Protection and Social Services.
- Financing Sources categories and sub-categories are designed to be self-explanatory. Expenditures that do not clearly fit a specific sub-category should be listed in the All Other sub-category that appears under both Public and International Sources. Please note that the list of Financing Sources categories and sub-categories is not exhaustive; however, it is indicative of the main sources of financing.
- Financing in the Central/National and Subnational sub-categories under Public Sources should only include revenue generated by the government and allocated to the AIDS response. It should not include development assistance of any type from international sources; the only possible exception would be budget support from donor organizations that cannot be differentiated from domestic revenues. If the total amount of budget support can be identified, it should appear under the proper International Sources sub-category (e.g. Bilaterals). If any budget support is included in the Central/National and/or Subnational sub-categories, please indicate this fact on the cover sheet (see above).
- Financing provided by a development bank should be designated either as Reimbursable (e.g. loans), which appears under Public Sources, or Non-reimbursable (e.g. grants), which appears under International Sources. Countries that receive both loans and grants from development banks should be careful to allocate these funds to the correct categories.
- Financing provided by individual bilateral donors does not need to be disaggregated by donor agency in the funding matrix.
- Financing provided by international foundations should be listed in the All Other sub-category in the International category. Funds received from domestic foundations should be listed in the All Other sub-category in the Public category.
- Providing information on financing from Private Sources is optional. However, countries are strongly encouraged to collect and report available data in this area in order to provide a more complete picture of the funds available for the AIDS response.

- The Private Sources column for Corporations should list funds spent in-country by companies in the various AIDS Spending Categories and sub-categories; the adjacent Consumer/Out-of-pocket column should list funds spent by individuals and/or families in the AIDS Spending Categories and sub-categories. (Note: It is likely that most entries in the Consumer/Out-of-pocket column will be in the Care and Treatment and selected Prevention categories and sub-categories.)
- If a country has a National Health Accounts programme, it should request the NASA-NHA Crosswalk, which is a comprehensive guide from UNAIDS that shows how to match outputs from that programme to the National Funding Matrix. Countries can contact the monitoring and evaluation officer in their UNAIDS country office or the Resource Tracking Unit at UNAIDS headquarters in Geneva.
- If a country is working from a Resource Flows Survey, it may be able to correlate information from sub-totals in the survey to the eight AIDS Spending Categories in the National Funding Matrix.
- Electronic versions of the *Notebook to Produce National AIDS Spending Assessments* and the *NASA-NHA Crosswalk* (see above) may be downloaded from the following page on the UNAIDS website: www.unaids.org/en/Coordination/FocusAreas/track-monitor-evaluate.asp. An electronic version of the National Funding Matrix may be downloaded as an Excel file from the same website.
- The UNAIDS Secretariat strongly recommends the NAC or equivalent organize a one-day workshop of relevant stakeholders to review the National Funding Matrix before it is submitted as part of the UNGASS reporting process. Relevant stakeholders should include federal and provincial/regional/state government ministries and departments, local and international civil society organizations, multilateral agencies, bilateral donors, foundations and commercial sector entities, as well as representatives from other relevant resource tracking initiatives.

This matrix is available electronically as an Excel spreadsheet, which is on the CD-ROM included with the hardcopy of these guidelines.

If you do not have the CD-ROM, please email the UNAIDS Evaluation Department (ungassindicators@unaids.org) to obtain the Excel file.

National Funding Matrix AIDS Spending Categories by Financing Sources

YEAR

Calendar Year: Yes _____ No _____
(specify beginning/end)

