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United Nations General Assembly  
Special Session on HIV/AIDS

Monitoring the Declaration of Commitment on HIV/AIDS

# GUIDELINES ON CONSTRUCTION OF CORE INDICATORS

2010 Reporting

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United Nations General Assembly  
Special Session on HIV/AIDS

Monitoring the Declaration of Commitment on HIV/AIDS

**GUIDELINES ON CONSTRUCTION OF  
CORE INDICATORS**

**2010 Reporting**

*March 2009  
Geneva, Switzerland*

Please submit your completed UNGASS Country Progress Report before 31 March 2010, using CRIS3 or the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)).

If the UNGASS reporting website, or CRIS3, is not used for submission of indicator data, please submit reports before 15 March 2010 to allow time for the manual entry of data in Geneva.

All submissions must be made in electronic format. If you also wish to share with us a printed copy of your report please post it to:

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# Table of contents

<b>Acknowledgements</b>	<b>5</b>
<b>Foreword</b>	<b>7</b>
<b>Acronyms</b>	<b>8</b>
<b>Introduction</b>	<b>9</b>
Purpose	9
Background	9
The current reporting period: 2008-2009	10
Country Progress Report Format	10
Indicators: overview	11
National Indicators for High-income Countries	11
Universal Access Target Setting	12
Implementation at National Level	12
Indicator Construction	12
Measurement Tools and Data Sources	12
Numerators and Denominators	13
Disaggregated Data: Essential Sex and Age Breakdowns	13
Recency and Representativeness of Survey Data	14
Interpretation and Analysis	15
Selection of Indicators	15
Role of Civil Society	16
Guidance on Submission	17
The Role of Monitoring Indicators in Evidence-based Advocacy	18
The Role of Monitoring Indicators in a Comprehensive National Monitoring and Evaluation System	19
<b>Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS</b>	<b>20</b>
National Commitment and Action Indicators	23
1. AIDS Spending	24
2. Government HIV and AIDS Policies	27
National Programme Indicators	29
3. Blood Safety	30
4. HIV Treatment: Antiretroviral Therapy	32
5. Prevention of Mother-to-Child Transmission	34
6. Co-management of Tuberculosis and HIV Treatment	37
7. HIV Testing in the General Population	39
8. HIV Testing in Most-at-risk Populations	40
9. Most-at-risk Populations: Prevention Programmes	42
10. Support for Children Affected by HIV and AIDS	44
11. Life-Skills based HIV Education in Schools	46
Knowledge and Behaviour Indicators	49
12. Orphans: School Attendance	50
13. Young People: Knowledge about HIV Prevention	52
14. Most-at-risk Populations: Knowledge about HIV Transmission Prevention	54
15. Sex Before the Age of 15	56

16. Higher-risk Sex	57
17. Condom Use During Higher-risk Sex	58
18. Sex Workers: Condom Use	59
19. Men Who Have Sex with Men: Condom Use	61
20. Injecting Drug Users: Condom Use	63
21. Injecting Drug Users: Safe Injecting Practices	65
Impact Indicators	67
22. Reduction in HIV Prevalence	68
23. Most-at-risk Populations: Reduction in HIV Prevalence	70
24. HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	72
25. Reduction in Mother-to-child Transmission	75
<b>Appendices</b>	<b>77</b>
Appendix 1. Country Progress Report template	79
Appendix 2. Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the <i>Declaration of Commitment on HIV/AIDS</i>	81
Appendix 3. National Funding Matrix	82
Appendix 4. National Composite Policy Index (NCPI) 2010	87
Appendix 5. Sample checklist for Country Progress Report	134
Appendix 6. Selected bibliography	135

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## Foreword

The *2001 Declaration of Commitment on HIV/AIDS* and the *2006 Political Declaration on HIV/AIDS* adopted by the UN General Assembly are the guiding force of the global response on AIDS. We must put all our efforts towards the goal of universal access to comprehensive HIV prevention, treatment, care and support by 2010 and halting and reversing the epidemic by 2015.

This document provides guidelines for monitoring progress made towards these goals and writing of the country progress reports to be submitted to the UN General Assembly in 2010.

The process of preparing the country progress reports should involve all partners involved in the AIDS response and provide an opportunity for reflection on the national response, its achievements as well as obstacles for achieving universal access goals.

Monitoring the response to the AIDS epidemic is essential to ensure that investments in AIDS achieve results.

Mr Michel Sidibe  
Executive Director  
UNAIDS

## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CRIS	Country Response Information System
DHS	Demographic and Health Surveys
EU	European Union
GRD	Global Response Database
HIV	Human Immunodeficiency Virus
N/A	Not Applicable
NAC	National AIDS Committee(s)
NAP	National AIDS Programme
NASA	National AIDS National Spending Assessment
NCPI	National Composite Policy Index
STI	Sexually Transmitted Infection(s)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
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 and their progress towards achieving national targets for universal access while simultaneously contributing to a better understanding of the global response to the AIDS pandemic, including progress towards meeting the global targets set 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.

## 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*, 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. In 2006 Member States of the United Nations renewed these commitments in a *Political Declaration on HIV/AIDS* to achieve universal access to HIV treatment, prevention, care and support by 2010.

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 national AIDS committees, 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 Monitoring and Evaluation Division established clear definitions for each indicator and mechanisms for collecting information on an ongoing basis.

For the reporting period of 2002 to 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 about two-thirds of the reports and people living with HIV were involved in just over half of them.

For the reporting period of 2004 to 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.

For the reporting period of 2006 to 2007, 153 Member States (80%) submitted Country Progress Reports in 2008. This represented a 12% increase in the number of countries reporting in the previous round. Of these reports, 45 were from sub-Saharan Africa, 20 from Asia and the Pacific, 32 from Latin America and the Caribbean, 18 from Eastern Europe and Central Asia, 9 from North Africa and the Middle East and 29 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 for all three rounds of reporting thus far. In 2008, for example, while the majority of countries completed the National Composite Policy Index questionnaire, less than half of those countries that stated the indicators on most-at-risk populations were relevant to their epidemic and response were able to provide data on these indicators. Furthermore, inadequately disaggregated data made it difficult to draw broader and more valid conclusions (*Report on the Global AIDS Epidemic 2008*).

## The current reporting period: 2008-2009

**In order to minimize the burden of reporting by Member States and to preserve trend data only minor changes were made to selected indicators for 2010 reporting**<sup>1</sup> Additional guidance and further clarity is provided on those indicators based on input received from a variety of partners; and an analysis of indicator performance in the 2006 to 2007 reporting round.

UNAIDS recommends strongly 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.

## Use of Additional Recommended Indicators to Monitor Country Progress

Donors, multilateral organizations and the United Nations system are working closely with national governments to harmonize monitoring indicators and reduce the reporting burden placed on countries. To this end, the UNAIDS Monitoring and Evaluation Reference Group has reviewed the indicators recommended by international partners for use in national-level reporting and obtained agreement to limit these to a set of 15 standardized additional indicators that compliment the UNGASS indicators. These indicators are available as a supplement to these and previous UNGASS Guidelines, and can be downloaded from the UNAIDS website. These indicators are intended for use at the national level and are not required for UNGASS reporting. However, if data are available for these indicators, countries may choose to report it in the narrative section of their Country Progress Reports.

## Country Progress Report Format

In response to input received, we have provided a Country Progress Report template 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 "Guidance on Submission" on page 17 of these guidelines.

<sup>1</sup> The four global level indicators have been removed from this publication as it is intended as guidance for national reporting. The global indicators are not designed to be included in Country Progress reports, and references to them in these Guidelines for national reporting created some confusion in previous rounds.

Appendix 1 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 UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) to enhance the completeness and quality of the data and to facilitate processing and analysis at both the country and global levels. The deadline for report submission using the UNGASS reporting website is 31 March 2010. If the website or CRIS3 are not used for reporting, reports must be submitted by 15 March 2010 to allow for the manual entry of data into the Global Response Database.

## Indicators: overview

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.

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.

The national-level UNGASS indicators are divided into three categories:

1. **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 treatment, 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.
2. **National knowledge and behaviour.** These indicators cover a range of specific knowledge and behavioural outcomes, including accurate knowledge about HIV transmission, sexual behaviours and school attendance among orphans.
3. **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 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 subepidemic 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.

Five 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 five indicators relate to antiretroviral treatment coverage, 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

In adopting the *Declaration of Commitment on HIV/AIDS*, high-income countries committed themselves 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 Monitoring and Evaluation Division ([ungassindicators@unaids.org](mailto:ungassindicators@unaids.org)) if they require further technical advice regarding reporting on their domestic programmes.

### **Monitoring the *Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia***

During the Irish Presidency of the Council of the European Union (first half of 2004) the EU Member States and neighbouring countries in Eastern Europe and Central Asia reaffirmed commitments made in the 2001 United Nations General Assembly Special Session on HIV/AIDS. Recognizing the tensions between reducing reporting burden and harmonizing reporting with the need to respect the specificities of the European region, it is anticipated that the monitoring of the *Dublin Declaration* will primarily be based on a sub-set of UNGASS indicators. The European Centre for Disease Control and Prevention (ECDC) is coordinating reporting on this *Declaration*. Data collection for this will take place in 2009. For further information on the monitoring of the *Dublin Declaration* please contact Mr Teymur Noori at the ECDC at [teymur.noori@ecdc.europa.eu](mailto:teymur.noori@ecdc.europa.eu)

## **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 has 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 documents 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 HIV monitoring and evaluation working groups in country. The Monitoring and Evaluation Division at the UNAIDS Secretariat is also available to provide support and can be reached via email at [ungassindicators@unaids.org](mailto:ungassindicators@unaids.org)

## **Indicator Construction**

This manual includes detailed guidelines for the construction of each national indicator. These guidelines include the purpose of the indicator, its applicability in a given country, the frequency with which relevant data should be gathered, recommended measurement tools, recommended methods of measurement and a summary interpretation of the indicator.

## **Measurement Tools and Data Sources**

The primary measurement tools are: (i) nationally representative, population-based sample surveys, such as Demographic and Health Surveys (DHS and DHS+), Multiple Indicator Cluster Surveys (MICS) and the Demographic and Health Survey/AIDS Indicator Survey (AIS); (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.

