

GLOBAL **AIDS** RESPONSE PROGRESS REPORTING 2012

GUIDELINES

Construction of Core Indicators for monitoring
the 2011 Political Declaration on HIV/AIDS



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GUIDELINES

Construction of Core Indicators for monitoring
the 2011 Political Declaration on HIV/AIDS

Please use the Global AIDS response progress reporting website (www.unaids.org/AIDSReporting) to submit your completed country Progress Report by 31 March 2012.

If you will not be using the reporting website for submission of indicator data, please submit your report before 15 March 2012 to allow time for the manual entry of data in Geneva.

Printed copies of the Country Progress Report may be posted to:

Team Leader, RMA
UNAIDS
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

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Foreword

The 2011 High Level Meeting on AIDS was a watershed in the global AIDS response. As United Nations Secretary-General Ban Ki-moon stated in his report to the UN General Assembly, “Bold decisions must be taken to dramatically reshape the AIDS response to reach zero new HIV infections, zero discrimination and zero AIDS-related deaths”. UN Member States unanimously endorsed the 2011 Political Declaration on HIV/AIDS and its new targets—by 2015 to reduce sexual transmission of HIV and HIV infection among people who inject drugs by half, to increase the number of people on treatment to 15 million, to halve TB-related deaths in people living with HIV, and to eliminate new HIV infections among children.¹

Building on the success of a decade of reporting against the targets agreed at the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS), the new Political Declaration has mandated UNAIDS to support countries to report on the new commitments and targets. The Declaration also provides for the Secretary-General to continue to provide regular reports to the General Assembly on progress achieved in realizing the commitments made in the new Declaration.

UNAIDS is requesting UN Member States to continue to report on national progress in the AIDS response. In 2010, 182 of the total of 192 UN Member States reported on their progress. The Country Reports received by UNAIDS on behalf of the Secretary-General were used to prepare regular global progress reports as mandated by the Political Declaration.

To assist Member States in preparing and submitting the next Country Progress Reports, UNAIDS has prepared these guidelines for the monitoring of the progress towards the targets set in the 2011 Political Declaration on HIV/AIDS. Through the growing wealth of information, data and analysis provided by national monitoring and evaluation systems, countries will continue to monitor and report on progress towards the 2015 targets.

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

I commend your efforts to achieve the bold targets set in June, 2011 and to make zero new HIV infections, zero discrimination and zero AIDS-related deaths a global reality. With your continued engagement and support, we can make this the beginning of the end of AIDS.



Mr. Michel Sidibé
Executive Director
UNAIDS

¹ Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic(s)
BSS	Behavioural Surveillance Survey
DHS	Demographic and Health Survey
EID	Early Infant Diagnosis
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user/people who inject drugs (latter preferred language)
ILO	International Labour Organization
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MSM	Men who have sex with men
NA	Not Applicable
NAC	National AIDS Committee(s)
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NGO	Nongovernmental Organization(s)
NSP	National Strategic Plan
NSP	Needle and Syringe Programmes
OECD	Organisation for Economic Co-operation and Development
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper
STI	Sexually Transmitted Infection(s)
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
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 purpose of this document is to provide guidance to national AIDS programmes and partners actively involved in the country response to AIDS on use of core indicators to measure and report on the national response. These guidelines should strengthen the consistency and transparency of the process used by national governments. This information can also be used to prepare national, regional and global progress reports on the implementation of the 2011 Political Declaration on HIV/AIDS.

Countries are strongly encouraged to integrate these 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 progress in achieving their national HIV targets. They will contribute to a better understanding of the global response to the AIDS pandemic, including progress towards meeting the global targets set in the 2011 Political Declaration on HIV/AIDS, and the Millennium Development Goals. These guidelines are designed to improve the quality and consistency of data collected at the country level, thus enhancing the accuracy of conclusions drawn from it, at national, as well as regional and global levels.

How to use these guidelines

These guidelines have been developed to help countries collect data and report on their national HIV response as effectively as possible. In the second section 'Core indicators for Global AIDS response progress reporting' readers will find pages devoted to each indicator, giving reasons for including it and methods for collecting, constructing, and measuring it. The indicator's strengths and weaknesses are also discussed. A Country Progress Report template and checklists are provided in the appendix.

Help is available at every stage of the process. Sources of help-including who to contact and how to reach them- are highlighted in this introductory section and pointed out with a blue 

Background

Ten years after the landmark UN General Assembly Special Session on HIV/AIDS (UNGASS), progress was reviewed at the 2011 UN General Assembly High Level Meeting on AIDS. A new Political Declaration on HIV/AIDS² with new commitments and bold new targets was adopted.

The 2011 declaration builds on two previous political declarations: the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. At UNGASS, in 2001, Member States unanimously adopted the Declaration of Commitment on HIV/AIDS. This declaration reflected global consensus on a comprehensive framework to achieve Millennium Development Goal Six-: halting and beginning to reverse the HIV epidemic by 2015. It recognized the need for multisectoral action on a range of fronts and addressed global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. The 2006 Political Declaration recognized the urgent need to achieve universal access to HIV treatment, prevention, care and support.

While these three declarations have been adopted only by governments, their 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 representing people living with HIV.

2 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

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Under the terms of the 2011 Political Declaration, a successful AIDS response should be measured by the achievement of concrete, time-bound targets. It calls for careful monitoring of progress in implementing commitments and requires the United Nations Secretary-General to issue annual progress reports. These reports are designed to identify challenges and constraints and recommend action to accelerate achievement of the targets.

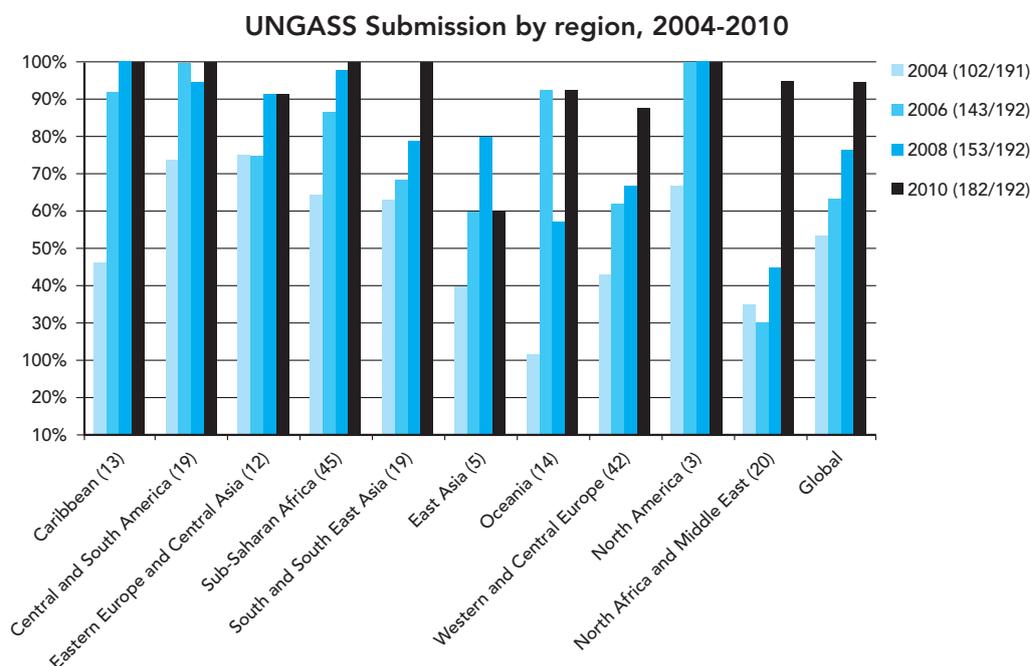
The guidelines in this document have been developed to enhance production of the individual country progress reports. These are used to monitor progress against the commitments and targets of the 2011 Political Declaration and form the basis of the Secretary-General's reports to the General Assembly.

Key targets in the 2011 Political Declaration

- The new Political Declaration on HIV, unanimously adopted by UN Member States in June 2011, sets forth bold new targets.
- Member States have committed to:
 1. Halve sexual transmission of HIV by 2015;
 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015;
 3. Ensure that no children are born with HIV by 2015;
 4. Increase access to antiretroviral therapy to get 15 million people on life saving treatment by 2015; and
 5. Reduce tuberculosis (TB) deaths in people living with HIV by 50% by 2015.
 6. Close the global resource gap for AIDS and work towards increasing funding to between US\$ 22 and US\$ 24 billion per year by 2015 and recognized that investments in the AIDS response is a shared responsibility.
- The Political Declaration clearly outlines the urgent need to increase access to HIV services for people most at risk of infection including men who have sex with men, people who inject drugs and sex workers
- The Political Declaration pledges to eliminate gender inequality, gender-based abuse and violence and to empower women and girls. This must be fulfilled without delay.

Reporting History

UNAIDS has collected Country Progress Reports from Member States for the purpose of monitoring the Political Declarations every two years since 2004. Response rates have increased from 102 (53%) Member States in 2004 to a record 182 (95%) in 2010 (see graph for regional response rates and trends over time).



The information provided by country progress reports represents the most comprehensive data on both the status of, and response to the epidemic. The data from the four previous reporting rounds are available online through AIDSinfo; aidsinfo.unaids.org, a data visualization and dissemination tool. that can be used for rapid production of charts, maps and tables, for presentations and analysis. Unedited country reports are available on <http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/>.

Reporting Format

When preparing Global AIDS response progress reports, countries should base their narrative reports on their national country reports. Where a recent national country report is available, this can be submitted as the narrative country progress report. A Country Progress Report template, with detailed instructions for completion of the different sections can be found in Appendix 1. The indicator data are considered an integral part of each Country Progress Report submission. Hence, both the narrative part of the Country Progress Report and the indicator data should be considered in the consultation and report preparation process as outlined in the section titled “Reporting” on page 20 of these guidelines

It is strongly recommended that countries submit the Global AIDS response progress reporting indicator data through the reporting website (www.unaids.org/AIDSreportingtool) 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 reporting website is 31 March 2012. If the website is not used for reporting, copies of reports (excel files etc.) must be submitted by 15 March 2012 to allow for the manual entry of data.

Global AIDS response progress reporting indicators are important for two reasons. First, they can help individual countries evaluate the effectiveness of their national response. This 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. At the same time this provides countries with insights into other national-level responses.

Prior to the 2011 General Assembly meeting on HIV/AIDS, indicators used in previous reporting rounds were rigorously reviewed, using an extensive evidence-based consultation process led by the UNAIDS Monitoring and Reference Group (MERG). The review was based on a series of consultations focusing on four themes: prevention; care and support; the enabling environment; and the health sector. Each thematic consultation was jointly led by a civil society partner and a UN organization. Participants included monitoring and evaluation experts from governments, civil society, academia, bilateral partners and multilateral organizations. Inclusion of indicators was based on explicit objective criteria as described in the Indicator Standards: Operational Guidelines for Selecting Indicators for the HIV Response³. In order to minimize the reporting burden and to preserve trend data, changes were only made to the existing indicator set when strictly necessary⁴.

Countries should consider the applicability of each indicator to their epidemic. When countries choose not to report on a particular indicator, they should provide their reasons for choosing not to report as

3 UNAIDS MERG Indicator Standards Operational Guidelines for Selecting Indicators for the HIV Response, Geneva 2010, can also be found at www.unaids.org/en/media/unaids/contentassets/documents/document/2010/4_3_MERG_Indicator_Standards.pdf

4 **Three new indicators were added:**

- Number of syringes distributed per person who injects drugs per year by needle and syringe programmes
- Percentage of infants born to HIV-infected women receiving a virological test for HIV within 2 months of birth
- Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months),

Five were modified:

- Proportion of the poorest households who received economic support in the last 3 months (completely modified)
- Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission (modified)
- Mother-to-child transmission rate (Modelled) (modified)
- NCPI: National Commitments and Policy Instrument (modified)
- Current school attendance among orphans and non-orphans aged 10-14 (modified)

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this enables differentiation between an absence of data, and the inapplicability of specific indicators to particular country situations.

Most of the national indicators are applicable to all countries. However, a few are applicable to specific HIV epidemic contexts only. For example, the behaviour indicators for key populations at higher risk are relevant in countries with concentrated epidemics as well as countries with generalized epidemics if they have a concentrated sub-epidemic affecting a specific key population at higher risk. Similarly, countries with a concentrated epidemic are encouraged to collect data on sexual behaviours among young people as a means of tracking trend changes that could influence the national response in the future.

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

Five of the national indicators are also Millennium Development Goal indicators:

- the percentage of young people who are living with HIV
- knowledge among young people about HIV
- condom use at last high-risk-sex
- school attendance among orphans
- ART treatment coverage

Data used by the UN Division of Statistics for reporting on the Millennium Development Goals are mainly sourced from data provided by Member States through Global AIDS response progress reporting.

Male circumcision is an important element of a comprehensive HIV prevention package in some countries with high HIV prevalence, low levels of male circumcision and generalized heterosexual epidemics. In this reporting round, these countries are encouraged to report on their male circumcision programmes in their narrative reports. Indicator data will be collected directly through a special study. In future reporting rounds, indicators on male circumcision will be included in the Global AIDS response progress reporting indicator set for these selected countries.

 Full definitions for all indicators used for the Global AIDS response progress reporting can be found in these guidelines. The indicators can also be found in the UNAIDS Indicator Registry at www.indicatorregistry.org This online database provides complete definitions of the Global AIDS response progress reporting indicators as well as other HIV indicators used at country level. From the Indicator Registry the indicators can also be exported to Excel, Word, or PDF.

National indicators for high-income countries

In adopting the 2011 Political Declaration on HIV/AIDS, high-income countries have committed themselves to reporting on progress made in their national responses to HIV. It is recognized that high-income countries may use 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 remove the need for high-income country data for monitoring global progress towards the Political Declaration on HIV/AIDS. European Union countries have used innovative ways to link global HIV monitoring systems more closely to regional circumstances.

 UNAIDS encourages other high-income countries to contact either the UNAIDS Response Monitoring and Analyses Team (AIDSreporting@unaids.org) if they require further technical advice regarding reporting on their domestic programmes, or the European Centre for Disease Prevention and Control (teymur.noori@ecdc.europa.eu) to learn more about the European approach of linking and harmonising global and regional monitoring systems.