Average Exchange Rate for the year _____

AIDS Spending Categories	Financing Sources													
	TOTAL (Local Currency)	Public Sources				International Sources					Private Sources (optional for UNGASS reporting)			
		Public Sub- Total	Central/ National	Sub- National	Dev. Bank Reimbursable	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non- Reimbursable	All Other International	Private Sub-Total	Corporations
TOTAL (Local Currency)														
1. Prevention (sub-total)														
1.1 Mass media														
1.2 Community mobilization														
1.3 Voluntary counselling and testing														
1.4 Programs for vulnerable and special populations														
1.5 Youth in school														
1.6 Youth out of school														
1.7 Prevention programs for PLHA														
1.8 Programs for sex workers and their clients														
1.9 Programs for MSM														
1.10 Harm reduction programs for IDUs														
1.11 Workplace activities														
1.12 Condom social marketing														
1.13 Public and commercial sector condom provision														
1.14 Female condom														
1.15 Microbicides														
1.16 Improving management of STIs														
1.17 Prevention of mother-to-child transmission														
1.18 Blood safety														
1.19 Post-exposure prophylaxis														
1.20 Safe medical injections														
1.21 Male Circumcision														
1.22 Universal precautions														
1.99 Others / Not-elsewhere classified														
2. Care and Treatment (sub-total)														
2.1 Outpatient care														
2.2 Provider initiated testing														
2.3 Opportunistic infection (OI) prophylaxis														
2.4 Antiretroviral therapy														
2.5 Nutritional support														
2.6 Specific HIV laboratory monitoring														
2.7 Dental care														
2.8 Psychological care														
2.9 Palliative care														
2.10 Home-based care														
2.11 Additional/informal providers														
2.12 In-patient Care														
2.13 Opportunistic infection (OI) treatment														
2.99 Others / Not-elsewhere classified														
3. Orphans and Vulnerable Children * (sub-total)														
3.1 Education														
3.2 Basic health care														
3.3 Family/home support														
3.4 Community support														
3.5 Administrative costs														
3.9 Others / Not-elsewhere classified														
4. Program Management and Administration Strengthening (sub-total)														
4.1 Programme management														
4.2 Planning and coordination														
4.3 Monitoring and evaluation														
4.4 Operations research														
4.5 Sero-surveillance														
4.6 HIV drug-resistance surveillance														
4.7 Drug supply systems														
4.8 Information technology														
4.9 Supervision of personnel														
4.10 Upgrading laboratory infrastructure														
4.11 Construction of new health centres														
4.99 Others / Not-elsewhere classified														
5. Incentives for Human Resources ** (sub-total)														
5.1 Monetary incentive for physicians														
5.2 Monetary incentive for nurses														
5.3 Monetary incentive for other staff														
5.4 Formative education and build-up of an AIDS workforce														
5.5 Training														
5.9 Others / Not elsewhere classified														
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)														
6.1 Monetary benefits														
6.2 In-kind benefits														
6.3 Social services														
6.4 Income generation														
6.9 Others / Not elsewhere classified														
7. Enabling Environment and Community Development (sub-total)														
7.1 Advocacy and strategic communication														
7.2 Human rights														
7.3 AIDS-specific institutional development														
7.4 AIDS-specific programs involving women														
7.9 Others / Not elsewhere classified														
8. Research excluding operations research which is included under (sub-total)														
8.1 Biomedical research														
8.2 Clinical research														
8.3 Epidemiological research														
8.4 Social science research														
8.5 Behavioural research														
8.6 Research in economics														
8.7 Research capacity strengthening														
8.8 Vaccine-related research														
8.9 Others / Not elsewhere classified														

* The term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for social support as orphan.

** The item on Incentives for Human Resources needs to be disaggregated from the costs for service delivery of the other activities, e.g. in the in- and out-patient service provision. Efforts need to be made to avoid double counting.

Appendix 7. National Composite Policy Index (NCPI) 2007

COUNTRY:

Name of the National AIDS Committee Officer in charge: _____

Signed: _____

Postal address: _____

Tel: _____

Fax: _____

E-mail: _____

Date of submission: _____

Instructions

Background

The following instrument measures one of the National Commitment and Action indicators, the National Composite Policy Index (NCPI), designed to assess progress in the development and implementation of national AIDS policies and strategies. **It is an integral part of the list of core UNGASS indicators and is to be completed and submitted as part of the 2007 UNGASS Country Progress Report.**

This third version of the NCPI has been updated to reflect new AIDS programmatic guidance and to be consistent with new and agreed to policy and implementation measurement tools.¹³

NCPI data were also submitted in previous UNGASS reporting rounds in 2003 and 2005. Countries are strongly advised to conduct a trend analysis on the key questions and include a description of the findings in the 2007 Country Progress Report.¹⁴

STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into two parts:

Part A to be administered to government officials.

