

Measuring the level of effort in the national and international response to HIV/AIDS: The AIDS Program Effort Index (API)

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Summary

UNAIDS, USAID and the POLICY Project have developed the AIDS Program Effort Index (API) to measure program effort in the response to the HIV/AIDS epidemic. The index is designed to provide a profile that describes national effort and the international contribution to that effort. The API was applied to 40 countries in 2000. The results show that program effort is relatively high in the areas of legal and regulatory environment, policy formulation and organizational structure. Political support was somewhat lower but increased the most from 1998. Monitoring and evaluation and prevention programs scored in the middle range, about 50 out of 100 possible points. The lowest rated components were resources and care. The API also measured the availability of key prevention and care services. Overall, essential services are available to about half of the people living in urban areas but to only about one-quarter of the entire population. International efforts to assist country programs received relatively high rating in all categories except care. The results presented here will be supplemented later this year with a new component on human rights and a score that compares countries on program effort.

Introduction

The success of HIV/AIDS programs can be affected by many factors including political commitment, program effort, socio-cultural context, political systems, economic development, and resources available. Many programs track low-level inputs (e.g., training workshops conducted, condoms distributed) or outcomes (e.g., percentage of acts protected by condom use). Measures of program effort are generally confined to the existence or lack of major program elements (e.g., condom social marketing, counseling and testing).

UNAIDS, USAID and the POLICY Project have collaborated to develop a score, called the AIDS Program Effort Index (API), that measures the key high level inputs by national programs and international agencies. This index is intended to measure program effort independent of program outputs. For example, program effort includes items such as the degree of political support, the amount of participation in the program and the resources devoted to the program but does not include output measures such as the proportion of acts protected by condom use. There are many uses for scores that measure program effort independent of output. At the global level, an effort score can be used to analyze the independent contribution of program effort to program success in a variety of social and cultural settings. At the country level an effort score can be used to compare the

national effort against that of other countries with similar settings or problems. The scores can also be used as a diagnostic tool, to indicate which program areas are weakest and which are strongest and to suggest corrective action. In this context the term “national program” encompasses not only the formal government program but also includes efforts by individuals, non-governmental associations, communities, etc.

A program effort score for family planning was first developed in 1972. The current version of that indicator scores countries on 30 items that are grouped into four components: policies and stage-setting activities, service and service-related activities, record keeping and evaluation, and availability of family planning methods. The score has been applied to approximately 100 countries in 1972, 1982, 1989, 1994 and 1999 (Ross and Mauldin, 1996 and Ross and Stover, forthcoming). The results have been used for global research as well as for country applications. Among the applications are studies of:

- social marketing (Sheon et al., 1987)
- community-based distribution (Ross et al., 1987)
- access to birth control (Camp and Speidel, 1987)
- improved contraceptive method mix (Jain, 1989)
- the determinants of contraceptive use (Entwisle, Mason and Hermalin, 1986)
- political commitment and strength (Ness and Ando, 1984)
- the prospects for achieving replacement level fertility (Mauldin and Ross, 1994)
- the interactions between program effort and social setting (Casetti, 1991 and 1992)
- factors critical to overall program improvement (Bulatao, 1993)
- the debate on whether family planning programs have a significant impact on fertility (Bongaarts, 1990 and 1994; Pritchett, 1994, Schultz, 1994)
- an assessment of the sustainability of family planning programs (Knight and Tsui, 1998).

A program effort score for HIV/AIDS will facilitate similar cross national research, provide a useful diagnostic tool for national programs and facilitate measurement of changes as a result of donor inputs.

Similar scores have been developed that measure the extent to which the policy environment is supportive of effective programs. The PASCA Project has applied a policy environment score for HIV/AIDS in Central America (Murgueytio, Merino and Stover, 1997) and the POLICY Project has applied policy environment scores for HIV/AIDS, family planning, safe motherhood, adolescents and post-abortion care.

The purpose of the API is to measure the amount of effort put into national HIV/AIDS programs by domestic institutions and by international organizations. The uses of the API include:

Description

1. To measure the level of national efforts (where national refers to all domestic inputs including central, regional and local by both governmental and non-governmental organizations)
2. To measure the level of effort of international assistance in each country
3. To measure changes over time in national and international efforts

Diagnosis

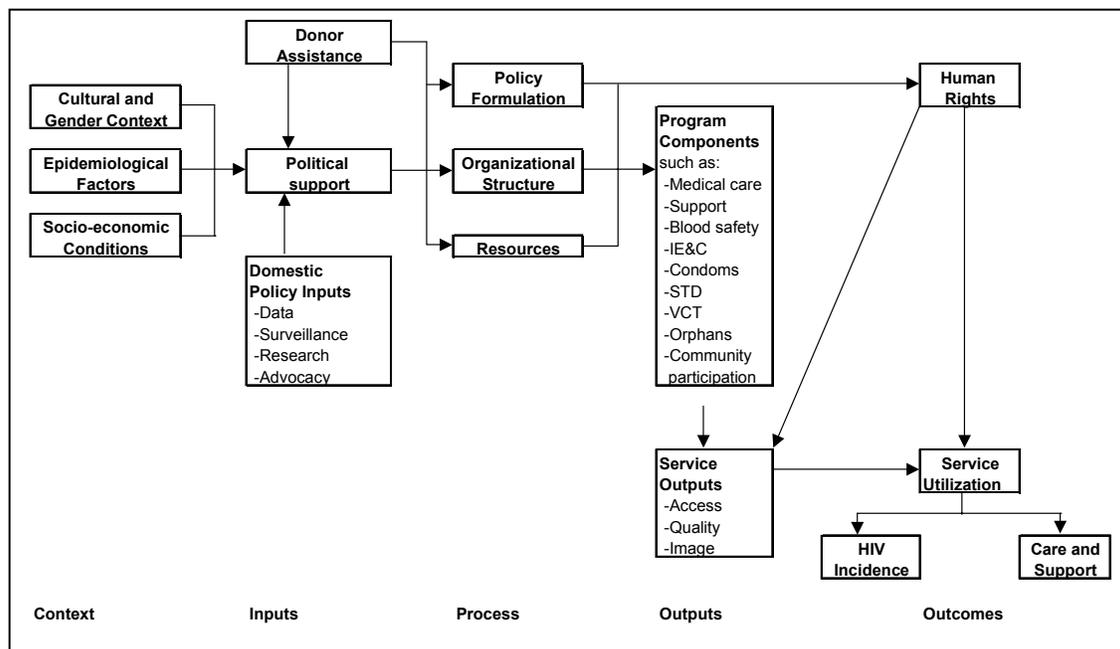
4. To serve as a diagnostic tool to indicate areas of strength and weakness in each country program

Evaluation/Impact

5. To determine the effects of international assistance on national efforts
6. To determine the effects national and international efforts on outcomes

Figure 1 shows the conceptual framework for the relationship between HIV/AIDS program effort and desired outcomes. This framework is adapted from a similar framework developed for family planning services by Tsui and others (Bertrand, Magnani and Knowles, 1994).