Monitoring the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia

In 2004, during the Irish Presidency of the Council of the European Union member states and neighboring countries in Eastern Europe and Central Asia adopted the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. The European Centre for Disease Prevention and Control (ECDC) is coordinating reporting on this Declaration. UNAIDS and the ECDC are working closely to coordinate and harmonize global and regional monitoring systems. This should both improve the relevance of reporting for countries in the region and reduce their reporting burden. Data collection will take place at the same time as for the current Global AIDS response progress reporting (March 2012). In collaboration with UNAIDS, the ECDC will provide technical assistance to European countries preparing reports for both Global AIDS response progress reporting 2012 and the Dublin Declaration 2012. For further information on the monitoring of the Dublin Declaration please contact Mr. Teymur Noori at the ECDC (teymur.noori@ecdc.europa.eu).

Towards Universal Access and the Millennium development Goals

AIDS is a critical development issue that affects the lives of millions of people. For this reason, combating HIV/AIDS is one of the Millennium Development Goals. The 2001 UNGASS Declaration of Commitment as well as the 2006 Political Declaration on Universal Access and the 2011 Political Declaration on HIV/AIDS reflect political support at the highest level for combined efforts to reverse the AIDS pandemic.

The monitoring and reporting of efforts to achieve universal access to HIV prevention, treatment, care and support fulfil Member States' obligations under the 2011 Political Declaration on HIV/AIDS. 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.

Implementation at national level

- ➔ Countries needing additional information on implementation should seek technical assistance from their UNAIDS Monitoring and Evaluation Advisers and HIV monitoring and evaluation working groups. Technical support is also available from the UNAIDS Regional M&E Advisers based at the Regional Support Team and from the Response Monitoring and Analysis Team at the UNAIDS Secretariat who can be reached via email at AIDSreporting@unaids.org.

Indicator construction

For each national indicator this manual provides the information needed to construct the indicator including:

- the purpose of the indicator;
- the frequency with which relevant data should be gathered;
- recommended measurement tools
- recommended methods of measurement
- summary interpretation of the indicator.

Measurement tools and data sources

The primary measurement tools are:

- (i) nationally representative, population-based sample surveys⁵
- (ii) behavioural surveillance surveys;
- (iii) specially-designed surveys and questionnaires, including surveys of specific population groups (e.g. specific service coverage surveys);
- (iv) patient tracking systems; (v) health information systems;
- (v) Sentinel Surveillance;
- (vi) the National Commitments and Policy Instrument (NCPI) 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 be used to 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. Examples include work with young people, key populations at higher risk and pregnant women.

In many countries, the bulk of the data required for the core national-level indicators may not be available from existing sources. Gathering such data 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, HIV data requirements can be added to the on-going data collection process.

⁵ such as the Demographic and Health Surveys (DHS), AIDS Indicator Surveys (AIS), and Multiple Indicator Cluster Surveys (MICS)

Numerators and denominators

For each core indicator, detailed instructions for measuring the national response are provided. Most core national-level indicators use numerators and denominators to calculate the percentages that measure the current state of the national response.

Countries are strongly encouraged to pay close attention to the dates attached to specific data when calculating an indicator. If data used for the numerator and denominator are collected at different times, the accuracy and validity of that information will be compromised.

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.

Disaggregated Data: sex and age

One of the key lessons learnt from previous rounds of reporting was the importance of obtaining disaggregated data, for example, breaking it down by sex and age. In 2010 almost 80% of countries submitted data files with at least some level of disaggregation. 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 both national and global levels. It is equally difficult to monitor access to activities, the equity of that access, the appropriateness of focusing on specific populations and meaningful change over time.

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. If possible, equity analyses should also be done. 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 efforts 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 be advised of the importance of disaggregated data, and make the collection and dissemination of the data a priority in their ongoing operations.

➡ The Global AIDS response progress reporting website (www.unaids.org/AIDSreporting) 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 should be disaggregated by sex and age. Where collecting disaggregated data has proved difficult, entry of partial data is possible, if necessary. This will allow time for capacity building on the importance of data quality, in particular the importance of recording sex and age information at the point of data collection.

In situations where disaggregated data are not readily available, 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, for help with accessing 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.

Recent and representative survey data

Use the most recently available nationally representative survey to calculate indicators that are based on general population surveys. This may mean that the data reported in this round will be the same as the

IMPLEMENTATION AT NATIONAL LEVEL

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 that survey samples of key populations are truly representative 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 confident that samples used for surveys of key populations at higher risk of HIV exposure are representative. Countries are advised to use the most recent survey of key populations that has been reviewed and endorsed by local technical experts, such as monitoring and evaluation technical working groups or national research councils.

Interpretation and analysis

As each core indicator is discussed later in this manual, so too are strengths and weaknesses. Countries should carefully review this section before they begin collecting and analysing data as it explains how to interpret each indicator and any potential issues related to it. The points raised in this section should be reviewed before finalization of the Country Progress Report to confirm the appropriateness of the findings for each indicator.

The strengths and weaknesses are designed to improve the accuracy and consistency of the data in Country Progress Reports submitted to UNAIDS. 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.

After compiling their progress reports countries are strongly encouraged to continue analysing their findings. This will enable them to better understand their national response and identify opportunities to improve that response. Countries should be looking closely at the linkages between policy, implementation of HIV programmes, verifiable behaviour change and changes in the epidemic. 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 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 such 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 to determine which ones are applicable in their situation. For example, a country with a concentrated epidemic among sex workers and men who have sex with men would not need to report on the core indicators related to people who inject drugs. However, they should regularly assess the situation to see whether injecting drug use is emerging as an issue that needs attention. They should calculate both the specific indicators for sex workers and men who have sex with men 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 key populations at higher risk to determine if any of these are applicable. For example, a country with a higher-prevalence epidemic may also have a concentrated sub-epidemic among people who inject drugs. It would therefore be valuable to also calculate and report on the indicators that relate to the key populations at higher risk.

When countries do not submit data for an indicator they are asked to state whether:

(i) data are not available to answer that indicator;

or

(ii) the indicator is not considered applicable to the epidemic situation in the country.

If it is felt that the area is relevant to the epidemic and response, but that the indicator itself is not relevant or appropriate for monitoring this issue, this should be stated in the online reporting tool comment boxes. If a country is using an alternative indicator to effectively monitor the issue in question the comment boxes may be used to describe it (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 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 also provide a valuable perspective on the issues included in the National Commitments and Policies Instrument (NCPI) and are well positioned to participate in the review and vetting process.

National AIDS Committees or their equivalents should seek input from the full spectrum of civil society, including nongovernmental organizations, networks of people living with HIV, faith-based organizations, women, young people, trade unions and community-based organizations, for their reports on the core national-level indicators underlying the 2011 Political Declaration 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.

National AIDS Committees or their equivalents should provide civil society organizations with easy access to their plans for data collection and denominator data. A straightforward mechanism for submitting and evaluating information for the Country Progress Report should be developed. Country Progress Reports should include data from civil society service providers and state the contribution of civil society to the national response to HIV, both 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 every country civil society representatives should be given 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 has ready access to it.

Country-level UNAIDS staff are available to assist with civil society input throughout the process.

In particular, UNAIDS country-level staff should:

- 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;
- ensure the dissemination of reports, including, whenever possible, reports in national languages.

Shadow reports by civil society will be accepted by UNAIDS for the 2012 round of reporting, as they were in previous rounds. 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.

IMPLEMENTATION AT NATIONAL LEVEL

Report contents

In 2012, countries are expected to provide a comprehensive report on all of the national indicators that are applicable to their response.

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 can 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.

National governments are responsible for reporting on national-level indicators with support from civil society and, where applicable, development partners. The procedures outlined in this manual should be used for collecting and calculating the necessary information for each indicator. The suggested report format (Appendix 1) can be used as a template for the narrative report submitted to UNAIDS.

Countries are also requested, when possible, to submit copies of primary reports from which data is drawn for the different indicators. These reports can be submitted through the online global reporting tool. This will facilitate the analyses of the data including trend analyses and comparisons between countries.

As discussed previously, and as required by the Political Declaration 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 many 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 Global AIDS Reporting website (www.unaids.org/AIDSreporting) will ensure that narrative reports are automatically posted on the website within one week after 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 at AIDSinfo⁶.

- ➔ If there are any questions, countries are advised to consult with UNAIDS locally or in Geneva at AIDSreporting@unaids.org. Updated information on Global AIDS response progress reporting will be made available on the UNAIDS internet site at: <http://www.unaids.org/AIDSreporting>

Guidance on submission

- ➔ Countries needing additional information on the reporting tool and the submission mechanisms should seek technical assistance from their UNAIDS Monitoring and Evaluation Advisers and HIV monitoring and evaluation working groups in country. The Response, Monitoring and Analysis Team at the UNAIDS Secretariat is also available to provide support and can be reached via email at AIDSreporting@unaids.org.

⁶ www.unaids.org/en/dataanalysis/tools/aidsinfo

Reporting tool

- ➡ Countries will submit their reports using an online global reporting tool found at <http://AIDSreportingtool.unaids.org>. Each country has an assigned national focal point that will be responsible for accessing this tool and entering their country information for submission.

Users can access the tool as an editor or viewer. Editors are able to add and make changes to the information to be submitted. Viewers are able to see the information that will be submitted, yet make no changes to it. The country's focal point is responsible for sharing the appropriate credentials to access the tool.

As mentioned previously, where countries do not submit data on an indicator, they should indicate whether this was due to an absence of appropriate data or because the indicator was not considered relevant to the epidemic. There are comment boxes where short explanatory notes stating how the numerator and denominator were calculated and assessing the accuracy of the composite and disaggregated data can be added.

To minimize reporting burden and facilitate the reporting process the Global AIDS response progress reporting and the WHO Universal Access health sector reporting will be coordinated and done through the same electronic reporting tool.

The country finalizes its submission by clicking the "submit" button. This closes the country's session in the online global reporting tool. The country will no longer be able to make editing changes or additions to its submission using this tool.

Problems with the online global reporting tool can be reported to AIDSreporting@unaids.org

Report submission

Progress reports should be submitted to UNAIDS online by 31 March 2012. This submission includes a narrative report (as a Microsoft Word file or a PDF file) and 30 Global AIDS indicators. The narrative report will be published on the UNAIDS website within one week of submission.

Wherever possible, data should be entered online, using the global reporting website (www.unaids.org/AIDSreporting). This will greatly facilitate data processing and minimize any errors associated with secondary data entry in Geneva.

Please note that countries not submitting their data online are asked to submit their reports by 15 March 2012 to allow time for the manual entry of data into the Global Response Database at UNAIDS Geneva.

To facilitate follow-up, 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:

Team Leader, Response Monitoring and Analyses Team
UNAIDS, 20 Avenue Appia CH-1211 Geneva 27, Switzerland

IMPLEMENTATION AT NATIONAL LEVEL

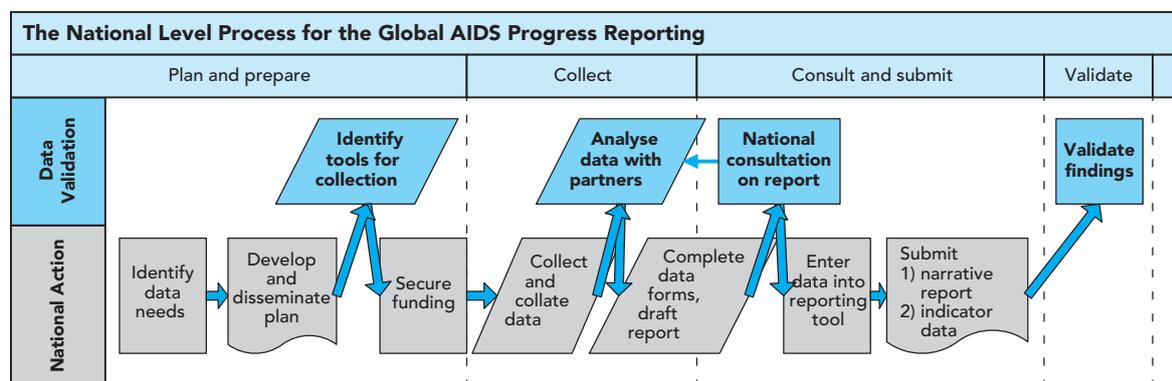
The national-level reporting process: Necessary actions

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:

1. identify data needs in line with the national strategic plan requirements and these Global AIDS Progress Indicator guidelines;
2. 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;
3. identify relevant tools for data collection;
4. secure required funding for the entire process of collecting, analysing and reporting the data;
5. collect and collate data in coordination with partner organizations from government, civil society and the international community;
6. analyse data in coordination with partner organizations from government, civil society and the international community;
7. complete the appropriate data forms and draft the accompanying Country Progress Report narrative;
8. allow stakeholders, including government agencies and civil society, to comment on the draft report;
9. validate data against the narrative and enter it into the Global AIDS response progress reporting website (www.unaids.org/AIDSreportingtool); and
10. submit (i) the narrative report and (ii) the indicator data to UNAIDS Geneva before **31 March 2012**, or by 15 March 2012 for countries not submitting data via online reporting.

It is important that the data that are reported are validated and reconciled between all partners in country. This process is supported in the online reporting tool through the ability to share the viewer credentials with national stakeholders. Several countries have reported that this feature enabled numerous civil society and other partners to view and provide inputs during the reporting process, hence allowing faster and wider stakeholder consultation and validation.

A summary checklist which may be used in the preparation and submission of the Country Progress Report is included as Appendix 4. The flow chart below illustrates the process.



Core indicators for Global AIDS response progress reporting

Individual indicators may be used to track more than one target.