Part A covers five areas:

1. Strategic plan
2. Political support
3. Prevention
4. Treatment, care and support
5. Monitoring and evaluation

Part B to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations.

Part B covers four areas:

1. Human rights
2. Civil society involvement
3. Prevention
4. Treatment, care and support

The overall responsibility for collating and submitting the information requested in the NCPI lies with the National Governments, through officials from the National AIDS Committee (NAC) (or equivalent) with support from UNAIDS and other partners.

PROPOSED STEPS FOR DATA GATHERING

1. Designation of two technical coordinators for the study (one for part A; one for part B)

Technical coordinators should be given responsibility to undertake the desk review and carry out interviews to answer specific questions. Preferably, the technical coordinator for Part A should be from the NAC (or equivalent) and for Part B should be a person outside the government. These persons should ideally be familiar with the issues and have a monitoring and evaluation background, and may request the assistance of consultants with a similar background.

¹³ Policy and Planning Effort Index or children orphaned and made vulnerable by HIV/AIDS, UNICEF 2005; Scaling up Towards Universal Access, UNAIDS 2006; Setting National Targets for Moving Towards Universal Access, UNAIDS 2006; Practical Guidelines for Intensifying HIV Prevention; UNAIDS 2007

¹⁴ see *Guidelines on construction of core indicators*, UNAIDS 2002 and UNAIDS 2005, respectively, for the key questions in previous NCPI questionnaires

2. Data gathering

Each section should be completed by (a) desk review and (b) interviewing key people most knowledgeable about that topic:

- *Strategic Plan and Political Support:* the Director or Deputy Director of the National AIDS Programme or National AIDS Council, the Heads of the AIDS Programme at provincial and at district levels and UNAIDS
- *Monitoring and Evaluation:* Officers of the National AIDS Committee or equivalent, Ministry of Health, HIV focal points of other ministries.
- *Human rights:* Ministry of Justice officials, human rights commissioners, and representatives of human rights and other relevant nongovernmental organizations and legal aid centres/institutions, persons living with HIV.
- *Civil society participation:* key representatives of major civil society organizations working in the area of HIV, persons living with HIV.
- *Prevention and Treatment, care and support:* Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and persons living with HIV.

3. Data entry, analysis and interpretation

Once the NCPI is fully completed, the technical coordinators need to carefully review all responses to determine if additional consultations or review of more documents are needed. It is important to analyze the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in policy/strategy development and implementation of programmes to tackle the country's AIDS epidemic. Comments on the agreements/discrepancies between overlapping questions in Part A and Part B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available. The NCPI findings need to be presented, discussed and agreed during the national UNGASS consultation workshop (see 4 below). It is strongly encouraged to enter the final agreed data in the Country Response Information System (CRIS). If this is not possible, an electronic version of the completed questionnaire should be submitted as an annex to the Country Progress Report.

4. Consultation workshop organized by the NAC (or equivalent)

It is strongly recommended that the NAC (or equivalent) organizes a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS Country Progress Report, including the results from the NCPI. It is expected that civil society organizations, including faith-based organizations, people living with HIV, gender equality groups, women's rights groups, human rights/legal advocacy organizations, and other major nongovernmental organizations are invited to participate.

NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI - PART A [to be administered to government officials]

Organisation	Name/Position	Respondents to Part A				
		[indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V

NCPI - PART B [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]

Organisation	Name/Position	Respondents to Part B			
		[indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV

Note: In the NCPI answers, N/A stands for “Not Applicable”

National Composite Policy Index questionnaire

Part A

[to be administered to government officials]

I. Strategic plan

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	Period covered: <i>[write in]</i>	Not Applicable (N/A)	No
-----	-----------------------------------	----------------------	----

IF NO or N/A, briefly explain

IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multisectoral strategy/action framework?