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. It is recognized that it may be challenging to monitor trends in behaviour and HIV prevalence of most-at-risk populations, and it will require a substantial level of effort to collect 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.

Since some behaviours of most-at-risk groups may be illegal or highly stigmatized, most-at-risk populations are typically marginalized and often mobile. It is therefore often extremely difficult to ascertain the size of these populations with any degree of precision. For this reason, the construction of the UNGASS indicators on most-at-risk populations does not require estimates of the size of these populations. Additionally, service providers working with most-at-risk populations often protect their clients' anonymity by not collecting data on individuals. As such, programme data often includes double-counting of individuals. For these two reasons the indicators are constructed using cross-sectional surveys of these populations.

## 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. In 2008 almost 80% of countries submitted at least some level of disaggregation in their indicator data files. While this represents a great improvement over previous rounds of reporting, it appears that a number of countries are still unable to adequately monitor age and sex differences in key indicators of their response. It remains 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, and 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 many of the data collected at subnational levels are 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 when being moved from the local to the national to the global level. When only partially disaggregated data are available, assessments must be made of the representativeness of the data when determining the total value to report for that indicator. For example, reporting data only 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 two of the most-affected populations in this pandemic.

The UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) clearly identifies 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 entry of partial data is possible, if necessary. This will allow time for capacity building surrounding data quality and the importance of recording sex and age information at the point of data collection.

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. Countries should seek technical assistance from the United Nations System, including the UNAIDS, WHO and UNICEF country offices, and its partners 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 the previous round, since such surveys are generally undertaken at five year intervals. **Nonetheless, it is important to report these data again in this reporting round as it communicates that these are still the best data currently available.**

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? 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

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.

If it is felt that the area is of relevance to the epidemic and response, but that the UNGASS indicator itself is not relevant or appropriate for the monitoring of this issue in a particular country this should be stated in the narrative report. If an alternative indicator is being effectively used to monitor the issue in question

in that country this indicator should be described in the narrative (including a full definition and method of measurement), along with any available data for the indicator.

## 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 Country 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, and; 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 and denominator data, as well as a straightforward mechanism for submitting and evaluating information for the Country Progress Report. Country Progress Reports should include data from civil society providers (including the faith-based sector) and state the contribution of civil society to the national response to HIV quantitatively and qualitatively. As part of this effort, civil society 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 members at the country level are available to help facilitate input from civil society throughout the process. In particular, UNAIDS country-level staff members 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 2009 round of reporting, as they were in 2003, 2005 and 2007. 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, where governments do not submit a Country Progress Report, or where data provided by government differs considerably from data collected by civil society monitoring government progress in service delivery. In accepting shadow reports, UNAIDS acknowledges the 'watchdog' function which many civil society organisations fulfil in their countries.

## Guidance on Submission

National governments, through their national AIDS committees or equivalents, are responsible for reporting on the national-level indicators with support from civil society and development 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 1) should be used for the report that is submitted to UNAIDS.

Progress Reports should be submitted to the UNAIDS Monitoring and Evaluation Division in Geneva by 31 March 2010. Country Progress Reports should include narrative section (as a Microsoft Word file or a PDF file) and files containing 25 UNGASS indicators.

The narrative report in Word or PDF format should be directly uploaded to the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) which will facilitate faster publication at UNAIDS website.

Wherever possible data should be entered directly through the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)). This will greatly facilitate data processing and will minimize any errors associated with secondary data entry in Geneva. Further detailed instructions on how to use this facility will be provided in due course.

In cases where countries plan to use the version 3 of the Country Response Information System (CRIS3) data may be exported from CRIS3 in Excel format. Please upload the Excel export to the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)). Please note that CRIS3 is not the same as the UNGASS data entry software that was distributed for the 2008 reporting round. The 2008 reporting software cannot be used for 2010 reporting.

It is not necessary to use both CRIS3 and direct online data entry through the UNGASS website.

Please note that countries that do not submit their data via the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) or CRIS3 are asked to submit their reports by 15 March 2010 to allow time for the manual entry of data into the Global Response 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. Please note that it is not necessary to have the Country Progress Report officially signed.

Printed copies of Reports may be sent to:

Dr Deborah Rugg  
Chief, Monitoring and Evaluation Division  
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.

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. Submission of Country Progress Reports through the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) will ensure that narrative reports are automatically posted on the website within 48 hours of submission. It is therefore important that the Report has been fully reviewed in the country and officially endorsed prior to submission to UNAIDS. Data must be validated against the narrative report and all data quality reviewed and checked prior to submission. In addition to the Country Progress Reports being posted on the UNAIDS website, the indicator data from the Reports will also be made available after a process of data cleaning, validation and reconciliation.

## The National-Level Reporting Process: Necessary Actions

Complete reporting on the core indicators is essential if the Country Progress Report 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 undertake the following tasks:

- 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.
- Draft the Country Progress Report narrative.
- Allow stakeholders, including government agencies and civil society, to comment on the draft report.
- Validate data against the narrative and enter it into the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)).
- Submit (i) the narrative report and (ii) the indicator data to UNAIDS Geneva before **31 March 2010**, or by **15 March 2010** for countries not submitting data via the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) or CRIS3.

It is important that the data reported are validated and reconciled between all partners in country. In previous years there were some cases where multiple differing values for the same indicator were reported through various international reporting processes. Substantial efforts at national and global level were then required to identify and correct contradictory data.

A summary checklist which may be used in the preparation and submission of the Country Progress Report is included as Appendix 5.

## 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 exacerbates obstacles to service access (e.g. policies, laws, resources, politics, customs, organizations, individuals)?

- What is the quality of services being delivered?
- Are services being delivered equitably and effectively?
- 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.

## The Role of Monitoring Indicators in a Comprehensive National Monitoring and Evaluation System

Ultimately the role of the national M&E system is to address three key questions of the response at national level:

- Are we doing the right things?
- Are we doing them right?
- Are we doing them on a scale large enough to make a difference?

The systematic tracking of standardized indicators is a fundamental element of a national monitoring system as it allows for comparisons over time and by geographic regions. However, indicators necessarily provide only a small piece of information about potentially very complex issues. As such, indicators are only ever intended as superficial vital signs of a response and can never provide all the information necessary to fully address each of these three questions. For effective programme management additional sources of information, using a variety of methods, are required. In order to ensure that the response to the HIV epidemic is effective and efficient, a truly functional national M&E system should aggregate indicator data from sectoral information systems and interpret these data in light of additional information from evaluations, operations research and other special studies.

For further information on the critical elements of a fully functional national monitoring and evaluation system for the HIV response please refer to the *Organizing Framework for a Functional National HIV Monitoring and Evaluation System* (UNAIDS, 2008).

### Towards Universal Access and the Millennium Development Goals

AIDS has been recognized as a critical development issue that affects the lives of millions of people. For this reason, combating AIDS is one of the Millennium Development Goals. The 2001 UNGASS *Declaration of Commitment* and the 2006 *Political Declaration on Universal Access* both reflect political support from the very highest level to our combined efforts to reverse the AIDS pandemic.

The monitoring and reporting of efforts to scale up to universal access to HIV prevention, treatment, care and support fulfils Member States obligations under the *Declaration of Commitment*. More importantly, it is through these efforts that we will be able to determine whether we can rise to the challenges posed by the pandemic and collectively meet this ambitious goal.

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

Indicators	Data Collection Frequency	Method of Data Collection
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## National Commitment and Action

### Expenditures

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 Assessment Financial resource flows
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### Policy Development and Implementation Status

2. National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Every 2 years	Desk review and key informant interviews
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### 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/ special survey
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 receive antiretroviral medicines 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 the 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 the 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 orphans and vulnerable children 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 within the last academic year	Every 2 years	School-based survey

## Indicators

## Data Collection Frequency

## Method of Data Collection

### 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 who have had sexual intercourse before the age of 15	Every 4–5 years	Population-based survey
16. Percentage of adults 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 adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last 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 who reported the use of a condom at last sexual intercourse	Every 2 years	Special survey
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Every 2 years	Special survey

### 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 2 years	Programme monitoring
25. Percentage of infants born to HIV-infected mothers who are infected	Annual	Treatment protocols and efficacy studies

\* Millennium Development Goals indicator





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## NATIONAL COMMITMENT AND ACTION INDICATORS

1. AIDS spending by category 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; and
  - monitoring and evaluation.  
Part B (to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations):
  - human rights;
  - civil society involvement;
  - prevention; and
  - 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.

## Domestic and international AIDS spending by categories and financing sources

<b>PURPOSE</b>	To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	2007, 2008 and 2009 calendar or fiscal year data (as available)
<b>MEASUREMENT TOOLS</b>	<p>Primary tool/method: National AIDS Spending Assessment (NASA)</p> <p>Alternative tools/methods:</p> <ol style="list-style-type: none"> <li>1) National Health Accounts—AIDS sub-accounts. There should not be any difference in the AIDS health spending measured by NASA or by the National Health Accounts sub-accounts. However, some activities performed outside the health system might not be included in National Health Accounts.</li> <li>2) Resource Flows 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 Resource Flows Survey. In addition, some population-related actions should be excluded from the total for AIDS.</li> </ol> <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 3).</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 children<sup>2</sup>
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 subcategories in each AIDS Spending Category; see Appendix 3)

Three main groups of financing sources:

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

(There are multiple subcategories for each source; see Appendix 3)

The National Funding Matrix is available on the UNGASS 2010 reporting website: [www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010).

**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.

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 3 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 3 needs to be submitted with the Country Progress Report.

**FURTHER INFORMATION**

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

- UNAIDS (2009). National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions. This publication is available at: <http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp>

<sup>2</sup> In the context of resource needs estimates and AIDS Spending Assessments, vulnerable children are defined as those that have at least one parent who is alive but seriously ill (mainly because of HIV) and unable to take care of them.