Targets	Indicators	
<p>Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015</p> <p><i>General population</i></p>	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*
	1.2	Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months
	1.4	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*
	1.5	Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results
	1.6	Percentage of young people aged 15–24 who are living with HIV*
<p><i>Sex workers</i></p>	1.7	Percentage of sex workers reached with HIV prevention programmes
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results
	1.10	Percentage of sex workers who are living with HIV
<p><i>Men who have sex with men</i></p>	1.11	Percentage of men who have sex with men reached with HIV prevention programmes
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results
	1.14	Percentage of men who have sex with men who are living with HIV
<p>Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015</p>	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results
	2.5	Percentage of people who inject drugs who are living with HIV
<p>Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths⁷</p>	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth
	3.3	Mother-to-child transmission of HIV (modelled)

IMPLEMENTATION AT NATIONAL LEVEL

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy*
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV
Target 6. Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources
Target 7. Critical Enablers and Synergies with Development Sectors	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months
	7.3	Current school attendance among orphans and non-orphans aged 10-14*
	7.4	Proportion of the poorest households who received external economic support in the last 3 months

* Millennium Development Goals indicator

7 The *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive* defines this target as:

1. Reduce the number of new HIV infections among children by 90%
2. Reduce the number of AIDS-related maternal deaths by 50%

For further information see: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf

TARGET 1. HALVE SEXUAL TRANSMISSION OF HIV BY 2015

General Population

- 1.1 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*
- 1.2 Percentage of young women and men who have had sexual intercourse before the age of 15
- 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months
- 1.4 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*
- 1.5 Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results
- 1.6 Percentage of young people aged 15–24 who are living with HIV*

Sex Workers

- 1.7 Percentage of sex workers reached with HIV prevention programmes
- 1.8 Percentage of sex workers reporting the use of a condom with their most recent client
- 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results
- 1.10 Percentage of sex workers who are living with HIV

Men who have Sex with Men

- 1.11 Percentage of men who have sex with men reached with HIV prevention programmes
- 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
- 1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results
- 1.14 Percentage of men who have sex with men who are living with HIV

*Millennium Development Goals indicator

1.1 Young people: Knowledge about HIV prevention

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

What it Measures

It measures progress towards universal knowledge of the essential facts about HIV transmission

Rationale

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

Numerator:	Number of respondents aged 15-24 years who gave the correct answer to all five questions
Denominator:	Number of all respondents aged 15–24
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) This indicator is constructed from responses to the following set of prompted questions: <ol style="list-style-type: none">1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?3. Can a healthy-looking person have HIV?4. Can a person get HIV from mosquito bites?5. Can a person get HIV by sharing food with someone who is infected?
Measurement Frequency:	Preferred: every two years; minimum: every 3–5 years
Disaggregation:	<ul style="list-style-type: none">• Sex• Age (15-19 and 20-24)

Explanation of Numerator

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?”

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.

Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.

Strengths and Weaknesses

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 DHS/AIS methodology and survey instruments, visit www.measuredhs.com

1.2 Sex before the age of 15

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

What it Measures

It measures progress in increasing the age at which young women and men aged 15–24 first have sex

Rationale

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

Numerator:	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
Denominator:	Number of all respondents aged 15–24 years
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
	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?
Measurement Frequency:	Every 3–5 years
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age (15–19 and 20–24)

Strengths and Weaknesses

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 DHS/AIS methodology and survey instruments, visit www.measuredhs.com

1.3 Multiple sexual partnerships

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

What it Measures

It measures progress in reducing the percentage of people who have multiple sexual partnerships

Rationale

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

Numerator:	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	Number of all respondents aged 15–49
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents' sexual histories are obtained. Analysis of sexual history is used to determine whether the respondent has had more than one partner in the preceding 12 month period
Measurement Frequency:	Every 3–5 years
Disaggregation:	<ul style="list-style-type: none">• Sex• Age (15-19, 20-24 and 25-49)

Strengths and Weaknesses

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 DHS/AIS methodology and survey instruments, visit www.measuredhs.com

1.4 Condom use at last sex among people with multiple sexual partnerships

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

What it Measures

It measures progress towards preventing exposure to HIV through unprotected among people with multiple sexual partners

Rationale

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

Numerator:	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
Denominator:	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months.
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents' sexual histories are obtained. Analysis of sexual history is used to determine whether the respondent has had more than one partner in the preceding 12 month period, and if so whether a condom was used the last time the respondent had sexual intercourse
Measurement Frequency:	3-5 years
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age 15-19, 20-24 and 25-49 years

Strengths and Weaknesses

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 DHS/AIS methodology and survey instruments, visit www.measuredhs.com

1.5 HIV testing in the general population

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

What it Measures

It measures progress in implementing HIV testing and counselling

Rationale

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

Numerator:	Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of all respondents aged 15-49 The denominator includes respondents who have never heard of HIV or AIDS
Calculation:	Numerator / Denominator
Method of Measurement:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) Respondents are asked: <ol style="list-style-type: none">1. I don't want to know the results, but have you been tested for HIV in the last 12 months? If yes: <ol style="list-style-type: none">2. I don't want to know the results, but did you get the results of that test?
Measurement Frequency:	Every 3 to 5 years
Disaggregation:	<ul style="list-style-type: none">• Sex• Age (15-19, 20-24 and 25-49)

Strengths and Weaknesses

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.

Knowledge of HIV test results in the past 12 months does not guarantee that a respondent knows their current HIV status. A respondent may have contracted HIV in the time since their last HIV test.

Further Information

For further information on DHS/AIS methodology and survey instruments, visit www.measuredhs.com

1.6 HIV prevalence in young people

Percentage of young people aged 15–24 who are living with HIV

What it Measures

It measures progress towards reducing HIV infection

Rationale

The goal in the response to HIV is to reduce HIV infection

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 trends in HIV prevalence figures for 15–24 years olds (or even earlier in 15-19-year-olds if this age breakdown is available). Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence

Epidemic Type:	Countries with generalized epidemics
Numerator:	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive
Denominator:	Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status
Calculation:	Numerator / Denominator
Method of Measurement:	UNAIDS/WHO guidelines for HIV sentinel surveillance
	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
	The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement Frequency:	Annual
Disaggregation:	None

Strengths and Weaknesses

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 key 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. 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 use consistent sites 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://data.unaids.org/publications/irc-pub06/jc954-anc-serosurveys_guidelines_en.pdf

1.7 Sex workers: prevention programmes

Percentage of sex workers reached with HIV prevention programmes

What it Measures

It measures progress in implementing basic elements of HIV prevention programmes for sex workers⁸

Rationale

Sex workers are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV and AIDS among sex workers as well as into the general population, it is important that they access these services

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations at higher risk. If so, they should calculate and report this indicator for those populations

Numerator:	Number sex workers who replied “yes” to both questions
Denominator:	Total number of sex workers surveyed
Calculation:	Numerator / Denominator
Method of Measurement:	Behavioural surveillance or other special surveys
	Sex workers are asked the following questions: <ol style="list-style-type: none"> 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)
	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 sex workers should be collected through civil society organizations that have worked closely with this population in the field
	Access to sex workers as well as the data collected from them must remain confidential
Measurement Frequency:	Every two years
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age (<25/25+)

Strengths and Weaknesses

Accessing and/or surveying sex worker populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, sex worker population being surveyed. If there are concerns that the data 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.

8. This indicator only covers two basic elements of prevention programmes for sex workers. It is recognised 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 or sex workers. 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.

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 the 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, and others. For further information on the elements of comprehensive HIV prevention programmes for sex workers 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.

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.

In addition to the above requested data, please report programme data if available for this indicator using the text box provided in the online reporting platform.

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.

1.8 Sex workers: condom use

Percentage of sex workers reporting the use of a condom with their most recent client

What it Measures

It measures progress in preventing exposure to HIV among sex workers through unprotected sex with clients

Rationale

Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, through consistent and correct condom use

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

Numerator: Number of Sex workers who reported that a condom was used with their last client

Denominator: Number of Sex workers who reported having commercial sex in the last 12 months

Calculation: Numerator / Denominator

Method of Measurement: Behavioural surveillance or other special surveys

Respondents are asked the following question:
Did you use a condom with your most recent client?

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 Sex workers as well as the data collected from them must remain confidential

Measurement Frequency: Every two years

- Disaggregation:**
- Sex
 - Age (<25/25+)

Strengths and Weaknesses

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, key populations at higher risk 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.

1.9 HIV testing in sex workers

Percentage of sex workers who received an HIV test in the past 12 months and know their results

What it Measures

It measures progress in implementing HIV testing and counselling among sex workers

Rationale

In order to protect themselves and to prevent infecting others, it is important for sex workers to know their HIV status. Knowledge of one’s status is also a critical factor in the decision to seek treatment. Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more Key populations at higher risk. If so, they should calculate and report this indicator for those populations

Numerator: Number of sex workers who have been tested for HIV during the last 12 months and who know their results

Denominator: Number of sex workers responding to these questions

Calculation: Numerator / Denominator

Method of Measurement: Behavioural surveillance or other special surveys

- Sex workers are asked the following questions:
1. Have you been tested for HIV in the last 12 months?
If yes:
 2. I don’t want to know the results, but did you receive the results of that test?

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 Sex workers as well as the data collected from them must remain confidential

Measurement Frequency: Every two years

- Disaggregation:**
- Sex
 - Age (<25/25+)

Strengths and Weaknesses

Accessing and/or surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample of the national, sex workers 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 sex workers 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:

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.

1.10 HIV prevalence in sex workers

Percentage of sex workers who are living with HIV

What it Measures

It measures progress on reducing HIV prevalence among sex workers

Rationale

Sex workers typically have higher HIV prevalence than the general population in both concentrated and generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among sex workers is a critical measure of a national-level response to HIV

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

Numerator:	Number of sex workers who test positive for HIV
Denominator:	Number of sex workers tested for HIV
Calculation:	Numerator / Denominator
Method of Measurement:	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011)
	This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites
	The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement Frequency:	Annual
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age (<25/25+)

Strengths and Weaknesses

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available. In analyzing prevalence data of sex workers 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 or participated in sex work for less than one year) This type of analysis also has the advantage of not being affected by the effect of ART in increasing survival and thereby increasing prevalence.

If prevalence estimates are available disaggregated by greater than and less than one year in sex work countries are strongly encouraged to report this disaggregation in their Country Progress Report, and to use the comments field in the reporting tool for this indicator to present disaggregated estimates.

Due to difficulties in accessing sex workers, biases in sero-surveillance 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 key 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 sex workers 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 use consistent sites when undertaking trend analyses.

Further Information

For further information, please consult the following website:

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

Revised guidelines on HIV surveillance for key populations at higher risk are available at:

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf

1.11 Men who have sex with men: prevention programmes

Percentage of men who have sex with men reached with HIV prevention programmes

What it Measures

It measures progress in implementing basic elements of HIV prevention programmes for MSM⁹

Rationale

Men who have sex with men (MSM) are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV and AIDS among MSM as well as into the general population, it is important that they access these services

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more Key populations at higher risk. If so, they should calculate and report this indicator for those populations

Numerator:	Number MSM who replied “yes” to both questions
Denominator:	Total number of MSM surveyed
Calculation:	Numerator / Denominator
Method of Measurement:	Behavioural surveillance or other special surveys
	Respondents are asked the following questions: <ol style="list-style-type: none"> 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)
	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 MSM should be collected through civil society organizations that have worked closely with this population in the field
	Access to MSM as well as the data collected from them must remain confidential
Measurement Frequency:	Every two years
Disaggregation:	Age (<25/25+)

Strengths and Weaknesses

Accessing and/or surveying MSM populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national MSM 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.

⁹ This indicator only covers two basic elements of prevention programmes for MSM. It is recognised 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 MSM. 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.

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 the population. 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, and others. For further information on the elements of comprehensive HIV prevention programmes for key populations at higher risk 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.

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.

In addition to the above requested data, please report programme data if available for this indicator using the text box provided in the online reporting platform.

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

1.12 Men who have sex with men: condom use

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

What it Measures

It measures progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner

Rationale

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with their most recent male partner is considered a reliable indicator of longer-term behaviour

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

Numerator:	Number of MSM who reported that a condom was used the last time they had anal sex
Denominator:	Number of MSM who reported having had anal sex with a male partner ¹⁰ in the last six months
Calculation:	Numerator / Denominator
Method of Measurement:	Behavioural surveillance or other special surveys
	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
	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 MSM as well as the data collected from them must remain confidential
Measurement Frequency:	Every two years
Disaggregation:	<ul style="list-style-type: none"> Age (<25/25+)

Strengths and Weaknesses

For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. This indicator does not give any idea of risk behaviour in sex with women among men who have sex with both women and men. In countries where men in the sub-population surveyed are likely to have partners of both sexes, condom

¹⁰ 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.

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.

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, men who have sex with men 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.

1.13 HIV testing in men who have sex with men

Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results

What it Measures

It measures progress in implementing HIV testing and counselling among men who have sex with men

Rationale

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

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key population at higher risk. If so, they should calculate and report this indicator for those populations

Numerator: Number of men who have sex with men who have been tested for HIV during the last 12 months and who know their results

Denominator: Number of men who have sex with men responding to these questions

Calculation: Numerator / Denominator

Method of Measurement: Behavioural surveillance or other special surveys

- Respondents are asked the following questions:
1. Have you been tested for HIV in the last 12 months?
If yes:
 2. I don’t want to know the results, but did you receive the results of that test?

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 MSM as well as the data collected from them must remain confidential

Measurement Frequency: Every two years

Disaggregation: • Age (<25/25+)

Strengths and Weaknesses

Accessing and/or surveying men who have sex with men can be challenging. Consequently, data obtained may not be based on a representative sample of the national, men who have sex with men 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 men who have sex with men 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:

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.

1.14 HIV prevalence in men who have sex with men

Percentage of men who have sex with men risk who are living with HIV

What it Measures

It measures progress on reducing HIV prevalence among men who have sex with men

Rationale

Men who have sex with men 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 men who have sex with men is a critical measure of a national-level response to HIV

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

Numerator:	Number of MSM who test positive for HIV
Denominator:	Number of MSM tested for HIV
Calculation:	Numerator / Denominator
Method of Measurement:	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011)
	This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites
	The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement Frequency:	Annual
Disaggregation:	<ul style="list-style-type: none"> Age (<25/25+)

Strengths and Weaknesses

In theory, assessing progress in reducing the occurrence of new infections is best done through monitoring changes in incidence over time. However, in practice, prevalence data rather than incidence data are available.

In analyzing prevalence data of men who have sex with men 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 first had sex with another man within the last year). This type of analysis also has the advantage of not being affected by the effect of ART in increasing survival and thereby increasing prevalence.

If prevalence estimates are available disaggregated by greater than and less than one year of sexual activity with other men countries are strongly encouraged to report this disaggregation in their Country Progress Report, and to use the comments field in the reporting tool for this indicator to present disaggregated estimates.