Number of Years:

1.2 Which sectors are included in the multisectoral strategy/action framework with a specific HIV budget for their activities?

Sectors included	Strategy/Action framework		Earmarked budget	
	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/Police	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young people	Yes	No	Yes	No
Other*: <i>[write in]</i>	Yes	No	Yes	No

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget, how is the money allocated?

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations		
a. Women and girls	a. Yes	No
b. Young women/young men	b. Yes	No
c. Specific vulnerable sub- populations ¹⁵	c. Yes	No
d. Orphans and other vulnerable children	d. Yes	No
Settings		
e. Workplace	e. Yes	No
f. Schools	f. Yes	No
g. Prisons	g. Yes	No
Cross-cutting issues		
h. HIV, AIDS and poverty	h. Yes	No
i. Human rights protection	i. Yes	No
j. PLHIV involvement	j. Yes	No
k. Addressing stigma and discrimination	k. Yes	No
l. Gender empowerment and/or gender equality	l. Yes	No

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes	No
-----	----

IFYES, when was this needs assessment /analysis conducted? Year:

IF NO, how were target populations identified?

¹⁵ Sub-populations that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

1.5 What are the target populations in the country? *[write in]*

1.6 Does the multisectoral strategy/action framework include an operational plan?

Yes	No
-----	----

1.7 Does the multisectoral strategy/action framework or operational plan include:

a. Formal programme goals?

Yes	No
-----	----

b. Clear targets and/or milestones?

Yes	No
-----	----

c. Detailed budget of costs per programmatic area?

Yes	No
-----	----

d. Indications of funding sources?

Yes	No
-----	----

e. Monitoring and Evaluation framework?

Yes	No
-----	----

1.8 Has the country ensured “full involvement and participation” of civil society¹⁶ in the development of the multisectoral strategy/action framework?

Active involvement	Moderate involvement	No involvement
--------------------	----------------------	----------------

IF active involvement, briefly explain how this was done:

IF NO or MODERATE involvement, briefly explain:

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

Yes	No
-----	----

¹⁶ Civil society includes among others: Networks of people living with HIV; women’s organizations; young people’s organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

Yes, all partners	Yes, some partners	No
-------------------	--------------------	----

<i>IF SOME or NO</i> , briefly explain
--

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

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

2.1 *IF YES*, in which development plans is policy support for HIV and AIDS integrated?

a)____ b)____ c)____ d)____ e) other

2.2 *IF YES*, which policy areas below are included in these development plans?

✓ Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention					
Treatment for opportunistic infections					
Antiretroviral therapy					
Care and support (including social security or other schemes)					
AIDS impact alleviation					
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support					
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support					
Reduction of stigma and discrimination					
Women's economic empowerment (e.g. access to credit, access to land, training)					
Other: <i>[write in]</i>					

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

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

- 3.1 **IF YES**, to what extent has it informed resource allocation decisions?

Low						High
0	1	2	3	4	5	

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes	No
-----	----

- 4.1 **IF YES**, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes	No
Condom provision	Yes	No
HIV testing and counselling*	Yes	No
STI services	Yes	No
Treatment	Yes	No
Care and support	Yes	No
Others: <i>[write in]</i>	Yes	No

***What is the approach taken to HIV testing and counselling?** Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:

5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	No
-----	----

- 5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes	No
-----	----

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes	No
-----	----

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and projected needs	Estimates only	No
-------------------------------	----------------	----

5.4 Is HIV and AIDS programme coverage being monitored?

Yes	No
-----	----

(a) **IFYES**, is coverage monitored by sex (male, female)?

Yes	No
-----	----

(b) **IFYES**, is coverage monitored by population sub-groups?

Yes	No
-----	----

IFYES, which population sub-groups?

--

(c) **IFYES**, is coverage monitored by geographical area?

Yes	No
-----	----

IFYES, at which levels (provincial, district, other)?

