Joint United Nations Programme on HIV/AIDS

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United Nations General Assembly
Special Session on HIV/AIDS

Monitoring the Declaration of Commitment on HIV/AIDS

GUIDELINES ON CONSTRUCTION OF CORE INDICATORS

UNAIDS/02.51E (English original, August 2002)
ISBN 92-9173-238-9

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Special Session on HIV/AIDS

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Geneva, Switzerland
August 2002

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Acknowledgements

The development of the indicators for the implementation of the Declaration of Commitment on HIV/AIDS and the accompanying guidelines would not have been possible without the assistance of numerous individuals, institutions, organizations and countries.

We would especially like to thank the following: the MEASURE Evaluation Project, particularly for its contributions at the beginning of the process of indicator development; Dr Simon Gregson for technical advice and assistance in the drafting of the guidelines; UNAIDS' Monitoring and Evaluation Reference Group (including evaluation experts from cosponsoring organizations, partner agencies, academic institutions, and nongovernmental organizations), for its guidance and regular feedback; participants of the 'Strengthening Monitoring and Evaluation of National HIV/AIDS Programmes in the Context of the Expanded Response' workshop, held in Dakar, Senegal in February 2002, for their comments; and UNAIDS' Cosponsors and Secretariat focal points for their input and support throughout the entire process.

Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC(s)	Antenatal clinic(s)
API	AIDS Programme Effort Index
BSS	Behavioural surveillance surveys
CCA	Common country assessments
CRIS	Country Response Information System
DAC	Development Assistance Committee
DHS	Demographic and health survey
EC	European Community
FHI	Family Health International
HIV	Human immunodeficiency virus
IDU(s)	Injecting drug user(s)
IEC	Information, education and communication
ILO	International Labour Organization
MEASURE	Monitoring and Evaluation to Assess and Use Results
MICS	Multiple Indicator Cluster Surveys
MTCT	Mother-to-child transmission
NAC(s)	National AIDS Council(s)
NAP(s)	National AIDS Programme(s)
NGO(s)	Nongovernmental organization(s)
NIDI	Netherlands Interdisciplinary Demographic Institute
NSP	National Strategic Plan
OECD	Organization for Economic Cooperation and Development
PCB	Programme Coordinating Board
PMTCT	Prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Papers
SPA	Service Provision Assessment
STD(s)	Sexually transmitted disease(s)
STI(s)	Sexually transmitted infection(s)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WHO	World Health Organization

Introduction

Background

At the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, in June 2001, governments from 189 countries committed themselves to a comprehensive programme of international and national action to fight the HIV/AIDS pandemic by adopting the Declaration of Commitment on HIV/AIDS[1]. The Declaration established a number of goals for the achievement of specific quantified and time-bound targets, including reductions in HIV infection among infants and young adults; improvements in HIV/AIDS education, health care and treatment; and improvements in orphan support.

The Declaration of Commitment also included a pledge, on the part of the United Nations General Assembly, that it would itself devote at least one full day per annum to reviewing the progress achieved in realizing the goals established. To facilitate this ongoing review process, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its partners have developed a set of core indicators that permit monitoring of measurable aspects of the various international and national actions, national programme outcomes, and national impact objectives envisaged in the Declaration of Commitment. Information obtained on these indicators will also be incorporated into reports and publications produced for broader dissemination and debate.

Purpose

The purpose of the current guidelines is to provide countries with technical guidance on the detailed specification of the indicators, on the information required and the basis of their construction, and on their interpretation. These guidelines aim to maximize the validity, internal consistency and comparability across countries and over time of the indicator estimates obtained, and to ensure consistency in the types of data and methods of calculation employed.

Global and national indicators for implementation of the Declaration of Commitment

The indicators are divided into two subgroups: global indicators and national indicators. The global indicators comprise a combination of five indicators that provide information on levels and trends in international commitment to HIV/AIDS control. UNAIDS and its partners are responsible for calculating the global-level indicators. Detailed specifications of these global indicators, the information required to measure them, and guidance on their interpretation are included in these guidelines for easy reference.

The national indicators are further subdivided into three categories:

i) Indicators of national **commitment and action**. These indicators focus on policy, strategic and financial inputs for the prevention of the spread of HIV infection, to provide care and support for those who are infected, and to mitigate the social and economic consequences of high morbidity and mortality;

ii) Indicators of national **programme and behaviour**. These indicators focus primarily on programme outputs, coverage and outcomes (e.g., increased knowledge about HIV/AIDS or altered behaviour);

iii) Indicators of national-level programme **impact**. These indicators measure the extent to which programme activities have succeeded in reducing rates of HIV infection.

For the first two of these categories of national indicators (national commitment and action, and national programme and behaviour), a higher score on an indicator implies better or improved

[1] Resolution A/RES/S-26/2.

performance. For example, if one country has a higher score on the indicator of life-skills-based HIV/AIDS education than another country, this suggests that the first country has a more comprehensive life-skills programme than the second. However, for the third category of indicators (those of national-level programme impact), higher scores on the indicators imply higher prevalence of HIV. Thus, for example, a country with a higher percentage of HIV-infected infants born to HIV-infected mothers would appear to have a less successful programme for preventing mother-to-child transmission of HIV. Clearly, cross-national comparisons will reflect differences in local conditions and differences in data quality as well as differences in programme performance.

The national indicators focus on progress within individual countries. Four of them are also Millennium Development Indicators, established to monitor progress in achieving the goals and targets set in the Millennium Declaration, adopted by all 189 Member States of the United Nations General Assembly in 2000. As far as possible, national indicators have been built on those that have previously been recommended for use in monitoring and evaluation of HIV/AIDS programmes.

Each of the national indicators is applicable to all countries, with the exception of the indicator covering injecting drug users (IDUs). This indicator is applicable to countries where injecting drug use is an established mode of HIV transmission. Similarly, countries with low and concentrated epidemics should report on an alternative indicator of HIV prevalence among high-risk-behaviour groups, as opposed to prevalence among young people obtained from antenatal clinic sentinel surveillance. It is recommended that countries with generalized epidemics also report on this indicator to track the epidemic among all key high-risk-behaviour groups.

A number of additional national indicators have been suggested in the guidelines that could complement or serve to elucidate the information obtained using the relevant core indicator in some settings. For example, an additional indicator might be calculated, utilized and reported on by a country to provide useful interim information in circumstances where calculation of the core indicator awaits the collection of specialist survey data. It is recommended that countries report on these additional indicators, especially those on median age at first sex; number of non-regular sexual partners in the last year; and condom use during last commercial sex.

For those indicators where the Declaration of Commitment requires a specific focus on the 15–24-year-old age group, it is recommended that data be obtained for the whole 15–49-year-old age range, with separate indicator scores being reported by gender for the 15–19-, 20–24- and 25–49-year-old age groups. The Declaration of Commitment listed specific targets to be achieved by 2005 and 2010 for 3 out of the 13 national indicators: knowledge about HIV/AIDS among young people; prevalence of HIV among young people; and prevalence of HIV among newborns.

Some of the targets set in the Declaration of Commitment apply only to those countries that are most affected by the HIV/AIDS pandemic. These and other indicators may be less relevant in countries that currently have low overall levels of HIV prevalence in which case they may be reported on less frequently. Even so, it is important to recognize that relatively small changes in behaviour have the potential to trigger rapid epidemics in these countries. To ensure that this potential is not realized, careful epidemiological surveillance and appropriate and effective HIV prevention must be maintained.

The indicators for monitoring implementation of the Declaration of Commitment will need to be revised from time to time to reflect experience in their use and changes in the course of HIV/AIDS epidemics and in approaches to HIV control. Thus, the identity, specification and method of construction of the core, alternative and additional indicators will be reviewed on a regular basis by UNAIDS and its partners and revisions will be made as and when necessary. Subsequent updates of the guidelines will be available on the UNAIDS website at www.unaids.org.

Guidelines on indicator construction

This manual begins with a list of the core indicators, their reporting schedules and methods of data collection. The list is followed by detailed guidelines for constructing the individual indicators and, in one case, a suggested alternative indicator.

Separate guidelines are presented on the basis and construction of each indicator. In each case, the guideline gives the rationale for the indicator, provides brief details of its purpose, describes the type of measurement tool, method of measurement, and any supplementary information requirements, and ends by highlighting points to be considered when interpreting estimates of the indicator. Targets are given for indicators only where these have been specified in the Declaration of Commitment. Individual countries may, of course, set and monitor progress against their own internal targets if they wish to do so. Where an additional indicator is suggested, this is described at the end of the guideline. Detailed guidance on measurement tools and methods of construction for these additional indicators is beyond the scope of the current guidelines[2]. However, some additional indicators, such as those on median age at first sex and the number of non-regular sexual partners in the last year can be calculated from the same data as are used to calculate the core indicator.

Measurement tools

The principal measurement tools required to provide the necessary data are nationally-representative, population-based sample surveys; schools, health facility and employer surveys; and specially-designed targeted surveys of marginalized groups. Other data requirements should be met from existing routine programme monitoring sources. It is envisaged that these will typically include education and health service records as well as specific HIV/AIDS or sexually transmitted infections (STIs) control programme and surveillance records.

It is anticipated that most of the data required to calculate the indicators will be available from pre-existing sources. In many countries, population-based surveys that collect much of this information (e.g., demographic and health surveys) are carried out on a regular basis. In other countries, similar surveys are conducted that can be extended to incorporate the necessary questions. Most countries also capture information from schools, health facilities and employers on a regular basis so that the HIV/AIDS information required for the indicators covering these areas should be relatively straightforward to collect. The one indicator for which a significant additional data collection effort may be required is that covering injecting drug users. In the meantime, countries may report on service coverage data for IDU services. Where necessary, technical support will be available through the Expanded Theme Groups at country level. In addition, assistance can be sought from the evaluation unit at the UNAIDS Secretariat at UNGASSindicators@unaids.org.