Due to difficulties in accessing men who have sex with men, biases in sero-surveillance 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 key 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 men who have sex with men 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 use consistent sites when undertaking trend analyses.

Further Information

For further information, please consult the following website:

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

Revised guidelines on HIV surveillance for key populations at higher risk are available at:

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf

TARGET 2. REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50% BY 2015

- 1.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes
- 1.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse
- 1.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected
- 1.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results
- 1.5 Percentage of people who inject drugs who are living with HIV

2.1 People who inject drugs: prevention programmes

Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes

What it Measures

It measures progress in improving coverage of an essential HIV prevention service for people who inject drugs

Rationale

Injecting drug use is the main route of transmission for approximately 10% of HIV infections globally and 30% of infections outside of sub Saharan Africa. Preventing HIV transmission through injecting drug use is one of the key challenges to reducing the burden of HIV

Needle and syringe programmes (NSPs) are one of nine interventions in the WHO UNODC and UNAIDS comprehensive package for the prevention, treatment and care of HIV among people who inject drugs

Needle and syringe programmes have the greatest impact on HIV prevention for people who inject drugs and there is a wealth of scientific evidence supporting its efficacy in preventing the spread of HIV see <http://www.who.int/hiv/topics/idu/needles/en/index.html>

Numerator:	Number of syringes distributed in past 12 months by NSPs
Denominator:	Number of people who inject drugs in the country
Calculation:	Numerator / Denominator
Method of Measurement:	Programme data used to count the number of syringes distributed (numerator) Size estimation of the number of people who inject drugs in the country (denominator)
Measurement Frequency:	Every two years
Disaggregation:	None

Strengths and Weaknesses

Some difficulties regarding how to count needles and syringes are reported. Some commonly used syringes are 1 or 2ml needle and syringe units while others are syringes to which additional needles need to be fitted. In most cases only data on the number of syringes distributed via NSPs but not pharmacy sales will be available.

Estimating the size of IDU populations at country level is not without its challenges. Many different definitions of people who inject drugs exist in the literature and there are ranges of estimates. The reference group to the United Nations on HIV and injecting drug use undertakes reviews of the available literature to produce estimates of the number of people who inject drugs and these can be used in the absence of size estimates.

Countries can monitor this indicator against the following coverage levels :

- Low: <100 syringes per IDU per year
- Medium: >100–<200 syringes per IDU per year
- High: >200 syringes per IDU per year

These levels are based upon studies in developed country settings investigating the levels of syringe distribution and impact on HIV transmission. Note that the levels required for the prevention of hepatitis C are likely to be much higher than those presented here.

Further Information

A full description of this indicator can be found in the WHO/UNODC/UNAIDS (2009) Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users at: <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>

For further information, please consult the following references:

WHO (2004). Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among IDUs: <http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html>

WHO (2004). Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among IDUs. <http://www.who.int/hiv/pub/idu/e4a-needle/en/index.html>

UNODC. Global Assessment Programme on drug abuse. Estimating prevalence: indirect methods for estimating the size of the drug problem. Vienna, UNODC, 2003.41

Hickman M et al. Estimating the prevalence of problematic drug use: a review of methods and their application. UN Bulletin on Narcotics, 2002, 54:15–32.42

U.S. Department of Health and Human Services, Centers for Disease Control, GAP Surveillance Team. Most at risk populations sampling strategies and design tool. HSS-CDC, 2009.43 Available at: <http://www.igh.org/surveillance>

<http://www.idurefgroup.unsw.edu.au/IDURGWeb.nsf/page/publications> (for more details on the Reference Group and to access reported country-level and global-level estimates of injecting drug use and HIV among injectors.

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/2011_Estimating_Populations_en.pdf (the WHO/UNAIDS working group on global HIV/AIDS and STI surveillance 2010 guidelines on estimating the size of populations most at risk to HIV).

WHO/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance (2011). Guidelines on surveillance among populations most at risk for HIV. See http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf

2.2 People who inject drugs: condom use

Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse

What it Measures

It measures progress in preventing sexual transmission of HIV among people who inject drugs

Rationale

Safer injecting and sexual practices among people who inject drugs 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) people who inject drugs 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 people who inject drugs. If so, it would be valuable for them to calculate and report on this indicator for this population

Numerator:	Number of people who inject drugs who reported that a condom was used the last time they had sex
Denominator:	Number of people who inject drugs who report having injected drugs and having had sexual intercourse in the last month
Calculation:	Numerator / Denominator
Method of Measurement:	Behavioural surveillance or other special surveys
	people who inject drugs are asked the following sequence of questions:
	1. Have you injected drugs at any time in the last month?
	2. If yes: Have you had sexual intercourse in the last month?
	3. If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse?
	Whenever possible, data for people who inject drugs 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
Measurement Frequency:	Every two years
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age (<25/25+)

Strengths and Weaknesses

Surveying people who inject drugs can be challenging. Consequently, data obtained may not be based on a representative sample of the national people who inject drugs being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.

Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which people who inject drugs use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among people who inject drugs and between people who inject drugs 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.

2.3 People who inject drugs: safe injecting practices

Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected

What it Measures

It measures progress in preventing injecting drug use-associated HIV transmission

Rationale

Safer injecting and sexual practices among people who inject drugs 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) people who inject drugs 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 people who inject drugs. If so, it would be valuable for them to calculate and report on this indicator for this population

Numerator: Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs

Denominator: Number of people who inject drugs who report injecting drugs in the last month

Calculation: Numerator / Denominator

Method of Measurement: Behavioural surveillance or other special surveys

Respondents are asked the following questions:

1. Have you injected drugs at any time in the last month?
2. If yes: The last time you injected drugs, did you use a sterile needle and syringe⁴?

Whenever possible, data for people who inject drugs should be collected through civil society organizations that have worked closely with this population in the field

Access to people who inject drugs as well as the data collected from them must remain confidential

Measurement Frequency: Every two years

Disaggregation:

- Sex
- Age (<25/25+)

Strengths and Weaknesses

Surveying people who inject drugs can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.

The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which people who inject drugs use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among people who inject drugs and between people who inject drugs 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.

2.4 HIV testing in people who inject drugs

Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results

What it Measures

It measures progress in implementing HIV testing and counselling among people who inject drugs

Rationale

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

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations at higher-risk. If so, they should calculate and report this indicator for those populations

Numerator: Number of people who inject drugs respondents who have been tested for HIV during the last 12 months and who know their results

Denominator: Number of people who inject drugs responding to these questions

Calculation: Numerator / Denominator

Method of Measurement: Behavioural surveillance or other special surveys

Respondents are asked the following questions:

1. Have you been tested for HIV in the last 12 months?
If yes:
2. I don't want to know the results, but did you receive the results of that test?

Whenever possible, data for people who inject drugs should be collected through civil society organizations that have worked closely with this population in the field

Access to people who inject drugs as well as the data collected from them must remain confidential

Measurement Frequency: Every two years

Disaggregation:

- Sex
- Age (<25/25+)

Strengths and Weaknesses

Accessing and/or surveying people who inject drugs can be challenging. Consequently, data obtained may not be based on a representative sample of the national, people who inject drugs 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 people who inject drugs 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/UNAIDS Working Group on Global HIV/AIDS and STI Surveillance (2011). *Guidelines on surveillance among populations most at risk for HIV*. See http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/2011_Estimating_Populations_en.pdf

Guidelines for using HIV testing technologies in surveillance: selection, evaluation and implementation (2010). See: http://www.who.int/hiv/pub/surveillance/hiv_testing_technologies_surveillance_.pdf

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.

2.5 HIV prevalence in people who inject drugs

Percentage of people who inject drugs who are living with HIV

What it Measures

It measures progress on reducing HIV prevalence among people who inject drugs

Rationale

People who inject drugs 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 people who inject drugs is a critical measure of a national-level response to HIV

Countries with generalized epidemics may also have a concentrated sub-epidemic among people who inject drugs. If so, it is valuable for them to calculate and report on this indicator for those populations

Numerator:	Number of people who inject drugs who test positive for HIV
Denominator:	Number of people who inject drugs tested for HIV
Calculation:	Numerator / Denominator
Method of Measurement:	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011)
	This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites or in the context of a surveillance survey
	The sentinel surveillance sites used for the calculation of this indicator should remain constant to allow for the tracking of changes over time
Measurement Frequency:	Annual
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age (<25/25+)

Strengths and Weaknesses

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 people who inject drugs 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). This type of analysis also has the advantage of not being affected by the effect of ART in increasing survival and thereby increasing prevalence.

If prevalence estimates are available disaggregated by greater than and less than one year of injecting drugs countries are strongly encouraged to report this disaggregation in their Country Progress Report, and to use the comments field for this indicator in the reporting tool to present disaggregated estimates.

Due to difficulties in accessing people who inject drugs, biases in sero-surveillance 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 key 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 people who inject drugs 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 use consistent sites when undertaking trend analyses.

Further Information

For further information, please consult the following website:

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

Revised guidelines on HIV surveillance for key populations at higher risk are available at:

http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf

TARGET 3. ELIMINATE MOTHER-TO-CHILD TRANSMISSION OF HIV BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS

- 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission
- 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth
- 3.3 Mother-to-child transmission of HIV (Modelled)

3.1 Prevention of mother-to-child transmission

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

What it Measures

It measures progress in preventing mother-to-child transmission of HIV through the provision of antiretroviral drugs. This is one of the four main methods for the prevention of mother-to-child transmission, along with primary prevention of HIV for women of childbearing age, prevention of unintended pregnancies among women living with HIV, and appropriate treatment, care and support for mothers living with HIV

This indicator allows countries to monitor the coverage with antiretroviral medicines of HIV-positive pregnant women to reduce the risk for transmission of HIV to infants. When disaggregated, this indicator can show increased access to more effective antiretroviral drug regimens for prevention of mother-to-child transmission of HIV in countries that are scaling up newer regimen categories. As the indicator measures antiretroviral drugs dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases. The postpartum regimen ('tail') to avoid transmission during breastfeeding and to reduce the mother's resistance to nevirapine are not captured by this indicator, even though they are recommended by WHO as standards of care for prevention of mother-to-child transmission of HIV. Because the tail is not included, the regimens below are not labelled with the standard names of Option A and B as described in WHO guidelines

Rationale

The risk for mother-to-child transmission can be reduced significantly by the complementary approaches of providing antiretroviral drugs (as treatment or as prophylaxis) to the mother and antiretroviral prophylaxis to the infant and using safe delivery practices and safer infant feeding

The data will be used to track progress toward global and national goals towards elimination of mother-to-child transmission; to inform policy and strategic planning; for advocacy; and leveraging resources for accelerated scale up

Numerator:	Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce mother-to-child transmission
Denominator:	Estimated number of HIV-positive pregnant women within the past 12 months
Calculation:	Numerator / Denominator
Method of Measurement:	For the numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms For the denominator: estimation models such as Spectrum, or antenatal clinic surveillance surveys in combination with demographic data and appropriate adjustments related to coverage of ANC surveys Programme monitoring and HIV surveillance
Measurement Frequency:	Annual or more frequently, depending on a country's monitoring needs
Disaggregation:	The numerator should be disaggregated by the four general options described below

Explanation of Numerator

The numerator should be disaggregated by the four general options¹¹ (the first three are recommended) for HIV-positive pregnant women for the prevention of mother-to-child transmission¹²:

Category	Description	Examples
a) antiretroviral therapy for HIV-positive pregnant women eligible for treatment	Triple antiretroviral regimen used primarily to improve mother's health and also to fully suppress viral replication fully before and during delivery and postpartum. It is given as a lifelong mother's therapy with the additional benefit of reducing mother-to-child transmission during pregnancy and postpartum periods.	<ul style="list-style-type: none"> • AZT + 3TC + NVP or • AZT + 3TC + EFV or • TDF + 3TC (or FTC) + NVP or • TDF + 3TC (or FTC) + EFV
b) maternal triple ARV prophylaxis;	Triple antiretroviral regimen used to prevent vertical HIV transmission, It is given from 14 weeks of pregnancy until cessation of breastfeeding,	<ul style="list-style-type: none"> • Triple ARV (from 14 wks until cessation of breastfeeding)** • AZT + 3TC + LPV-r • AZT + 3TC + ABC • AZT + 3TC + EFV • TDF + 3TC (or FTC) + EFV <p>**stop ARV 1 week after complete exposure to breast milk.</p>
c) maternal AZT;	AZT used as antiretroviral prophylaxis. It is given from 14 weeks of pregnancy.	<ul style="list-style-type: none"> • Antepartum AZT (from 14 weeks of pregnancy) • sd-NVP at onset of labour* • AZT + 3TC during labour & delivery* • AZT + 3TC for 7 days postpartum* <p>*sd-NVP and AZT-3TC can be omitted if mother receives > 4 wks AZT antepartum.</p>
d) single-dose nevirapine only(not recommended but should be recorded until phased out);	A single dose of nevirapine administered during labour, as antiretroviral prophylaxis.	Single-dose nevirapine.

The number of women receiving a specific antiretroviral drug regimen should be counted.

11 The antiretroviral drug regimen categories for prevention of mother-to-child transmission of HIV are (http://whqlibdoc.who.int/publications/2010/9789241599818_eng.pdf)

12 While national PMTCT programmes are encouraged to move towards using more efficacious regimens, when SD-NVP is provided, it should be recorded and reported.

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Explanation of Denominator

Two methods can be used to estimate the denominator:

1. a projection model, such as that provided by Spectrum software; use the output “number of pregnant woman needing prevention of mother-to-child transmission of HIV”; or
2. multiply the number of women who gave birth in the past 12 months (which can be obtained from estimates of the central statistics office or the United Nations Population Division or pregnancy registration systems with complete data) by the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in antenatal care clinics and appropriate adjustments related to coverage of ANC surveys.) if Spectrum projections are unavailable.

To ensure comparability the Spectrum output will be used for the denominator when global analyses are done.

Strengths and Weaknesses

This indicator allows countries to monitor the coverage with antiretroviral medicines of HIV-positive pregnant women to reduce the risk for transmission of HIV to infants. When disaggregated, this indicator can show increased access to more effective antiretroviral drug regimens for prevention of mother-to-child transmission of HIV in countries that are scaling up newer regimen categories. As the indicator measures antiretroviral drugs dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases. This indicator does not capture the use of appropriate postpartum regimens (“tail”) for the mother (to reduce transmission and viral resistance) and for the infant (to reduce peripartum transmission) which should accompany antiretroviral drug regimens to reduce peripartum mother-to-child transmission.