- UNFPA/UNAIDS/Netherlands Interdisciplinary Demographics Institute. Details on Resource Flows Surveys, instruments, countries sampled and more details on this tool are available at: [www.resourceflows.org](http://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: <http://www.who.int/nha>
- Health Systems 20/20/USAID (2004). Methodological Guidelines for Conducting a National Health Accounts Sub-analysis for HIV/AIDS. This publication can be found at: <http://www.healthsystems2020.org/>

## 2. Government HIV and AIDS Policies

### National Composite Policy Index (NCPI)

PURPOSE	To assess progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws
APPLICABILITY	All countries
DATA COLLECTION FREQUENCY	Every two years. The National Composite Policy Index is ideally completed in the last 6 months of the reporting period (i.e., between June and December 2009 for the 2010 reporting round). As a variety of stakeholders need to be consulted, it is important to allow adequate time for the data gathering and data consolidation process.
MEASUREMENT TOOL	National Composite Policy Index questionnaire (see Appendix 4)
METHOD OF MEASUREMENT	<p>The National Composite Policy Index questionnaire is divided in two parts which cover the following areas:</p> <p>Part A - to be administered to government officials</p> <ol style="list-style-type: none"> <li>I. Strategic plan</li> <li>II. Political support</li> <li>III. Prevention</li> <li>IV. Treatment, care and support</li> <li>V. Monitoring and evaluation</li> </ol> <p>Part B - to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations</p> <ol style="list-style-type: none"> <li>I. Human rights</li> <li>II. Civil society involvement</li> <li>III. Prevention</li> <li>IV. Treatment, care and support</li> </ol> <p>Some questions occur in both Part A and Part B to ensure that the views of both the national government and nongovernment respondents, whether in agreement or not, are obtained.</p>

Each section should be completed by (a) conducting a desk review of relevant documents and (b) interviewing key people most knowledgeable about the topic. It is important to submit a fully completed National Composite Policy Index: check the relevant standardized responses as well as provide further information in the open text boxes where requested. This will facilitate a better understanding of the current country situation, provide examples of good practice for others to learn from, and pin-point some issues for further improvement. National Composite Policy Index responses reflect the overall policy, strategy, legal and programme implementation environment of the HIV response. The open text boxes provide an opportunity to comment on issues that are perceived as important but insufficiently captured in the questions as asked e.g. important sub-national variations; the level of implementation of strategies, policies, laws or regulations; explanatory notes; comments on the data sources etc. In general, *draft* strategies, policies, or laws are *not* considered 'in existence' (i.e. there is no opportunity yet to expect their influence on programme implementation) so questions about whether such a document exists should be answered with 'no'. It would, however, be useful to state that such documents are in draft form in the relevant open text box.

While the responsibility for submitting the consolidated National Composite Policy Index data lies with the national government, the assistance of technical coordinators for data gathering, data consolidation and data validation is strongly advised. Accurate completion of the National Composite Policy Index

requires the involvement of a range of stakeholders which should include representatives of civil society organizations. It is strongly recommended to (a) organize an initial workshop with key stakeholders to agree on the National Composite Policy Index data gathering process (including relevant documents for desk review, organizational representatives to be interviewed, process to be used for determining final responses, timeline); and to (b) organize a final workshop with key stakeholders to present, discuss and validate the National Composite Policy Index findings before official submission as part of the UNGASS Country Progress Report. Agreement on the final National Composite Policy Index data does not require that discrepancies, if any, between overlapping questions in Part A and Part B be reconciled; it simply means that when there are different perspectives, that Part A respondents agree on their responses, Part B respondents agree on their responses, and that both are submitted.

If not already the case, it is useful to collate all key documents (i.e. policies, strategies, laws, guidelines, reports etc) related to the HIV response in one place which allows easy access by all stakeholders (such as a website). This will not only facilitate validation of National Composite Policy Index responses but, even more importantly, increase awareness about and encourage use of these important documents in the implementation of the national HIV response going forward.

## INTERPRETATION

- The National Composite Policy Index is the most comprehensive standardized questionnaire available to assess the policy, strategy, legal and programme implementation environment for the HIV response. Although the National Composite Policy Index is generally referred to as an ‘indicator’ or an ‘index’, it is not used in that sense. While it is possible to calculate an overall score by assigning a value to each response, the importance of the Index lies in the process of data collection and data reconciliation between different stakeholders, detailed analysis of the responses, and its use in strengthening the national HIV response. The National Composite Policy Index process provides a unique opportunity for the variety of stakeholders to take stock of progress made and to discuss what still needs to be done to support an effective and efficient HIV response. When completed in a truly collaborative manner, inviting appropriate representation and respecting different views, the National Composite Policy Index process can play an important role in strengthening in-country collaboration and increasing shared ownership of the HIV response.
- It is important to analyse the data for each of the National Composite Policy Index sections and include a write-up in the narrative section of the Country Progress Report in terms of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country’s HIV response. 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 National Composite Policy Index data since 2003, where available<sup>3</sup>.

<sup>3</sup> Compare NCPI in *Guidelines on construction of core indicators*, UNAIDS 2002, 2005, and 2007 respectively, for selecting questions for which trends can be calculated.

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## 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 women and men with advanced HIV infection receiving antiretroviral therapy\*
5. Percentage of HIV-positive pregnant women who received antiretroviral medication to reduce the risk of mother-to-child transmission
6. Percentage of 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 by prevention programmes
10. Percentage of orphaned and vulnerable children 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

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\* Millennium Development Goals indicator

### 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. The following methodologies are two key components of quality assurance in screening.

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

<b>PURPOSE</b>	To assess progress in screening of blood donations in a quality-assured manner
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	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
<b>METHOD OF MEASUREMENT</b>	<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 officers responsible for the National Blood Programme in the Ministry of Health</p> <p>The following information is required to measure this indicator.</p> <ol style="list-style-type: none"> <li>1. The total number of blood units that were donated in the country</li> <li>2. For each blood centre and blood screening laboratory that screens donated blood for HIV:             <ol style="list-style-type: none"> <li>i. The number of units of blood donated in each blood centre/ blood screening laboratory;</li> <li>ii. The number of donated units screened in the blood centre/blood screening laboratory;</li> </ol> </li> </ol>



- iii. If the blood centre/blood screening laboratory followed documented standard operating procedures for HIV screening;
- iv. If the blood centre/blood screening laboratory participated 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 a quality assured manner. For the purposes of data collection screening in a quality assured manner is defined as screening performed in blood centres/ blood screening laboratories that (i) follow documented standard operating procedures *and* (ii) participate in an external quality assurance (EQA) 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 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](http://www.who.int/bloodsafety)
- [www.who.int/diagnostics\\_laboratory](http://www.who.int/diagnostics_laboratory)
- [www.who.int/worldblooddonorday](http://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 has been shown to reduce mortality amongst 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

<b>PURPOSE</b>	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	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.
<b>MEASUREMENT TOOL</b>	For the numerator: facility-based antiretroviral therapy registers or drug supply management systems. For the denominator: HIV prevalence estimation models such as Spectrum.
<b>METHOD OF MEASUREMENT</b>	Programme monitoring and HIV surveillance
<b>Numerator:</b>	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period
<b>Denominator:</b>	Estimated number of adults and children with advanced HIV infection  This indicator should be disaggregated by sex and age (<15, 15+)⁴ and percentages given for 2008 and 2009 to track annual trends in coverage.
<b>Explanation of Numerator:</b>	The numerator can be generated by counting the number of adults and children who received antiretroviral combination 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 drugs 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.

⁴ Where possible, for children the indicator should be further disaggregated by the ages <1, 1-4, 5-14 years.

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 antiretroviral therapy and on antiretroviral therapy 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 facility-based antiretroviral therapy registers or drug supply management systems. 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. This estimation must take into consideration a variety of factors including, but not limited to, the current numbers of people with HIV, the current number of patients on antiretroviral therapy, and the natural history of HIV from infection to enrolment on antiretroviral therapy.

Denominator estimates are most often based on the latest data available from sentinel surveillance used with a HIV modelling programme such as Spectrum. For further information on estimates of HIV need and the use of Spectrum please refer to the UNAIDS/WHO Reference Group on Estimates, Modelling and Projections methodology.<sup>5</sup>

Need or eligibility for antiretroviral therapy should follow the WHO definitions for the diagnosis of advanced HIV (including AIDS) for adults and children.<sup>6</sup>

## 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 antiretroviral therapy 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.

<sup>5</sup> [http://www.unaids.org/en/HIV\\_data/Methodology/default.asp](http://www.unaids.org/en/HIV_data/Methodology/default.asp)

<sup>6</sup> <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 regimens for the mother with or without prophylaxis to the infant, implementation of safe delivery practices and use of safer infant feeding practices.

### Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

<b>PURPOSE</b>	To assess progress in preventing mother-to-child transmission of HIV
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Data should be collected continuously at the facility level and should be aggregated periodically.
<b>MEASUREMENT TOOL</b>	For the numerator: programme monitoring tools, such as patient registers and summary reporting forms. For the denominator: antenatal clinic surveillance surveys in combination with demographic data, or estimation models such as Spectrum.
<b>METHOD OF MEASUREMENT</b>	Programme monitoring and HIV surveillance
<b>Numerator:</b>	Number of HIV-infected pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission in the last 12 months
<b>Denominator:</b>	Estimated number of HIV-infected pregnant women in the last 12 months
	Data for this indicator should be provided for both 2008 and 2009 to track annual trends in coverage.
	Wherever possible, the numerator for this indicator should be disaggregated by the type of antiretroviral regimen

**Explanation of numerator:** There are four general antiretroviral categories that HIV-infected women can receive for the prevention of mother-to-child transmission.

Categories	Further clarification	Examples
1) Single-dose Nevirapine only	One dose of nevirapine for mother given at or around birth	Single Dose (SD) NVP
2) Prophylactic regimens using a combination of two antiretroviral drugs	A prophylactic regimen that uses more than one antiretroviral drug for mothers to prevent HIV transmission and is started before labour and delivery	- AZT + SD NVP - AZT + SD NVP +7 day post-partum tail of AZT/3TC - AZT + 3TC - AZT + 3TC + SD NVP
3) Prophylactic regimens using a combination of three antiretroviral drugs	Highly active regimen for mother-to-child transmission prophylaxis designed to fully suppress viral replication prior to and during delivery and for a variable duration post partum	- AZT + 3TC + NNRTI or - AZT + 3TC +PI or - AZT + 3TC + NRTI
4) Antiretroviral therapy for HIV-infected pregnant women eligible for treatment	Antiretroviral therapy for HIV positive pregnant women eligible for treatment	Standard national treatment regimen - AZT + 3TC + NNRTI or - AZT + 3TC +PI or - AZT + 3TC + NRTI

HIV-infected women receiving any antiretroviral therapy, including specifically for prophylaxis, meet the definition for the numerator. Countries should report the total number of HIV-infected pregnant women who were provided with any antiretrovirals as the numerator. This should be disaggregated by regimen type. Disaggregation should be by options one to four above (if other regimens are used the details of these regimens should be provided).