Methods of measurement

Details on method of calculation and on specific data requirements are given for each indicator. Calculation of a number of the indicators entails the initial computation of a numerator and a denominator for a percentage score calculation. Where this is the case, precise definitions are given for both the numerator and the denominator. Some indicators summarize information collected on several interrelated topics. Where this is the case, information on each of the component topics must be provided. In most instances, information is required disaggregated by gender, urban-rural residence etc., so that comparisons of indicator scores between population subgroups can be made. Finally, supplementary information is needed to aid interpretation of some indicators. Requirements for such information are noted in the guidelines, as appropriate.

Where data are extracted from routine programme records, these should be recorded on a consistent basis from year to year, preferably either by calendar year or by financial year. Similarly, data

[2] See the UNAIDS/MEASURE (2000) *National AIDS Programmes: A guide to monitoring and evaluation*, and FHI (2000) *Behavioural surveillance surveys: guidelines for repeated behavioural surveys in populations at risk of HIV,* for detailed guidance on measurement tools and methods of construction for additional indicators.

for specific time points should always be presented using the same reference date—i.e., calendar or financial year end. Details of the dates and periods used when extracting such data should be specified on the indicator return forms. It is particularly important to check the dates and periods used in initial reports before compiling subsequent returns.

The data to be applied in these calculations should, wherever possible, be collected using the standard forms of questions specified in the guidelines. This will help to ensure minimization of reporting bias, particularly where cross-country comparisons are made.

Interpretation

Notes are provided at the end of each guideline on any significant assumptions that are made in the calculation of the indicator and on any factors that may tend to introduce bias into the estimates. Particular attention is paid to highlighting factors that can cause distortion in temporal trends or cross-country comparisons of the indicator, because these may lead to incorrect conclusions being drawn as to the absolute and relative effectiveness of alternative programmes.

Reporting

National governments, through their National AIDS Councils (NACs) or equivalent, are responsible for compiling the national-level indicators with support from UNAIDS and its partners. The national information should be collected in accordance with the procedures described in this manual and must be reported on using standard forms, which are included with these guidelines. NACs (or equivalent) in countries will be responsible for ensuring that the necessary data are collated and submitted in a timely fashion. However, they may delegate or contract out some or all of this work to appropriately qualified individuals or academic institutions. The standard forms include the special formulae used in the computation of individual indicator scores.

Completed forms should be returned to the UNAIDS Secretariat in Geneva. These completed forms should be accompanied by a narrative report highlighting success, as well as constraints and future national plans of action to improve performance, specifically in areas where data indicate weaknesses against national targets. It is expected that all levels of society, including civil society organizations and the private sector (see Appendix 2), will participate in the preparation and dissemination of the national report. UNAIDS strongly recommends that national governments organize a national workshop and/or a broad consultation forum to discuss the major findings of the national report prior to submitting it to UNAIDS. UN Theme Groups and Expanded Theme Groups in country are available to assist the NAC (or equivalent) in facilitating this process. All national reports will be made public on the UNAIDS website. The Country Response Information System (CRIS), which is expected to be operational in all countries by 2004, will serve as an information system for national responses and will house all data obtained on core and additional indicators for use in monitoring implementation of the Declaration of Commitment.

Varying preferred and minimum frequencies of reporting have been determined for the different indicators. These reflect likely differences in the availability of the data needed to calculate the various indicators. For example, reports on indicators that require data from population-based surveys must be provided at least every four-to-five years, while reports for indicators based on routine programme monitoring information are generally required at two-year intervals. The reporting schedule for the indicators is set out in Appendix 1 to these guidelines.

In principle, the methods described in these guidelines can also be applied at the subnational level. However, they require detailed data that are less likely to be available and too expensive or less feasible to collect at the local level. Furthermore, the standardized methodology described in these guidelines has been designed to facilitate the construction of global estimates from national-level data and to make it possible to conduct cross-country comparisons. Simpler, faster and more flexible approaches, tailored to local conditions, may therefore be more appropriate to guide decision-making at, for example, the district level.

Core indicators for implementation of the Declaration of Commitment

(approved by the Programme Coordinating Board of UNAIDS, May 2002)

Global level

Global commitment and action

Indicators	Reporting schedule	Method of data collection
1. Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition	Annual	Survey on financial resource flows
2. Amount of public funds available for research and development of vaccines and microbicides	Annual	Survey on financial resource flows
3. Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes	Annual	Desk review
4. Percentage of international organizations that have HIV/AIDS workplace policies and programmes	Annual	Desk review
5. Assessment of HIV/AIDS advocacy efforts	Annual	Qualitative desk assessment(s)

National level

1. National commitment and action

1. Amount of national funds spent by governments on HIV/AIDS	Biennial	Survey on financial resource flows
2. National Composite Policy Index	Biennial	Country assessment questionnaire

2. National programme and behaviour

1. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	Biennial	School-based survey and education programme review
2. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	Biennial	Workplace survey
3. Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counselled	Biennial	Health facility survey
4. Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	Biennial	Programme monitoring and estimates
5. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	Biennial	Programme monitoring and estimates
6. Percentage of IDUs who have adopted behaviours that reduce transmission of HIV*	Biennial	Special survey
7. 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** **(Target: 90% by 2005; 95% by 2010)**	Every 4–5 years	Population-based survey
8. Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner**	Every 4–5 years	Population-based survey
9. Ratio of current school attendance among orphans to that among non-orphans, aged 10–14**	Every 4–5 years	Population-based survey

3. Impact

1. Percentage of young people aged 15–24 who are HIV-infected** **(Target: 25% in most affected countries by 2005 25% reduction, globally, by 2010)**	Biennial	HIV sentinel surveillance
2. Percentage of HIV-infected infants born to HIV-infected mothers **(Target: 20% reduction by 2005; 50% reduction by 2010)**	Biennial	Estimate based on programme coverage

* Applicable to countries where injecting drug use is an established mode of HIV transmission

** Millennium Development Goal indicators

GLOBAL COMMITMENT AND ACTION INDICATORS

1. Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition
2. Amount of public funds available for research and development of vaccines and microbicides
3. Percentage of transnational companies that are present in developing countries and that have HIV/AIDS workplace policies and programmes
4. Percentage of international organizations that have HIV/AIDS workplace policies and programmes
5. Assessment of HIV/AIDS advocacy efforts

International funding for HIV/AIDS

Amount of funds spent by international donors on HIV/AIDS in developing countries and countries in transition

PURPOSE	To monitor the flow of international aid for HIV/AIDS
FREQUENCY	Annual
MEASUREMENT TOOL	UNAIDS/United Nations Population Fund (UNFPA)/Netherlands Interdisciplinary Demographic Institute (NIDI) survey on financial resource flows.
METHOD OF MEASUREMENT	Survey questionnaires are distributed annually to selected international donors that fund HIV/AIDS and sexually transmitted disease (STD) activities. 'International donors' comprise members of the Organization for Economic Cooperation and Development (OECD)/Development Assistance Committee (DAC) countries, multilateral organizations, international nongovernmental organizations (NGOs), major private foundations, and international and regional banks that provide assistance to HIV/AIDS-related programmes. A list of these agencies is maintained by UNAIDS. The total number of agencies contacted and the response rate achieved will be noted. Any major changes in survey coverage between survey rounds will also be noted.

INTERPRETATION

- The list of international donors contacted is not exhaustive and some may fail to respond. Also, HIV/AIDS-related aspects are often integrated within broader activities, making isolation of their specific costs problematic. For these reasons, the indicator is likely to be an underestimate of total international donor expenditure on HIV/AIDS and fluctuations in the indicator will reflect variations in response to the survey as well as genuine trends in funding levels.
- Funding provided through regional groupings such as the European Community (EC) is included in the indicator, with appropriate adjustments to prevent double-counting.
- Previously, the survey instrument on resource flows did not disaggregate resources spent on HIV/AIDS and STDs. However, as from 2002, financial data will be disaggregated by STD control activities; HIV/AIDS prevention; HIV/AIDS clinical care and treatment; and HIV/AIDS support and impact mitigation. International funding for condom promotion and distribution will be reported on separately.

Public funding for research and development

Amount of public funds available for research and development of vaccines and microbicides

PURPOSE	To monitor the flow of public resources for the development of global public goods
FREQUENCY	Annual
MEASUREMENT TOOL	Survey on financial resource flows
METHOD OF MEASUREMENT	Survey questionnaires are distributed annually to countries with governments that provide funding to research institutions for research and development of vaccines and microbicides.

INTERPRETATION

- This indicator provides a proxy measure of the commitment of governments to HIV/AIDS research and development. Public funding from governments is only a small fraction of the total expenditure on research and development of vaccines and microbicides.
- Public funding for items such as drugs for the treatment of HIV/AIDS and other STDs is minimal and is therefore not included in this indicator.

Workplace HIV/AIDS control in transnational companies

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

PURPOSE

To assess progress in implementing workplace policies and programmes to combat HIV/AIDS in transnational companies.

FREQUENCY

Annual

MEASUREMENT TOOL

Desk review and key informant interviews

METHOD OF MEASUREMENT

The United Nations Conference on Trade and Development (UNCTAD) list of the 100 largest transnational companies ranked by foreign assets, plus an additional 10 transnational companies in the mining and tourism sectors, are asked to state whether they currently implement personnel policies and procedures that cover, as a minimum, *all* of the following aspects:

1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.
2. Workplace-based HIV/AIDS prevention, control and care programmes that cover: (a) the basic facts on HIV/AIDS; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) voluntary counselling and testing (VCT); (e) sexually transmitted infection (STI) diagnosis and treatment; and (f) provision of HIV/AIDS-related drugs.

