THE LEVEL OF EFFORT IN THE NATIONAL RESPONSE TO HIV/AIDS: THE AIDS PROGRAM EFFORT INDEX (API) 2003 ROUND

USAID, UNAIDS, WHO, AND THE POLICY PROJECT

DECEMBER 2003

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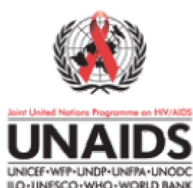

As part of a collaborative effort with countries to improve national AIDS monitoring and evaluation, UNAIDS, USAID, World Health Organization, and the POLICY Project developed the AIDS Program Effort Index (API). POLICY received funds to implement the 2003 API under USAID Contract No. HRN-C-00-00-00006-00 and from UNAIDS. POLICY is implemented by the Futures Group International in collaboration with Research Triangle Institute (RTI) and the Centre for Development and Population Activities (CEDPA). The views expressed in this document do not necessarily represent those of the funding agencies.

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SUMMARY

UNAIDS, USAID, and the POLICY Project developed the AIDS Program Effort Index (API) to measure program effort in the response to the HIV/AIDS epidemic. The index is designed to provide a current profile of national effort and a measure of change over time. The API was applied to 40 countries in 2000; a revised index was applied in 54 countries in early 2003.

The results show that program effort is relatively high in the areas of political support, policies, and planning with average scores above 70 percent of the maximum effort. Prevention programs and the legal and regulatory environment are the next most highly rated components with scores between 60 and 70 percent. The human rights component received the lowest score. Respondents reported that legal structures are in place to protect human rights but that resources and enforcement efforts are lacking. Resource availability and mitigation effort also received low scores. By region, Eastern and Southern Africa has the highest overall scores. West and Central Africa and Asia also scored relatively high, with Latin America and the Caribbean and Eastern Europe somewhat lower. The average score for all countries increased slightly from 56 percent in 2000 to 61 percent in 2003. The largest increases were for political support, resources, and care and treatment.

The API survey shows clearly that all countries have some organized effort to combat the HIV/AIDS epidemic. Most countries have good policies and organizational structures in place. The weakest areas are in the implementation of the policies and plans. Countries with the strongest effort, such as Brazil, Senegal, Thailand, and Uganda, all have strong political commitment and a national consensus that lead to significant effort to implement comprehensive programs.

ABBREVIATIONS

APES	AIDS Policy Environment Score
API	AIDS Program Effort Index
BCC	Behavior change communication
CDC	Centers for Disease Control
IDU	Injecting drug user
IEC	Information, education, and communication
MSM	Men who have sex with men
NGO	Nongovernmental organization
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

INTRODUCTION

The success of HIV/AIDS programs can be affected by many factors, including political commitment, program effort, socio-cultural context, political systems, economic development, extent and duration of the epidemic, and resources available. Many programs track low-level inputs (e.g., training workshops conducted, condoms distributed) or outcomes (e.g., percentage of acts protected by condom use). Measures of program effort are generally confined to the existence or lack of major program elements (e.g., condom social marketing, counseling and testing). To assist countries in such evaluation efforts, several guides have been developed by the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the United States Agency for International Development (USAID) and other organizations (see, for example, "Meeting the Behavioural Data Collection Needs of National HIV/AIDS and STD Programmes" and "National AIDS Programs: A Guide to Monitoring and Evaluation of HIV/AIDS Programs"). However, information about the policy environment, level of political support, and other contextual issues affecting the success and failure of national AIDS programs has not been addressed previously.

Background

As part of a collaborative effort with countries to improve national AIDS monitoring and evaluation, UNAIDS, USAID, and the POLICY Project developed a score, called the AIDS Program Effort Index (API), that measures the key high-level inputs by national programs and international agencies. This index is intended to measure program effort independent of program outputs. For example, program effort includes items such as the degree of political support, the amount of participation of civil society, and the availability of resources but does not include output measures such as the proportion of sex acts protected by condom use or HIV prevalence. There are many uses for scores that measure program effort independent of output. At the global level, an effort score can be used to analyze the independent contribution of program effort to program success in a variety of social and cultural settings. At the country level, an effort score can be used as a diagnostic tool to indicate the strength of various program areas and to suggest corrective action. In this context, the term "national program" encompasses not only the formal government program but also includes efforts by individuals, nongovernmental organizations (NGOs), communities, the commercial sector and so forth.