In option number four, HIV-infected pregnant women who are eligible for antiretroviral therapy 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.

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 can compile data for the numerator from patient registers at antenatal clinics, delivery and care sites, and post-partum care and HIV service sites.

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 model<sup>7</sup> such as Spectrum;<sup>8</sup> 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 or estimates from the UN Population Division, 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 in order to monitor trends in regimen use, and 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. Some countries may not have a system in place yet to collect and report coverage of antiretroviral provision for prevention of mother-to-child transmission by the various regimen possibilities, however, the goal should be to set 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, antiretroviral drug 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 living 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 therapy 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>

<sup>7</sup> Methodology described by UNAIDS/WHO Reference Group on Estimates Modelling and Projections: [http://www.unaids.org/en/HIV\\_data/Methodology/default.asp](http://www.unaids.org/en/HIV_data/Methodology/default.asp)

<sup>8</sup> [http://www.unaids.org/en/HIV\\_data/Epidemiology/epissoftware.asp](http://www.unaids.org/en/HIV_data/Epidemiology/epissoftware.asp)

## 6. Co-management of Tuberculosis and HIV Treatment

Tuberculosis (TB) is a leading cause of morbidity and mortality in people living with HIV, including 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

<b>PURPOSE</b>	To assess progress in detecting and treating TB in people living with HIV
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	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.
<b>MEASUREMENT TOOL</b>	Facility antiretroviral therapy registers and reports; programme monitoring tools
<b>METHOD OF MEASUREMENT</b>	Programme data and estimates of incident TB cases in people living with HIV
<b>Numerator:</b>	Number of adults with advanced HIV infection who received antiretroviral combination 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
<b>Denominator:</b>	Estimated number of incident TB cases in people living with HIV  Annual estimates of the number of incident TB cases in people living with HIV in high TB burden countries are calculated by WHO and are available at: <a href="http://www.who.int/tb/country/en">http://www.who.int/tb/country/en</a>  Data for this indicator should be disaggregated by sex and by adults (>15 years) and children (<15 years).

### 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. Incident TB cases are defined as new cases that have occurred in that year, and specifically excludes latent cases. 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 therapy, 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 therapy record TB diagnosis and treatment, as this information has important implications for antiretroviral therapy eligibility and choice of antiretroviral regimen. It is therefore recommended that the date of starting TB treatment is recorded in the antiretroviral therapy register.

If possible, the number of patients started on TB treatment among those in HIV care but not yet on antiretroviral therapy 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:

- WHO (2009). *Global Tuberculosis Control: Surveillance, Planning, Financing*. 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

<b>PURPOSE</b>	To assess progress in implementing HIV testing and counselling
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Every 4 to 5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked:</p> <ol style="list-style-type: none"> <li>1. I don't want to know the results, but have you been tested for HIV in the last 12 months?</li> <li>2. If yes: I don't want to know the results, but did you get the results of that test?</li> </ol>
<b>Numerator:</b>	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results
<b>Denominator:</b>	<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/start.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 subepidemic 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

<b>PURPOSE</b>	To assess progress in implementing HIV testing and counselling among most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated subepidemic within a generalized epidemic
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Behavioural surveillance or other special surveys
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> <li>1. Have you been tested for HIV in the last 12 months?</li> </ol> <p>If yes:</p> <ol style="list-style-type: none"> <li>2. I don't want to know the results, but did you receive the results of that test?</li> </ol>
<b>Numerator:</b>	Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results
<b>Denominator:</b>	<p>Number of most-at-risk population included in the sample</p> <p>Data for this indicator should be disaggregated by sex and age (&lt;25/25+).</p> <p>Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with the populations 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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO.
- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

## 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 subepidemic 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

<b>PURPOSE</b>	To assess progress in implementing basic elements of HIV prevention programmes for most-at-risk populations <sup>9</sup>
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated subepidemic within a generalized epidemic
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Behavioural surveillance or other special surveys
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> <li>1. Do you know where you can go if you wish to receive an HIV test?</li> <li>2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?</li> </ol> <p>Injecting drug users should be asked the following additional question:</p> <ol style="list-style-type: none"> <li>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)?</li> </ol>
<b>Numerator:</b>	Number of most-at-risk population respondents who replied “yes” to both (all three for injecting drug users) questions
<b>Denominator:</b>	<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 (&lt;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>

<sup>9</sup> This indicator only covers two basic elements of prevention programmes for most-at-risk populations. It is recognized that the indicator does not measure the frequency with which members of these populations access services, nor the quality of these services. These limitations suggest that the indicator may overestimate the coverage of HIV prevention services for most-at-risk populations. While continued monitoring of this indicator is recommended in order to determine trends in coverage of minimum services, additional measures are required in order to accurately determine whether adequate HIV prevention services are being provided for these populations.

## 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), treatment of sexually transmitted diseases, opioid substitution therapy for injecting drug users, and others. For further information on the elements of comprehensive HIV prevention programmes most-at-risk populations please see the *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*.

This indicator asks about services accessed in the past 12 months. If you have data available on another time period, such as the last 3 or 6 months or the last 30 days, please include this additional data in the comments section of the reporting tool.

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 process was initiated in 2008 and will inform the review of the UNGASS reporting system which is scheduled for 2010. 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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO.
- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

## 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

<b>PURPOSE</b>	To assess progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17
<b>APPLICABILITY</b>	High HIV-prevalence countries
<b>DATA COLLECTION FREQUENCY</b>	Every 4 to 5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
<b>METHOD OF MEASUREMENT</b>	<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"> <li>1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months?</li> <li>2. Has this household received school-related assistance, including school fees, within the last 12 months? (This question is to be asked only of children aged 5–17.)</li> <li>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?</li> <li>4. Has this household received other social support, including socioeconomic support (e.g. clothing, extra food, financial support, shelter) and/or instrumental support (e.g. help with household work, training for caregivers, childcare, legal services) within the last three months?</li> </ol> <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>
<b>Numerator:</b>	Number of orphaned and vulnerable children 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)
<b>Denominator:</b>	<p>Total number of orphaned and vulnerable children aged 0–17</p> <p>For the purposes of this indicator and in accordance with UNICEF definitions (see reference below), an orphan is defined as a child below the age of 18 that has lost one or both parents.</p>

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](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 implemented effectively, 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.

<b>PURPOSE</b>	To assess progress towards implementation of life-skills based HIV education in all schools
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	School survey or education programme review
<b>METHOD OF MEASUREMENT</b>	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?
<b>Numerator:</b>	Number of schools that provided life-skills based HIV education in the last academic year
<b>Denominator:</b>	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/lifeskills/index_hiv_aids.html)
- [http://www.unicef.org/aids/index\\_documents.html](http://www.unicef.org/aids/index_documents.html)



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## 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 sex before the age of 15
16. Percentage of adults aged 15–49 who have had sex with more than one partner in the last 12 months
17. Percentage of adults 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 using sterile injecting equipment the last time they injected
21. Percentage of injecting drug users reporting the use of a condom the last time they had sex

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\* 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

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

## INTERPRETATION

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](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 people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

<b>PURPOSE</b>	To assess progress towards universal knowledge of the essential facts about HIV transmission
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Preferred: every two years; minimum: every 4 to 5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
<b>METHOD OF MEASUREMENT</b>	<p>This indicator is constructed from responses to the following set of prompted questions.</p> <ol style="list-style-type: none"> <li>1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?</li> <li>2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. Can a person get HIV from mosquito bites?</li> <li>5. Can a person get HIV by sharing food with someone who is infected?</li> </ol>
<b>Numerator:</b>	Number of respondents aged 15–24 years who gave the correct answer to all five questions
<b>Denominator:</b>	<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 AIDS.

This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it can be used to ensure that pre-existing high levels of knowledge are maintained.

## FURTHER INFORMATION

For further information on how to access DHS data please consult the following website:

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

## 14. Most-at-risk Populations: Knowledge about HIV Transmission Prevention

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

Note: countries with generalized epidemics may also have a concentrated subepidemic 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**

<b>PURPOSE</b>	To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated subepidemic within a generalized epidemic
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Special behavioural surveys such as the Family Health International Behavioural Surveillance Survey for most-at-risk populations
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following five questions.</p> <ol style="list-style-type: none"> <li>1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?</li> <li>2. Can using condoms reduce the risk of HIV transmission?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. Can a person get HIV from mosquito bites?</li> <li>5. Can a person get HIV by sharing a meal with someone who is infected?</li> </ol>
<b>Numerator:</b>	Number of most-at-risk population respondents who gave the correct answers to all five questions
<b>Denominator:</b>	<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 (&lt;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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO.
- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

## 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

<b>PURPOSE</b>	To assess progress in increasing the age at which young women and men aged 15–24 first have sex
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Every 4 to 5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
<b>METHOD OF MEASUREMENT</b>	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?
<b>Numerator:</b>	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
<b>Denominator:</b>	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.

### FURTHER INFORMATION

For further information on how to access DHS data please consult the following website:

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

## 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 who 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

<b>PURPOSE</b>	To assess progress in reducing the percentage of people who have higher-risk sex
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Every 4 to 5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
<b>METHOD OF MEASUREMENT</b>	<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>
<b>Numerator:</b>	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
<b>Denominator:</b>	<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.