Numerator: Number of employers with HIV/AIDS policies and regulations that meet all of the above criteria.

Denominator: Number of employers surveyed (110).

Copies of written personnel policies and regulations should be obtained and assessed wherever possible.

Workplace HIV/AIDS control in international organizations

Percentage of international organizations that have HIV/AIDS workplace policies and programmes

PURPOSE

To assess progress in implementing workplace policies and programmes to combat HIV/AIDS in international organizations.

FREQUENCY

Annual

MEASUREMENT TOOL

Desk review and key informant interviews

METHOD OF MEASUREMENT

Major international organizations—United Nations, EC, bilateral and other international organizations with global coverage and a development, humanitarian or emergency-relief mandate—are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, *all* of the following aspects:

1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.
2. Workplace-based HIV/AIDS prevention, control and care programmes that cover: (a) the basic facts on HIV/AIDS; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) VCT; (e) STI diagnosis and treatment; and (f) provision of HIV/AIDS-related drugs.
3. Training for HIV/AIDS control in conflict, emergency and disaster situations*.

Numerator: Number of major international organizations with HIV/AIDS policies and regulations that meet the above criteria.

Denominator: Number of major international organizations for which policies and procedures were reviewed.

A core list of major international organizations that fulfil the necessary criteria for global coverage and a development, humanitarian or emergency-relief mandate for the purposes of calculating this indicator will be maintained by UNAIDS.

Copies of written personnel policies and regulations should be obtained and assessed wherever possible.

INTERPRETATION

- This indicator does not specifically address international peacekeeping forces: it is expected that national governments will train their peacekeepers as part of their national strategy that addresses HIV/AIDS among national uniformed services, including armed forces and civil defence forces.

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

HIV/AIDS advocacy

Assessment of HIV/AIDS advocacy efforts

PURPOSE	To assess advocacy efforts to enhance the global response to HIV/AIDS
FREQUENCY	Annual
MEASUREMENT TOOL	Qualitative desk assessment
METHOD OF MEASUREMENT	Qualitative review and analysis of: • media reports • public pronouncements of political leaders • international declarations • global/regional conferences • UNAIDS policies and statements

INTERPRETATION

- Qualitative assessments of the level of advocacy from one year to the next are subject to judgement bias.

NATIONAL COMMITMENT AND ACTION INDICATORS

1. Amount of national funds spent by governments on HIV/AIDS
2. National Composite Policy Index
   - A. Strategic plan
   - B. Prevention
   - C. Human rights
   - D. Care and support

Government funding for HIV/AIDS

Amount of national funds spent by governments on HIV/AIDS

PURPOSE

To monitor the flow of national funding for HIV/AIDS as a measure of national government's economic commitment to fight HIV/AIDS

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

UNAIDS/UNFPA/NIDI survey on financial resource flows

METHOD OF MEASUREMENT

Survey of national government expenditure on HIV/AIDS programmes. The costs of any multilateral or bilateral international donor-funded government programmes should be excluded. Similarly, all local NGO programmes should be excluded, except for programmes (or parts of programmes) that are funded by the national government.

Allocated national funds comprise expenditure on the following four categories of programme, totals for each of which should be specified separately:

1. STD control activities
2. HIV prevention
3. HIV/AIDS clinical care and treatment
4. HIV/AIDS impact mitigation

INTERPRETATION

- This indicator is a measure of economic commitment to enhancing the national response to HIV/AIDS. It is not intended to be used as a measure of resource availability.
- In larger and more decentralized countries, national expenditures at lower levels may not be captured fully in a centrally-administered survey so the total amount of national expenditure on combating HIV/AIDS may be under-reported.

Government HIV/AIDS policies

National Composite Policy Index

PURPOSE

To assess progress in the development of national-level HIV/AIDS policies and strategies

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

Country assessment questionnaire (see Appendix 3)

METHOD OF MEASUREMENT

The composite index covers four broad areas of policy:

A. Strategic plan

B. Prevention

C. Human rights

D. Care and support

A number of specific policy indicators have been identified for each of these policy areas (see list on page 22). A separate index is calculated for each policy area by adding up the scores (yes = 1, no = 0) for the relevant specific policy indicators and calculating the overall percentage score. The composite index is calculated by taking the average of the scores for the four components.

Where appropriate, the score for a specific policy indicator should be assessed with reference to the standards and criteria provided (see Appendix 3).

INTERPRETATION

- The simple quantitative nature of the National Composite Policy Index means that it does not give information on the effectiveness of national policies and strategies. Therefore, a separate AIDS Programme Effort Survey will be conducted in selected countries to assess the effectiveness of national policies and strategies.

A. Strategic plan

1. Country has developed multisectoral strategies to combat HIV/AIDS.
2. Country has integrated HIV/AIDS into its general development plans.
3. Country has a functional national multisectoral HIV/AIDS management/coordination body.
4. Country has a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society
5. Country has a functional HIV/AIDS body that assists in the coordination of civil society organizations.
6. Country has evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes.
7. Country has a strategy that addresses HIV/AIDS issues among its national uniformed services (including armed forces and civil defence forces).

B. Prevention

1. Country has a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS.
2. Country has a policy or strategy promoting reproductive and sexual health education for young people.
3. Country has a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection.
4. Country has a policy or strategy that promotes IEC and other health interventions for cross-border migrants.
5. Country has a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities.
6. Country has a policy or strategy to reduce mother-to-child HIV transmission.

C. Human rights

1. Country has laws and regulations that protect against discrimination people living with HIV/AIDS.
2. Country has laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS.
3. Country has a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations.
4. Country has a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee.

D. Care and support

1. Country has a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups.
2. Country has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups.
3. Country has a policy or strategy to address the additional needs of orphans and other vulnerable children.

NATIONAL PROGRAMME AND BEHAVIOUR INDICATORS

1. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year
2. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes
3. Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counselled
4. Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
5. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy
6. Percentage of IDUs who have adopted behaviours that reduce transmission of HIV*
7. 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**
   (Target: 90% by 2005; 95% by 2010)
8. Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner**
9. Ratio of current school attendance among orphans to that among non-orphans, aged 10–14**

* Applicable to countries where injecting drug use is an established mode of HIV transmission
** Millennium Development Goal indicators

Life-skills-based HIV/AIDS education in schools

School-based HIV prevention programmes have the potential to reach vast numbers of young people. Those programmes that offer participatory and interactive life-skills training on individual, social and environmental factors that affect the risks of HIV transmission have proven to be more effective in bringing about behavioural change—delayed age at first sex, condom use, reduced number of sexual partners, etc.—than more formal approaches that concentrate on providing information.

Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year

PURPOSE

To assess progress in implementing life-skills-based HIV/AIDS education in schools to combat HIV/AIDS

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

School-based survey or education programme review

METHOD OF MEASUREMENT

Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills-based HIV/AIDS education and are then asked the following questions:

1. Does your school have at least one qualified teacher who has received training in participatory life-skills-based HIV/AIDS education in the last five years?
2. If the answer to question 1 is "yes": Did this person teach life-skills-based HIV/AIDS education on a regular basis to each grade in your school throughout the last academic year?

The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes and skills (e.g., interpersonal communication, negotiation, decision-making and critical thinking skills and coping strategies) that assist young people in maintaining safe lifestyles. Wherever possible, the teacher training should have been done in accordance with the latest UNICEF guidelines (http://www.unicef.org/programme/lifeskills).

At least 30 hours of tuition per year per grade of pupil is required if life-skills-based HIV/AIDS education is to qualify as 'standard' tuition for the purposes of calculating this indicator.

Numerator: Number of schools with staff members trained in, and regularly teaching, life-skills-based HIV/AIDS education

Denominator: Number of schools surveyed

Indicator scores are required for all schools combined and for primary and secondary schools separately, each according to private/public status and urban/rural setting. Church schools should be treated as private schools for this purpose. Where a school provides both primary and secondary education, information should be collected and reported separately for each level of education.

Primary and secondary school enrolment rates for the most recent academic year should be stated

INTERPRETATION

- It is important that life-skills-based HIV/AIDS education be initiated in the early grades of primary school and then continued throughout schooling, with content and methods being adapted to the age and experience of the students. Where schools provide both primary and secondary education, at least one teacher should have been trained to teach life-skills-based HIV/AIDS education at each of these levels.
- The indicator provides useful information on trends in the coverage of life-skills-based HIV/AIDS education within schools. However, the substantial variations in the levels of school enrolment that exist within and between countries must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Complementary strategies that address the needs of out-of-school youth will be particularly important in countries where school enrolment rates are low.
- The indicator is a measure of coverage. The quality of education provided may also differ between countries and over time.