--

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	No
-----	----

Overall, how would you rate <i>strategy planning efforts</i> in the HIV and AIDS programmes in 2007 and in 2005?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</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. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?

President/Head of government

Yes	No
-----	----

Other high officials

Yes	No
-----	----

Other officials in regions and/or districts

Yes	No
-----	----

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes	No
-----	----

IF NO, briefly explain:

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

2.2 **IF YES**, who is the Chair?

[write in name and title/function]

2.3 **IFYES**, does it:

have terms of reference?	Yes	No
have active Government leadership and participation?	Yes	No
have a defined membership?	Yes	No
include civil society representatives? <i>IFYES</i> , what percentage? <i>[write in]</i>	Yes	No
include people living with HIV?	Yes	No
include the private sector?	Yes	No
have an action plan?	Yes	No
have a functional Secretariat?	Yes	No
meet at least quarterly?	Yes	No
review actions on policy decisions regularly?	Yes	No
actively promote policy decisions?	Yes	No
provide opportunity for civil society to influence decision-making?	Yes	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

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

Yes	No
-----	----

3.1 **IFYES**, does it include?

Terms of reference	Yes	No
Defined membership	Yes	No
Action plan	Yes	No
Functional Secretariat	Yes	No
Regular meetings	Yes	No
	Frequency of meetings:	

IFYES, What are the main achievements?

IF YES, What are the main challenges for the work of this body?

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?

Percentage:

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes	No
Technical guidance/materials	Yes	No
Drugs/supplies procurement and distribution	Yes	No
Coordination with other implementing partners	Yes	No
Capacity-building	Yes	No
Other: <i>[write in]</i>		

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No
-----	----

- 6.1 **IF YES**, were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes	No
-----	----

- 6.2 **IF YES**, which policies and legislation were amended and when?

Policy/Law:	Year:
-------------	-------

Policy/Law:	Year:
-------------	-------

[List as many as relevant]

Overall, how would you rate <i>strategy planning efforts</i> in the HIV and AIDS programmes in 2007 and in 2005?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>												

III. Prevention

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

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

- 1.1 **IF YES**, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	
Delay sexual debut	
Be faithful	
Reduce the number of sexual partners	
Use condoms consistently	
Engage in safe(r) sex	
Avoid commercial sex	
Abstain from injecting drugs	
Use clean needles and syringes	
Fight against violence against women	
Greater acceptance and involvement of people living with HIV	
Greater involvement of men in reproductive health programmes	
Other: <i>[write in]</i>	

- 1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No
-----	----

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

Yes	No
-----	----

- 2.1 Is HIV education part of the curriculum in

primary schools?

Yes	No
-----	----

secondary schools?

Yes	No
-----	----

teacher training?

Yes	No
-----	----

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

Yes	No
-----	----

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No
-----	----

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes	No
-----	----

<i>IF NO</i> , briefly explain:

3.1 *IF YES*, which sub-populations and what elements of HIV prevention do the policy/strategy address?

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other sub-populations* [write in]
Targeted information on risk reduction and HIV education						
Stigma & discrimination reduction						
Condom promotion						
HIV testing & counselling						
Reproductive health, including STI prevention & treatment						
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A	
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle & syringe exchange		N/A	N/A	N/A	N/A	

Overall, how would you rate <i>policy efforts</i> in support of HIV prevention in 2007 and in 2005?												
2007		Poor									Good	
		0	1	2	3	4	5	6	7	8	9	10
2005		Poor									Good	
		0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:												

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes	No
-----	----

IF NO, how are HIV prevention programmes being scaled-up?:

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The activity is available in		
	<i>all</i> districts* in need	<i>most</i> districts* in need	<i>some</i> districts* in need
Blood safety			
Universal precautions in health care settings			
Prevention of mother-to-child transmission of HIV			
IEC on risk reduction			
IEC on stigma and discrimination reduction			
Condom promotion			
HIV testing & counselling			
Harm reduction for injecting drug users			
Risk reduction for men who have sex with men			
Risk reduction for sex workers			
Programmes for other vulnerable sub-populations			
Reproductive health services including STI prevention & treatment			
School-based AIDS education for young people			
Programmes for out-of-school young people			
HIV prevention in the workplace			
Other <i>[write in]</i>			