### FURTHER INFORMATION

For further information on how to access DHS data please consult the following website:

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

## 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 who used a condom during their last sexual intercourse**

<b>PURPOSE</b>	To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Every 4 to 5 years
<b>MEASUREMENT TOOL</b>	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked:</p> <ol style="list-style-type: none"> <li>1. In the last 12 months, how many different people have you had sexual intercourse with?</li> </ol> <p>If more than one, the respondent is asked:</p> <ol style="list-style-type: none"> <li>2. Did you or your partner use a condom the last time you had sexual intercourse?</li> </ol>
<b>Numerator:</b>	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
<b>Denominator:</b>	<p>Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months</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 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.

### FURTHER INFORMATION

For further information on how to access DHS data please consult the following website:

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

## 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 subepidemic among sex workers. If so, it would be valuable for them to calculate and report on this indicator for this population.

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

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Special surveys for the numerator and denominator, including the Family Health International Behaviour Surveillance Survey for sex workers
<b>METHOD OF MEASUREMENT</b>	Respondents are asked the following question: Did you use a condom with your most recent client?
<b>Numerator:</b>	Number of respondents who reported that a condom was used with their last client
<b>Denominator:</b>	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.

This indicator asks about commercial sex in the past twelve months. If you have data available on another time period, such as the last 3 or 6 months, please include this additional data in the comments section of the reporting tool.

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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

## 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 subepidemic among men who have sex with men. If so, it would be valuable for them to calculate and report on this indicator for this population.

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

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, including countries with concentrated sub-epidemics within a generalized epidemic
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Special surveys including the Family Health International Behavioural Surveillance Survey for men who have sex with men
<b>METHOD OF MEASUREMENT</b>	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
<b>Numerator:</b>	Number of respondents who reported that a condom was used the last time they had anal sex
<b>Denominator:</b>	Number of respondents who reported having had anal sex with a male partner <sup>10</sup> 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 subpopulation 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.

<sup>10</sup> This includes both regular and non-regular partners, and both paid and unpaid sex. As with all indicators this indicator only provides a limited piece of information. For a comprehensive assessment of patterns of risk associated with male to male sex further information is needed, including information on the types and numbers of partners and whether the individual is the receptive or insertive partner.

This indicator asks about male-to-male sex in the past six months. If you have data available on another time period, such as the last 3 or 12 months, please include this additional data in the comments section of the reporting tool.

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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.



## 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 subepidemic 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

<b>PURPOSE</b>	To assess progress in preventing sexual transmission of HIV
<b>APPLICABILITY</b>	Countries where injecting drug use is an established mode of HIV transmission
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Special surveys including the Family Health International Behavioural Surveillance Survey for injecting drug users
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following sequence of questions.</p> <ol style="list-style-type: none"> <li>1. Have you injected drugs at any time in the last month?</li> <li>2. If yes: have you had sexual intercourse in the last month?</li> <li>3. If yes in answer to both 1 and 2: did you use a condom when you last had sexual intercourse?</li> </ol>
<b>Numerator:</b>	Number of respondents who reported that a condom was used the last time they had sex <sup>11</sup>
<b>Denominator:</b>	<p>Number of respondents who report having injected drugs and 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 (&lt;25/25+).</p> <p>Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

### INTERPRETATION

Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data 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.

<sup>11</sup> This includes both regular and non-regular partners, and both paid and unpaid sex. As with all indicators this indicator only provides a limited piece of information. For a comprehensive assessment of patterns of risk associated with sex and injecting drug use further information is needed, including information on the types and numbers of partners.

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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO.
- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

## 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

<b>PURPOSE</b>	To assess progress in preventing injecting drug use-associated HIV transmission
<b>APPLICABILITY</b>	Countries where injecting drug use is an established mode of HIV transmission
<b>DATA COLLECTION FREQUENCY</b>	Every two years
<b>MEASUREMENT TOOL</b>	Special surveys including the Family Health International Behaviour Surveillance Survey for injecting drug users
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following questions.</p> <ol style="list-style-type: none"> <li>1. Have you injected drugs at any time in the last month?</li> <li>2. If yes: The last time you injected drugs, did you use a sterile needle and syringe<sup>12</sup>?</li> </ol>
<b>Numerator:</b>	Number of respondents who report using sterile injecting equipment the last time they injected drugs
<b>Denominator:</b>	<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 (&lt;25/25+).</p> <p>Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>

### INTERPRETATION

Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data 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.

<sup>12</sup> This question may need to be modified in certain local contexts. In certain drug injecting cultures, for example, needles and syringes may be exposed to HIV without being shared between users (e.g. through shared drug solutions). The questions used must ascertain that the needle and syringe used were actually sterile.

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.

To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.

## FURTHER INFORMATION

For further information, please consult the following references:

- WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO.
- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

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## 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

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\* Millennium Development Goals indicator

## 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

<b>PURPOSE</b>	To assess progress towards reducing HIV infection
<b>APPLICABILITY</b>	Countries with generalized epidemics
<b>DATA COLLECTION FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	WHO guidelines for HIV sentinel surveillance
<b>METHOD OF MEASUREMENT</b>	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.
<b>Numerator:</b>	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive
<b>Denominator:</b>	Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status
	The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time.
	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 have included HIV testing in population-based surveys. If a country has produced HIV prevalence estimates from survey data these estimates should be included in the comments box for this indicator to allow for comparisons between multiple surveys. If available, survey based estimates should be disaggregated by sex.

The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to exclude new sites from the calculation of this indicator when undertaking trend analyses.

## FURTHER INFORMATION

For further information, please consult the following website:

- [http://www.unaids.org/en/HIV\\_data/Methodology/default.asp](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 subepidemic 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

<b>PURPOSE</b>	To assess progress on reducing HIV prevalence among most-at-risk populations
<b>APPLICABILITY</b>	Countries with concentrated or low-prevalence epidemics, where routine surveillance among pregnant women is not recommended; also includes countries with concentrated subepidemic within a generalized epidemic
<b>DATA COLLECTION FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	UNAIDS/WHO <i>Second Generation Surveillance Guidelines</i> ; Family Health International guidelines on sampling in population groups
<b>METHOD OF MEASUREMENT</b>	This indicator is calculated using data from HIV tests conducted among members of most-at-risk population groups in the primary sentinel site or sites
<b>Numerator:</b>	Number of members of the most-at-risk population who test positive for HIV
<b>Denominator:</b>	Number of members of the most-at-risk population tested for HIV  Prevalence estimates should be disaggregated by sex and age (<25/25+).  The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time.

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 analysing 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 therapy 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.

The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to exclude new sites from the calculation of this indicator when undertaking trend analyses.

Revised guidelines on HIV surveillance on most-at-risk populations are currently being prepared by the WHO/UNAIDS Global Working Group on STI/HIV Surveillance. For further information please refer to: <http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/default.asp>.

## FURTHER INFORMATION

For further information, please consult the following website:

- [http://www.unaids.org/en/HIV\\_data/Methodology/default.asp](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 antiretroviral therapy programme is to increase survival among infected individuals. As provision of antiretroviral therapy is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. 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

<b>PURPOSE</b>	To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated.
<b>MEASUREMENT TOOL</b>	Programme monitoring tools; cohort/group analysis forms
<b>METHOD OF MEASUREMENT</b>	Antiretroviral therapy registers and antiretroviral therapy cohort analysis report form
<b>Numerator:</b>	Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment
<b>Denominator:</b>	Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period, including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 12.
<b>Definitions:</b>	<p>This indicator should be disaggregated by sex and age (&lt;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 2009, 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 2008. If the reporting period is 1 July 2008 to 30 June 2009, countries will include patients who started antiretroviral therapy from 1 July 2007 to 30 June 2008.</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 therapy. For example, patients who started antiretroviral therapy during the 12-month period from 1 January to 31 December 2007 will have reached their 12-month outcomes for the reporting period of 1 January to 31 December 2008.</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](http://www.unaids.org/en/HIV_data/Methodology/default.asp)  
Number of adults and children in the antiretroviral therapy start-up groups initiating 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 antiretroviral therapy in May 2006 (at month 12) is on antiretroviral therapy 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 therapy 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 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.

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.

## INTERPRETATION

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 antiretroviral therapy) 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 retention on treatment at 24, 36, and 48 months and yearly thereafter. 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. The retention on antiretroviral therapy at 12 months therefore needs to be interpreted in view of the baseline characteristics of the cohort of patients at the start of antiretroviral therapy: mortality will be higher in sites where patients accessed antiretroviral therapy at a later stage of infection. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term effectiveness of antiretroviral therapy.

## 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 interventions, including breast milk substitute (where this is part of the country's policy on prevention of mother-to-child transmission). Nevertheless, substantial reductions in mother-to-child transmission can be achieved through approaches such as short-course antiretroviral prophylaxis.

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

<b>PURPOSE</b>	To assess progress towards eliminating mother-to-child HIV transmission
<b>APPLICABILITY</b>	All countries
<b>DATA COLLECTION FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Spectrum, or other statistical modelling that uses programme coverage and efficacy studies
<b>METHOD OF MEASUREMENT</b>	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 prevention of mother-to-child transmission of HIV through increased provision of antiretroviral medicines. The Spectrum HIV estimation modelling software takes into consideration the type of antiretroviral regimen as well as additional factors that influence HIV transmission rates such as infant feeding practices. For further information on Spectrum please consult the webpage of the UNAIDS/WHO Estimates and Projections Reference Group listed below.

### FURTHER INFORMATION

For further information, please consult the following website:

- [http://www.unaids.org/en/HIV\\_data/Methodology/default.asp](http://www.unaids.org/en/HIV_data/Methodology/default.asp)



# Appendices





# Appendix 1. 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.

## UNGASS COUNTRY PROGRESS REPORT [Country Name]

*Reporting period: January 2008–December 2009*

**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 2008–December 2009 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 2008–December 2009.

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 4) 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 learned with other countries.

## VI. Major challenges and remedial actions

Instructions: This section should focus on:

- (a) progress made on key challenges reported in the 2007 UNGASS Country Progress Report, if any;
- (b) challenges faced throughout the reporting period (2008–2009) 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 4).