ADDITIONAL INDICATOR

Percentage of primary and secondary schools where life-skills-based HIV/AIDS education is taught

APPLICABILITY	All countries
FREQUENCY	Biennial
MEASUREMENT TOOL	Education programme review

NPBI-1

Life-skills-based HIV/AIDS education in schools

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I:
Data requirements

	Primary schools			Secondary schools			All schools		
	Urban	Rural	National	Urban	Rural	National	Urban	Rural	National

NUMERATOR

Instructions:

i) Select *only* those schools that provided information (*ex*cluding "don't know") to *all* 3 questions (i.e. questions 1 to 3 below)
ii) Line 1: enter the number of schools that stated that they had a teacher trained in the last 5 years to teach life-skills-based HIV/AIDS education
iii) Line 2: enter the number of schools that answered "yes" to the question in line 1 and who also reported that their trained teachers taught HIV/AIDS education on a regular basis to all classes in the last academic year

1. **School has at least one teacher trained in the last 5 years to teach life-skills-based HIV/AIDS education**
   - Public sector schools
   - Private sector schools

2. **School has staff member(s) trained to teach HIV/AIDS education in the last 5 years who has taught the subject on a regular basis to all classes in the last academic year**
   - Public sector schools
   - Private sector schools

DENOMINATOR

3. **Number of schools surveyed**
   - Public sector schools
   - Private sector schools

4. **Total number of schools in the country*:**
   - Public sector schools
   - Private sector schools
   - Public and private schools

PART II:
Indicator computation

INDICATOR SCORES BY TYPE AND LOCATION OF SCHOOL

5. **Divide the number of schools (public and private) that reported having a staff member trained to teach HIV/AIDS life-skills-based education (line 2) by the total number covered by the survey (line 3) and multiply the result by 100.**

INDICATOR SCORES BY TYPE OF SCHOOL (NATIONAL)

6. **i) Calculate the weighted average of the urban and rural indicator scores (line 5) using the number of schools in urban and rural areas (line 4) as the weights.**
   ii) Calculate the weighted average of the indicator scores (line 5) by type and location of school using the numbers for each type and location of school (line 4) as the weights.

* From Ministry of Education statistics.

Workplace HIV/AIDS control

Formal sector workers are central to the development efforts of low-income countries. Business productivity is being undermined by the HIV/AIDS epidemic through the detrimental effects of higher morbidity and mortality on staff performance, absenteeism and turnover, skills shortages and low workforce morale. Individual workers frequently have large numbers of dependent relatives. Male workers, in particular, are often at high risk of acquiring and transmitting HIV, especially where labour migration is common. Those infected may also suffer stigma and discrimination in the workplace. However, the workplace is often a highly convenient and conducive setting for HIV control activities and workplace-based interventions have proven to be effective.

Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes

PURPOSE

To assess progress in implementing workplace policies and programmes to combat HIV/AIDS

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

Survey of the 30 largest employers—25 private sector, 5 public sector

METHOD OF MEASUREMENT

Private sector employers are selected on the basis of the size of the labour force. Public sector employers should be the ministries of transport, labour, tourism, education and health. Employers are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, *all* of the following aspects:

1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.
2. Workplace-based HIV/AIDS prevention, control and care programmes that cover: (a) the basic facts on HIV/AIDS; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) VCT; (e) STI diagnosis and treatment; and (f) provision of HIV/AIDS-related drugs.

Numerator: Number of employers with HIV/AIDS policies and regulations that meet *all* of the above criteria

Denominator: Number of employers surveyed (30)

Copies of written personnel policies and regulations should be obtained and assessed wherever possible.

Indicator scores are required for all employers combined and for the private and public sectors separately.

Estimates of the size of the male and female formal sector workforce should also be provided.

INTERPRETATION

- People employed in small businesses and the informal sector often constitute a significant proportion of the workforce but are less likely to be reached by workplace HIV/AIDS programmes. Therefore, this indicator provides an over-estimate of the extent to which workers are covered by these programmes. Nevertheless, trends in this indicator will provide a useful guide to incremental improvements in national coverage.
- The indicator is useful even in countries where HIV prevalence is low because early action in educating workers on HIV prevention is essential if the serious economic and social consequences of HIV/AIDS are to be avoided.

NPBI-2

Workplace HIV/AIDS control

Source of data used: name

Source of data used: type

Date data collected (day/month/year) to

PART I:
Data requirements

	Men	Women	All
FORMAL SECTOR EMPLOYMENT			
1. Formal sector workforce ('000s)			
2. Population aged 15-64 years ('000s)			
Formal sector employment rate			

	Public sector	Private sector	All employers in sample
NUMERATOR			
Anti-discrimination-at-work policies			
3. Staff recruitment and promotion			
4. Staff benefits			
5. Number of employers providing *both* of the above			
Workplace HIV/AIDS prevention, control and care programmes			
6. HIV/AIDS education			
7. Work-related hazards and safeguards			
8. Condom distribution			
9. Voluntary counselling and testing			
10. STI services			
11. Provision of HIV/AIDS-related drugs			
12. Number of employers providing *all* of the above			
Comprehensive workplace policies			
13. Number of employers with anti-discrimination policies (line 5) *and* workplace programmes (line 12)			
DENOMINATOR			
14. Number of employers in sample	**5**	**25**	**30**

PART II:
Indicator computation

INDICATOR SCORES BY EMPLOYMENT SECTOR			
15. Divide the number of employers with comprehensive workplace policies (line 13) by the total number of employers in the sample (line 14) and multiply the result by 100.			

Sexually transmitted infections: comprehensive case management

The risk of HIV transmission is substantially increased when one or both partners in a sexual relationship have another sexually transmitted infection. Thus, the availability and utilization of services to treat and contain the spread of STIs can reduce the rate of HIV transmission within a population. One of the cornerstones of STI control is comprehensive case management of patients with symptomatic STIs.

Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counselled

PURPOSE

To assess progress in implementing universally effective STI diagnosis, treatment and counselling

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

Health facility survey—based on the UNAIDS/MEASURE (2000) *National AIDS Programme: A guide to monitoring and evaluation*

METHOD OF MEASUREMENT

Data are collected in observations of provider-client interaction at a sample of health-care facilities offering STI services. See *Evaluation of a National AIDS Programme: A Methods Package,* UNAIDS/WHO (1999), for details on how to select this sample. Providers are assessed on history-taking, examination, proper diagnosis and treatment of patients, and effective counselling, including counselling on partner notification, condom use and HIV testing.

'Appropriate' diagnosis and treatment and counselling procedures in any given country are those specified in national STI service guidelines.

A 'health-care facility' is defined as any setting (i.e., including public, private, and church sectors) where health-care services are provided by one or more medically-qualified personnel.

Numerator: Number of STI patients for whom the correct procedures were followed on: (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) effective counselling on partner notification, condom use and HIV testing.

Denominator: Number of STI patients for whom provider-client interactions were observed.

Disaggregated indicator scores should be reported for men and women and for patients under and over 20 years of age.

Scores for each component of the indicator (i.e., history-taking, examination, diagnosis and treatment, and counselling) must be reported, in addition to the overall indicator score.

INTERPRETATION

- This composite indicator reflects the competence of health-service providers to correctly identify and treat STIs, the availability of the necessary equipment, drugs and materials, and the provision of appropriate counselling to patients.
- The indicator reflects the quality of services provided but not the cost or accessibility of these services.
- The standard for 'appropriate' care upon which the measurement of the indicator is based may vary between countries (or over time). Currently, syndromic management is seen as the most practical approach in high-prevalence, low-income countries, since there are fewer bottlenecks in diagnosis.

ADDITIONAL INDICATOR

Percentage of public STI clinics where VCT services for HIV are provided and/or referred to other facilities

APPLICABILITY	All countries
FREQUENCY	Biennial
MEASUREMENT TOOL	Programme monitoring

NPBI-3 Sexually transmitted infections: comprehensive case management

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I:
Data requirements

	Males			Females			Both sexes		
	<20	20+	All ages	<20	20+	All ages	<20	20+	All ages

NUMERATOR

Instructions:

i) **Select *only* those patients for whom provider-client interactions were observed on *all* 4 aspects**
ii) **Lines 1-4: enter the number of patients for whom the correct procedures were followed by category of patient (i.e., sex/age group)**
iii) **Line 5: enter the number of patients for whom the correct procedures were followed on *all* 4 aspects**

	Males <20	Males 20+	Males All ages	Females <20	Females 20+	Females All ages	Both sexes <20	Both sexes 20+	Both sexes All ages
1. History-taking									
2. Examination									
3. Diagnosis and treatment									
4. Counselling covering partner notification, condom use and HIV testing									
5. Number of STI patients for whom correct procedures were followed on *all* of the above									

DENOMINATOR

	Males <20	Males 20+	Males All ages	Females <20	Females 20+	Females All ages	Both sexes <20	Both sexes 20+	Both sexes All ages
6. Number of respondents for whom provider-client interactions were observed on *all* of the above 4 aspects (lines 1-4)									

PART II:
Indicator computation

INDICATOR SCORES BY SEX AND AGE GROUP

	Males <20	Males 20+	Males All ages	Females <20	Females 20+	Females All ages	Both sexes <20	Both sexes 20+	Both sexes All ages
7. Divide the number of respondents who received correct treatment for all 4 aspects (line 5) by the number whose treatment was observed on all 4 aspects (line 6) and multiply the result by 100.									

Prevention of MTCT: antiretroviral prophylaxis

In the absence of preventative interventions, infants born to, and breastfed by, HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery, or after delivery through breastfeeding. The risk of MTCT can be reduced through the complementary approaches of antiretroviral prophylaxis for the mother, with or without prophylaxis to the infant, implementation of safe delivery practices, and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months.

Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT

PURPOSE

To assess progress in preventing mother-to-child HIV transmission

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

Programme monitoring and estimates

METHOD OF MEASUREMENT

The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from programme monitoring records. Only those women who completed the full course should be included.

The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT *could potentially have been given* is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates).

Numerator: Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months.

Denominator: Estimated number of HIV-infected pregnant women.

The decision as to whether or not to include women who receive treatment from private sector and NGO clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. Private sector and NGO clinics that provide prescriptions for antiretrovirals but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of MTCT-reduction services.