Countries are encouraged to track and report the actual (or estimated if actual data are unavailable) percentage distribution of the various regimens, so that the impact of antiretroviral drugs on mother-to-child transmission can be modelled on the basis of the efficacy of the regimens. When countries do not have a system for collecting and reporting data on the provision and coverage of different antiretroviral drug regimens for the prevention of mother-to-child transmission of HIV, they should establish such a system. Countries that have mechanisms for providing HIV-positive pregnant women with antiretroviral drugs at community level should have a system for collecting related data.

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 websites:

<http://www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html>

<http://www.who.int/hiv/pub/me/en/index.html>

3.2 Early infant diagnosis

Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

What it Measures

It measures progress in the extent to which infants born to HIV-positive women are tested within the first 2 months of life to determine their HIV status and eligibility for ART, disaggregated by test results

Rationale

Infants infected with HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. WHO recommends national programmes to establish the capacity to provide early virological testing of infants for HIV at 6 weeks, or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progression is rapid in children; they need to be put on treatment as early as possible because without early treatment almost 50% of children would be dead by the second year

Numerator:	Number of infants who received an HIV test within 2 months of birth, during the reporting period. Infants tested should only be counted once
Denominator:	Number of HIV-positive pregnant women giving birth in the last 12 months
Calculation:	Numerator / Denominator
Method of Measurement:	Early Infant Diagnosis (EID) testing laboratories for the numerator, and Spectrum estimates, central statistical offices, and/or sentinel surveillance for the denominator
Measurement Frequency:	Annual or more frequently, depending on a country's monitoring needs

Explanation of Numerator

To be collected from databases held at EID testing laboratories. The numerator should represent the number of *infants* who received virologic testing within 2 months of birth; it should not represent the number of samples tested at the laboratory. Data should be aggregated from the laboratory data bases. Where possible, double counting should be minimized when aggregating data to produce national-level data. It is expected that the number of infants receiving more than one virologic test in the first 2 months of life will be low. Efforts should be made to include all public, private and NGO-run health facilities that are providing HIV testing for HIV-exposed infants.

If information is available about the test results (positive, negative, indeterminate, and rejected for testing by the laboratory) can also be reported. When reporting this information only the most recent test result for an infant tested in the first 2 months of life should be included.

Explanation of Denominator

This is a proxy measure for number of infants born to HIV-positive women.

Two methods can be used to estimate the denominator:

- Using a projection model such as the one provided by Spectrum software use the output “*the number of pregnant woman needing PMTCT*” as a proxy,

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or;

- b) Multiplying the total number of women who gave birth in the last 12 months, (which can be obtained from central statistics office estimates of births or the UN Population Division estimates) *by* the most recent national estimate of HIV prevalence in pregnant women (which can be derived from HIV sentinel surveillance in ANC clinic and appropriate adjustments related to coverage of ANC surveys), if Spectrum projections are unavailable.

To ensure comparability the Spectrum output will be used for the denominator when global analyses are done.

Strengths and Weaknesses

This indicator allows countries to monitor progress in providing early HIV virologic testing to HIV-exposed infants aged 2 months or less, critical for appropriate follow-up care and treatment. By limiting the age to two months of life or less, the chance of repeat tests for the same infant which can lead to double counting is also eliminated. Viewing changes in this indicator over time can provide actionable indications related to PMTCT ARV coverage, and the relationship between PMTCT coverage and EID-coverage. The only three fields needed for this indicator: date of sample collection, age at collection (actual or calculated based upon date of birth), and results are systematically entered into central EID testing databases at testing laboratories. Due to the small number of testing laboratories, and the electronic format of testing databases, this indicator does not have a heavy collection burden. Data quality at the laboratories is generally high, resulting in a robust indicator. The indicator does not capture the number of children with a definitive diagnosis (i.e. of HIV infection), or measure whether appropriate follow-up services were provided to the child based on interpretation of test results. It also does not measure the quality of testing nor the system in place for testing. A low value of the indicator could, however, signal systemic weaknesses, including poor country-level management of supplies of HIV virologic test kits, poor data collection and mismanagement of testing samples. Disaggregation by test results **cannot** be used as a proxy for overall MTCT transmission rates. If either the EID coverage of national need or the EID testing coverage *in the first two months of life* is very low, low positivity rates *among infants tested* will not necessarily mean program success, as many other infants who are likely positive are not represented in this sample.

While early virological testing is a critical intervention for identifying infected infants, it is also important for countries to strengthen the quality of HIV-exposed infant follow-up and to train health providers to recognize signs and symptoms of early HIV infection among exposed infants, particularly where access to virological testing is limited. Inappropriate management of supplies can negatively affect the value of the indicator and significantly reduce access to HIV testing for infants born to HIV-positive women. Countries should ensure that appropriate systems and tools, particularly tools for LMIS, are in place to procure, distribute and manage supplies at facility, district and central level.

Further Information

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

WHO, UNICEF, UNAIDS, Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report, September 2010 <http://www.who.int/hiv/pub/2009progressreport/en/index.html>

PEPFAR, Next generation indicators reference guide, 2009

GFATM Monitoring and Evaluation Toolkit. Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, February, 2009

WHO/UNICEF. Monitoring and evaluating the prevention of mother-to-child transmission of HIV

3.3 Mother-to-child transmission of HIV (modelled)

Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months

What it Measures

It measures progress towards eliminating mother-to-child HIV transmission

Rationale

Efforts have been made to increase access to interventions that can significantly reduce mother-to-child transmission, including combination antiretroviral prophylactic and treatment regimens and strengthened infant-feeding counselling. It is important to assess the impact of PMTCT interventions in reducing new paediatric HIV infections through mother-to-child transmission

The percentage of children who are HIV-positive should decrease as the coverage of interventions for PMTCT and the use of more effective regimens increases

Numerator: The numerator is the estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women

Denominator: Estimated number of HIV positive women who delivered in the previous 12 months

Calculation: Numerator / Denominator

Method of Measurement: The mother-to-child transmission probability differs with the antiretroviral drug regimen received and infant-feeding practices. The transmission can be calculated by using the Spectrum model. The Spectrum¹³ computer programme uses the information on:

- a. the distribution of HIV-positive pregnant women receiving different antiretroviral regimens prior to and during delivery (peripartum) by CD4 category of the mother
- b. the distribution of women and children receiving antiretrovirals after delivery (postpartum) by CD4 category of the mother
- c. the percent of infants who are not breastfeeding in PMTCT programmes by age of the child
- d. mother-to-child transmission of HIV probabilities based on various categories of antiretroviral drug regimen and infant feeding practices¹⁴

The estimated national transmission rate is reported in the Children 0-14 summary display in Spectrum. This variable can also be calculated using the variables in Spectrum on “New HIV infections” for children 0-14 years¹⁵ and dividing this by the variable “Women in need of PMTCT”

¹³ Spectrum software is a suite of models that can be used to project the impact of the HIV epidemic. Spectrum is developed by Futures Institute and can be downloaded from <http://www.futuresinstitute.org/Pages/Spectrum.aspx>.

¹⁴ Default values exist in Spectrum if data are not available from the country.

¹⁵ In the Spectrum model, children 0-14 can only become infected through mother to child transmission, and thus represents the estimated number of children newly infected with HIV, which is represented by the Spectrum output variable “New HIV infections (children 0-14)”.

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There is not enough information available about other HIV transmission routes for children to include such infections in the model. In addition other modes of transmission are believed to be a small fraction of the overall infections among children. The Spectrum output variable “New HIV infections for children 0-1 years” is not used because some infections due to breastfeeding will take place after age 1 year

Measurement Annual

Frequency:

Disaggregation: None

Strengths and Weaknesses

Over time, this indicator assesses the ability of PMTCT programmes by estimating the impact of increases in the provision of antiretroviral drugs and the use of more efficacious regimens and optimal infant feeding practice. This indicator is generated from a model, which provides estimates of HIV infection in children. The estimated indicator is reliant on the assumptions and data used in the model. The indicator may not be a true measure of mother-to-child transmission. For example, in countries where other forms of PMTCT (e.g. caesarean section) are widely practised, the indicator will overestimate mother-to-child transmission. It also relies on programme data that often captures antiretroviral drug regimens provided rather than taken, thus could underestimate mother-to-child transmission.

This indicator allows countries to assess the impact of PMTCT programmes by estimating the HIV transmission rate from HIV positive women to their children. It is difficult to follow up mother-child pairs, particularly at national level, because of the lag in reporting and the multiple health facility sites that mother-child pairs can visit for the wide range of PMTCT and child care interventions delivered over a timespan. In countries where data are available, facility attendance is high, and confirmatory tests are conducted systematically, efforts should be made to monitor the impact through directly assessing the percentage of children found to be HIV-positive among those born to HIV-positive mothers. All countries should make efforts to monitor the HIV status and survival of children born to HIV-positive women, gathered during follow-up health care visits.

Further Information

<http://www.who.int/hiv/pub/me/en/index.html>

TARGET 4. HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL TREATMENT BY 2015

- 4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*
- 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

**Millennium Development Goals indicator*

4.1 HIV treatment: antiretroviral therapy

Percentage of eligible adults and children currently receiving antiretroviral therapy

What it Measures

Progress towards providing antiretroviral combination therapy to all people eligible for treatment

Rationale

As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral therapy (ART) has been shown to reduce mortality 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 counseling for family caregivers

Numerator:	Number of eligible adults and children currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period
Denominator:	Estimated number of eligible adults and children
Calculation:	Numerator / Denominator
	Percentages should be given for 2011 to track annual trends in coverage
Method of Measurement:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent full year of data (monthly or quarterly data aggregated) should be used for annual reporting
	Programme monitoring and HIV surveillance For the numerator: facility-based antiretroviral therapy registers or drug supply management systems. For the denominator: HIV estimation models such as Spectrum
Measurement Frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting
Disaggregation:	<ul style="list-style-type: none"> • Sex • Age (<15, 15+) • Where possible, for children the indicator should be further disaggregated by the ages <1, 1-4, 5-14 years

Explanation of Numerator

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 eligible adults and children who ever started antiretroviral therapy 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.

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-positive pregnant women who are eligible for antiretroviral therapy and on antiretroviral therapy for their own treatment are included in this indicator.

The number of eligible adults and children 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 into antiretroviral therapy.

Denominator estimates are most often based on the latest data available from sentinel surveillance used with a HIV modeling 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, Modeling and Projections methodology.¹⁶

Need or eligibility for antiretroviral therapy should follow the WHO definitions for the diagnosis of advanced HIV (including AIDS) for adults and children.¹⁷

Strengths and Weaknesses

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.

Further Information

<http://www.who.int/hiv/topics/treatment/en/index.html>

¹⁶ <http://www.epidem.org/reports.htm>

¹⁷ <http://www.who.int/hiv/pub/arv/adult2010/en/index.html>

4.2 Twelve month retention on antiretroviral therapy

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

What it Measures

It measures progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy

Rationale

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

Numerator: Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment

Denominator: 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 antiretroviral therapy, those who have stopped antiretroviral therapy, and those recorded as lost to follow-up at month 12

Calculation: Numerator / Denominator

Method of Measurement: Programme monitoring tools; cohort/group analysis forms

Antiretroviral therapy registers and antiretroviral therapy cohort analysis report form

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 January 1 to December 31 2011, countries will calculate this indicator by using all patients who started antiretroviral therapy any time during the 12-month period from January 1 to December 31 2010. If the reporting period is July 1 2010 to June 30,2011, countries will include patients who started antiretroviral therapy from July 1, 2009 to June 30, 2010

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 antiretroviral therapy. For example, patients who started antiretroviral therapy during the 12-month period from January 1 to December 31 2009 will have reached their 12-month outcomes for the reporting period of January 1 to December 31 2011

Measurement Frequency: 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

Disaggregation:

- Sex
- Age (<15, 15+)

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:

- Number of adults and children in the antiretroviral therapy start-up groups initiating antiretroviral therapy at least 12 months prior to the end of the reporting period;
- Number of adults and children still alive and on antiretroviral therapy at 12 months after initiating treatment.

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

For example, for those patients who started antiretroviral therapy in May 2009, if at any point during the period May 2009 to May 2010 these patients die, are lost to follow-up (and do not return), or stop treatment (and do not restart), then at month 12 (May 2010), they are not on antiretroviral therapy, and not included in the numerator. Conversely, a patient who started antiretroviral therapy in May 2009 and who missed an appointment in June 2009, but is recorded as on antiretroviral therapy in May 2010 (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 2009 is recorded as being alive and on antiretroviral therapy after 12 months, regardless of what happens from May 2009 to May 2010.

Explanation of Denominator

The denominator is the total number of adults and children in the antiretroviral therapy start-up groups who initiated antiretroviral therapy at any point during the 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome.

For example, for the reporting period January 1 to December 31 2009, this will include all patients who started antiretroviral therapy during the 12-month period from January 1 to December 31 2008. 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.

Strengths and Weaknesses

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.

TARGET 4: HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL TREATMENT BY 2015

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 ART. 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 ART. 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 ART.