HIV and AIDS have always been politically sensitive issues. Decades of experience in other highly politicized areas, such as family planning, have shown that strong political commitment is crucial to program success. The greatest difficulty with measuring political commitment is finding any objective measure. Most measures are subjective, limiting their use for inter-country comparison and for measuring trends over time.

In the field of family planning and reproductive health, composite indicators have been constructed to reflect the level of political support for the provision of family planning services (Ross and Stover, 2001) and safe motherhood (Bulatao and Ross, 2001). These are based on the opinions of a designated mix of experts chosen to reflect a variety of institutional and professional views about a number of different aspects of political context and commitment.

Similar program effort scores have been developed that measure the extent to which the policy environment is supportive of effective programs. The PASCA Project has applied the AIDS Policy Environment Score (APES) for HIV/AIDS in Central America (Nunez, Murgueytio, and Stover, 1999). The APES is intended to measure the degree to which the policy environment in a particular country supports efforts to prevent the spread of HIV/sexually transmitted infections (STIs); provides quality care for people with AIDS; ensures the rights of people with AIDS; and ameliorates the negative impacts of

AIDS on individuals, families, communities, and society. The USAID-funded POLICY Project has applied policy environment scores in other areas, including adolescent reproductive health (Wynter, Hardee, and Russell-Brown, 2003).

UNAIDS has recently implemented a National Composite Policy Index to measure progress toward specific goals of the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (UNAIDS, 2003).

Purpose

The purpose of the API is to measure the amount of effort put into national HIV/AIDS programs by domestic institutions and by international organizations. It is part of a broad effort to measure a series of indicators relevant to national AIDS programs.

The uses of the API include:

Description

1. To measure the level of national efforts (where 'national' refers to all domestic inputs including central, regional, and local by both government and NGOs)
2. To measure changes over time

Diagnosis

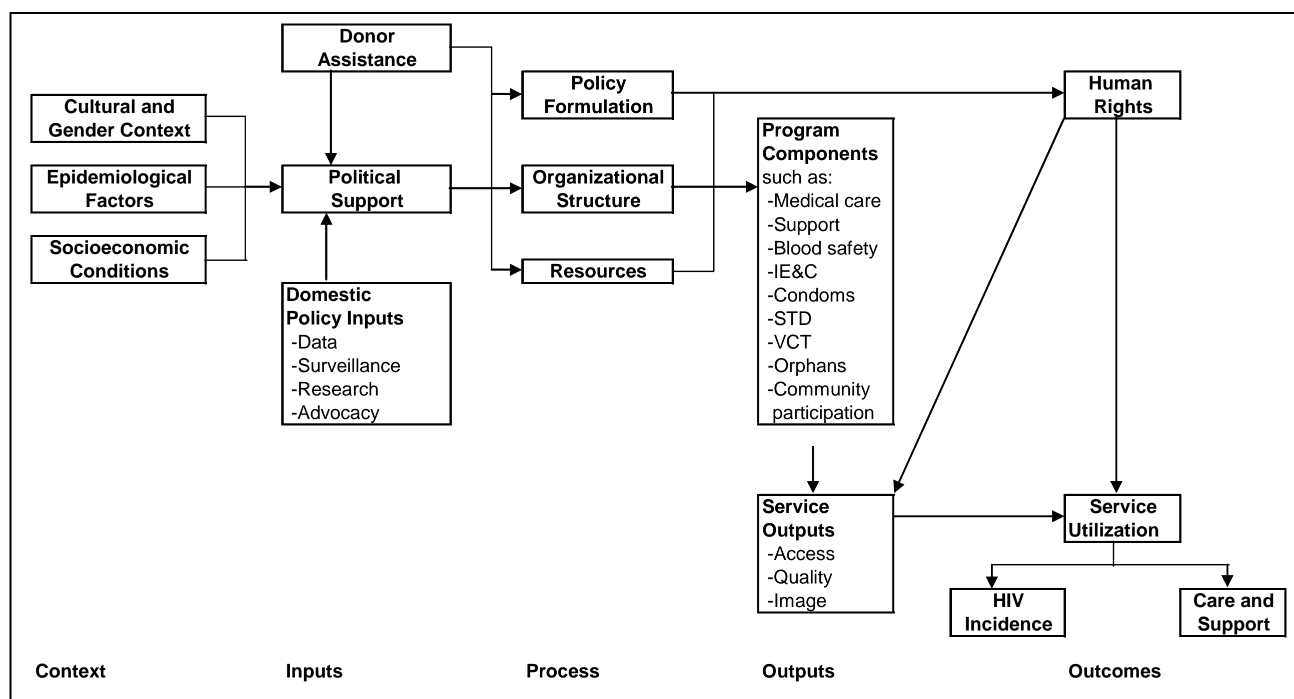
3. To serve as a diagnostic tool to indicate areas of strength and weakness in each country program

Evaluation/Impact

4. To determine the effects of national and international efforts on outcomes

Figure 1 shows the draft conceptual framework for the relationship between HIV/AIDS program effort and desired outcomes. This draft conceptual framework was adapted from a similar framework developed for family planning services (Tsui et al., 1993).