The definition of a 'full course' of antiretroviral prophylaxis will depend on the country's policy on antiretroviral prophylaxis to reduce the risk of MTCT and may or may not include a dose for newborns. Details of the definition used should be provided.

Separate estimates of the numbers of pregnant women provided with antiretroviral prophylaxis at public sector and private sector clinics should be given.

INTERPRETATION

- In many countries, the estimate of HIV prevalence among pregnant women used in the calculation of this indicator will be based on antenatal clinic (ANC)-based HIV surveillance data. In some of these countries, large numbers of pregnant women do not have access to ANC services or choose not to make use of them. Pregnant women with HIV may be more or less likely to use ANC services (or public rather than private ANC services) than those who are not infected, particularly where antiretroviral prophylaxis can be accessed via such services. In such circumstances, this indicator should be interpreted with reference to recent estimates of utilization of national ANC services.
- Voluntary testing and counselling for HIV and antiretroviral prophylaxis to reduce MTCT can be made available but, ultimately, it is up to individual women to decide whether or not to make use of these services. Thus, a country's score on this indicator will reflect the degree of interest in these services (partly a function of the way in which they are promoted), as well as the extent to which they are available.
- Countries will apply different definitions as to what constitutes a 'full course' of antiretroviral prophylaxis. Thus, inter-country comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case.
- This indicator does not measure compliance with the antiretroviral treatment regime because it is not possible to monitor drug compliance, unless direct supervision is undertaken.

ADDITIONAL INDICATOR

Percentage of public ANC attendees using clinics where VCT services for HIV are provided and/or referred to other facilities

APPLICABILITY	Countries with generalized epidemics
FREQUENCY	Biennial
MEASUREMENT TOOL	Programme monitoring

NPBI-4

Prevention of MTCT: antiretroviral prophylaxis

Source of data used: name

Source of data used: type

Date data collected (day/month/year) | | | | to | | | |

PART I:
Data requirements

	Public sector	Private sector	Total
NUMERATOR			
1. Number of HIV-infected pregnant women provided with ARV therapy to reduce the risk of MTCT in the last month			
DENOMINATOR			
2. Number of women who gave birth in the last 12 months*			
3. HIV prevalence in pregnant women (%)**			
4. Estimated number of HIV-infected pregnant women in the country in the last 12 months			

To calculate line 4, multiply line 2 by line 3, and divide the product by 100.

PART II:
Indicator computation

INDICATOR SCORES BY HEALTH SECTOR

5. Divide the number of HIV-infected pregnant women provided with ARV therapy (line 1) by the relevant sector by the number of HIV-infected pregnant women in the country (line 4) and multiply the result by 100.			

* Use national Central Statistics Office estimates of current annual births.
** In most countries, national sentinel surveillance estimates of HIV prevalence among antenatal clinic attendees can be used.

HIV treatment: antiretroviral combination therapy

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

Percentage of people with advanced HIV infection receiving antiretroviral combination therapy

PURPOSE

To assess progress in providing antiretroviral combination therapy to all people with advanced HIV infection

APPLICABILITY

All countries

FREQUENCY

Biennial

MEASUREMENT TOOL

Programme monitoring

METHOD OF MEASUREMENT

The number of people (i.e., adults and children) with advanced HIV infection who currently receive antiretroviral combination therapy can be calculated as follows:

A: Number of people receiving treatment at start of year

+

B: Number of people who commenced treatment in the last 12 months

–

C: Number of people for whom treatment was terminated in the last 12 months (including those who died).

For the purpose of this indicator, the number of people with advanced HIV infection is taken to be 15% of the total number of people currently infected. The latter is estimated using the most recent national sentinel surveillance data.

Numerator: Number of people with advanced HIV infection who receive antiretroviral combination therapy according to the nationally approved treatment protocol (or WHO/UNAIDS standards).

Denominator: Number of people with advanced HIV infection.

Private sector antiretroviral provision should be included in the calculation of the indicator wherever possible and the extent of such provision should be recorded separately.

The start and end dates of the period for which the antiretroviral combination therapy is given should be stated. Overlaps between reporting periods should be avoided wherever possible.

INTERPRETATION

- The indicator permits monitoring of 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 with advanced stages of HIV infection will vary according to the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral therapy among adults and children. The proportion currently recommended for use in calculating this indicator (15%) is a crude estimate and may be subject to revision. This figure is particularly relevant in situations where the current coverage of antiretroviral combination therapy is low.
- The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of VCT services, perceptions of effectiveness and possible side effects of treatment, etc.
- Preventative antiretroviral therapy for the purpose of prevention of MTCT and post-exposure prophylaxis are not included in this indicator.

ADDITIONAL INDICATOR

Percentage of health facilities with the capacity to deliver appropriate care to people living with HIV/AIDS

APPLICABILITY	All countries
FREQUENCY	Biennial
MEASUREMENT TOOL	Health facility survey (UNAIDS/MEASURE (2000), *National AIDS Programmes: A guide to monitoring and evaluation*)

NPBI-5

HIV treatment: antiretroviral combination therapy

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I: Data requirements	**Males** Public	Private	Total	**Females** Public	Private	Total	**Both sexes** Public	Private	Total
NUMERATOR									
1. Number of people receiving ARV therapy at the beginning of the year ('000)									
2. Number of people who commenced treatment in the last 12 months ('000)									
3. Number of people receiving ARV therapy at the start of the year who died during the year ('000)									
4. Number of people for whom treatment was discontinued for other reasons ('000)									
5. Number of people receiving ARV therapy at the end of the year ('000)									
Calculate line 5 by adding lines 1 & 2 and then subtracting lines 3 & 4									
DENOMINATOR									
6. Number of people (adults and children) with HIV infection in the total population ('000)*									
7. Percentage of people with HIV who are at an advanced stage of infection**									
8. Number of people with advanced HIV infection ('000)									
Calculate line 8 by multiplying line 6 by line 7 and dividing the product by 100.									

PART II:
Indicator computation

INDICATOR SCORES BY SEX AND HEALTH SECTOR

9. Divide the number of people with advanced HIV infection currently receiving ARV therapy (line 5) by the total number with advanced HIV infection (line 8) and multiply the result by 100.									

* From national HIV sentinel surveillance estimates.
** Use default estimate of 15% if locally-specific data are not available.

Injecting drug users: safe injecting and sexual practices

Safe injecting and sexual practices among injecting drug users (IDUs) are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission among IDUs using contaminated injecting equipment is extremely high; and (ii) IDUs can provide a reservoir of infection from which HIV spreads (e.g., through sexual transmission) to the wider population.

Percentage of IDUs who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid sharing injecting equipment and use condoms

PURPOSE

To assess progress in preventing of IDU-associated HIV transmission

APPLICABILITY

Countries where IDU is an established mode of HIV transmission

FREQUENCY

Biennial

MEASUREMENT TOOL

Time-location cluster sample survey or targeted snowball sample survey (see behavioural surveillance survey (BSS) manual)

METHOD OF MEASUREMENT

Survey respondents are asked the following sequence of questions:

1. Have you injected drugs at any time in the last month?
2. If the answer to question 1 is "yes": Have you shared injecting equipment at any time in the last month?
3. Have you had sexual intercourse in the last month?
4. If the answers to questions 1 & 3 are *both* "yes": Did you (or your partner) use a condom when you last had sex?

Numerator: Number of respondents who report having never shared injecting equipment during the last month *and* who also reported that a condom was used the last time they had sex.

Denominator: Number of respondents who report injecting drugs in the last month *and* having had sexual intercourse in the last month.

Indicator scores are required for all IDUs and disaggregated by age: those aged less than 25 and those over 25.

Wherever possible, data for IDUs should be collected through service organizations that traditionally work with these populations. Access to IDU survey participants as well as the data collected from them must remain confidential.

INTERPRETATION

- Gaining access to IDUs poses a significant challenge. Thus, data obtained may not be based on a representative sample of the national IDU population. This will need to be borne in mind when interpreting results and especially when cross-country comparisons are made.
- The extent of IDU-associated HIV transmission within a country depends upon: (i) the size, stage and pattern of dissemination of the national HIV epidemic; (ii) the extent of injecting drug use; (iii) the degree to which IDUs use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among IDUs and between IDUs and the wider population. This indicator provides information on the third of these factors and partial information on the fourth.

NPBI-6

Injecting drug users: safe injecting and sexual practices

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I:
Data requirements

	Males			Females			Both sexes		
	<25	25+	All ages	<25	25+	All ages	<25	25+	All ages

NUMERATOR

Instructions:

- **i)** **Line 1: enter the number of respondents who stated that they had injected drugs in the last month**
- **ii)** **Line 2: enter the number of injecting drug users (line 1) who stated that they had shared drug injecting equipment in the last month**
- **iii)** **Line 3a: enter the number of *all* injecting drug users (line 1) who stated that they had had a sexual partner in the last month**
- **iv)** **Line 3b: enter the number of injecting drug users *who never shared injecting equipment in the last month* (line 2) who stated that they had had a sexual partner in the last month**
- **v)** **Line 4a: enter the number of *all* injecting drug users (line 1) who answered "yes" to the question in line 3 and who reported using condoms on the most recent occasion they had sex**
- **vi)** **Line 4b: enter the number of injecting drug users *who never shared injecting equipment in the last month* (line 2) and answered "yes" to the question in line 3 who reported using condoms on the most recent occasion they had sex**

1. Injected drugs sometime in the last month
2. Injecting drug users in the last month who *avoided* sharing injecting equipment in the last month

3a. Injecting drug users in the last month who had sexual intercourse in the last month

3b. Injecting drug users in the last month who *avoided* sharing injecting equipment but had sexual intercourse in the last month

4a. Injecting drug users in the last month who used condoms during the most recent sexual intercourse (in the last month)

4b. Injecting drug users in the last month who never shared injecting equipment and used condoms during the most recent sexual intercourse (in the last month)

5. **Avoided sharing injecting drug equipment *and* used condoms during most recent sexual intercourse in the last month (line 4b)**
6. Avoided sharing injecting drug equipment and *either* avoided having sex *or* used condoms during most recent sexual intercourse (all in the last month) (line 2 - line 3b + line 4b)

DENOMINATOR

7. **Numbers of respondents who reported having injected drugs in the last month *and* having had sex in the last month**

PART II:
Indicator computation

INDICATOR SCORES BY SEX AND AGE-GROUP

8. **Divide the number of respondents who reported having avoided sharing injecting drug equipment and avoided having unprotected sex in the last month (line 5) by the total number who reported having injected drugs and having had sex in the last month (line 7) and multiply the result by 100**

* This information can be used to calculate the proportion of *all* recent injecting drug users (i.e., including those who did not have sex in the last month) who avoided *all* forms of behaviour associated with risk of HIV transmission within the last month. In calculating this proportion, line 1 (rather than line 7) must be used as the denominator.