* Districts or equivalent geographical/de-centralized level in urban and rural areas

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>												

IV. Treatment, care and support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes	No
-----	----

- 1.1 **IF YES**, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes	No
-----	----

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

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

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV treatment, care and support services	The service is available in		
	<i>all</i> districts* in need	<i>most</i> districts* in need	<i>some</i> districts* in need
Antiretroviral therapy			
Nutritional care			
Paediatric AIDS treatment			
Sexually transmitted infection management			
Psychosocial support for people living with HIV and their families			
Home-based care			
Palliative care and treatment of common HIV-related infections			
HIV testing and counselling for TB patients			
TB screening for HIV-infected people			
TB preventive therapy for HIV-infected people			
TB infection control in HIV treatment and care facilities			
Cotrimoxazole prophylaxis in HIV-infected people			
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			
HIV treatment services in the workplace or treatment referral systems through the workplace			
HIV care and support in the workplace (including alternative working arrangements)			
Other programmes: <i>[write in]</i>			

*Districts or equivalent de-centralized governmental level in urban and rural areas

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	No
-----	----

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

Yes	No
-----	----

4.1 **IFYES**, for which commodities?: *[write in]*

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

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

5.1 **IFYES**, is there an operational definition for OVC in the country?

Yes	No
-----	----

5.2 **IFYES**, does the country have a national action plan specifically for OVC?

Yes	No
-----	----

5.3 **IFYES**, does the country have an estimate of OVC being reached by existing interventions?

Yes	No
-----	----

IFYES, what percentage of OVC is being reached?

% *[write in]*

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>												

IV. Monitoring and evaluation

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

Yes	Years covered: <i>[write in]</i>	In progress	No
-----	----------------------------------	-------------	----

1.1. **IF YES**, was the M&E plan endorsed by key partners in M&E?

Yes	No
-----	----

1.2. **IF YES**, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	No
-----	----

1.3. **IF YES**, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	No
-------------------	--------------------	-----------------------------	----

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes	No
behavioural surveillance	Yes	No
HIV surveillance	Yes	No
a 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 M&E plan?

Yes	Years covered: <i>[write in]</i>	In progress	No
-----	----------------------------------	-------------	----

3.1 **IF YES**, has funding been secured?

Yes	No
-----	----

4. Is there a functional M&E Unit or Department?

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

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

4.1 **IF YES**, is the M&E Unit/Department based

in the NAC (or equivalent)?	Yes	No
in the Ministry of Health?	Yes	No
elsewhere? <i>[write in]</i>		

4.2 **IF YES**, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff:		
Position: <i>[write in]</i>	Full time / Part time?	Since when?:
Position: <i>[write in]</i>	Full time / Part time?	Since when?:
Position: <i>[write in]</i>	Full time / Part time?	Since when?:
Position: <i>[write in]</i>	Full time / Part time?	Since when?:

Etc.

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

Yes	No
-----	----

IF YES, describe the role of civil society representatives and people living with HIV in the working group?

6. Does the M&E Unit/Department manage a central national database?

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

6.1 **IF YES**, what type is it? *[write in]*

6.2 **IF YES**, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

Yes	No
-----	----

6.3 Is there a functional* Health Information System?

National level	Yes	No
Sub-national level IF YES , at what level(s)? <i>[write in]</i>	Yes	No

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

6.4 Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

Yes	No
-----	----

7. To what extent is M&E data used in planning and implementation?

Low												High
	0	1	2	3	4	5						

What are examples of data use?

What are the main challenges to data use?