Figure 1. Conceptual Framework of Program Effort and Outcomes



The various social, cultural, economic, and epidemiological factors define the context of the national response to the HIV/AIDS epidemic. These factors may have a powerful influence on the epidemic and the response to it but are largely outside the control of the program. The political response is influenced by these outside factors and also by various domestic efforts to define the extent and nature of the epidemic (through data collection), understand the effects of programs to combat the epidemic (through research), and influence policymakers in certain directions (through advocacy and awareness-raising efforts by domestic governmental and nongovernmental groups). Donor activities in policy dialogue and research also may influence the amount and type of political support for HIV/AIDS programs.

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

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

The API is intended to measure the effort put into HIV prevention and care. It does not measure the socioeconomic context of the epidemic and response nor does it measure the outcomes. Therefore, the API includes all those items contained in the conceptual framework under inputs, process, and outputs. The human rights component is also included even though it is an outcome, because it is also influences service outputs and service utilization.

METHODOLOGY

Background

The API was developed in 1998 through a collaborative process involving the POLICY Project, UNAIDS, USAID, and many interested organizations and individuals and was applied in 40 countries in 2000 (UNAIDS, 2001).

The index contains 10 components corresponding to key boxes in the conceptual framework. The components are:

- Political support
- Policy and planning
- Organizational structure
- Program resources
- Evaluation, monitoring, and research
- Legal and regulatory environment
- Human rights
- Prevention programs
- Care and treatment services
- Mitigation programs

In the 2000 round of the API, there were 100 individual items grouped into these components.[1] Respondents scored each item on a scale of 0 to 5, where 0 indicated the complete lack of effort (e.g., no policy), 5 indicated the maximum score (e.g., a well designed policy in place and being implemented), and scores in between indicated various degrees of quality and implementation. This system was designed to provide evaluations of the quality of effort in addition to the existence of a policy or program. However, analysis of the 2000 results indicated that respondents in different countries used different frames of reference in rating the items. As a result, it was difficult to compare scores across countries.

To address this problem, the API was redesigned for the 2003 round. The same 10 components are used, but the contents have been revised. Instead of asking respondents to rate the national policy on a scale of 0–5, the revised questionnaire asks for "Yes/No" responses to questions about the existence of a policy and a number of characteristics of the policy. This removes some of the judgment from the scores and makes them more easily compared across countries. The revised questionnaire contains 167 of these specific items.

Since these "Yes/No" items cannot capture all the elements of program effort, respondents are asked to provide a summary rating, on a scale of 0–10, for each component. This captures some of the elements that are hard to quantify and provides a score that can be compared with the previous round. In order to gauge progress since 2000, respondents were asked to score each item twice, once for 2003 and once for 2001.

The final score for each component is the average of the qualitative summary score and the quantitative item score. The qualitative summary score is divided by 10 to adjust the range to 0–1. The quantitative

[1] Mitigation was included with care in the 2000 round so there were only nine effort components. In addition, the 2000 round included components for international effort and service availability that were not repeated in the 2003 round.

item score is the proportion of maximum possible score. For most components, this is the proportion of "Yes/No" questions answered "Yes". For the resources component, the adequacy of resources is scored from 0 to 3. The quantitative item score for this component is the proportion of the maximum possible points.

The complete questionnaire is provided in Appendix C.

Implementation in 2003

The revised 2003 questionnaire was field-tested in Haiti and Kenya. The questionnaire and accompanying guidelines were translated into Spanish, French, Brazilian Portuguese, Continental Portuguese, and Russian. The survey was then conducted in 54 countries globally. The number of countries was expanded from the 2000 survey effort in order to improve geographic representation and to include more countries with severe epidemics. All 40 countries from the 2000 round were included as well as all countries in the top 40 when ranked according to numbers of people infected with HIV as estimated in 2001 by UNAIDS/WHO.

National consultants implemented the API in each country. Consultants were independent of the national HIV/AIDS program and UNAIDS but had good knowledge of the program and were familiar with those people considered experts in each subject area of the questionnaire.