Young people's knowledge about HIV prevention

HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV/AIDS is an essential prerequisite—although often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

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

PURPOSE

To assess progress in achieving universal knowledge of the essential facts about HIV transmission

APPLICABILITY

All countries

TARGETS

2005 – 90%
2010 – 95%

FREQUENCY

Preferred: biennial

Minimum: every 4–5 years

MEASUREMENT TOOL

Population-based survey such as DHS, UNICEF MICS, BSS (youth section)

METHOD OF MEASUREMENT

This indicator is constructed from responses to the following set of prompted questions:

1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

Numerator: Number of respondents (aged 15–24 years) who gave the correct answers to *all* five questions.

Denominator: Number of respondents (15–24) who gave answers (*including* "don't know") to all five questions.

Those who have never heard of HIV/AIDS should be excluded from the numerator but included in the denominator.

Indicator scores are required for all respondents aged 15–24 years *and* for males and females, separately, each according to urban/rural residence.

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

INTERPRETATION

- The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners.
- Correct knowledge of false modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safe sexual behaviour, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.
- This indicator is particularly useful in countries where knowledge about HIV/AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained.

NPBI-7

Young people's knowledge about HIV prevention

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I:
Data requirements

	Males			Females			Both sexes		
	Urban	Rural	National	Urban	Rural	National	Urban	Rural	National

NUMERATOR

Instructions:

i) **Select *only* those respondents who gave answers (including "don't know") to *all* 5 questions**
ii) **Lines 1-5: enter the number of respondents who gave the correct answer by category of respondent (i.e., male-urban, male-rural, etc.)**
iii) **Line 6: enter the number of respondents who gave the correct answers to *all* 5 questions**

1. HIV can be avoided by having sex with only one faithful, uninfected partner
2. HIV can be avoided by using condoms
3. A healthy-looking person can have HIV
4. A person can get HIV from mosquito bites
5. A person can get HIV by sharing a meal with someone who is infected

6. **Numbers of respondents giving the correct answers to *all* of the above 5 questions**

DENOMINATOR

7. **Numbers of respondents (aged 15-24) who gave answers (including "don't know") to all of the above 5 questions or had never heard of AIDS**
8. Percentage of the national population (aged 15-24) who live in urban areas*

PART II:
Indicator computation

INDICATOR SCORES BY SEX AND RESIDENCE

9. **Divide the number of respondents who gave the correct answers to all 5 questions (line 6) by the number who answered all 5 questions (line 7) and multiply the result by 100.**

INDICATOR SCORES BY SEX (NATIONAL)

10. **i) Calculate the weighted average of the urban and rural indicator scores (line 9) using the percentages who live in urban and rural areas (line 8) as the weights.**
ii) Take the simple average of the national scores for men and women to get the combined score.

* From National Census Office statistics.

Young people's condom use with non-regular partners

Consistent correct use of condoms within non-regular sexual partnerships substantially reduces the risk of sexual HIV transmission. This is especially important for young people who often experience the highest rates of HIV acquisition because they have low prior exposure to infection and (typically) relatively high numbers of non-regular sexual partnerships. Consistent condom use with non-regular sexual partners is important even in countries where HIV prevalence is low because it can prevent the spread of HIV in circumstances where non-regular relationships are common. Condom use is one measure of protection against HIV/AIDS; delaying age at first sex, reducing the number of non-regular sexual partners, and being faithful to one uninfected partner are equally important.

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

PURPOSE

To assess progress in preventing early-age exposure to HIV through unprotected sex with non-regular partners

APPLICABILITY

All countries

FREQUENCY

Preferred: biennial

Minimum: every 4–5 years

MEASUREMENT TOOL

Population-based survey such as DHS, UNICEF MICS, BSS (youth)

METHOD OF MEASUREMENT

Survey respondents aged 15–24 years are asked whether they have commenced sexual activity (or otherwise this is inferred from responses to a question on age at first sex). Those who report sexual activity (whether currently married or unmarried) are then asked the following questions:

1. In the last 12 months, have you had sexual intercourse with a non-regular partner who was neither your spouse nor someone you were living with?
2. If the answer to question 1 is "yes": How many non-regular partners have you had sex with in the last 12 months?
3. If the answer to question 1 is "yes": Did you (or your partner) use a condom the last time you had sex with your most recent non-regular partner?

Numerator: Number of the respondents (aged 15–24) who reported having had a non-regular (i.e., non-marital and non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.

Denominator: Number of respondents (15–24) who reported having had a non-regular sexual partner in the last 12 months.

Indicator scores are required for all respondents aged 15–24 years *and* for males and females, separately, each according to urban/rural residence.

The percentage of young people who said they had started having sex and the percentage of these who had had a non-regular sexual partner in the last 12 months should be stated.

INTERPRETATION

- This indicator shows the extent to which condoms are used by young people who engage in non-regular sexual relationships. However, the broader significance of any given indicator score will depend upon the extent to which young people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on percentages of young people who have started having sex and (of these) that have engaged in a non-regular partnership within the last year.
- The maximum protective effect of condoms in non-regular sexual intercourse is achieved when their use is consistent rather than occasional. The current indicator will provide an over-estimate of 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 in the most recent sexual act with a non-regular partner will generally reflect the trend in consistent condom use with such partners.
- Condom use is just one measure of protection against HIV/AIDS. Delaying first sex, reducing the number of non-regular sexual partners, and remaining faithful to one's non-infected partners are equally important. Thus, countries are strongly advised to report on the suggested additional indicators on median age at first sex and higher-risk sex in the last year, using data from the same survey instrument as the one proposed for calculating the core indicator.

ADDITIONAL INDICATORS

Median age at first sex

APPLICABILITY	All countries
FREQUENCY	4–5 years
MEASUREMENT TOOL	Population-based survey
METHOD OF MEASUREMENT	The median age at first sex is taken to be the age at which the cumulative proportion of those young men or young women currently aged 15–24 who have had penetrative sexual intercourse reaches 50% (UNAIDS/MEASURE (2000), *National AIDS Programmes: A guide to monitoring and evaluation*).

Higher-risk sex in the last year

APPLICABILITY	All countries
FREQUENCY	4–5 years
MEASUREMENT TOOL	Population-based survey
METHOD OF MEASUREMENT	Percentage of 15–24-year-olds who have been sexually active in the last 12 months and have had sex with a non-marital, non-cohabiting partner in the same period (UNAIDS/MEASURE (2000), *National AIDS Programmes: A guide to monitoring and evaluation*)

Condom use during last commercial sex

APPLICABILITY	All countries
FREQUENCY	4–5 years
MEASUREMENT TOOL	Time-location cluster sample survey or targeted snowball sample survey
METHOD OF MEASUREMENT	Percentage of sex workers who report using a condom with their most recent client, of those surveyed having sex with any clients in the last 12 months (UNAIDS/MEASURE (2000), *National AIDS Programmes: A guide to monitoring and evaluation*)

Condom use during last anal sex between men

APPLICABILITY	Countries where men who have sex with men (MSM) are a recognized vulnerable group
FREQUENCY	4–5 years
MEASUREMENT TOOL	Time-location cluster sample survey or targeted snowball sample survey
METHOD OF MEASUREMENT	Percentage of men or their partners who used a condom during last anal sex with a male partner in the last 6 months (UNAIDS/MEASURE (2000), *National AIDS Programmes: A guide to monitoring and evaluation*)

NPBI-8

Young people's condom use with non-regular partners*

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I:
Data requirements

	Males			Females			Both sexes		
	Urban	Rural	National	Urban	Rural	National	Urban	Rural	National

NUMERATOR

Instructions:

- **i)** Calculate median age at first sex (UNAIDS/MEASURE (2000), *National AIDS Programmes: A Guide to Monitoring and Evaluation)*; enter in Line 1.
- **ii)** Select *only* those respondents (aged 15-24) who gave answers (*e*xcluding "don't know") to *all* of questions 2 to 5 below
- **ii)** Line 2: enter the number of respondents who stated that they had commenced sexual activity
- **iv)** Line 3: enter the number of respondents who stated that they had had any form of sexual relationship in the last 12 months
- **v)** Line 4: enter the number of respondents who stated that they had had a non-regular sexual partner in the last 12 months (NB: a 'non-regular' sexual partner here is someone the respondent was not married to and not cohabiting with at the time they had sex)
- **vi)** Line 5: enter the number of respondents who answered "yes" to the question in line 2 and who reported using condoms when they last had sex with this non-regular partner

1. Median age at first sex*
2. Commenced sexual activity
3. Sexual partner within the last 12 months*
4. Non-regular sexual partner within the last 12 months*
5. **Had a non-regular sexual partner within the last 12 months and used condoms the last time had sex with this partner**

DENOMINATOR

6. **Numbers of respondents (aged 15-24) who reported having had a non-regular sexual partner in the last 12 months (i.e., line 4 above)**
7. Percentage of the national population (aged 15-24) who live in urban areas**

PART II:
Indicator computation

INDICATOR SCORES BY SEX AND RESIDENCE

8. **Divide the number of respondents who reported using condoms with their last non-regular partner (line 5) by the number who reported having had a non-regular sexual partner in the last 12 months (line 6) and multiply the result by 100.**

INDICATOR SCORES BY SEX (NATIONAL)

9. **i) Calculate the weighted average of the urban and rural indicator scores (line 8) using the percentages who live in urban and rural areas (line 7) as the weights.**
ii) Take the simple average of the national scores for men and women to get the combined score.