Further Information

<http://www.who.int/hiv/topics/treatment/en/index.html>

TARGET 5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50 PER CENT BY 2015

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

5.1 Co-management of tuberculosis and HIV treatment

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

What it Measures

It measures progress in detecting and treating TB in people living with HIV

Rationale

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

Numerator:	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
Denominator:	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: http://www.who.int/tb/country/en
Calculation:	Numerator / Denominator
Method of Measurement:	Facility antiretroviral therapy registers and reports; programme monitoring tools Programme data and estimates of incident TB cases in people living with HIV
Measurement Frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here
Disaggregation:	Sex Age (<15, 15+)

Strengths and Weaknesses

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 ART, 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 ART 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:

World Health Organization (2009). *Global Tuberculosis Control: Surveillance, Planning, Financing*. Geneva: World Health Organization. <http://www.who.int/tb/country/en>

TARGET 6. REACH A SIGNIFICANT LEVEL
OF ANNUAL GLOBAL EXPENDITURE
(BETWEEN \$22 BILLION AND \$24 BILLION)
IN LOW-AND MIDDLE INCOME COUNTRIES

6.1 Domestic and international AIDS spending by categories and financing sources

TARGET 6: REACH A SIGNIFICANT LEVEL OF ANNUAL GLOBAL EXPENDITURE (BETWEEN \$22 BILLION AND \$24 BILLION) IN LOW AND MIDDLE-INCOME COUNTRIES

6.1 AIDS spending

Domestic and international AIDS spending by categories and financing sources

What it Measures

It measures how funds are spent at the national level and where those funds are sourced in an accurate and consistent manner

Rationale

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 annual global HIV expenditures, which is an important component of Monitoring the 2011 Political Declaration 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

Measurement Tool: Primary tool/method:

- 1) National AIDS Spending Assessment (NASA)

Alternative tools/methods:

- 2) National Health Accounts - AIDS sub-accounts. There should not be any difference in the AIDS health spending measured by NASA or by the NHA sub-accounts. However, some activities performed outside the health sector might not be included in National Health Accounts
- 3) Resource Flows (RF) Survey. There has been an alignment process and countries that have been selected in the sample of this survey and have responded to the questionnaires may enter the information in the funding matrix at the aggregated level by main activities. Some activities performed outside the health sector might not be included in this RF Survey. In addition, some population-related actions should be excluded from the total for AIDS

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 2)

Method of Measurement:	<p>The indicator on domestic and international AIDS spending is reported by completing the National Funding Matrix. Appendix 2 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 2 needs to be submitted with the Country Progress Report</p> <p>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:</p> <ol style="list-style-type: none"> 1. Prevention; 2. Care and treatment; 3. Orphans and vulnerable children¹⁸; 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) <p>(There are multiple sub-categories in each AIDS Spending Category; see Appendix 2)</p> <p>Three main groups of financing sources:</p> <ol style="list-style-type: none"> 1. Domestic public; 2. International; 3. Domestic private (optional for GLOBAL AIDS PROGRESS REPORT reporting) <p>(There are multiple sub-categories for each source; see Appendix 6)</p>
Measurement Frequency:	<p>2009, 2010 and 2011 (as available)</p> <p>Calendar or fiscal year data (as available)</p>

Strengths and Weaknesses

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.

¹⁸ 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.

TARGET 6: REACH A SIGNIFICANT LEVEL OF ANNUAL GLOBAL EXPENDITURE (BETWEEN \$22 BILLION AND \$24 BILLION) IN LOW AND MIDDLE-INCOME COUNTRIES

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/dataanalysis/tools/nasapublications/>

UNFPA/UNAIDS/NIDI. Details on Resource Flows Surveys, survey instruments, countries sampled and more details on this tool are available at: www.resourceflows.org

World Bank/WHO/USAID (2003). Guide to Producing National Health Accounts. This publication and other tools for National Health Accounts and AIDS sub-accounts can be found at:
<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: www.healthsystems2020.org

USAID/Health Systems 20/20/UNAIDS (2009). Linking NASA and NHA Concepts and Mechanics. This publication is available at: <http://www.unaids.org/en/dataanalysis/tools/nasapublications/>

TARGET 7: CRITICAL ENABLERS AND SYNERGIES WITH DEVELOPMENT SECTORS

- 7.1 National Commitments and Policy Instrument (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)
- 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months
- 7.3 Current school attendance among orphans and non-orphans aged 10-14*
- 7.4 Proportion of the poorest households who received external economic support in the last 3 months

**Millennium Development Goals indicator*

7.1 Government HIV and AIDS policies

National Commitments and Policy Instrument (NCPI)

What it Measures

It measures progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws

Rationale

This indicator tracks progress made in implementing the laws, regulations and policies necessary for an effective response to HIV

Method of Measurement:	<p>National Commitments and Policy Instrument (see Appendix 3)</p> <p>The NCPI questionnaire is divided in two parts which cover the following areas:</p> <p>Part A to be administered to government officials</p> <p>Part A covers:</p> <ul style="list-style-type: none"> I. Strategic plan II. Political support and leadership III. Human rights IV. Prevention V. Treatment, care and support VI. Monitoring and evaluation <p>Part B to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations</p> <p>Part B covers:</p> <ul style="list-style-type: none"> I. Civil society involvement¹⁹ II. Political support and leadership III. Human rights IV. Prevention V. Treatment, care and support <p>Some questions occur in both Part A and Part B to ensure that the views of both the government and nongovernment respondents, whether in agreement or not, are obtained</p>
Measurement Frequency:	<p>Every two years. The NCPI is ideally completed in the last 6 months before submission (i.e. between October 2011 and March 2012 for the 2012 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</p>

¹⁹ Including civil society involvement in Monitoring and Evaluation.

Methods

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 NCPI: 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 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 NCPI 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 NCPI requires the involvement of a range of stakeholders which should include representatives of civil society organizations. It is strongly recommended (a) 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, process to be used for determining final responses), timeline; (b) to organize a final workshop with key stakeholders to present, discuss and validate the NCPI findings before official submission as part of the Global AIDS Progress Report. 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 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 of these important documents in the implementation of the national HIV response going forward.

Strengths and weaknesses

The NCPI is the most comprehensive standardized questionnaire available to assess the policy, strategy, legal and programme implementation environment for the HIV response. Although the NCPI is generally referred to as an 'indicator' it is not used in that sense. The importance of the NCPI 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 NCPI 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 NCPI 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 NCPI 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 NCPI data since 2003, where available²⁰.

²⁰ Compare NCPI in *Guidelines on construction of core indicators*, UNAIDS 2002, 2005, 2007 and 2009 respectively, for selecting questions for which trends can be calculated.

7.2 Prevalence of recent intimate partner violence

Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

What it Measures

It measures progress in reducing prevalence of intimate partner violence against women (as an outcome itself and as a proxy for gender inequality)

An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated

Rationale

Globally, and particularly in sub-Saharan Africa, the observed high rates of HIV infection in women have brought into sharp focus the problem of violence against women. There is growing recognition that women and girls’ risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. Studies conducted in many countries indicate that a substantial proportion of women have experienced violence in some form or another at some point in their life. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not²¹

Numerator:	Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of these partners in the past 12 months
Denominator:	Total women surveyed aged 15-49 who currently have or had an intimate partner
Calculation:	Numerator / Denominator
Method of Measurement:	Population based surveys that are already being used within countries, such as WHO Multi-country surveys, DHS/AIS (domestic violence module) ²² , International Violence Against Women Surveys (IVAWS)
	Data collection on violence against women requires special methodologies that adhere to the ethical and safety standards ²³ to ensure that information is gathered in an ethical manner that does not pose a risk to study subjects, and in a way that maximizes data validity and reliability
Measurement Frequency	3-5 years
Disaggregation:	<ul style="list-style-type: none"> • Age (15-19, 20-24 and 25-49) • HIV status (if available)

21 <http://www.who.int/gender/violence/en/vawinformationbrief.pdf>
 22 The questions asked in the DHS module on domestic violence and the WHO multi-country study on domestic violence and women’s health are slightly different. However, the estimates produced from either methodology are comparable.
 23 WHO ethical and safety guidelines for collecting data on violence against women. 2003, <http://www.who.int/gender/documents/en/final%20recommendations%2023%20oct.pdf>.

Explanation of Numerator

Ever married or partnered women aged 15-49 include women who have ever been married or had an intimate partner. An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. These women are asked if they experienced physical or sexual violence from a male intimate partner in the past 12 months. Physical or sexual violence is determined by asking women if their partner did any of the following:

- Slapped her or threw something at her that could hurt her
- Pushed her or shoved her
- Hit her with a fist or something else that could hurt
- Kicked, dragged, or beat her up
- Choked or burnt her
- Threatened her with, or actually used a gun, knife or other weapon against her
- Physically forced her to have sexual intercourse against her will
- Forced her to do something she found degrading or humiliating
- Made her afraid of what he would do if she did not have sexual intercourse with him

Those reporting at least one incident corresponding to any one of these items the last 12 months are included in the numerator.

Explanation of Denominator

Total women surveyed aged 15-49 who currently have or had an intimate partner.

Strengths and Weaknesses

This indicator assesses progress in reducing the proportion of women who have experienced recent IPV, as an outcome in of itself. Further, the indicator should also be interpreted as a proxy for gender equality. A change in the prevalence level of recent violence over time will indicate a change in the level of gender equality—which is one of the structural factors driving the HIV epidemic. Gender equality has a clear, inverse relationship with IPV: In countries where IPV is high, gender equality, women's rates of education, and women's reproductive health and rights are low.²⁴

The indicator focuses on recent IPV, rather than ever experience of IPV, in order to enable monitoring and evaluating progress over time. Ever experience of IPV would show little change over time, no matter what the level of programming, since the numerator would include the same women for as long as they fell into the target age group. Sustained reductions in IPV are not possible without fundamental changes in unequal gender norms, gender relations at the household and community level, women's legal and customary rights, gender inequalities in access to health care, education, and economic and social resources, and male involvement in reproductive and child health. Thus, changes in this one IPV indicator will be a bellwether for changes in the status and treatment of women in all the different societal domains, which in turn directly and indirectly contributes to reduced risk of HIV.

Even after adhering to the WHO ethical and safety guidelines and providing a good setting in which to conduct interviews, there will always be some women who will not disclose this information. This means that estimates will likely be more conservative than the actual level of violence which has taken place in the surveyed population

The complex relationship between violence against women and HIV has been conceptually illustrated in a comprehensive review of the current state of evidence and practice in developing and implementing interventions and strategies to address the intersection of violence against women and HIV.²⁵ For over a decade, research world-wide has documented the undeniable link between violence against women (VAW) and HIV. Studies have demonstrated an association between VAW and HIV as both a contributing factor for

²⁴ Investing in gender equality: ending violence against women and girls. UNIFEM Brief, Oct. 2010.

²⁵ WHO (2010). Addressing violence against women and HIV/AIDS: What works? Geneva, WHO.

infection as well as a consequence of infection.²⁶ This relationship operates through a variety of direct and indirect mechanisms.²⁷ For example:

- fear of violence may keep women from insisting on condom use by a male partner whom they suspect is HIV infected;
- fear of IPV may keep women from disclosing their HIV status or seeking treatment;²⁸
- forced vaginal penetration increases the likelihood of HIV transmission;
- rape is one manifestation of gender inequality and can result in HIV infection, although this represents a minority of cases
- Rape, other sexual and physical abuse can result in psychological distress that is manifested in risky sexual behaviour, with the result of becoming infected with HIV.

Further Information

Investing in gender equality: ending violence against women and girls. UNIFEM Brief, Oct. 2010.: WHO (2010).

Addressing violence against women and HIV/AIDS: What works? Geneva, WHO.

Dunkle KL, Head S, Garcia Moreno C. Current intervention strategies at the intersection of gender-based violence and HIV: A systematic review of the peer-reviewed literature describing evaluations of interventions addressing the interface between gender, violence and HIV. Geneva, WHO, 2009

Program on International Health and Human Rights at Harvard School of Public Health (2009). Gender-Based Violence and HIV, final draft report.

Maman, Suzanne, Jacquelyn Campbell, Michael D. Sweat, Andrea C. Gielen. (2000)

The intersections of HIV and violence: directions for future research and interventions Social Science & Medicine 50 459-478.

26 Dunkle KL, Head S, Garcia Moreno C. Current intervention strategies at the intersection of gender-based violence and HIV: A systematic review of the peer-reviewed literature describing evaluations of interventions addressing the interface between gender, violence and HIV. Geneva, WHO, 2009 (in press), and Program on International Health and Human Rights at Harvard School of Public Health (2009). Gender-Based Violence and HIV, final draft report.

27 Maman, Suzanne, Jacquelyn Campbell, Michael D. Sweat, Andrea C. Gielen. (2000) The intersections of HIV and violence: directions for future research and interventions Social Science & Medicine 50 459-478.

28 Program on International Health and Human Rights at Harvard School of Public Health (2009). Gender-Based Violence and HIV, final draft report.

7.3 Orphans school attendance

Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)

What it Measures

It measures progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans

The indicator is split up in two parts so comparisons can be made between orphans and non orphans:

Part A: current school attendance rate of orphans aged 10-14 primary school age, secondary school age

Part B: current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent

Rationale

AIDS deaths in adults occur just at the time in their lives when they are forming families and bringing up children. Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can 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

Numerator:	Part A: Number of children who have lost both parents and who attend school aged 10-14, primary school age, secondary school age Part B: Number of children both of whose parents are alive, who are living with at least one parent and who attend school aged 10-14, primary school age, secondary school age
Denominator:	Part A: Number of children who have lost both parents Part B: Number of children both of whose parents are alive who are living with at least one parent
Calculation:	For both part A and B: Numerator / Denominator
Method of Measurement:	Population-based survey (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey) For every child aged 10-14, of primary school age, and secondary school age, living in a household, a household member is asked: <ol style="list-style-type: none">1. Is this child's natural mother still alive? If yes, does she live in the household?2. Is this child's natural father still alive? If yes, does he live in the household?3. Did this child attend school at any time during the school year?
Measurement Frequency:	Preferred: Every two years Minimum: every 4–5 years
Disaggregation:	<ul style="list-style-type: none">• Sex

Explanation of Numerator

The *definition of primary school age and secondary school age* should be consistent with the UNESCO definition and as currently used for calculating other education-specific indicators such as net primary school enrolment/attendance rate and net secondary school enrolment/attendance rate for each country.

The primary school age and secondary school age populations may vary slightly from country to country. Therefore this indicator uses the terms ‘primary school age’ and ‘secondary school age’ as currently applied in standard international measurements including in major survey programmes such as DHS or MICS to allow each country to apply its own national age ranges for primary and secondary school. The important point is to compare current school attendance of orphans and non-orphans across primary school and secondary school rather than by specific ages.