Figure 1 Conceptual Framework of Program Effort and Outcomes



The various social, cultural, economic and epidemiological factors define the context of the national response to the HIV/AIDS epidemic. These factors may have a powerful influence on the epidemic and the response to it, but are largely outside the control of the

program. The political response is influenced by these outside factors and also by various domestic efforts to: define the extent and nature of the epidemic (through data collection), understand the effects of programs to combat the epidemic (through research) and influence policy makers in certain directions (through advocacy and awareness raising efforts by domestic governmental and non-governmental groups). Donor activities in policy dialogue and research also may influence the amount and type of political support for HIV/AIDS programs.

Political and donor support determine the way the response will be organized. This includes the development and implementation of national and operational policies, the structure of the program and the amount of funding and human resources that are devoted to it. These factors determine the program components, which lead directly to service outputs (access, quality and image). To the extent that these services are utilized by the population, the program will have an effect on reducing HIV incidence and improving the quality and amount of care and support services provided to people living with HIV/AIDS and their families.

Policy formulation directly affects the human rights situation through formal policies, laws and regulations and the environment within which these laws are implemented. Protection of the human rights of people affected by HIV/AIDS is a desired outcome in itself. The human rights environment also may affect service outputs and utilization.

The API is intended to measure the effort put into HIV prevention and care. It does not measure the socio-economic context of the epidemic and response nor does it measure the outcomes. Therefore the API includes all those items contained in the conceptual framework under Inputs, Process and Outputs. Human Rights is also included even though it is an outcome, because it is also influences Service Outputs and Service Utilization.

Methodology

The API is a composite indicator composed of a number of individual items grouped into key categories. Each item is scored on a scale of 0-5 by knowledgeable individuals. The item scores are averaged for each category to produce a category score that does not depend on the number of items in the category. The category scores form a profile describing the program effort of each country.

The API was implemented in each country by national consultants. These consultants were recommended by the UNAIDS Country Programme Advisor or Theme Group Chairperson. Consultants were independent of the national program and UNAIDS but had good knowledge of the program and the people involved.

Judgments are provided by 15 - 25 people in each country. Respondents are not meant to be a representative sample but are carefully selected for their knowledge and viewpoint. The goal is to find the 15-25 most knowledgeable people from a variety of backgrounds.

Fewer respondents would not be enough to cover all the important backgrounds, while more respondents could require including people less knowledgeable about program effort. Respondents are selected from a variety of backgrounds, including:

Government

- AIDS control program
- Ministry of Health
- Military
- Social Security Administration

Donors

- UNAIDS
- UNAIDS Co-Sponsors
- USAID
- Other international donors
- Representatives of large donor-funded projects

Non-governmental organizations

- AIDS service NGOs
- NGOs representing people living with HIV/AIDS
- Human rights organizations
- Advocacy organizations

Civil Society

- Religious organizations
- Research groups
- Universities
- Medical associations
- Journalists

Private sector

- Chambers of Commerce
- Large commercial enterprises
- Unions

The respondents were selected by the national consultants. The consultants were instructed to find individuals with a good understanding of the functioning of the national program and to select two to four respondents from each major type.

Since one of the purposes of the API is to measure change, the participants are asked to rate each item twice, once for the current situation and once for the situation two years ago.

The questionnaire contains 100 individual items grouped into eleven components. The components are:

- Political support, PS
- Policy formulation, PF
- Organizational structure, OS
- Program resources, PR
- Evaluation, monitoring and research, ME
- Legal and regulatory environment, LR
- Human rights, HR
- Prevention programs, PP
- Care programs, CP
- Service availability, SA
- United National role, UN

In addition, most components contain items that refer to international assistance. In the analysis these items are removed from the other components and combined to form a twelfth component:

- International assistance, IN

The individual items in each category are listed in Appendix C.

The API was field-tested in six countries (Cambodia, Mexico, the Philippines, Romania, Senegal and Zambia) in 1999 (Stover, 1999). On the basis of the field test modifications were made to the questionnaire.

The API has now been implemented in 40 countries by national consultants. The national consultants selected the respondents according to the guidelines given above, delivered the questionnaires and ensured that they were completed. The national consultants and the number of respondents per country are listed in Appendix D. The distribution of respondents by type is shown in Table 1. Data entry and processing was done at The Futures Group International.

Table 1. Distribution of respondents by type

Respondent type	Percent of all respondents
AIDS Control Program	9%
Other government	14%
NGO	21%
AIDS Service Organization	1%
Representatives of People Living with HIV-AIDS	2%
Private sector	3%
International staff of donor agency	10%
National staff of donor agency	10%
Representative of civil society	18%
University	6%
Other	5%
Total	100%

The strength of this approach to measuring program effort is that it provides a comprehensive assessment of the full range of elements that constitute program effort. The index allows the respondents to judge both the existence of certain activities and their quality. This makes the API a very flexible indicator that can capture qualities that are not easy to measure with indicators that are not based on judgment. However, there are limitations associated with this approach. Since the scores rely on the subjective judgments of the respondents, the scores depend to some degree on the exact respondents chosen. In addition, the range of responses is rather large. This makes it difficult to detect true differences between countries and changes in the score over short periods of time.

Results

The results of the analysis of the full implementation of the API in 38 countries are presented below. This analysis revealed that respondents did not adequately understand the scoring of the human rights component. That component is being revised and will be scored at country meetings in early 2001. Therefore, the results shown below do not include the human rights component.