* The data collected here also provide the information needed for the first two additional indicators recommended in the UNGASS indicator. guidelines
** From National Census Office statistics (as for NPBI-7).

Orphans' school attendance

HIV/AIDS is claiming the lives of ever-growing numbers of adults just when they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly uncertain future. Orphanhood is frequently accompanied by prejudice and increased poverty—factors that can further jeopardize children's chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important, therefore, to monitor the extent to which AIDS support programmes succeed in securing the educational opportunities of orphaned children.

Ratio of current school attendance among orphans to that among non-orphans aged 10–14

PURPOSE	To assess progress in preventing relative disadvantage in school attendance among orphans *versus* non-orphans.
APPLICABILITY	All countries
FREQUENCY	Preferred: biennial Minimum: every 4–5 years
MEASUREMENT TOOL	Population-based survey such as DHS, UNICEF Multiple Indicator Cluster surveys (MICS) or other representative survey
METHOD OF MEASUREMENT	Ratio of the current school attendance rate of children aged 10–14 both of whose *biological* parents have died to the current school attendance rate of children aged 10–14 whose parents are both still alive and who currently live with at least one biological parent.
Orphans' schools attendance (1)	**Numerator**: Number of children who have lost both parents and are still in school. **Denominator**: Number of children who have lost both parents.
Non-orphans' school attendance (2)	**Numerator**: Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school. **Denominator**: Number of children whose parents are both still alive and who live with at least one parent.
Calculate the ratio of (1) to (2)	Indicator scores are required for all children aged 10–14 years and for boys *and* girls, separately. Where possible, the indicator should also be calculated by single year of age (see section on interpretation). The minimum number of orphaned 10–14-year-old children needed to calculate this indicator is 50 (see section on interpretation).

INTERPRETATION

- The definitions of an orphan and non-orphan used here, i.e., child aged 10–14 years at last birthday, both of whose parents are still alive, have died respectively, are chosen so that the maximum effect of disadvantage resulting from orphanhood can be identified and tracked over time. The age range of 10–14 years is used because younger orphans are more likely to have only recently lost their parents, 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 had less time to die and older children are more likely to have left school. Thus, the value of this indicator will tend to be slightly greater than 1, even when orphans suffer no relative disadvantage.

- Typically, the data used to measure this indicator will be 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.
- The indicator does not distinguish children who lost their parents due to HIV/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.

ADDITIONAL INDICATOR

Percentage of children less than 15 years old who are orphans

This indicator provides information on trends in the extent of the orphan burden within a population. Loss of the father, of the mother, and of both parents may each have different implications. Similarly, orphanhood at different ages is liable to carry different consequences. Ideally, therefore, data should be collected by the kind of orphanhood (maternal, paternal and double) and by five-year age-group as well as by gender of child.

APPLICABILITY	All countries
FREQUENCY	4–5 years
MEASUREMENT TOOL	Population-based household survey
METHOD OF MEASUREMENT	Number of children in orphan category and age group divided by number of children in age group times 100 (UNAIDS/MEASURE (2000), *National AIDS Programmes: A guide to monitoring and evaluation*)

NPBI-9a

Orphans' school attendance (boys)

Data source: name

Data source: type

Date collection period (day/month/year) to

Indicator of orphan school attendance	Children in school		Total children		Children in school: % of total		
	Urban	Rural	Urban	Rural	Urban	Rural	National*
URBAN & RURAL COVERAGE							
1. Enter percentages of all urban & rural *households* in the country that were sampled in the population survey							
NON-ORPHANS' SCHOOL ATTENDANCE							
2. Non-orphans (both parents alive)							
Ages: 10							
11							
12							
13							
14							
10-14							
ORPHANS' SCHOOL ATTENDANCE							
3. All orphans (one parent dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
4. Paternal orphans (only father dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
5. Maternal orphans (only mother dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
6. Double orphans (both parents dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
INDICATOR SCORES BY RESIDENCE*							
7. Divide the rate of school attendance among double orphans (line 6) by the rate for non-orphans (line 2) and multiply the result by 100.							
INDICATOR SCORES ADJUSTED FOR DIFFERENCES IN AGE*							
8. Age-standardized ratios							

* National rates will be computed by adjusting for any differences in the coverage of urban and rural households in the survey (i.e.,using the information given in line 1) and in numbers of orphaned and non-orphaned children per household in urban and rural areas. The numbers of double orphans (line 6) should equal the number of all orphans (line 3) minus the numbers of paternal (line 4) and maternal (line 5) orphans.

NPBI-9b

Orphans' school attendance (girls)

Data source: name

Data source: type

Date collection period (day/month/year) to

Indicator of orphan school attendance	Children in school		Total children		Children in school: % of total		
	Urban	Rural	Urban	Rural	Urban	Rural	National*
URBAN AND RURAL COVERAGE							
1. Enter percentages of all urban and rural households in the country that were sampled in the population survey							
NON-ORPHANS' SCHOOL ATTENDANCE							
2. Non-orphans (both parents alive)							
Ages: 10							
11							
12							
13							
14							
10-14							
ORPHANS' SCHOOL ATTENDANCE							
3. All orphans (one parent dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
4. Paternal orphans (only father dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
5. Maternal orphans (only mother dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
6. Double orphans (both parents dead)							
Ages: 10							
11							
12							
13							
14							
10-14							
INDICATOR SCORES BY RESIDENCE*							
7. Divide the rate of school attendance among double orphans (line 6) by the rate for non-orphans (line 2) and multiply the result by 100.							
INDICATOR SCORES ADJUSTED FOR DIFFERENCES IN AGE*							
8. Age-standardized ratios							

* National rates will be computed by adjusting for any differences in the coverage of urban and rural households in the survey (i.e., using the information given in line 1) and in numbers of orphaned and non-orphaned per household in urban and rural areas. The numbers of double orphans (line 6) should equal the number of all orphans (line 3) minus the numbers of paternal (line 4) and maternal (line 5) orphans.

IMPACT INDICATORS

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

(Target: 25% in most affected countries by 2005

25% reduction globally by 2010)

Percentage of HIV-infected infants born to HIV-infected mothers

(Target: 20% reduction by 2005; 50% reduction by 2010)

* Millennium Development Goal indicator

Reduction in HIV prevalence

The ultimate goal in the fight against HIV/AIDS is to eradicate HIV infection. As the highest rates of new HIV infections typically occur among young adults, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people—a 25% reduction in the most affected countries by 2005, and a 25% reduction globally by 2010.

A. Core:

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

PURPOSE	To assess progress towards eradicating HIV infection
APPLICABILITY	Countries with generalized epidemics
TARGETS	2005 – 25% reduction (most affected countries) 2010 – 50% reduction
FREQUENCY	Biennial
MEASUREMENT TOOL	WHO guidelines for HIV sentinel surveillance
METHOD OF MEASUREMENT	This indicator is calculated using data from pregnant women attending ANCs in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas. **Numerator**: Number of ANC attendees (aged 15–24) tested whose HIV test results are positive. **Denominator**: Number of ANC attendees (15–24) tested for their HIV infection status. Median figures should be used for other urban and rural areas. Indicator scores should be given for the whole age range (15–24 years) and disaggregated by five-year age group (i.e., 15–19-year-olds and 20–24-year-olds). The proportions of the total female population aged 15–24 living in the capital city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.

INTERPRETATION

- HIV prevalence at any given age is the difference between the cumulative numbers of people who have become infected with HIV up to this age and the number who 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 most vulnerable and rising mortality rather than behavioural 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 behavioural change should first become detectable in HIV prevalence figures for the 15–19-year-old age group. Where available, parallel behavioural surveillance survey (BSS) data should be used to aid interpretation of trends in HIV prevalence.

- In countries where first sexual intercourse occurs at an older age and/or levels of contraception are high, HIV prevalence among pregnant 15–24-year-old women will differ from that among all women in the age group.
- This indicator 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 subpopulations with high-risk behaviours.

OR

B. Alternative:

HIV prevalence among sex workers and their clients, injecting drug users, men having sex with men

PURPOSE

To assess progress towards eradicating HIV infection.

APPLICABILITY

Countries with low HIV prevalence or concentrated epidemics, where it is not recommended to conduct routine surveillance among pregnant women.

FREQUENCY

Biennial

MEASUREMENT TOOL

UNAIDS/WHO *Second Generation Surveillance Guidelines*; FHI guidelines on sampling in population groups

METHOD OF MEASUREMENT

This indicator is calculated using data from HIV tests conducted among members of chosen population groups in the capital city.

Numerator: Number of members of population groups tested whose HIV test results are positive.