## 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 submit your complete UNGASS Country Progress Report **before 31 March 2010** using the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)).*

*Please direct all enquiries related to UNGASS reporting to UNAIDS Monitoring and Evaluation Division at: [ungassindicators@unaids.org](mailto:ungassindicators@unaids.org).*

*If the Country Response Information System version 3 (CRIS3) or the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)) is not used for submission of indicator data, please submit reports by 15 March 2010 to allow time for the manual entry of data into the Global Response Database in Geneva.*

## Appendix 2. 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<br>(please specify) | Yes | No |
- 2) With inputs from
- Ministries:
- |                            |     |    |
|----------------------------|-----|----|
| Education                  | Yes | No |
| Health                     | Yes | No |
| Labour                     | Yes | No |
| Foreign Affairs            | Yes | No |
| Others<br>(please specify) | Yes | No |
- |                              |     |    |
|------------------------------|-----|----|
| Civil society organizations  | Yes | No |
| People living with HIV       | Yes | No |
| Private sector               | Yes | No |
| United Nations organizations | Yes | No |
| Bilaterals                   | Yes | No |
| International NGOs           | Yes | No |
| Others<br>(please specify)   | Yes | No |
- 3) Was the report discussed in a large forum? Yes No
- 4) Are the survey results stored centrally? Yes No
- 5) Are data available for public consultation? Yes No
- 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 3. National Funding Matrix – 2010

### 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: 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 subcategories 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 subcategories under Public Sources of financing?

\_\_\_\_ Yes \_\_\_\_ No

# National Funding Matrix — 2010

## Background

The National Funding Matrix is available on the UNGASS 2010 reporting website: [www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010). 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 Accounts<sup>13</sup> 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 subcategories. Across the eight spending categories there are a total of 77 subcategories. It is important to note that all of the spending categories and subcategories 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 subcategories, ranging from voluntary counselling and testing to condom social marketing to blood safety; seven of the remaining eight spending categories have fewer than 10 subcategories each. The purpose of the categories and subcategories 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 subcategories. Public Sources has four subcategories: 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 subcategories: 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

<sup>13</sup> 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.

that this coordinator have good knowledge of tools and methodologies currently in use 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 subcategories. Any categories or subcategories that are not applicable in a country should be clearly identified; explanations for categories or subcategories 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 subtotal for each of the eight AIDS Spending Categories, which captures all funding from all sources for all subcategories in a given category.
- Amounts in each category or subcategory should be reported in local currency. However, it is also important to report the average exchange rate to US dollars for the calendar or fiscal year being reported; see the National Funding Matrix cover sheet on page 82.
- Spending categories and subcategories are designed to be self-explanatory. Expenditures that do not clearly fit a specific subcategory should be listed in the Other/Not Classified Elsewhere subcategory that appears in each of the eight AIDS Spending Categories. (Detailed descriptions of the categories and subcategories 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 subcategory; 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 subcategories are designed to be self-explanatory. Expenditures that do not clearly fit a specific subcategory should be listed in the All Other subcategory that appears under both Public and International Sources. Please note that the list of Financing Sources categories and subcategories is not exhaustive; however, it is indicative of the main sources of financing.
- Financing in the Central/National and Subnational subcategories 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 subcategory (e.g. Bilaterals). If any budget support is included in the Central/National and/or Subnational subcategories, 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 subcategory in the International category. Funds received from domestic foundations should be listed in the All Other subcategory 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 subcategories; the adjacent Consumer/Out-of-pocket column should list funds spent by individuals and/or families in the AIDS Spending Categories and subcategories. (*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 subcategories.*)
- 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 subtotals 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 *National AIDS Spending Assessment (NASA) Classification taxonomy and Definitions* may be downloaded from the following page on the UNAIDS website: [www.unaids.org/en/Coordination/FocusAreas/track-monitor-evaluate.asp](http://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.

The National Funding Matrix is available on the UNGASS 2010 reporting website: [www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010).

If you do not have access to UNGASS 2010 online reporting tool, please submit the National Funding Matrix by email to UNAIDS AIDS Financing and Economics (AFE) Division ([nfm@unaids.org](mailto:nfm@unaids.org)).

The National Funding Matrix is to be submitted through the UNGASS reporting website.

YEAR \_\_\_\_\_  
 Calendar Year: Yes \_\_\_\_\_ No \_\_\_\_\_  
 Fiscal Year: \_\_\_\_\_ (specify beginning/end)  
 Currency used in Matrix: \_\_\_\_\_  
 Average Exchange Rate for the year \_\_\_\_\_

**National Funding Matrix  
 AIDS Spending Categories by Financing Sources**

AIDS Spending Categories	Financing Sources																	
	TOTAL	Public Sources						International Sources						Private Sources (optional for UNGASS reporting)				
		Public Sub-Total	Central / National	Sub-National	Dev. Bank Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub-Total	For-profit institutions / Corporations	Household funds	All Other Private
<b>TOTAL</b>																		
<b>1. Prevention (sub-total)</b>																		
1.01 Communication for social and behavioural change																		
1.02 Community mobilization																		
1.03 Voluntary counselling and testing																		
1.04 Risk-reduction for vulnerable and accessible populations																		
1.05 Prevention - Youth in school																		
1.06 Prevention - Youth out-of-school																		
1.07 Prevention of HIV transmission aimed at people living with HIV																		
1.08 Prevention programmes for sex workers and their clients																		
1.09 Programmes for men who have sex with men																		
1.10 Harm-reduction programmes for injecting drug users																		
1.11 Prevention programmes in the workplace																		
1.12 Condom social marketing																		
1.13 Public and commercial sector male condom provision																		
1.14 Public and commercial sector female condom provision																		
1.15 Microbicides																		
1.16 Prevention, diagnosis and treatment of sexually transmitted infections																		
1.17 Prevention of mother-to-child transmission																		
1.18 Male Circumcision																		
1.19 Blood safety																		
1.20 Safe medical injections																		
1.21 Universal precautions																		
1.22 Post-exposure prophylaxis																		
1.98 Prevention activities not disaggregated by intervention																		
1.99 Prevention activities not elsewhere classified																		
<b>2. Care and Treatment (sub-total)</b>																		
<b>2.01 Outpatient care</b>																		
2.01.01 Provider-initiated testing and counselling																		
2.01.02 Opportunistic infection outpatient prophylaxis and treatment																		
2.01.03 Antiretroviral therapy																		
2.01.04 Nutritional support associated to ARV therapy																		
2.01.05 Specific HIV-related laboratory monitoring																		
2.01.06 Dental programmes for people living with HIV																		
2.01.07 Psychological treatment and support services																		
2.01.08 Outpatient palliative care																		
2.01.09 Home-based care																		
2.01.10 Traditional medicine and informal care and treatment																		
2.01.98 Outpatient care services not disaggregated by intervention																		
2.01.99 Outpatient Care services not elsewhere classified																		
<b>2.02 In-patient care</b>																		
2.02.01 Inpatient treatment of opportunistic infections																		
2.02.02 Inpatient palliative care																		
2.02.98 Inpatient care services not disaggregated by intervention																		
2.02.99 In-patient services not elsewhere classified																		
2.03 Patient transport and emergency rescue																		
2.98 Care and treatment services not disaggregated by intervention																		
2.99 Care and treatment services not elsewhere classified																		
<b>3. Orphans and Vulnerable Children (sub-total)</b>																		
3.01 OVC Education																		
3.02 OVC Basic health care																		
3.03 OVC Family/home support																		
3.04 OVC Community support																		
3.05 OVC Social services and administrative costs																		
3.06 OVC Institutional care																		
3.98 OVC services not disaggregated by intervention																		
3.99 OVC services not elsewhere classified																		
<b>4. Program Management and Administration Strengthening (sub-total)</b>																		
4.01 Planning, coordination and programme management																		
4.02 Administration and transaction costs associated with managing and disbursing funds																		
4.03 Monitoring and evaluation																		
4.04 Operations research																		
4.05 Serological-surveillance (Serosurveillance)																		
4.06 HIV drug-resistance surveillance																		
4.07 Drug supply systems																		
4.08 Information technology																		
4.09 Patient tracking																		
4.10 Upgrading and construction of infrastructure																		
4.11 Mandatory HIV testing (not voluntary counselling and testing)																		
4.98 Program Management and Administration Strengthening not disaggregated by type																		
4.99 Program Management and Administration Strengthening not elsewhere classified																		
<b>5. Human resources (sub-total)</b>																		
5.01 Monetary incentives for human resources																		
5.02 Formal education to build-up an HIV workforce																		
5.03 Training																		
5.98 Incentives for Human Resources not specified by kind																		
5.99 Incentives for Human Resources not elsewhere classified																		
<b>6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)</b>																		
6.01 Social protection through monetary benefits																		
6.02 Social protection through in-kind benefits																		
6.03 Social protection through provision of social services																		
6.04 HIV-specific income generation projects																		
6.98 Social protection services and social services not disaggregated by type																		
6.99 Social protection services and social services not elsewhere classified																		
<b>7. Enabling Environment</b>																		
7.01 Advocacy																		
7.02 Human rights programmes																		
7.03 AIDS-specific institutional development																		
7.04 AIDS-specific programmes focused on women																		
7.05 Programmes to reduce Gender Based Violence																		
7.98 Enabling Environment and Community Development not disaggregated by type																		
7.99 Enabling Environment and Community Development not elsewhere classified																		
<b>8. Research excluding operations research which is included under (sub-total)</b>																		
8.01 Biomedical research																		
8.02 Clinical research																		
8.03 Epidemiological research																		
8.04 Social science research																		
8.05 Vaccine-related research																		
8.98 Research not disaggregated by type																		
8.99 Research 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 4. National Composite Policy Index (NCPI) 2010

### COUNTRY:

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

\_\_\_\_\_

Postal address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel: \_\_\_\_\_

Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of submission: \_\_\_\_\_

## Instructions

The following instrument measures progress in the development and implementation of national HIV policies, strategies and laws. **It is an integral part of the core UNGASS indicators and is to be completed and submitted as part of the 2010 UNGASS Country Progress Report.**

This fourth version of the National Composite Policy Index (NCPI) has been updated to reflect new HIV programmatic guidance and to be consistent with new and agreed to policy and implementation measurement tools.<sup>14</sup> Additional guidance has been included to increase validity of the responses and comparability across different countries. The majority of questions are identical to the 2005 and 2007 NCPI, hence countries are able and are strongly advised to conduct a trend analysis and include a description of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country's HIV response. 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 available<sup>15</sup>.

### STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into **two parts**.

#### **Part A to be administered to government officials.**

Part A covers:

- I. Strategic plan
- II. Political support
- III. Prevention
- IV. Treatment, care and support
- V. Monitoring and evaluation

#### **Part B to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations.**

Part B covers:

- I. Human rights
- II. Civil society involvement
- III. Prevention
- IV. Treatment, care and support

Some questions occur in both Part A and Part B to ensure that the views of both the national government and nongovernmental respondents, whether in agreement or not, are obtained.

It is important to submit a fully completed NCPI. Please check the relevant standardized responses as well as provide further information in the open text boxes where requested. This will facilitate a better understanding of the current country situation, provide examples of good practice for others to learn from, and pin-point some issues for further improvement. NCPI responses reflect the overall policy, strategy, legal and programme implementation environment of the HIV response. The open text boxes provide an opportunity to comment on anything that is perceived to be important but insufficiently captured by the standardized questions (e.g. important subnational variations; the level of implementation of laws, policies or regulations; explanatory notes; comments on data sources etc). In general, *draft* strategies, policies, or laws are *not* considered 'in existence' (i.e. there is no opportunity yet to expect their influence on programme

<sup>14</sup> Policy and Planning Effort Index for 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

<sup>15</sup> Compare NCPI in *Guidelines on construction of core indicators*, UNAIDS 2002, 2005, and 2007 respectively, for selecting questions for which trends can be calculated.

implementation) so questions about whether such a document exists should be answered with 'no'. It would, however, be useful to state that such documents are in draft form in the relevant open text box.

The overall responsibility for collating and submitting the information requested in the NCPI lies with the national government, through officials from the National AIDS Committee (NAC) (or equivalent).

## PROPOSED STEPS FOR DATA GATHERING AND DATA VALIDATION

The NCPI is ideally completed in the last 6 months of the reporting period (i.e. between June and December 2009 for the 2010 reporting round). As a variety of stakeholders need to be consulted, it is important to allow adequate time for the data gathering and data consolidation process.

### 1. Designate two technical coordinators (one for part A; one for part B)

Technical coordinators should be given responsibility to undertake the desk review, to carry out interviews as needed, to bring together relevant stakeholders, and to facilitate collating and consolidating the NCPI data. Preferably, the technical coordinator for Part A is from the NAC (or equivalent) and for Part B is a person outside the government. They should ideally have a monitoring and evaluation background, knowledge of the main actors in the national HIV response, and an understanding of the national policy and legal environment.

### 2. Agree with stakeholders on the NCPI data gathering and validation process

Accurate completion of the NCPI requires the involvement of a range of stakeholders which should include representatives of civil society organizations. It is strongly recommended to organize an initial workshop with key stakeholders to agree on the NCPI data-gathering process including relevant documents for desk review, organizational representatives to be interviewed, the process to be used for determining final responses, and the timeline.

### 3. Obtain data

The submitted NCPI data should represent the most recent stock-taking of the policy, strategic and legal environment. As the process involves a range of stakeholders and data need to be consolidated before official submission to UNAIDS, it is important to allow adequate time for completion.

Each section should be completed by completing the following tasks:

#### (i). Desk review of relevant documents

If not already the case, it is useful to collate all key documents (i.e. policies, strategies, laws, guidelines, reports etc) related to the HIV response in one place which allows easy access by all stakeholders (such as a website). This will not only facilitate validation of NCPI responses but, even more importantly, increase awareness about and encourage use over time of these important documents in the implementation of the national HIV response.

#### (ii). Interviewing (or other ways of obtaining the information efficiently) key people most knowledgeable about the specific topic including, but not restricted to the following:

- *For Strategic Plan and Political Support sections:* the Director or Deputy Director of the National AIDS Programme or National AIDS Committee (or equivalent), the Heads of the AIDS Programme at provincial and at district levels (or equivalent decentralised levels).
- *For Monitoring and Evaluation section:* Officers of the National AIDS Committee (or equivalent), Ministry of Health, HIV focal points of other ministries, the national monitoring and evaluation technical working group.
- *For Human Rights questions:* Ministry of Justice officials and human rights commissioners for questions in Part A; representatives of human rights and other civil society organizations and legal aid centres/institutions working in the area of HIV for questions in Part B.
- *For Civil Society Participation section:* key representatives of major civil society organizations working in the area of HIV. These specifically include representatives from networks of people living with HIV and from most-at-risk and other vulnerable populations.

- *For Prevention and Treatment, Care and Support sections:* Ministries and major implementing agencies/organizations in those areas, including nongovernmental organizations and networks of people living with HIV.

Note that interviewees are requested to provide responses as representatives of their institutions or constituencies, not their own personal views.

#### **4. Validate, analyse and interpret data**

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 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 policy/strategy development and implementation of programmes to tackle the country's HIV 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.

It is strongly recommended to organize a final workshop with key stakeholders to present, discuss and validate the NCPI responses and the write-up of the findings before official submission. It is expected that representatives from civil society organizations working in the area of HIV are invited to participate. These specifically include representatives from networks of people living with HIV and from most-at-risk and other vulnerable populations. Ideally, the workshop would review the results from the last reporting round highlighting changes since that time and focus on validation of the NCPI data. Agreement on the final NCPI data does not require that discrepancies, if any, between overlapping questions in Part A and Part B be reconciled; it simply means that when there are different perspectives, that Part A respondents agree on their responses, Part B respondents agree on their responses, and that both are submitted. If there are no established mechanisms in place, the workshop can also provide an opportunity to discuss further collaboration between relevant stakeholders to address key gaps identified through the NCPI process.

#### **5. Enter and submit data**

Submit the final NCPI data before 31 March 2010, using the dedicated software provided on the UNGASS reporting website ([www.unaids.org/UNGASS2010](http://www.unaids.org/UNGASS2010)). If this is not possible, an electronic version of the completed questionnaire should be submitted as an appendix to the Country Progress Report before 15 March 2010 to allow time for the manual entry of data in Geneva.

## NCPI Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

Highlight concerns –if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

## NCPI Respondents

[Indicate information for **all** 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]

Organization	Names/Positions	Respondents to Part A				
		[indicate which parts each respondent was queried on]				
		A.I	A.II	A.III	A.IV	A.V

Add details for **all** respondents.

### NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B			
		[indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV

Add details for **all** respondents.

# National Composite Policy Index (NCPI) questionnaire

## Part A

[to be administered to government officials]

### I. STRATEGIC PLAN

#### 1. Has the country developed a national multisectoral strategy to respond to HIV?

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

Yes	No	Not Applicable (N/A)
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Period covered:

[write in]

**IF NO or NOT APPLICABLE**, briefly explain why.

**IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.**

1.1 How long has the country had a multisectoral strategy?

Number of Years:

[write in]

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

Sectors	Included in strategy		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*: [write in]	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 for some or all of the above sectors**, explain what funding is used to ensure implementation of their HIV-specific activities?

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

<b>Target populations</b>		
a. Women and girls	a. Yes	No
b. Young women/young men	b. Yes	No
c. Injecting drug users	c. Yes	No
d. Men who have sex with men	d. Yes	No
e. Sex workers	e. Yes	No
f. Orphans and other vulnerable children	f. Yes	No
g. Other specific vulnerable subpopulations*	g. Yes	No
<b>Settings</b>		
h. Workplace	h. Yes	No
i. Schools	i. Yes	No
j. Prisons	j. Yes	No
<b>Cross-cutting issues</b>		
k. HIV and poverty	k. Yes	No
l. Human rights protection	l. Yes	No
m. Involvement of people living with HIV	m. Yes	No
n. Addressing stigma and discrimination	n. Yes	No
o. Gender empowerment and/or gender equality	o. Yes	No

1.4 Were target populations identified through a needs assessment?

Yes	No
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**IF YES**, when was this needs assessment conducted?

Year:

[write in]

\* Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

**IF NO**, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

*[write in]*

1.6 Does the multisectoral strategy include an operational plan?

Yes	No
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1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes	No
b. Clear targets or milestones?	Yes	No
c. Detailed costs for each programmatic area?	Yes	No
d. An indication of funding sources to support programme implementation?	Yes	No
e. A monitoring and evaluation framework?	Yes	No

1.8 Has the country ensured “full involvement and participation” of civil society\* in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement
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**IF active involvement**, briefly explain how this was organised:

\* 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 men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.



**IF NO or MODERATE involvement**, briefly explain why this was the case:

- 1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No
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- 1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No
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**IF SOME or NO**, briefly explain for which areas there is no alignment / harmonization and why

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A
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- 2.1 **IF YES**, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes	No	N/A
b. Common Country Assessment / UN Development Assistance Framework	Yes	No	N/A
c. Poverty Reduction Strategy	Yes	No	N/A
d. Sector-wide approach	Yes	No	N/A
e. Other: <i>[write in]</i>	Yes	No	N/A

2.2 **IF YES**, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	Yes	No
Treatment for opportunistic infections	Yes	No
Antiretroviral treatment	Yes	No
Care and support (including social security or other schemes)	Yes	No
HIV impact alleviation	Yes	No
Reduction of <i>gender</i> inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No
Reduction of <i>income</i> inequalities as they relate to HIV prevention/treatment, care and /or support	Yes	No
Reduction of stigma and discrimination	Yes	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
Other: <i>[write in]</i>	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic 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 for addressing HIV 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 the uniformed services?

Behavioural change communication	Yes	No
Condom provision	Yes	No
HIV testing and counselling	Yes	No
Sexually transmitted infection services	Yes	No
Antiretroviral treatment	Yes	No
Care and support	Yes	No
Others: <i>[write in]</i>	Yes	No

**If HIV testing and counselling is provided to uniformed services**, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	No
-----	----

5.1 **IF YES**, for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other:	<i>[write in]</i>	Yes

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

Briefly comment on the degree to which these laws are currently implemented:

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	No
-----	----

6.1 **IF YES**, for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: <i>[write in]</i>	Yes	No

**IF YES**, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

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

Yes	No
-----	----

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	No
-----	----

7.2 Have the estimates of the size of the main target populations been updated?

Yes	No
-----	----

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

Estimates of current and future needs	Estimates of current needs only	No
---------------------------------------	---------------------------------	----

7.4 Is HIV programme coverage being monitored?

Yes	No
-----	----

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

Yes	No
-----	----

(b) **IF YES**, is coverage monitored by population groups?