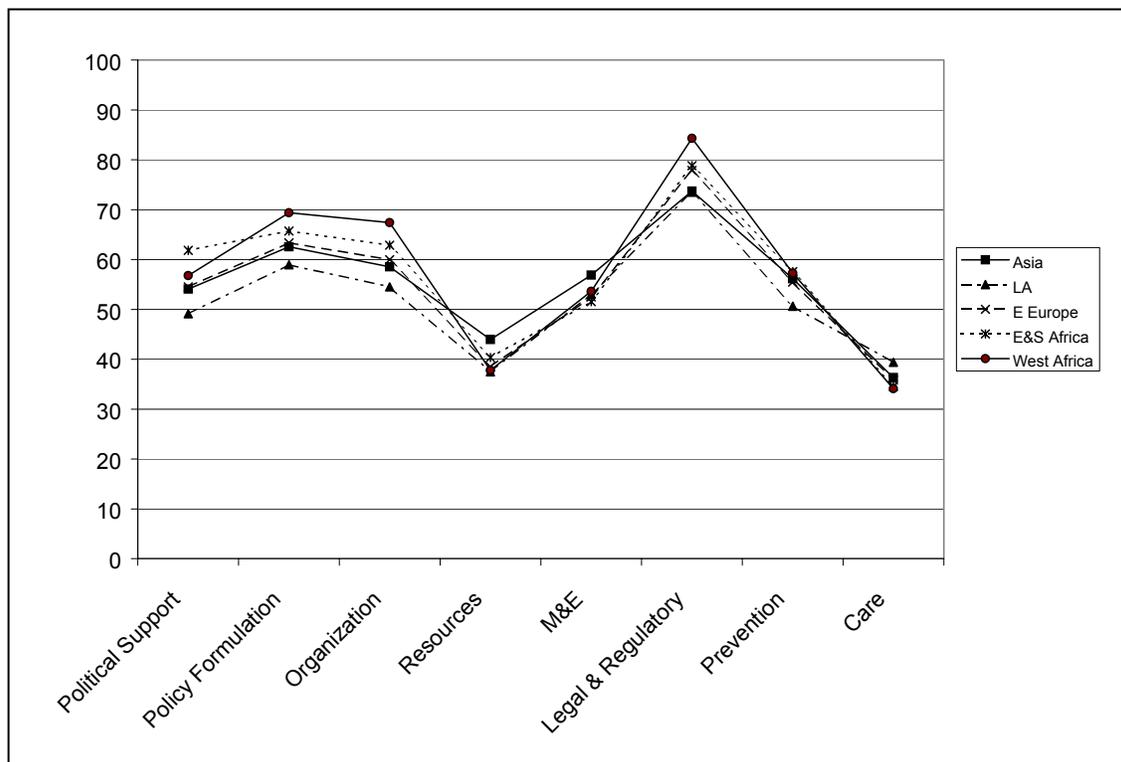
API for policy and programs in 2000

The results for the policies and program components of the API are shown in Appendix A. All scores have a minimum of zero, indicating no effort, and a maximum of 100, for the best possible effort. Actual component scores for individual countries range from a low of 15 to a high of 93.

Profile of program effort

The average scores by component and region are shown in Figure 2. All five regions show the same pattern of effort by component. The remarkable consistency in the pattern across regions indicates that countries around the world face similar problems in confronting the epidemic, regardless of their approach.

Figure 2. AIDS Program Effort Index by component and region - 2000



- Programs are judged to be doing a particularly good job on legal and regulatory issues, with scores above 70 percent. This indicates that the laws, regulations and practices generally support effective interventions. For example, in most countries condom advertising is allowed and there are few restrictions on who may receive STI services.
- Policy formulation is judged to be good. Respondents in most countries reported that formal policies and laws were in place that established program goals and strategies, organized a multi-sectoral effort and involved a variety of stakeholders in policy dialogue.
- Prevention programs also scored relatively well indicating that respondents in most countries felt that the major components of an effective program were in place.
- The organization and structure of the national program was also judged to be relatively good. Most countries have a national government program in place and attempt to include non-governmental organizations and representatives.
- Resources (funding) and care received the worst scores. Most respondents felt that the funding of the program was inadequate and that the care provided was insufficient to meet the need.
- It is interesting to note that the policy formulation and the legal and regulatory environment components score higher than political commitment. This indicates that, in many cases, the lack of political commitment may not preclude the development of a policy and legal framework for an AIDS program, especially where substantial international assistance is provided. However, the scores for resources and care lag behind those for political commitment. Since care is generally funded primarily from national resources, while donor contributions help to pay for prevention in many countries, this may indicate that political commitment is required for mobilizing national resources and funding care.

Country rankings

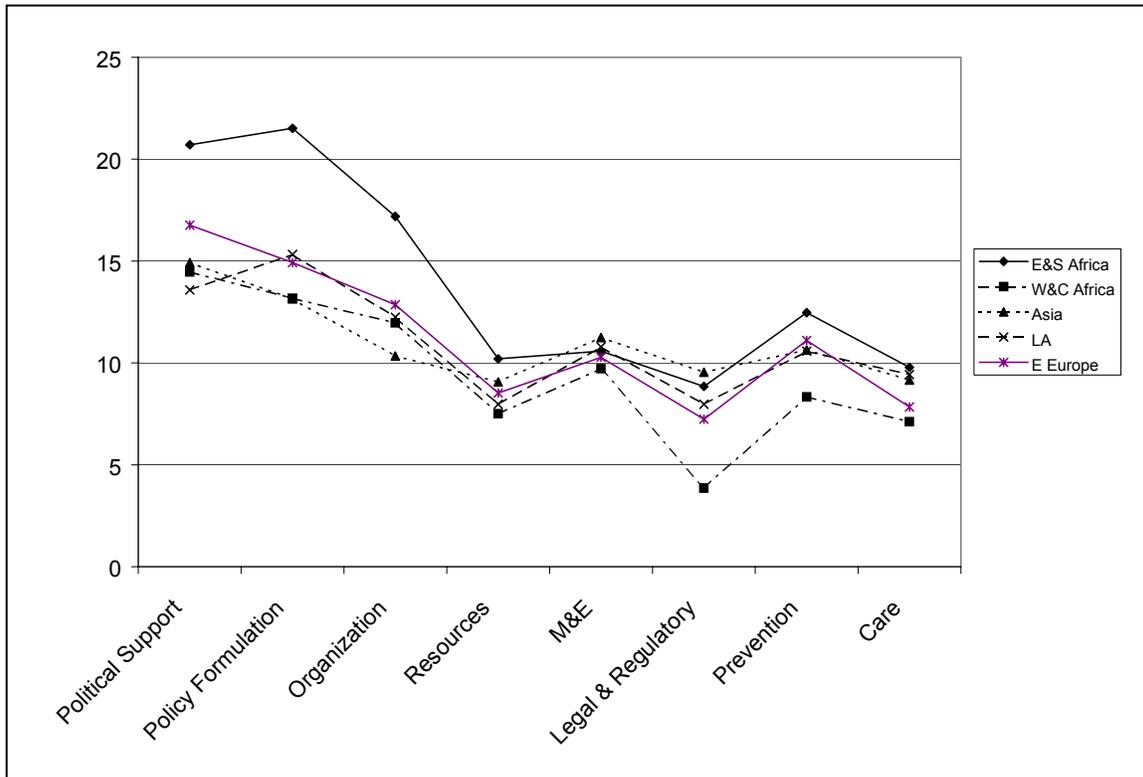
It would be possible to calculate total scores for each country and rank all countries from strongest to weakest program effort. However, such a ranking is not justified with these scores. Although all respondents completed the same questionnaire, it is likely that respondents in each country used different standards in rating effort. A separate effort will be undertaken in early 2001 to get international experts to compare program effort across a range of countries. These scores will be used to rank countries on a consistent scale. Results should be available by the middle of 2001.

Change in API for policy and programs from 1998 to 2000

Figure 3 shows the change in component scores by region from 1998 to 2000. The respondents judged that there had been a large increase in political commitment and

policy formulation during the past two years, especially in Eastern and Southern Africa. A number of countries in Eastern and Southern Africa have passed and implemented new national HIV/AIDS policies, including Kenya, Ethiopia, Uganda and Zimbabwe. In addition, more and more leaders are speaking about HIV/AIDS. This increase has raised the scores for political commitment and policy formulation from around 40 percent to about 60 percent. Scores for the other components also increased on average, but by much smaller amounts.

Figure 3. Change in API from 1998 to 2000 by component and region



Highest and lowest rated items

The 10 highest rated items across all countries are shown in Table 2. The high scores for the legal/regulatory component is reflected in the fact that five of the top rated items are from this component. Respondents in most countries reported that condom programs are well supported. Five of the top items refer to the legal environment and distribution of condoms.