8. In the last year, was training in M&E conducted

At national level?	Yes	No
IF YES , Number of individuals trained: <i>[write in]</i>		
At sub-national level?	Yes	No
IF YES , Number of individuals trained: <i>[write in]</i>		
Including civil society?	Yes	No
IF YES , Number of individuals trained: <i>[write in]</i>		

Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005:												

Part B

[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

I. Human rights

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

Yes	No
-----	----

1.1 **IF YES**, specify: *[write in]*

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	No
-----	----

2.1 **IF YES**, for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes	No
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other: <i>[write in]</i>		

IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented:

IFYES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes	No
-----	----

3.1 **IFYES**, for which sub-populations?

Women	Yes	No
Young people	Yes	No
IDU	Yes	No
MSM	Yes	No
Sex Workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Other: <i>[write in]</i>		

IFYES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

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

Yes	No
-----	----

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

Yes	No
-----	----

IF YES, briefly describe this mechanism

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?

Yes	No
-----	----

IF YES, describe some examples

7. Does the country have a policy of free services for the following:

HIV prevention services	Yes	No
Anti-retroviral treatment	Yes	No
HIV-related care and support interventions	Yes	No

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes	No
-----	----

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Yes	No
-----	----

9.1 Are there differences in approaches for different most-at-risk populations?

Yes	No
-----	----

IF YES, briefly explain the differences:

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No
-----	----

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes	No
-----	----

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

Yes	No
-----	----

IF YES, describe the effectiveness of this review committee

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No
-----	----

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	No
-----	----

- Performance indicators or benchmarks for

a) compliance with human rights standards in the context of HIV efforts

Yes	No
-----	----

b) reduction of HIV-related stigma and discrimination

Yes	No
-----	----

IF YES, on any of the above questions, describe some examples:

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes	No
-----	----

14. Are the following legal support services available in the country?

- Legal aid systems for HIV and AIDS casework

Yes	No
-----	----

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No
-----	----

- Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes	No
-----	----

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

Yes	No
-----	----

IF YES, what types of programmes?

Media	Yes	No
School education	Yes	No
Personalities regularly speaking out	Yes	No
Other: <i>[write in]</i>		

Overall, how would you rate the <i>policies, laws and regulations</i> in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?												
2007	Poor										Good	
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>												

Overall, how would you rate the <i>effort to enforce</i> the existing policies, laws and regulations in 2007 and in 2005?												
2007	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>												

II. Civil society¹⁷ participation

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

Low						High
0	1	2	3	4	5	

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

Low						High
0	1	2	3	4	5	

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

- a. in both the National Strategic plans and national reports?

Low						High
0	1	2	3	4	5	

- b. in the national budget?

Low						High
0	1	2	3	4	5	

4. Has the country included civil society in a National Review of the National Strategic Plan?

Yes	No
-----	----

IF YES, when was the Review conducted? Year: *[write in]*

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low						High
0	1	2	3	4	5	

List the types of organizations representing civil society in HIV and AIDS efforts:

¹⁷ Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

6. To what extent is civil society able to access

- a. adequate financial support to implement its HIV activities?

Low						High
0	1	2	3	4	5	

- b. adequate technical support to implement its HIV activities?

Low						High
0	1	2	3	4	5	

Overall, how would you rate the efforts to increase <i>civil society participation</i> in 2007 and in 2005?											
2007	Poor										Good
		0	1	2	3	4	5	6	7	8	9 10
2005	Poor										Good
		0	1	2	3	4	5	6	7	8	9 10
<i>Comments on progress made since 2005:</i>											

III. Prevention

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes	No
-----	----

IF NO, how are HIV prevention programmes being scaled-up?:

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

- ✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	The service is available in		
	all districts* in need	most districts* in need	some districts* in need
Blood safety			
Universal precautions in health care settings			
Prevention of mother-to-child transmission of HIV			
IEC on risk reduction			
IEC on stigma and discrimination reduction			
Condom promotion			
HIV testing & counselling			
Harm reduction for injecting drug users			
Risk reduction for men who have sex with men			
Risk reduction for sex workers			
Programmes for other most-at-risk populations			
Reproductive health services including STI prevention & treatment			
School-based AIDS education for young people			
Programmes for out-of-school young people			
HIV prevention in the workplace			
Other programmes: <i>[write in]</i>			