Strengths and Weaknesses

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

7.4 External economic support to the poorest households

Proportion of the poorest households who received external economic support in the last 3 months

What it Measures

It measures progress in providing external economic support to poorest households affected by HIV and AIDS

Rationale

Economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programs. This indicator reflects the growing international commitment to HIV-sensitive social protection. It recognizes that the household should be the primary unit of analysis since many of the care and support services are directed to the household level. Tracking coverage of households with orphans and within the poorest quintile remains a developmental priority

Numerator:	<p>Number of the poorest households that received any form of external economic support in the last 3 months</p> <p><i>External economic support</i> is defined as free economic help (Cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter) that comes from a source other than friends, family or neighbours unless they are working for a community-based group or organization. This source is most likely to be the national government or a civil society organization</p>
Denominator:	<p>Total number of poorest households</p> <p><i>Poorest households</i> are defined as a household in the bottom wealth quintile. Countries should use the exact indicator definition and method of measurement for standardized progress monitoring and reporting at national and global levels. This will allow monitoring of changes over time and comparisons across different countries. However, countries can add or exclude other categories locally (for example, other wealth quintiles) depending on the country needs with respect to national program planning and implementation</p>
Calculation:	<p>Numerator / Denominator</p>
Method of Measurement:	<p>Population-based surveys such as Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey</p> <p>An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile to identify the poorest 20% of households. However, since it is not possible to identify the poorest households at the time of data collection, questions on economic support should be asked to all households. Only those who fall in the lowest wealth quintile will be included in the indicator</p>

As part of a household survey, a household roster should be used to list all members of the household together with their ages, and identify all households with children less than 18 years of age, and with orphans, in the last year before the survey. Questions are then asked for each such household about the types of economic support received in the last 3 months, and the primary source of the help

The household heads or respondents are asked the following questions about the type of external economic support they have received in the last 3 months

Has your household received any of the following forms of external economic support in the last 3 months:

- a) Cash transfer (e.g., pensions, disability grant, child grant, to be adapted according to country context)
- b) Assistance for school fees
- c) Material support for education (e.g., uniforms, school books etc)
- d) Income generation support in cash or kind e.g. agricultural inputs
- e) Food assistance provided at the household or external institution (e.g., at school)
- f) Material or financial support for shelter
- g) Other form of economic support (specify)

An assessment of the household's wealth (through an assessment of asset ownership) is completed at the data analysis stage using the wealth quintile at which point it will be possible to assess the extent to which the poorest households are receiving external support

Measurement Frequency:

Every 4–5 years

Disaggregation:

It is recommended that the indicator is disaggregated by type of external economic support in order to track the different types of economic support provided – particularly to be able to distinguish between access to free social assistance such as cash transfers (often targeted at poor labour-constrained households) and livelihoods support which is often targeted at poor households which are less labour-constrained. It is also recommended that the indicator is disaggregated by whether or not households have orphans as orphaning remains a major determinant of vulnerability, particularly in relation to access to services. Where possible, data should also be disaggregated by rural versus urban residence. For countries which opt to add data collection on households in other wealth quintiles in addition to those in the bottom quintile, the indicator can also be compared with other wealth quintiles to track whether external economic support is reaching the bottom quintile compared to wealthier quintiles

Strengths and Weaknesses

This indicator reflects new evidence of the need for a greater focus on wealth dimensions of vulnerability and the fact that targeting on the basis of extreme poverty in high prevalence contexts ensures good coverage of poor households affected by HIV and AIDS²⁹. Proxy indicators of AIDS affectedness (such as “chronic illness”) have often been poorly associated with HIV, have weak associations with adverse developmental outcomes, and have proven difficult to define in household questionnaires.

²⁹ Evidence from social assistance programmes in Malawi and Zambia has shown the effectiveness of using vulnerability criteria without specific reference to AIDS to target children and families affected by AIDS. These programmes target the ultra poor and labour constrained and in using these criteria researchers found that 80% of all households directly affected by HIV and AIDS that are ultra poor and labour constrained were reached. (UNICEF 2007).

This indicator demonstrates changing levels of economic support for the poorest households. In high prevalence contexts, in particular, the majority are likely to be HIV affected. The indicator also demonstrates changes in the composition of external support (e.g. cash, food, livelihoods) received by poor households.

The indicator does not measure directly economic support to HIV infected and affected households, which is difficult to establish during a survey, but implicitly suggests that households living in the bottom wealth quintile in high prevalence contexts are more likely to be negatively impacted by HIV and AIDS and in need of economic assistance. In order to keep measurement as simple as possible, the indicator does not attempt to identify the different sources of support to households but this should be partly captured in National AIDS Spending Assessments (NASA).

The collection of data through population-based surveys, particularly DHS and MICS, means that the indicator does not capture the status of people living outside of households such as street children, children in institutions and internally displaced populations. Separate surveys are needed to track coverage for such vulnerable populations.

Further Information

For further information, please consult the following website:

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

APPENDICES

- Appendix 1. Country Progress Report template
- Appendix 2. National Funding Matrix 2012
- Appendix 3. National Commitments and Policy Instrument (NCPI) 2012
- Appendix 4. Sample checklist for Country Progress Report
- Appendix 5. Selected bibliography

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. It is highly recommended that the indicator data are submitted through the recommended online reporting tool.

COUNTRY PROGRESS REPORT [Country Name]

Submission date: fill in the date of the formal submission of the country report to UNAIDS

Table of Contents

I. 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) Indicator data in an overview table

II. Overview of the AIDS epidemic

[Instructions: This section should cover the detailed status of the HIV prevalence in the country during the period January 2010–December 2011 based on sentinel surveillance and specific studies. The source of information for all data provided should be included.]

III. 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 2010–December 2011.

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 indicator data. Where relevant, these data should also be presented and analysed by sex and age groups. Countries should also use data from the National Commitments and Policy Instrument (NCPI) (see Appendix 3) 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 reported data.

IV. 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.

V. Major challenges and remedial actions

Instructions: This section should focus on:

- (a) progress made on key challenges reported 2012 Country Progress Report, if any;
- (b) challenges faced throughout the reporting period (2010-2011) that hindered the national response, in general, and the progress towards achieving targets, in particular; and,
- (c) concrete remedial actions that are planned to ensure achievement of agreed targets.

VI. Support from the country's development partners (if applicable)

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 targets.

VII. 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 Commitments and Policy Instrument (NCPI) (see Appendix 3).

ANNEXES

- ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS
- ANNEX 2: National Commitments and Policy Instrument (NCPI)

*Please submit your complete Global AIDS Progress Report **before 31 March 2012** using the recommended reporting tool.*

Please direct all enquiries related to Global AIDS Reporting to the UNIDS Secretariat at: AIDSreporting@unaids.org

Appendix 2. National Funding Matrix – 2012

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 2009: calendar year _____ or fiscal year _____

Reporting Cycle 2010: calendar year _____ or fiscal year _____

Reporting Cycle 2011: 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: 2009: _____ / 2010: _____

/ 2011: _____

Methodology: _____

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

Unaccounted Expenditures: _____

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

2009: _____

2010: _____

2011: _____

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

2009: _____ Yes _____ No / 2010: _____ Yes _____ No / 2011: _____ Yes _____ No

AIDS spending National Funding Matrix – 2012

Background

The AIDS Spending indicator is used to measure target # 6 of the 2011 Political Declaration on HIV/AIDS: “Reach a significant level of annual global expenditure (between \$22 billion and \$24 billion) in low and middle-income countries”. AIDS Spending is reported completing the National Funding Matrix: AIDS Spending by category and by financing 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 and Resource Flows Surveys, so as to transfer information from these tools to the matrix. For countries using the NASA, the matrix is one of the outputs of this tool. (Countries interested in implementing the NASA are encouraged to contact UNAIDS for additional information on this tool.)

Structure of the matrix

The National Funding Matrix has two basic components:

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

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

Each spending category includes multiple sub-categories. Across the eight spending categories there are a total of 91 sub-categories. It is important to note that all of the spending categories and sub-categories are AIDS-specific; for example, expenditures listed under Enabling Environment and Community Development should only be those that are directly attributable to the AIDS response.

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

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

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

Instructions

- The National AIDS Authority/Committee or equivalent should designate a technical coordinator to manage the collection and input of relevant data for the National Funding Matrix. It is recommended that this coordinator have good knowledge of tools and methodologies currently in use in the country for collecting this type of financial data (i.e. National AIDS Spending Assessment, National Health Accounts, Resource Flows Survey). Also, it is encouraged that the coordinator contact

other national resource tracking point persons, such as those in the Ministry of Health, who have been involved in reporting expenditures for HIV. The purpose of their involvement is to engender agreement on the national estimate for HIV expenditures and to avoid duplicate initiatives.

- Countries are requested to include as much detail in the National Funding Matrix as possible, including breakdowns by all applicable AIDS Spending and Funding Source Categories and sub-categories. Any categories or sub-categories that are not applicable in a country should be clearly identified; explanations for categories or sub-categories that do not include estimates for any other reason should be provided as part of the cover sheet to the matrix.
- The financial data in the matrix must be actual expenditures. They should not include budget figures that have not been validated as actual expenditures nor should the data reflect commitment or obligation figures. The actual expenditures must correspond to the calendar or fiscal year(s) of 2009, 2010 and/or 2011 (as available).
- The total for each line item should include funding from all sources listed for that item. In addition, there should be a sub-total for each of the eight AIDS Spending Categories, which captures all funding from all sources for all sub-categories in a given category.
- Amounts in each category or sub-category should be reported in local currency. However, it is also important to report the average exchange rate to US dollars for the calendar or fiscal year being reported; see the National Funding Matrix cover sheet on page 104.
- Spending categories and sub-categories are designed to be self-explanatory. Expenditures that do not clearly fit a specific sub-category should be listed in the Other/Not Classified Elsewhere sub-category that appears in each of the eight AIDS Spending Categories. (Detailed descriptions of the categories and sub-categories are available in the UNAIDS-published *National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions*. See reference below.)
- Expenditures should only be counted in a single category or sub-category; they should never be double counted. For example, expenditures on activities for Orphans and Vulnerable Children should not be listed again under Social Protection and Social Services.
- Financing Sources categories and sub-categories are designed to be self-explanatory. Expenditures that do not clearly fit a specific sub-category should be listed in the All Other sub-category that appears under both Public and International Sources. Please note that the list of Financing Sources categories and sub-categories is not exhaustive; however, it is indicative of the main sources of financing.
- Financing in the Central/National and Subnational sub-categories under Public Sources should only include revenue generated by the government and allocated to the AIDS response. It should not include development assistance of any type from international sources; the only possible exception would be budget support from donor organizations that cannot be differentiated from domestic revenues. If the total amount of budget support can be identified, it should appear under the proper International Sources sub-category (e.g. Bilaterals). If any budget support is included in the Central/National and/or Subnational sub-categories, please indicate this fact on the cover sheet (see above).
- Financing provided by a development bank should be designated either as Reimbursable (e.g. loans), which appears under Public Sources, or Non-reimbursable (e.g. grants), which appears under International Sources. Countries that receive both loans and grants from development banks should be careful to allocate these funds to the correct categories.
- Financing provided by individual bilateral donors does not need to be disaggregated by donor agency in the funding matrix.
- Financing provided by international foundations should be listed in the All Other sub-category in the International category. Funds received from domestic foundations should be listed in the All Other sub-category in the Public category.
- Providing information on financing from Private Sources is optional. However, countries are strongly encouraged to collect and report available data in this area in order to provide a more complete picture of the funds available for the AIDS response.

- Key Populations at higher risk: all programmes targeting populations at higher risk, including risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs) and programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection should be coded and cross-classified under the corresponding AIDS Spending Category: *ASC.01.08 Prevention programmes for sex workers and their clients: ASC.01.09, Programmes for men who have sex with men (MSM) or ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs).*
- All programmes targeting other specific populations (e.g. Indigenous groups, Migrants/mobile populations, Military, Police and other uniformed services, etc.), including risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs) and programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection should be coded and cross-classified under the corresponding AIDS Spending Category: *ASC.01.04 Risk-reduction programmes for vulnerable and accessible populations.*
- Programmes targeting the General Populations: all programmes targeting the general population, including risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs) and programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection should be coded and cross-classified under the corresponding AIDS Spending Category: *ASC.01.01 Communication for social and behaviour change, ASC.01.02 Community mobilization, ASC.01.03 HIV testing and counselling (HCT), ASC.01.12 Condom social marketing, ASC.01.13 Public and commercial sector male condom provision and ASC.01.14 Public and commercial sector female condom provision.*
- Incentives for Human resources: These expenditures are aimed at ensuring the availability of human resources for the AIDS response. Incentives for human resources refer to training, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories. For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions—*ASC.01 Prevention* and *ASC.02 Care and treatment*—and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well—*ASC.04 (Programme Management)*. Thus, the salary of a doctor should be accounted on the programmatic intervention where this doctor directly intervenes. Only the additional monetary incentive for the doctor, to work in a specific geographical area or for working on HIV, is to be classified under *ASC.05 Incentives for Human Resources*. Incentives for human resources covers mainly nurses and doctors.
- The Private Sources column for Corporations should list funds spent in-country by companies in the various AIDS Spending Categories and sub-categories; the adjacent Consumer/Out-of-pocket column should list funds spent by individuals and/or families in the AIDS Spending Categories and sub-categories. (Note: It is likely that most entries in the Consumer/Out-of-pocket column will be in the Care and Treatment and selected Prevention categories and sub-categories.)
- If a country has a National Health Accounts - AIDS sub-accounts, it should implement a NASA-NHA Crosswalk in order to fill the Funding Matrix with the NHA – AIDS sub-accounts results. The document *Linking NASA and NHA Concepts and Mechanics* is a comprehensive guide that shows how to crosswalk the spending categories from NHA-AIDS sub-accounts to the National Funding Matrix. Countries can contact the monitoring and evaluation officer in their UNAIDS country office or the Response Monitoring and Analyses Team at UNAIDS headquarters in Geneva.
- If a country is working from a Resource Flows Survey, it may be able to correlate information from sub-totals in the survey to the eight AIDS Spending Categories in the National Funding Matrix.

APPENDIX

- Electronic versions of the *Notebook to Produce National AIDS Spending Assessment* and the *National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions* may be downloaded from the following page on the UNAIDS website: <http://www.unaids.org/en/dataanalysis/tools/nasapublications/>. 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 Global AIDS Progress 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 Global AIDS Progress reporting tool (www.unaids.org/AIDSreportingtool).

Once the National Funding Matrix is filled, it has to be submitted through the Global AIDS Progress online reporting tool.

If you do not have access to the Global AIDS Progress reporting tool, please submit the National Funding Matrix by email to UNAIDS (AIDSreporting@unaids.org).