Table 2. The ten top-rated items across all countries

Component	Item	Score (0-5)
Legal/Regulatory	There are no restrictions on the importation of condoms.	4.28
Legal/Regulatory	Condom advertising is allowed.	4.27
Legal/Regulatory	There are no restrictions on condom distribution.	4.11
Legal/Regulatory	There are no restrictions on who may receive STI services.	4.09
Organizational Structure	The Director of the AIDS Control Programme is full-time and reports to an influential superior officer.	3.62
Policy Formulation	Formal program goals exist.	3.52
Prevention	Guidelines to reduce the risk of HIV transmission to health workers	3.45
Legal and regulatory	NGO registration procedures are clear, straightforward and fair	3.44
Prevention	Social marketing program for condoms.	3.33
Prevention	Functioning logistics system for condoms	3.26

In contrast, Table 3 shows the ten items with the lowest rating across all countries. Most of these items are from the care and resource components. The items rating the implementation of both the comprehensive and essential care packages are among the ten lowest-rated items. Clearly the respondents felt that care was receiving much less attention than the other program components. Similarly, four of the seven items on national program resources were among the lowest-rated items. Most respondents felt that the domestic resources were inadequate. These two components are closely related, since most care is funded with domestic resources.

Table 3. The ten lowest-rated items across all countries

Component	Item	Score (0-5)
Care	A comprehensive program exists to provide needed support to AIDS orphans.	1.15
Care	A comprehensive package of care and support is provided throughout the national health system. This includes all the items of the intermediate package plus antiretroviral therapy, diagnosis and treatment of MAC, CMV, multi-drug resistant TB, toxoplasmosis and HIV-associated malignancies.	1.16
Resources	The private sector plays a significant role in funding HIV/AIDS prevention and care programs.	1.21
Resources	Adequate funding is available for care of people living with HIV/AIDS.	1.25
Resources	Adequate funding is available for programs to mitigate the impacts of AIDS.	1.53
Care	An intermediate package of care and support is provided throughout the national health system. This includes all the items of the essential package plus enhanced TB management (active case finding among people with HIV/AIDS, improved diagnosis of extrapulmonary TB and TB prophylaxis), cotrimoxazole prophylaxis, systemic antifungals, treatment of Kaposi's sarcoma with essential drugs and treatment of cervical cancer with surgery.	1.87
Resources	Adequate funding is available for public prevention programs.	1.90
Prevention	Programs to prevent mother-to-child transmission by providing testing, counseling, antiretroviral treatment and infant feeding programs.	2.08
Evaluation and Research	A behavioral surveillance system exists and functions regularly.	2.08
Care	An essential package of care and support is provided throughout the national health system. The essential packages includes voluntary counseling and testing for HIV; psychosocial support; palliative care; treatment for pneumonia, oral and vaginal candidiasis, and pulmonary TB; and regulated delivery of care, in particular of TB, STIs and advanced care options.	2.15

Service availability

The scores for service availability by region are shown in Figure 4 and by country in Appendix B. These scores represent the proportion of the appropriate population in the capital city that has access to each of the services. Access to safe blood is judged to be very good in all regions. For all other services considerable problems exist. Access to condoms, STI services and information is high compared to the other services but reaches only about 50 percent of the population. The other services (voluntary counseling and testing, care, support, services for youth and services to prevent mother-to-child transmission) are available to only about one-third of the appropriate population. Needle exchange programs (NEP) are not widely available anywhere, even in Eastern Europe where IVDU is an important transmission route.

Figure 4 describes access in the capital city. Access in other urban areas and rural areas is generally less. Respondents were asked to rate access in other urban and rural areas relative to the capital city. When the availability of all of these services is averaged and discounted for the reduced availability in areas outside the capital city (weighted by the geographic distribution of the population) the pattern shown Figure 5 and Appendix C emerges. This is the proportion of the national population that has access to prevention and care services. According to this calculation about 50 percent of the urban population has access to services but only about 25 percent of the total population has reasonable access to these services. This suggests that there is still a large amount of improvement required in providing access to basic preventive and care services even in capital cities, but even more so in other urban and rural areas. Services in rural areas are particularly poor in Africa and Latin America.

Figure 4. Service availability in the capital city by region - 2000

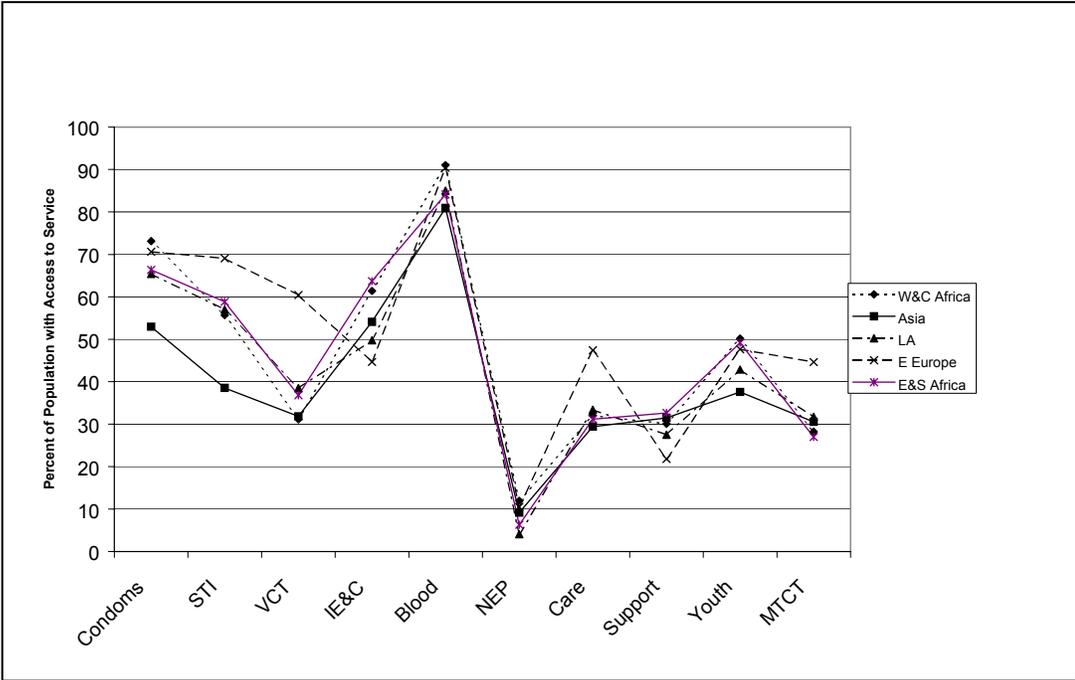
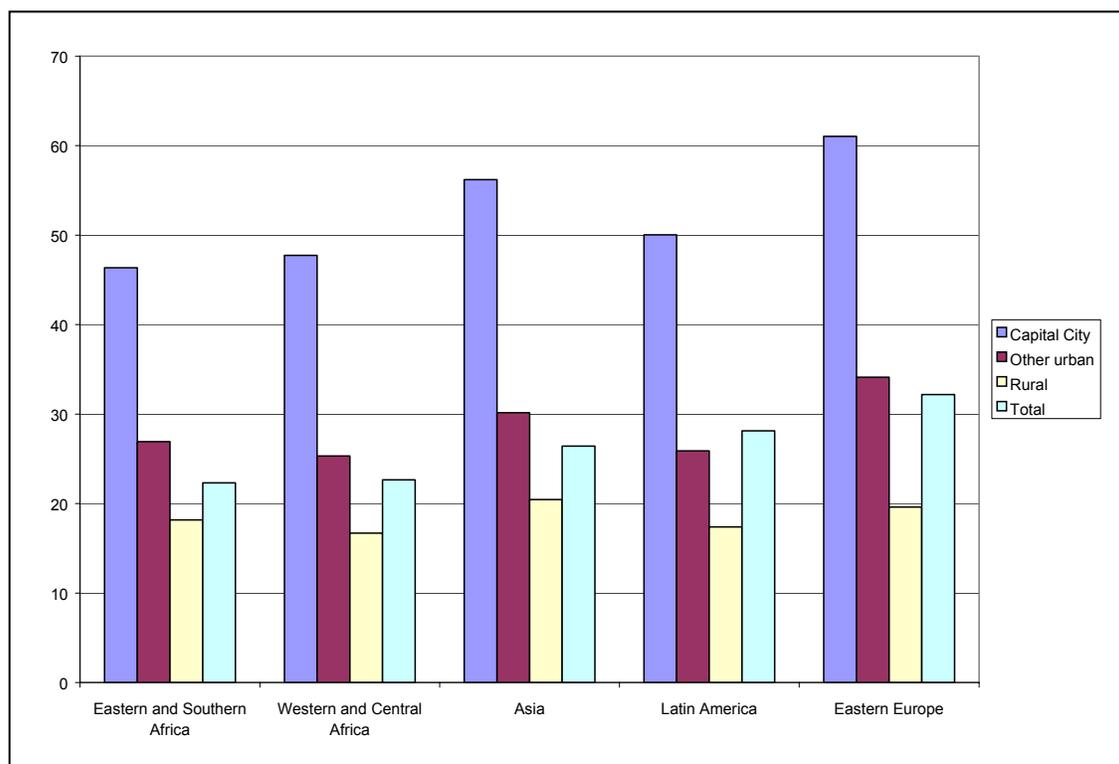