*Districts or equivalent geographical/de-centralized levels in urban and rural areas

Overall, how would you rate the efforts in the <i>implementation</i> of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>											

IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes	No
-----	----

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

- ✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support services	The service is available in		
	<i>all</i> districts* in need	<i>most</i> districts* in need	<i>some</i> districts* in need
Antiretroviral therapy			
Nutritional care			
Paediatric AIDS treatment			
Sexually transmitted infection management			
Psychosocial support for people living with HIV and their families			
Home-based care			
Palliative care and treatment of common HIV-related infections			
HIV testing and counselling for TB patients			
TB screening for HIV-infected people			
TB preventive therapy for HIV-infected people			
TB infection control in HIV treatment and care facilities			
Cotrimoxazole prophylaxis in HIV-infected people			

*Districts or equivalent geographical de-centralized governmental levels in urban and rural areas

HIV and AIDS treatment, care and support services	The service is available in		
	<i>all</i> districts* in need	<i>most</i> districts* in need	<i>some</i> districts* in need
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			
HIV treatment services in the workplace or treatment referral systems through the workplace			
HIV care and support in the workplace (including alternative working arrangements)			
Other programmes: <i>[write in]</i>			

*Districts or equivalent geographical de-centralized governmental levels in urban and rural areas

Overall, how would you rate the efforts in the <i>implementation</i> of HIV treatment, care and support programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
<i>Comments on progress made since 2005:</i>											

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	50-75%	>75%
Prevention for vulnerable sub-populations				
- IDU	<25%	25-50%	50-75%	>75%
- MSM	<25%	25-50%	50-75%	>75%
- Sex workers	<25%	25-50%	50-75%	>75%
Counselling and Testing	<25%	25-50%	50-75%	>75%
Clinical services (OI/ART)*	<25%	25-50%	50-75%	>75%
Home-based care	<25%	25-50%	50-75%	>75%
Programmes for OVC**	<25%	25-50%	50-75%	>75%

*OI Opportunistic infections;

**OVC Orphans and other vulnerable children

3. Does the 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
-----	----	-----

5.1 **IF YES**, is there an operational definition for OVC in the country?

Yes	No
-----	----

5.2 **IF YES**, does the country have a national action plan specifically for OVC?

Yes	No
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5.3 **IF YES**, does the country have an estimate of OVC being reached by existing interventions?

Yes	No
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IF YES, what percentage of OVC is being reached?

% [write in]

Appendix 8. Sample checklist for Country Progress Report

- Data needs assessment completed to identify data gaps based on last round of UNGASS reporting
- Report writing process established, including timelines and milestones, and roles of NAC, government agencies, UN agencies, civil society and other relevant partners.
- Funding secured for all aspects of the reporting process.
- Data collection, vetting and analysis process established, including:
 - Identification of relevant tools and sources for data collection for each indicator
 - Timeline for data collection in line with other data collection efforts, including those via funding agencies such as the Global Fund, PEPFAR and UN agencies
 - Reporting timeline for facility-based indicators for national level aggregation
 - Data vetting and triangulation workshops with the aim of reaching consensus on the correct value for each indicator
- Protocols established for data processing and management, including:
 - Basic data cleaning and validation
 - One database for analysis and reporting purposes
- Relevant data analysed in coordination with partner organizations from government, civil society and the international community
- Report drafted
- Indicator data entered into CRIS (preferred) or equivalent data management systems (only if CRIS is not available)
- Consistency check performed for data included in the narrative report and data entered into CRIS/electronic data forms
- Draft report finalized
- Consensus reached with stakeholders, including government agencies and civil society, on the final report to be submitted
- Report and required data forms submitted to UNAIDS Geneva (ungassindicators@un aids.org) by **31 January 2008**, or by 15 January if CRIS is not used for indicator data submission.
- Focal point established in country for communications between UNAIDS Secretariat in case of any queries related to the report and/or the data submitted.

Appendix 9. Selected bibliography

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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.

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