Denominator: Number of members of population groups tested for their HIV infection.

This indicator should be reported for the capital city only, to avoid biases in trends over time. In recent years, many countries have expanded the number of sentinel sites to include more rural ones, leading to biased trends resulting from aggregation of data from these sites.

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.
- Due to the difficulties in access to the high-risk population groups, biases in serosurveillance data are likely to be far more significant than in data from a more generalized population, such as women attending antenatal clinics.
- The period during which people are sex workers, sex workers' clients, injecting drug users or men having sex with men 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 these population groups in the capital city will provide a useful indication of HIV prevention programme performance in the capital city but will not be representative of the situation in the country as a whole.

II-1A Reduction in HIV prevalence

Data source: name

Data source: type

Data collection period (day/month/year) to

PART I: Data requirements	**Capital city**			**Other urban areas**			**Rural**		
	HIV+	Tested	HIV+%	HIV+	Tested	HIV+%	HIV+	Tested	HIV+%
1. 15-year-olds									
2. 16-year-olds									
3. 17-year-olds									
4. 18-year-olds									
5. 19-year-olds									
6. 20-year-olds									
7. 21-year-olds									
8. 22-year-olds									
9. 23-year-olds									
10. 24-year-olds									
11. Percentage of the national population (aged 15-24) who live in capital city, other urban & rural areas*									

PART II:
Indicator computation

INDICATOR SCORES BY URBAN/RURAL RESIDENCE

12. 15-19-year-olds									
13. 20-24-year-olds									
14. 15-24-year-olds									

* From National Census Office statistics

II-1B Reduction in HIV prevalence

Data requirements Complete only those sections that are considered relevant to the country	**Data source:** Name	Type	Collection period		**Capital city** HIV+	Tested	HIV+%
1. Female sex workers			from /	to /			
2. Clients of female sex workers			from /	to /			
3. Injecting drug users			from /	to /			
4. Men who have sex with men			from /	to /			
5. Other (specify): _____			from /	to /			

Reduction in mother-to-child transmission

In high-income countries, strategies such as antiretroviral treatment during pregnancy and following birth and use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In developing countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using VCT and reproductive health and maternal- and child-health services that offer MTCT prevention support. Nevertheless, substantial reductions in MTCT can be achieved in these settings through approaches such as short-course antiretroviral prophylaxis.

Percentage of HIV-infected infants born to HIV-infected mothers

PURPOSE

To assess progress towards eliminating mother-to-child HIV transmission

APPLICABILITY

All countries

TARGETS

2005 – 20% reduction
2010 – 50% reduction

FREQUENCY

Biennial

MEASUREMENT TOOL

Estimates based on programme coverage

METHOD OF MEASUREMENT

The indicator can be calculated by taking the weighted average of the probabilities of MTCT for pregnant women receiving and not receiving antiretroviral, the weights being the proportions of women receiving and not receiving ARV, respectively. Expressed as a simple mathematical formula:

Indicator score = { T*(1-e) + (1-T) } * v

where:

T = proportion of HIV-infected pregnant women provided with antiretroviral treatment

v = MTCT rate in the absence of any treatment

e = efficacy of treatment provided

T is simply national programme and behaviour indicator #4. Default values of 25% and 50%, respectively, can be used for v and e. However, where scientific estimates of the efficacy of the specific forms of antiretroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded.

The most common forms of treatment provided during the last 12 months should be noted.

INTERPRETATION

- This indicator focuses on prevention of MTCT of HIV through increased provision of antiretroviral prophylaxis. Thus, the effect of breastfeeding on MTCT of HIV is ignored and the indicator may yield underestimates of true rates of MTCT in countries where long periods of breastfeeding

are common. Similarly, in countries where other forms of prevention of MTCT of HIV (e.g., caesarean section) are widely practised, the indicator will typically provide overestimates of MTCT. For these reasons, trends in this indicator may not reflect overall trends in MTCT of HIV.

- National programme and behaviour indicator # 4 may provide a poor estimate for T in circumstances where usage of antenatal clinic services is low.

Appendices

II-2 Reduction in mother-to-child transmission

Data source: name

Data source: type PROGRAMME MONITORING

Data collection period (day/month/year) to

PART I:
Data requirements % of total

1. **Proportion of HIV+ pregnant women provided with ARV treatment***	**T**	
2. **MTCT rate in the absence of any treatment (%)**	***v***	**25.0**
3. **Efficacy of treatment provided (proportionate reduction in MTCT rate)**	***e***	**0.5**

List below the 3 most common forms of treatment provided during the last 12 months and the percentages of all treatment that each represents.

PART II:
Indicator computation

INDICATOR SCORE

4. Calculate the indicator score using the formula:
{ T*(1-*e*) + (1-T) } * *v*

* From national programme and behaviour indicator 4.

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

	Global commitment and action	National commitment and action	National programme and behaviour	Impact
2003	Indicators # 1–5	Indicators # 1–2	Indicators # 1–9	Indicators # 1–2
2004	√			
2005*	√	√	Indicators # 1–9	√
2006	√			
2007	√	√	Indicators # 1–6	√
2008	√			
2009	√	√	Indicators # 1–6	√
2010*	√		Indicator # 7	√

- Countries are encouraged to report on all national indicators (national commitment and action; national programme and behaviour; impact) in 2003, using existing data. These figures will then be used as baseline estimates in the monitoring process.
- Progress on national programme and behaviour indicators 1–6 and impact indicators 1–2 should be reported biennially—that is, in 2005, 2007 and 2009.
- Countries are encouraged to carry out population-based surveys required for national programme and behaviour indicators (7, 8, 9) in 2003 for reporting in 2005.

* The Declaration of Commitment has listed specific targets to be achieved by 2005 and 2010 for national programme and behaviour indicator 7 and impact indicators 1 and 2.

Consultation/preparation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicators forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify)	Yes	No

2) With inputs from

Ministries:

Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No

Civil society organizations	Yes	No
People living with HIV/AIDS	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilaterals	Yes	No
International NGOs	Yes	No
Others (please specify)	Yes	No

3)	Was the report discussed in a large forum?	Yes	No
4)	Are the survey results stored centrally?	Yes	No
5)	Are data available for public consultation?	Yes	No

Name / title: _____

Date: _____

Signature: _____

National Composite Policy Index Questionnaire

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS? (Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors.)

Yes	No	N/A
Comments:		

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

Yes	No	N/A
Comments:		

3. Does your country have a functional national multisectoral HIV/AIDS management/coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes	No	N/A
Comments:		

4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes	No	N/A
Comments:		

5. Does your country have a functional HIV/AIDS body that assists in the coordination of civil society organizations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

Yes	**No**	**N/A**
Comments:		

6. Has your country evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes?

Yes	**No**	**N/A**
Comments:		

7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil defence forces?

Yes	**No**	**N/A**
Comments:		

Prevention

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

Yes	No	N/A
Comments:		

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

Yes	No	N/A
Comments:		

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)

Yes	No	N/A
If yes, please list the groups:		
Comments:		

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

Yes	No	N/A
Comments:		

5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to, condoms, sterile needles and HIV tests.)

Yes	**No**	**N/A**
If yes, please list Groups: Commodities:		
Comments:		

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

Yes	**No**	**N/A**
Comments:		

Human rights

1. Does your country have laws and regulations that protect against discrimination people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?

Yes	**No**	**N/A**
Comments:		

2. Does your country have laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

Yes	**No**	**N/A**
If yes, please list groups:		
Comments:		

3. Does your country have a policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable populations?

Yes	**No**	**N/A**
Comments:		

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

Yes	**No**	**N/A**
Comments:		

Care and support

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

Yes	**No**	**N/A**
If yes, please list Groups:	Commodities:	
Comments:		

2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups? (HIV/AIDS-related medicines include antiretrovirals and drugs for the prevention and treatment of opportunistic infections and palliative care.)

Yes	**No**	**N/A**
If yes, please list Groups:	Commodities:	
Comments:		

3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

Yes	**No**	**N/A**
Comments:		

Selected bibliography

UNAIDS/MEASURE (2000) *National AIDS Programmes: A guide to monitoring and evaluation.* Geneva: UNAIDS. http://www.cpc.unc.edu/measure/guide/guide.html

UNAIDS (2000) *Protocol for the identification of discrimination against people living with AIDS*. Geneva: UNAIDS.

UNAIDS/WHO (1999) *Evaluation of a National AIDS Programme: A methods package—prevention of HIV infection*. Geneva: UNAIDS.

UNAIDS/Family Health International (2000) *Second generation surveillance for HIV: The next decade*. Geneva: UNAIDS.

Family Health International (2000) *Behavioural surveillance surveys: Guidelines for repeated behavioural surveys in populations at risk of HIV*. Arlington, USA: Family Health International. http://www.fhi.org/en/aids/wwdo/wwd12a.html#anchor545312

WHO (2002) *Indicators for monitoring and evaluation of HIV/AIDS care and support programme* (draft), Geneva: WHO.

www.measuredhs.com/data (a useful indicator database)

The purpose of these guidelines is to provide National AIDS Councils (or equivalent) with technical guidance on how to measure the core indicators for the implementation of the Declaration of Commitment on HIV/AIDS, adopted by Member States of the United Nations during the United Nations General Assembly Special Session on HIV/AIDS in June 2001. These guidelines provide technical guidance on the detailed specifications of the core indicators, on the information required and the basis of their construction, and on their interpretation. The guidelines also aim to maximize the validity, internal consistency and comparability across countries and over time of the indicator estimates obtained. In particular, the guidelines aim to ensure consistency in the types of data and methods of calculation employed.

Joint United Nations Programme on HIV/AIDS

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