Yes	No
-----	----

**IF YES**, for which population groups?

Briefly explain how this information is used:

(c) Is coverage monitored by geographical area?

Yes	No
-----	----

**IF YES**, at which geographical levels (provincial, district, other)?

Briefly explain how this information is used:



## II. POLITICAL SUPPORT

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

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums 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 coordination body (i.e., a National AIDS Council or equivalent)?

Yes	No
-----	----

**IF NO**, briefly explain why not and how AIDS programmes are being managed:

- 2.1 **IF YES**, when was it created?

Year: *[write in]*

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

Name: Position/Title: *[write in]*





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

Percentage:

[write in]

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes	No
Technical guidance	Yes	No
Procurement and distribution of drugs or other supplies	Yes	No
Coordination with other implementing partners	Yes	No
Capacity-building	Yes	No
Other: <span style="float: right;">[write in]</span>	Yes	No

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

Yes	No
-----	----

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

Yes	No
-----	----

**IF YES**, name and describe how the policies / laws were amended:



### 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

a. Be sexually abstinent	
b. Delay sexual debut	
c. Be faithful	
d. Reduce the number of sexual partners	
e. Use condoms consistently	
f. Engage in safe(r) sex	
g. Avoid commercial sex	
h. Abstain from injecting drugs	
i. Use clean needles and syringes	
j. Fight against violence against women	
k. Greater acceptance and involvement of people living with HIV	
l. Greater involvement of men in reproductive health programmes	
m. Males to get circumcised under medical supervision	
n. Know your HIV status	
o. Prevent mother-to-child transmission of HIV	
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	N/A
-----	----	-----

- 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 *most-at-risk or other vulnerable sub-populations*?

Yes	No
-----	----

*IF NO*, briefly explain:

--

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

✓ Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Other populations* [write in]
Targeted information on risk reduction and HIV education						
Stigma and discrimination reduction						
Condom promotion						
HIV testing and counselling						
Reproductive health, including sexually transmitted infections prevention and 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	

\* IDU = injecting drug user

\*\* MSM = men who have sex with men



## 4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't Agree	N/A
IEC* on risk reduction	Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School-based HIV education for young people	Agree	Don't Agree	N/A
HIV prevention for out-of-school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other: <i>[write in]</i>	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the <i>implementation</i> of HIV prevention programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
<i>Since 2007, what have been key achievements in this area:</i>											
<i>What are remaining challenges in this area:</i>											

\* IEC = information, education, communication

#### 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 address barriers for women?

Yes	No
-----	----

- 1.2 *IF YES*, does it address barriers for most-at-risk populations?

Yes	No
-----	----

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No
-----	----

*IF YES*, how were these determined?

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

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other: <i>[write in]</i>	Agree	Don't Agree	N/A

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 therapy drugs, condoms, and substitution drugs?

Yes	No
-----	----

**IF YES**, for which commodities?:

*[write in]*



Overall, how would you rate the efforts in the <i>implementation</i> of HIV treatment, care and support programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
<i>Since 2007, what have been key achievements in this area:</i>											
<i>What are remaining challenges in this area:</i>											

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

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

5.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

Yes	No
-----	----

5.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No
-----	----

5.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No
-----	----

**IF YES**, what percentage of orphans and vulnerable children is being reached? % *[write in]*

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
<i>Since 2007, what have been key achievements in this area:</i>											
<i>What are remaining challenges in this area:</i>											

## V. MONITORING AND EVALUATION

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

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

**IF NO**, briefly describe the challenges:

1.1 **IF YES**, years covered: *[write in]*

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

Yes	No
-----	----

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

Yes	No
-----	----

1.4 **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
-------------------	--------------------	-----------------------------	----

**IF YES, but only some partners or IF NO**, briefly describe what the issues are:



**IF YES**, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

**IF NO**, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

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

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

5.1 **IF YES**, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	No
in the Ministry of Health?	Yes	No
Elsewhere? <i>[write in]</i>	Yes	No



**IF YES**, briefly describe who the representatives from civil society are and what their role is:

**7. Is there a central national database with HIV- related data?**

Yes	No
-----	----

7.1 **IF YES**, briefly describe the national database and who manages it *[write in]*

7.2 **IF YES**, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above

b. Yes, but only some of the above:

*[write in]*

c. No, none of the above

7.3 Is there a functional\* Health Information System?

At national level	Yes	No
At subnational level <b>IF YES</b> , at what level(s)? <span style="float: right;"><i>[write in]</i></span>	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)

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

Yes	No
-----	----

**9. To what extent are M&E data used**

9.1 in developing / revising the national AIDS strategy?:

Low						High
	0	1	2	3	4	5

Provide a specific example:

What are the main challenges, if any?

9.2 for resource allocation?:

Low					High
0	1	2	3	4	5

Provide a specific example:

What are the main challenges, if any?

9.3 for programme improvement?:

Low					High
0	1	2	3	4	5

Provide a specific example:

What are the main challenges, if any?

**10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:**

a. Yes, at all levels

b. Yes, but only addressing some levels:

[write in]

c. No

**10.1 In the last year, was training in M&E conducted**

At national level?	Yes	No
<b>IF YES</b> , Number trained:		[write in]
At subnational level?	Yes	No
<b>IF YES</b> , Number trained:		[write in]
At service delivery level including civil society?	Yes	No
<b>IF YES</b> , Number trained:		[write in]

**10.2 Were other M&E capacity-building activities conducted other than training?**

Yes	No
-----	----

**IF YES**, describe what types of activities:

[write in]

Overall, how would you rate the <i>M&amp;E efforts</i> of the HIV programme in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
<i>Since 2007, what have been key achievements in this area:</i>											
<i>What are remaining challenges in this area:</i>											



## Part B

[to be administered to representatives from civil society 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? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes	No
-----	----

- 1.1 **IF YES**, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision: *[write in]*

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes	No
-----	----

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

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: <span style="float: right;"><i>[write in]</i></span>	Yes	No

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

Briefly describe the content of these laws:

Briefly comment on the degree to which they are currently implemented:

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

Yes	No
-----	----

3.1 **IF YES**, for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: <i>[write in]</i>	Yes	No

**IF YES**, briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

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

Yes	No
-----	----

**IF YES**, briefly describe how human rights are mentioned in this HIV policy or strategy:

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

Yes	No
-----	----

**IF YES**, briefly describe this mechanism:

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations 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:

a. HIV prevention services	Yes	No
b. Antiretroviral treatment	Yes	No
c. HIV-related care and support interventions	Yes	No

**IF YES**, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	No
-----	----

- 8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support 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 and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes	No
-----	----

*IF YES*, briefly describe the content of this policy:

- 9.1 *IF YES*, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes	No
-----	----

*IF YES*, briefly explain the different types of approaches to ensure equal access for different populations:

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 HIV 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 including people living with HIV?

Yes	No
-----	----

**IF YES**, describe the approach and 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 compliance with human rights standards in the context of HIV efforts

Yes	No
-----	----

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

## 13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV 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 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
-----	----



## II. CIVIL SOCIETY\* PARTICIPATION

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

Low						High
0	1	2	3	4	5	

**Comments and examples:**

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

Low						High
0	1	2	3	4	5	

**Comments and examples:**

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

- a. the national AIDS strategy?

Low						High
0	1	2	3	4	5	

- b. the national AIDS budget?

Low						High
0	1	2	3	4	5	

- c. national AIDS reports?

Low						High
0	1	2	3	4	5	

\* 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 men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.



**Comments and examples:**

**4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?**

- a. developing the national M&E plan?

Low						High
0	1	2	3	4	5	

- b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low						High
0	1	2	3	4	5	

- c. M&E efforts at local level?

Low						High
0	1	2	3	4	5	

**Comments and examples:**

**5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?**

Low						High
0	1	2	3	4	5	

**Comments and examples:**

## 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

### Comments and examples:

## 7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	51-75%	>75%
Prevention for most-at-risk-populations				
- Injecting drug users	<25%	25-50%	51-75%	>75%
- Men who have sex with men	<25%	25-50%	51-75%	>75%
- Sex workers	<25%	25-50%	51-75%	>75%
Testing and Counselling	<25%	25-50%	51-75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51-75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51-75%	>75%
Home-based care	<25%	25-50%	51-75%	>75%
Programmes for OVC**	<25%	25-50%	51-75%	>75%

\*ART = Antiretroviral Therapy; OI= Opportunistic infections

\*\*OVC = Orphans and other vulnerable children

Overall, how would you rate the efforts to increase <i>civil society participation</i> in 2009?											
2009	Very poor									Excellent	
	0	1	2	3	4	5	6	7	8	9	10
Since 2007, what have been key achievements in this area:											
What are remaining challenges in this area:											

### III. PREVENTION

#### 1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No
-----	----

**IF YES**, how were these specific needs determined?

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

##### 1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't Agree	N/A
IEC* on risk reduction	Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School-based HIV education for young people	Agree	Don't Agree	N/A
HIV Prevention for out-of-school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other: <i>[write in]</i>	Agree	Don't Agree	N/A

\* IEC = information, education, communication



## IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No
-----	----

*IF YES*, how were these specific needs determined?

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

- 1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A

Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other programmes: <i>[write in]</i>	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the <i>implementation</i> of HIV treatment, care and support programmes in 2009?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
<i>Since 2007, what have been key achievements in this area:</i>											
<i>What are remaining challenges in this area:</i>											

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

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

2.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

Yes	No
-----	----

2.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No
-----	----

2.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No
-----	----

**IF YES**, what percentage of orphans and vulnerable children is being reached? % *[write in]*



## Appendix 5. 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 CRIS3 (preferred) or equivalent data management systems (only if CRIS3 is not available)
- Consistency check performed for data included in the narrative report and data entered into CRIS3/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@unaid.org](mailto:ungassindicators@unaid.org)) by **31 March 2010**, or by 15 March 2010 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 6. Selected bibliography

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten United Nations agencies in a common effort to respond to the AIDS 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 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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