AIDS Spending Categories	TOTAL (Local Currency)	Public Sub-Total	Central / National	Sub- National	Dev. Banks 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
TOTAL (Local Currency)																		
1. Prevention (sub-total)																		
1.01 Communication for social and behavioural change																		
1.02 Community mobilization																		
1.03 Voluntary counseling and testing (VCT)																		
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 (STI)																		
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																		
2. Care and Treatment (sub-total)																		
2.01 Outpatient care (sub-total)																		
2.01.01 Provider- initiated testing and counseling																		
2.01.02 Opportunistic infection (OI) 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 PLHIV																		
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 services																		
2.01.98 Outpatient care services not disaggregated by intervention																		
2.01.99 Outpatient Care services not elsewhere classified																		
2.02 In-patient care (sub-total)																		
2.02.01 Inpatient treatment of opportunistic infections (OI)																		
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																		

Appendix 3: National Commitments and Policy Instrument (NCPI) 2012

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 indicators and is to be completed and submitted as part of the 2012 Country Progress Report.**

This fifth version of the NCPI and the first revised version since the tool changed the name to National Commitments and Policy Instrument (NCPI), instead of the earlier National Composite and Policy Index (NCPI) has been updated to reflect new HIV programmatic guidance and to be consistent with the new 2011 Political Declaration on HIV/AIDS. 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, 2007 and 2009 NCPI to allow for trend analyses. Countries 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 available³⁰.

I. STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into **two parts**, (the different sections under part A and part B have been slightly reorganized since last reporting round).

Part A to be administered to government officials.

Part A covers:

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

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

Part B covers:

- I. Civil Society involvement
- II. Political support and leadership
- III. Human rights
- IV. Prevention
- V. 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.

For questions that pertain to key populations at higher risk for HIV (heretofore referred to as “key populations” and other vulnerable populations, the following definition is applied: Key populations are defined as **most at risk for HIV (heretofore referred to as “key populations”)** within a defined epidemiological context, that have significantly higher levels of risk of acquiring and transmitting HIV, and with higher rates of mortality and/or morbidity; access or uptake of relevant services is often significantly lower than the rest of the population. Depending on the disease and the country context, some population groups may require explicit attention (for example, people who inject drugs, sex workers, and men who have sex

³⁰ Compare NCPI in Guidelines on construction of core indicators, UNAIDS 2003, 2005, 2007, 2009 respectively, for selecting questions for which trends can be calculated.

with men). Other populations that may be vulnerable to HIV are women and girls; transgender persons; clients of sex workers; prisoners; refugees, migrants or internally displaced populations; people living with HIV; adolescents, and young people; vulnerable children and orphans; people with disabilities, ethnic minorities; people in low-income groups; people living in rural or geographically isolated settings or other group(s) specific to the country context.

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 sub-national 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 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 and any specifics about them 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).

II. PROPOSED STEPS FOR DATA GATHERING AND DATA VALIDATION

The NCPI is ideally completed in the last 6 months before submission (i.e. between October 2011 and March 2012 for the 2012 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 understanding of the national policy and legal environment, a monitoring and evaluation background, and knowledge of the main actors in the national HIV response.

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 including representatives of a variety 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 include completion of 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, including representatives from networks of people living with HIV and from key populations and other vulnerable sub-populations, 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 key populations and other vulnerable sub-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 key populations and other vulnerable sub-populations. It is also important that persons with gender expertise and expertise with other key populations be involved in the review and validation process. 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 2012, using the dedicated software provided on the Global AIDS Progress reporting website (www.unaids.org/AIDSReporting). 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 2012 to allow time for the manual entry of data in Geneva.

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	A.VI

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	B.V

Add details for all respondents.

National Commitments and Policy Instrument (NCPI)

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
-----	----

IF YES, what was the period covered *[write in]*:

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.

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. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[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
Education	Yes	No	Yes	No
Health	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Other <i>[write in]</i> :	Yes	No	Yes	No
	Yes	No	Yes	No

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 key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations ³¹	Yes	No
SETTINGS		
Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

³¹ Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?

KEY POPULATIONS

1.5. Does the multisectoral strategy include an operational plan?

Yes	No
-----	----

1.6. Does the multisectoral strategy or operational plan include:

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

1.7. Has the country ensured “full involvement and participation” of civil society³² in the development of the multisectoral strategy?

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

IF ACTIVE INVOLVEMENT , briefly explain how this was organised:

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

³² Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

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

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

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No	N/A
-------------------	--------------------	----	-----

IF SOME PARTNERS 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
-----	----	-----

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS	Yes	No	N/A
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other [write in]:	Yes	No	N/A
	Yes	No	N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S)	Yes	No	N/A
HIV impact alleviation	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support (including social security or other schemes)	Yes	No	N/A

APPENDIX

Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other[write in below]:	Yes	No	N/A

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

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

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation 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
-----	----

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?³³

Yes	No
-----	----

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes	No
-----	----

5.2. 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
---------------------------------------	---------------------------------	----

5.3. 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
-----	----

³³ Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

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:

5.4. Has the country developed a plan to strengthen health systems?

Yes	No
-----	----

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

APPENDIX

6. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate strategy planning efforts in your country’s HIV programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers

Yes	No
-----	----

B. Other high officials at sub-national level

Yes	No
-----	----

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes	No
-----	----

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

--

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?

Yes	No
-----	----

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

--

APPENDIX

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
IF YES, what is his/her name and position title?		
Have a defined membership?	Yes	No
IF YES, how many members?		
Include civil society representatives?	Yes	No
IF YES, how many?		
Include people living with HIV?	Yes	No
IF YES, how many?		
Include the private sector?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

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

IF YES, briefly describe the main achievements:
What challenges remain in this area:

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

	%
--	---

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

	Yes	No
Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]:	Yes	No

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

Yes	No
-----	----

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

Yes	No
-----	----

<i>IF YES, name and describe how the policies / laws were amended</i>
<i>Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:</i>

APPENDIX

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

<p><i>Since 2009</i>, what have been key achievements in this area:</p>
<p>What challenges remain in this area:</p>

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations <i>[write in]</i> :	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No
-----	----

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:

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

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

2. Does the country have laws, regulations or policies that present obstacles³⁴ to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No
-----	----

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations ³⁵ [write in below]:	Yes	No

³⁴ These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: “laws that criminalize same sex relationships”; “laws that criminalize possession of condoms or drug paraphernalia”; “loitering laws”; “laws that preclude importation of generic medicines”; “policies that preclude distribution or possession of condoms in prisons”; “policies that preclude non-citizens from accessing ART”; “criminalization of HIV transmission and exposure”; “inheritance laws/rights for women”; “laws that prohibit provision of sexual and reproductive health information and services to young people”, etc.

³⁵ Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers:

IV. 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
-----	----

<i>IF YES</i> , what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes	No
Avoid commercial sex	Yes	No
Avoid inter-generational sex	Yes	No
Be faithful	Yes	No
Be sexually abstinent	Yes	No
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No
Other [write in below]:	Yes	No

- 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 to promote life-skills based HIV education for young people?*

Yes	No
-----	----

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

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 key or other vulnerable sub-populations?

Yes	No
-----	----

Briefly describe the content of this policy or strategy:

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

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

APPENDIX

	IDU ³⁶	MSM ³⁷	Sex workers	Customers of Sex Workers	Prison inmates	Other populations ³⁸ [write in]
Condom promotion						
Drug substitution therapy						
HIV testing and counseling						
Needle & syringe exchange						
Reproductive health, including sexually transmitted infections prevention and treatment						
Stigma and discrimination reduction						
Targeted information on risk reduction and HIV education						
Vulnerability reduction (e.g. income generation)						

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

³⁶ IDU = People who inject drugs

³⁷ MSM = men who have sex with men

³⁸ Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

APPENDIX

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC ³⁹ on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other [write in]:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

³⁹ IEC = information, education, communication.

V. TREATMENT, CARE AND SUPPORT

1. *Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?*

Yes	No
-----	----

<i>If YES, Briefly identify the elements and what has been prioritized:</i>

Briefly identify how HIV treatment, care and support services are being scaled-up?

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

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A

APPENDIX

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other[write in]:	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes	No
-----	----

Please clarify which social and economic support is provided:

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

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

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

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

IF YES, for which commodities?

5. *Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?*

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

APPENDIX

6. 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
-----	----	-----

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

Yes	No
-----	----

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

Yes	No
-----	----

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

Yes	No
-----	----

6.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

VI. MONITORING AND EVALUATION

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

Yes	In Progress	No
-----	-------------	----

Briefly describe any challenges in development or implementation:

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

--

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

Yes, all partners	Yes, some partners	No	N/A
-------------------	--------------------	----	-----

Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it address:		
Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No

APPENDIX

A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In Progress	No
-----	-------------	----

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

	%
--	---

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

Yes	In Progress	No
-----	-------------	----

Briefly describe any obstacles:

4.1. Where is the national M&E Unit based?

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

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]			

	Fulltime	Part time	Since when?
Temporary Staff [Add as many as needed]			

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	No
-----	----

Briefly describe the data-sharing mechanisms:
What are the major challenges in this area:

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No
-----	----

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

Yes	No
-----	----

IF YES , briefly describe the national database and who manages it.

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

Yes, all of the above	Yes, but only some of the above	No, none of the above
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IF YES , but only some of the above, which aspects does it include?

6.2. *Is there a functional Health Information System⁴⁰?*

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

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

Yes	No
-----	----

⁴⁰ Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?

8. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other <i>[write in]:</i>	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

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

At national level?	Yes	No
IF YES , what was the number trained:		
At subnational level?	Yes	No
IF YES , what was the number trained		
At service delivery level including civil society?	Yes	No
IF YES , how many?		

9.1. Were other M&E capacity-building activities conducted other than training?

Yes	No
-----	----

APPENDIX

<i>IF YES</i> , describe what types of activities

10. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

<i>Since 2009</i> , what have been key achievements in this area:

What challenges remain in this area:

National Commitments and Policy Instrument (NCPI)

Part B

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

I. CIVIL SOCIETY⁴¹ INVOLVEMENT

1. *To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) 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 (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) 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:

⁴¹ Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

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3. *To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:*

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The national HIV budget?

LOW					HIGH
0	1	2	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

4. *To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) 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. Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

5. *To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?*

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

6. *To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) 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?*

	<25%	25-50%	51-75%	>75%
Prevention for key-populations				
People living with HIV	<25%	25-50%	51-75%	>75%
Men who have sex with men	<25%	25-50%	51-75%	>75%
People who inject drugs	<25%	25-50%	51-75%	>75%
Sex workers	<25%	25-50%	51-75%	>75%
Transgendered people	<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

8. *Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?*

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:

What challenges remain in this area:

II. POLITICAL SUPPORT AND LEADERSHIP

1. *Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?*

Yes	No
-----	----

IF YES, describe some examples of when and how this has happened:

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III. HUMAN RIGHTS

- 1.1 *Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:*

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations <i>[write in]:</i>	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	No
-----	----

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Briefly comment on the degree to which they are currently implemented:

2. Does the country have laws, regulations or policies that present obstacles⁴² to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No
-----	----

⁴² These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: “laws that criminalize same sex relationships”; “laws that criminalize possession of condoms or drug paraphernalia”; “loitering laws”; “laws that preclude importation of generic medicines”; “policies that preclude distribution or possession of condoms in prisons”; “policies that preclude non-citizens from accessing ART”; “criminalization of HIV transmission and exposure”; “inheritance laws/rights for women”; “laws that prohibit provision of sexual and reproductive health information and services to young people”; etc

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations ⁴³ [write in]:	Yes	No

Briefly describe the content of these laws, regulations or policies:
Briefly comment on how they pose barriers:

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes	No
-----	----

⁴³ Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

Briefly describe the content of the policy, law or regulation and the populations included.

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

Yes	No
-----	----

<i>IF YES</i> , 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, key populations and other vulnerable populations?*

Yes	No
-----	----

<i>IF YES</i> , briefly describe this mechanism:

6. *Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle “yes” or “no” as applicable).*

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
	Yes	No	Yes	No	Yes	No
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services ⁴⁴	Yes	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?

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

Yes	No
-----	----

- 7.1. *In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?*

Yes	No
-----	----

8. *Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?*

Yes	No
-----	----

<i>IF YES, Briefly describe the content of this policy/strategy and the populations included:</i>

⁴⁴ Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key 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:

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

Yes	No
-----	----

IF YES, briefly describe the content of the policy or law:

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

a. 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
-----	----

b. 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:

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)⁴⁵?

Yes	No
-----	----

b. Programmes for members of the judiciary and law enforcement⁴⁶ on HIV and human rights issues that may come up in the context of their work?

Yes	No
-----	----

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

a. Legal aid systems for HIV casework

Yes	No
-----	----

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

Yes	No
-----	----

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No
-----	----

IF YES , what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other [write in]:	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

45 Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

46 Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

<i>Since 2009, what have been key achievements in this area:</i>
What challenges remain in this area:

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

<i>Since 2009, what have been key achievements in this area:</i>
What challenges remain in this area:

IV. 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 to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC ⁴⁷ on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A

⁴⁷ IEC = information, education, communication

APPENDIX

HIV prevention component	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other <i>[write in]:</i>	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

V. TREATMENT, CARE AND SUPPORT

1. *Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?*

Yes	No
-----	----

IF YES, Briefly identify the elements and what has been prioritized:
Briefly identify how HIV treatment, care and support services are being scaled-up?

- 1.1. *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 to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	4	N/A
HIV testing and counselling for people with TB	1	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3	4	N/A
Nutritional care	1	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A

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HIV treatment, care and support service	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3	4	N/A
Sexually transmitted infection management	1	2	3	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3	4	N/A
TB preventive therapy for people living with HIV	1	2	3	4	N/A
TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other[write in]:	1	2	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

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

Yes	No
-----	----

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
-----	----

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

	%
--	---

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

Appendix 4. Sample checklist for Country Progress Report

- 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 recommended reporting tool
- Consistency check performed for data included in the narrative report and data entered into 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 (AIDSreporting@unaids.org) by 31 March 2012
- 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 5. Selected bibliography

- UNAIDS (2010) *12 Components M&E System Assessment - Guidelines to support preparation, implementation and follow up activities*. Geneva: UNAIDS
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UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative United Nations partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support. Learn more at unaids.org.

The paper used in this report is FSC approved.



The purpose of these guidelines is to provide countries with technical guidance on how to measure the core indicators for the monitoring of the 2011 Political Declaration on HIV/AIDS. 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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