Figure 5. Service availability by location and region – 2000

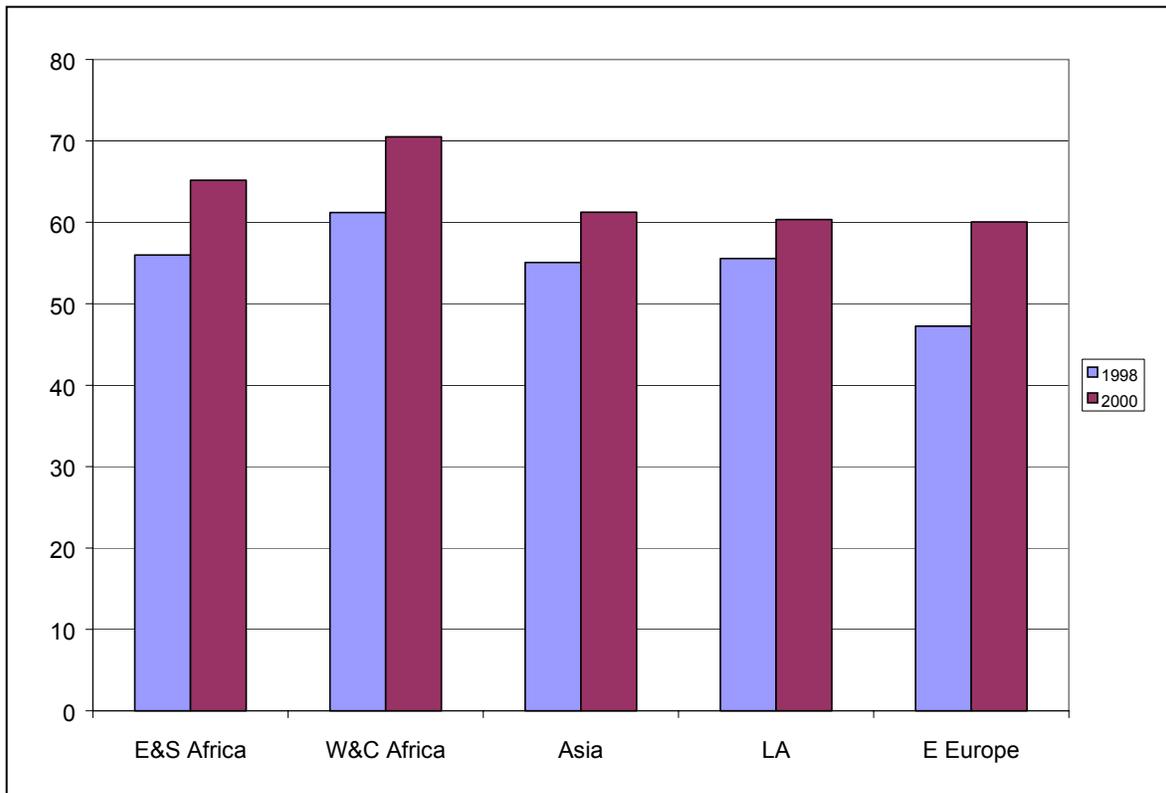


The contribution of the United Nations and other international agencies

The API questionnaire also measures the contribution of United Nations and other international agencies to national program effort. The contribution of United Nations agencies is rated in a special section of the questionnaire devoted to the impact of the United Nations agencies. In addition, questions about the role of international agencies were included in each of the policy and program components. These items were extracted and examined separately to determine the contribution of all international agencies. The results were nearly identical to those for the United Nations agencies.

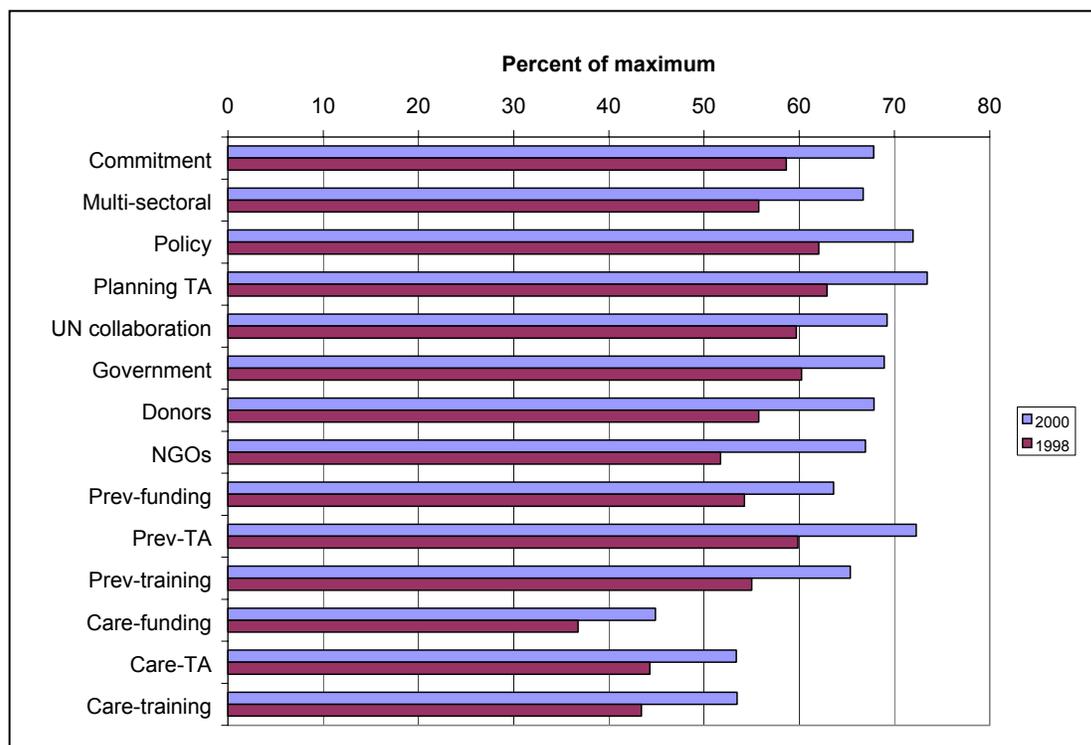
The contribution of the United Nations agencies to program effort by region and year is shown in Figure 6. In general, respondents judged that the UN and other international agencies made important contributions to national effort. The scores are 60 percent or higher for all regions in 2000. These scores are somewhat higher than the scores for domestic effort. The UN and other international agencies contribute more in Africa than in the other regions, but the contribution is significant everywhere. This contribution increased noticeably from 1998 to 2000 in all regions, with the largest increase recorded in Eastern Europe, the region with the lowest score in 1998.

Figure 6. The contribution of United Nations agencies to program effort



The contribution of United Nations agencies by component and year is shown in Figure 7. The contribution for all the components except care is uniformly high in 2000. Increases from 1998 to 2000 tended to be greater in the areas in most need, so that by 2000 the contribution is about equal across all of the components except care. Support for care clearly lags all other components.

Figure 7. The contribution of United Nations agencies by type of assistance - 1998 and 2000



Conclusions

The AIDS Program Effort Index (API) is designed to measure the amount of program effort devoted to national programs to stop the spread of HIV/AIDS and to address the consequences of the epidemic. Based on the countries studied to date, several conclusions can be drawn.

1. All countries studied have organized at least some reasonable effort. No country received a total score (averaged across all components) lower than 39. On the other hand, no country received a total score higher than 77. Thus, there is considerable room for improvement in all countries.
2. Respondents judged that the best efforts have occurred in the legal and policy areas. The highest scores were given to the legal and regulatory structure and policy formulation. Even here, however, considerable improvement is required, primarily to ensure that the legal structure that is in place is used to protect the human rights of people affected by HIV/AIDS.

3. The political commitment of national leaders to confront HIV/AIDS has been a major concern to many. Commitment has been weak in the past and this has affected programs in a variety of ways. In the past two years, however, political commitment has increased more than any other component. The increase has been especially marked in Eastern and Southern Africa. Although political commitment is still lacking in many areas, it is encouraging to see that it has been increasing in recent years.
4. One of the weakest areas is resources. Respondents felt that the resources devoted to HIV/AIDS programs are inadequate to support an effective response. Although respondents felt that resources had increased over the last two years, the increase was quite small compared to the other components. The increased political commitment has not yet led to a similar increase in resources.
5. The API shows quite clearly that the effort being made to care for people living with HIV/AIDS is the weakest component of most programs. Care is the lowest rated component in all regions and the service availability items relating to care were the lowest rated.
6. Service availability is a major problem for most countries. Even in the capital cities the majority of the population do not have access to most services. The best scores were given to safe blood, condoms and STI services. All other services reach less than half of the appropriate population. The situation is even worse in other urban and rural areas.
7. United Nations agencies and other international donors are making a significant contribution to program effort. Respondents judged international assistance to be a positive factor in most country programs. The contribution is greatest for policy, planning and prevention and weakest for care.

Next steps

The information in this report as well as country data sheets will be provided to each participating country. Each country will be encouraged to review these results and discuss their implications for improving program effort.

A new human rights component is being developed. It will be scored in each country and added to the overall profile.

A separate effort to compare program effort across countries is underway. This effort should result in scores that are internationally comparable. This will allow countries to see how they compare with other countries in their region and will allow international organizations to consider variations in program effort in planning their assistance strategies.

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Appendix A. AIDS Program Effort Index by Component and Country - 2000

	Political support	Policy formulation	Organizational structure	Program resources	Eval., mon., res.	Legal and regulatory	Prevention programs	Care programs
Eastern and Southern Africa								
Ethiopia	63	61	44	26	32	74	46	24
Kenya	63	70	70	42	47	81	58	32
Malawi	71	74	78	54	68	83	62	48
Mozambique	63	71	67	50	57	82	56	39
Rwanda	59	63	59	36	46	80	57	37
South Africa	60	57	67	35	42	74	46	28
Tanzania	55	59	55	38	52	82	64	41
Uganda	66	75	68	42	60	78	59	31
Zambia	64	60	56	35	53	74	56	29
Zimbabwe	61	72	67	43	61	81	73	52
Average	60	64	61	39	51	77	56	35
Western Africa and Central Africa								
Benin	51	73	69	39	59	87	66	34
Burkina Faso	51	52	59	38	43	79	49	28
Congo, D.R.	43	76	67	24	52	83	50	38
Cote d'Ivoire	55	64	70	35	56	83	60	41
Ghana	65	70	61	46	54	90	61	23
Mali	64	78	68	40	47	81	58	37
Nigeria	62	65	70	44	59	86	49	28
Senegal	61	78	75	39	61	87	66	46
Average	57	69	67	38	54	84	57	34
Asia								
Cambodia	56	61	59	47	59	75	52	47
China	50	61	51	38	57	57	53	37
Indonesia	47	58	51	37	47	68	50	23
Nepal	48	52	52	36	47	74	46	15
Philippines	60	76	73	56	69	75	66	48
Vietnam	63	66	64	50	63	93	70	47
Average	54	63	59	44	57	74	56	36
Latin America								
Brazil	70	80	80	70	71	85	73	73
Dominican Republic	45	67	58	30	57	75	50	32
El Salvador	43	50	46	33	48	67	45	40
Guatemala	54	60	52	35	50	70	51	34
Guyana	36	45	35	25	22	74	37	19
Haiti	53	52	59	35	42	75	50	28
Honduras	52	66	61	47	67	75	55	46
Mexico	46	53	55	32	49	62	51	40
Nicaragua	40	54	51	24	49	77	41	29
Panama	53	53	48	31	43	76	44	43
Peru	51	60	57	48	72	73	58	38
Average	49	58	55	37	52	74	51	38

	Political support	Policy formulation	Organizational structure	Program resources	Eval., mon., res.	Legal and regulatory	Prevention programs	Care programs
Eastern Europe								
Belarus	46	61	62	39	58	78	63	44
Kazakhstan	42	45	49	25	41	77	52	17
Russia	35	56	45	28	38	78	57	43
Ukraine	43	57	48	20	46	82	52	24
Average	41	55	51	28	46	79	56	32
Grand average	54	63	60	38	52	78	55	36

Appendix B. Service availability scores for capital cities by country and service- 2000

	Condoms	STI	VCT	IE&C	Blood	NEP	Care	Support	Youth	MTCT
Eastern and Southern Africa										
Ethiopia	76	54	27	64	94	4	23	21	50	10
Kenya	62	61	31	58	92	0	38	37	38	25
Malawi	77	75	59	78	99	40	33	38	59	24
Mozambique	51	46	23	47	53	18	22	31	50	31
Rwanda	60	56	40	63	88	23	23	28	49	24
South Africa	37	32	28	25	92	23	17	18	41	10
Tanzania	64	55	39	67	83	4	35	30	46	31
Uganda	71	62	61	73	86	0	37	43	61	27
Zambia	66	51	36	60	94	0	17	49	57	30
Zimbabwe	75	75	40	73	97	12	33	35	50	37
Average	67	59	39	65	87	11	28	34	52	26
Western and Central Africa										
Burkina Faso	68	39	20	49	84	20	13	24	34	16
Congo, D.R.	49	34	16	62	41	8	19	22	33	20
Cote d'Ivoire	79	56	42	58	84	12	30	30	56	35
Ghana	82	59	23	69	94	0	33	21	54	19
Mali	77	69	46	64	98	16	57	49	49	37
Nigeria	64	47	21	51	53	7	27	29	41	18
Senegal	60	55	24	67	96	12	27	26	58	34
Average	68	51	28	60	78	11	29	29	46	26
Asia										
China	73	73	47	42	79	8	34	23	43	30
Indonesia	45	26	19	47	81	4	22	26	29	19
Nepal	67	44	22	46	79	19	19	16	28	17
Philippines	61	51	45	61	81	15	37	37	46	42
Vietnam	80	67	57	87	94	32	55	54	69	59
Average	65	52	38	57	83	16	33	31	43	33
Latin America										
Brazil	54	61	67	64	97	24	80	53	73	62
Dominican Republic	74	63	38	66	89	0	36	31	50	29
El Salvador	45	50	30	37	88	7	35	29	32	33
Guatemala	57	45	28	39	76	10	34	28	32	28
Guyana	67	65	43	51	91	6	31	25	50	24
Haiti	62	41	27	55	91	10	16	20	41	13
Honduras	55	45	50	56	82	11	33	31	45	28
Nicaragua	57	47	36	39	81	9	22	19	40	31
Panama	76	77	51	45	97	8	53	44	45	49
Peru	64	56	45	44	84	1	34	26	40	46

	Condoms	STI	VCT	IE&C	Blood	NEP	Care	Support	Youth	MTCT
Average	61	55	42	50	88	8	37	31	45	34
Eastern Europe										
Belarus	79	77	77	68	98	44	73	53	68	70
Kazakhstan	73	61	50	43	74	6	53	20	41	49
Russia	81	83	61	59	98	8	39	25	59	59
Ukraine	59	63	70	33	100	18	51	20	43	26
Average	73	71	64	51	92	19	54	30	53	51
Grand average	65	56	41	57	86	13	34	31	48	33

Appendix C. Combined service availability scores by country – 2000

	Capital	Other Urban	Rural	Total
Eastern and Southern Africa				
Africa				
Ethiopia	47	22	15	17
Kenya	47	26	19	26
Malawi	33	18	13	16
Mozambique	39	23	15	19
Rwanda	48	27	17	18
South Africa	33	18	13	16
Tanzania	50	31	23	26
Uganda	58	34	20	24
Zambia	51	29	17	25
Zimbabwe	57	41	31	36
Average	46	27	18	22
Western and Central Africa				
Benin	57	30	24	30
Burkina Faso	40	22	12	15
Congo, D.R.	33	15	10	13
Cote d'Ivoire	52	25	15	26
Ghana	50	33	25	30
Mali	61	31	19	25
Nigeria	39	22	13	18
Senegal	50	24	15	24
Average	48	25	17	23
Asia				
China	49	27	16	20
Indonesia	74	44	31	46
Nepal	38	17	11	13
Philippines	51	27	20	26
Vietnam	69	36	24	28
Average	56	30	20	26
Latin America				
Brazil	68	44	33	44
Dominican Republic	53	23	16	31
El Salvador	42	23	14	23
Guatemala	41	18	12	18
Guyana	49	23	15	22
Haiti	41	19	13	20
Honduras	47	26	19	26
Nicaragua	41	22	13	24
Panama	60	29	21	37

Peru	49	24	13	28
Average	49	25	17	27
Eastern Europe				
Belarus	74	44	31	46
Kazakhstan	56	25	17	24
Russia	63	39	18	35
Ukraine	52	28	13	25
Average	61	34	20	32
Grand average	51	28	18	26

Appendix C. Items in the AIDS Program Effort Index

I. POLITICAL SUPPORT

1. High-level national government support exists for effective policies and programs.
2. Public opinion supports effective programs and policies.
3. Top government civil servants outside of the MOH recognize AIDS/STIs as a priority problem.
4. Major religious organizations support effective policies and programs.
5. Private sector leaders support effective policies and programs.
6. There are local activities to build support for effective AIDS programs aimed at high-level political and community leaders.
7. There is awareness among policy makers that improving women's social and economic status is important to AIDS prevention.
8. International organizations have made a significant contribution to strengthening the political commitment of top leaders.

II. POLICY FORMULATION

1. A favorable national policy exists.
2. Formal program goals exist.
3. Specific and realistic strategies to meet program goals exist.
4. A national coordinating body exists and functions effectively.
5. Ministries other than Health are involved in policy formulation.
6. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector, women's groups and special interest groups.
7. International organizations have facilitated policy formulation through the provision of technical assistance and guidelines.
8. International organizations have facilitated planning through the provision of technical assistance and guidelines.

III. ORGANIZATIONAL STRUCTURE

1. The AIDS Control Program or National AIDS Commission is placed high in the government structure.
2. The Director of the AIDS Control Programme is full-time and reports to an influential superior officer.
3. A multi-sectoral approach has been implemented and functions well.
4. The private sector is formally included in the AIDS Control Program.
5. Efforts are made to ensure community participation.
6. There is good coordination between activities of the national government, local government, NGOs, private sector and international donors.

IV. PROGRAM RESOURCES

1. Resources are allocated according to priority guidelines.
2. Resource allocation decisions are based on considerations of the cost-effectiveness of interventions.
3. Current funding can be used flexibly in order to support effective new programs.
4. Adequate funding is available for public prevention programs.
5. Adequate funding is available for care of people living with HIV/AIDS.
6. Adequate funding is available for programs to mitigate the impacts of AIDS.
7. The private sector plays a significant role in funding HIV/AIDS prevention and care programs.
8. International organizations have provided a significant portion of funding for prevention programs.
9. International organizations have provided a significant portion of funding for care programs.

V. EVALUATION, MONITORING AND RESEARCH

1. Operational and financial plans are developed that correspond to objectives and targets.
2. Evaluation and research results are actively employed in policy formulation and program planning.
3. Mechanisms and structures for monitoring and evaluation, such as a formal evaluation unit, exist within the program.
4. Special studies are undertaken as needed to improve the program.
5. A sentinel surveillance system for HIV infection exists and functions regularly.
6. A behavioral surveillance system exists and functions regularly.

VI. LEGAL AND REGULATORY ENVIRONMENT

1. Condom advertising is allowed.
2. There are no restrictions on the importation of condoms.
3. There are no restrictions on condom distribution.
4. There are no restrictions on who may receive STI services.
5. NGO registration procedures are clear, straightforward and fair.
6. Rape, sexual abuse and domestic violence are perceived as serious offenses and offenders are adequately prosecuted.
7. International conferences, documents, guidelines, covenants, conventions and treaties have been incorporated into national law or contributed to legal and regulatory reform.

VIII. PREVENTION PROGRAMS

1. Guidelines to reduce the risk of HIV transmission to health workers.
2. An active program to promote accurate HIV/AIDS reporting by the media.
3. A functioning logistics system for drugs for the treatment of STIs and opportunistic infections.
4. A functioning logistics system for condoms.
5. A social marketing program for condoms.
6. Special prevention programs for high-risk groups.
7. Confidential counseling and testing services.
8. Family life education for youth.
9. Programs to prevent mother-to-child transmission by providing testing, counseling, antiretroviral treatment and infant feeding programs.
10. National information, education and communications (IE&C) program.
11. A harm reduction programs for injecting drugs users (including needle exchange, substitution treatment, peer education, condom promotion, demand reduction and prevention).
12. People living with HIV/AIDS are formally included in the program.
13. International programs have contributed significantly to the training of local staff working in prevention programs.
14. International research has contributed significantly to the design of program interventions.
15. International organizations have helped program design and implementation through technical assistance and guidelines.

IX. CARE PROGRAMS

1. Up-to-date policies and guidelines exist for the care and support of people living with HIV/AIDS.
2. An essential package of care and support is provided throughout the national health system. The essential packages includes voluntary counseling and testing for HIV; psychosocial support; palliative care; treatment for pneumonia, oral and vaginal candidiasis, and pulmonary TB; and regulated delivery of care, in particular of TB, STIs and advanced care options.
3. An intermediate package of care and support is provided throughout the national health system. This includes all the items of the essential package plus enhanced TB management (active case finding among people with HIV/AIDS, improved diagnosis of extrapulmonary TB and TB prophylaxis), cotrimoxazole prophylaxis, systemic antifungals, treatment of Kaposi's sarcoma with essential drugs and treatment of cervical cancer with surgery.
4. A comprehensive package of care and support is provided throughout the national health system. This includes all the items of the intermediate package plus antiretroviral therapy, diagnosis and treatment of MAC, CMV, multi-drug resistant TB, toxoplasmosis and HIV-associated malignancies.
5. A comprehensive program exists to provide needed support to AIDS orphans.
6. International programs have contributed significantly to the training of local staff working in care programs.
7. International research has significantly contributed to the design of care programs.
8. International organizations have significantly helped program design and implementation through technical assistance and guidelines.

X. SERVICE AVAILABILITY

1. What percent of sexually active adults in the capital city have reasonably convenient access to the following services:
 - a. Condoms
 - b. STI treatment
 - c. Voluntary counseling and testing
 - d. IE&C programs on HIV prevention
2. What percent of blood transfusions in the capital city use screened blood?
3. What percent of injecting drug users in the capital city have reasonably convenient access to needle exchange programs?
4. What percent of HIV+ people in the capital city have reasonably convenient access to quality medical care of HIV-related problems?
5. What percent of HIV+ people in the capital city have reasonably convenient access to family and personal support to cope with the effects of HIV?
6. What percent of youth in the capital city have reasonably convenient access to information about safe sexual practices?

7. What percent of pregnant women in the capital city have reasonably convenient access to programs to prevent mother-to-child transmission of HIV?
8. How do services in other urban areas compare to those in the capital city?
9. How do services in rural areas compare to those in the capital city?

XI. UNITED NATIONS ROLE

1. UN agencies have made a significant contribution to strengthening the political commitment of top leaders.
2. UN agencies have made a significant contribution to increasing the number and types of institutions involved in the response to HIV/AIDS.
3. UN agencies have facilitated policy formulation through the provision of technical assistance and guidelines.
4. UN agencies have facilitated planning through the provision of technical assistance and guidelines.
5. UN agencies collaborate effectively with each other on HIV/AIDS.
6. UN agencies and the national government collaborate effectively on HIV/AIDS.
7. UN agencies and bilateral donors collaborate effectively on HIV/AIDS.
8. UN agencies and non-governmental organizations (including organizations of people living with HIV/AIDS) collaborate effectively on HIV/AIDS.
9. UN agencies have provided a significant amount of funding for HIV/AIDS prevention programs.
10. UN agencies have helped in the design and implementation of HIV/AIDS prevention programs through technical assistance and guidelines.
11. UN agencies have contributed significantly to the training of local staff working in HIV/AIDS prevention programs.
12. UN agencies have provided a significant amount of funding for HIV/AIDS care programs.
13. UN agencies have helped in the design and implementation of HIV/AIDS care programs through technical assistance and guidelines.
14. UN agencies have contributed significantly to the training of local staff working in HIV/AIDS care programs.

Appendix D. National Consultants Who Implemented the API

Country	Consultant	Number of Respondents
Belarus	Irina Albertovna Mironova	25
Benin	Edouard Wallace	28
Brazil	Euclides Ayres de Castilho	39
Burkina Faso	A. Yvonne Tavi-Outtara	20
China	Ruotao Wang	21
Congo, D.R.	Emile Bongo Beni	21
Cote d'Ivoire	Grazia Tibaldeschi	30
Dominican Republic	William Rafael Duke	30
El Salvador	Ada Auxiliadora Orellana Gonzalez	32
Ethiopia	Melaku Rufael	23
Ghana	Christopher N.L. Tetteh	19
Guatemala	Sergio Aguilar	24
Guyana	Birchete Bonita Harris	27
Haiti	Marie-Dalberg La Fontant Pierre	25
Honduras	Edna Maradiaga	29
Indonesia	Chris Green	17
Kazakhstan	Margaret Stuart	28
Kenya	Sobie Mulindi.	28
Madagascar	Andriamahenina	22
Malawi	Wilfred Alexander Chalamira Nkhoma	17
Mali	Ismaila Samba Traore	20
Mexico	José Romero	19
Mozambique	Luis Alberto Macave	17
Nepal	Mahesh Pradhan	23
Nicaragua	Fernando Campos	27
Nigeria	Adiele Onyeze	26
Panama	Rina Castro de Barba	25
Peru	Ricardo Alberto Furman Wolf	24
Philippines	Tes Cucueco	25
Russia	Elena Yakovlevna Mogilevskaya	18
Rwanda	Ruth Kornfield	28
Senegal	Idrissa Diop	21
South Africa	Paddy Sipho Nhlapo	17
Tanzania	Peter Riwa	22
Uganda	Susan Kasedde	20
Ukraine	Oliynyk Igor	19
Vietnam	Dao Thi Khanh Hoa	27
Zambia	Jolly Kamwanga	19
Zimbabwe	David Munodawafa	23