The survey process conducted by the national consultants differed somewhat from that implemented during the 2000 round. During the earlier round, national consultants selected 15–25 respondents from diverse backgrounds who were knowledgeable about their country's national AIDS program. During the 2003 round, each national consultant identified a small number of expert respondents for each of the 10 components. Most frequently, at least two respondents were interviewed for each component in order to corroborate the answers. A range of one to 13 experts responded to any given component, with an average of four respondents per component.

Consultants were directed to conduct personal, individual, or small group interviews to ensure that the items on the questionnaire were well understood and to maximize accuracy and completeness. The interview time per respondent ranged from 30 to 60 minutes. Responses were not linked to individual respondents in order to maintain confidentiality. Expert respondents were encouraged to respond to only those items and components of the questionnaire about which they felt sufficiently knowledgeable. On average, 16 respondents were interviewed for each country. Respondents were not meant to be a representative sample but were carefully selected for their professional and in-depth knowledge. Respondents were selected from each of the following backgrounds:

Government
National and provincial AIDS control programs
Ministry of Health
Other ministries
National Drug Control Program
Military
Social Security Administration
Human Rights Commission
Law Reform Commission
National Blood Transfusion Center
National Multisectoral Taskforce/Commission
Parliamentarians

Civil Society
Religious organizations
Research groups
Teaching hospitals and health clinics
Universities
Medical associations and colleges
Journalists

Private Sector
Chambers of Commerce
Large commercial enterprises
Unions
Attorneys and legal specialists

Nongovernmental Organizations
AIDS service NGOs
Family planning associations
Organizations representing people living with HIV/AIDS
Human rights organizations
Advocacy organizations
Legal assistance centers
Child welfare services
Red Cross

Donors
UNAIDS
UNAIDS Co-Sponsors
USAID
CDC
Country and regional offices of other international donors
Representatives of large donor-funded projects
Embassies
National and international foundations

The national consultants are listed in Appendix B. The distribution of respondents by type is shown in Table 1.

After completing all interviews for a country, each national consultant combined the responses from all interviews into a single summary response. Consultants used their discretion in recording majority responses, consensus responses, or otherwise indicating responses that best describe the national AIDS program. Data entry and processing was done at the Futures Group.

Short country reports were prepared on the basis of the initial results. These reports were sent to the national program and to UNAIDS/WHO and USAID representatives in each country for review. Any comments received were incorporated into the final scores.

Table 1. Distribution of Respondents by Type

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

Interpretation of Scores

The API scores are based on responses that are a mixture of fact and judgment. Many items are simple statements of fact, such as “A national strategic plan exists.” Responses to these items should reflect the true situation in each country and scores based on these items alone could be compared across countries. Some items that appear to be simple statements of fact actually require some judgment, such as “Senior government officials speak out favorably about HIV/AIDS at least twice a year.” This statement requires an assessment about the number of officials speaking out, their ranking in the government hierarchy, and the content of their statements. Other items, such as the summary assessments for each component, are purely the judgments of the chosen respondents. On the subjective items, respondent expectations may play a role in their assessments. If respondents expect their government to do a lot, they may give a low score to a level of effort that might receive a higher score from another respondent who does not expect the government to do very much. The extent to which these expectations vary across countries will affect the usefulness of the scores for international comparisons.

The frame of reference of the respondents may change with time. In the mid-1990s, respondents in some Central American countries gave their programs reasonably good scores on resource availability. By 2000, however, these scores had dropped considerably, not because the amount of resources available had declined, but because expectations about what was feasible had been raised by UNGASS and speeches by prominent people at international and regional conferences.

As a result, the API scores do not provide an objective measure of effort that can be used to rank countries precisely. Completely objective scores could be developed from the subset of API items that are the least subject to respondent judgment. However, these scores would not provide a rich picture of overall program effort. The API scores as presented here represent a self-assessment. They show how well national respondents think their national program is doing when asked to rate the program on a list of important items. As such, the scores are most useful to national programs for examining their own level and profile of effort and deciding where increased efforts are needed.

While the API scores do not provide a precise ranking of countries, they are useful for looking at broad categories of effort. It is comforting to note that the programs that are generally recognized as having the strongest program effort (e.g., Brazil, Senegal, Thailand, and Uganda) do score in the top group of countries. Of course, the high scores for these countries could simply be a reflection of the fact that respondents think these are good programs and, therefore, give high scores to most components. The

combination of fact-based items with the more subjective ones is intended to avoid this problem, but we cannot be entirely sure how successful this effort has been.

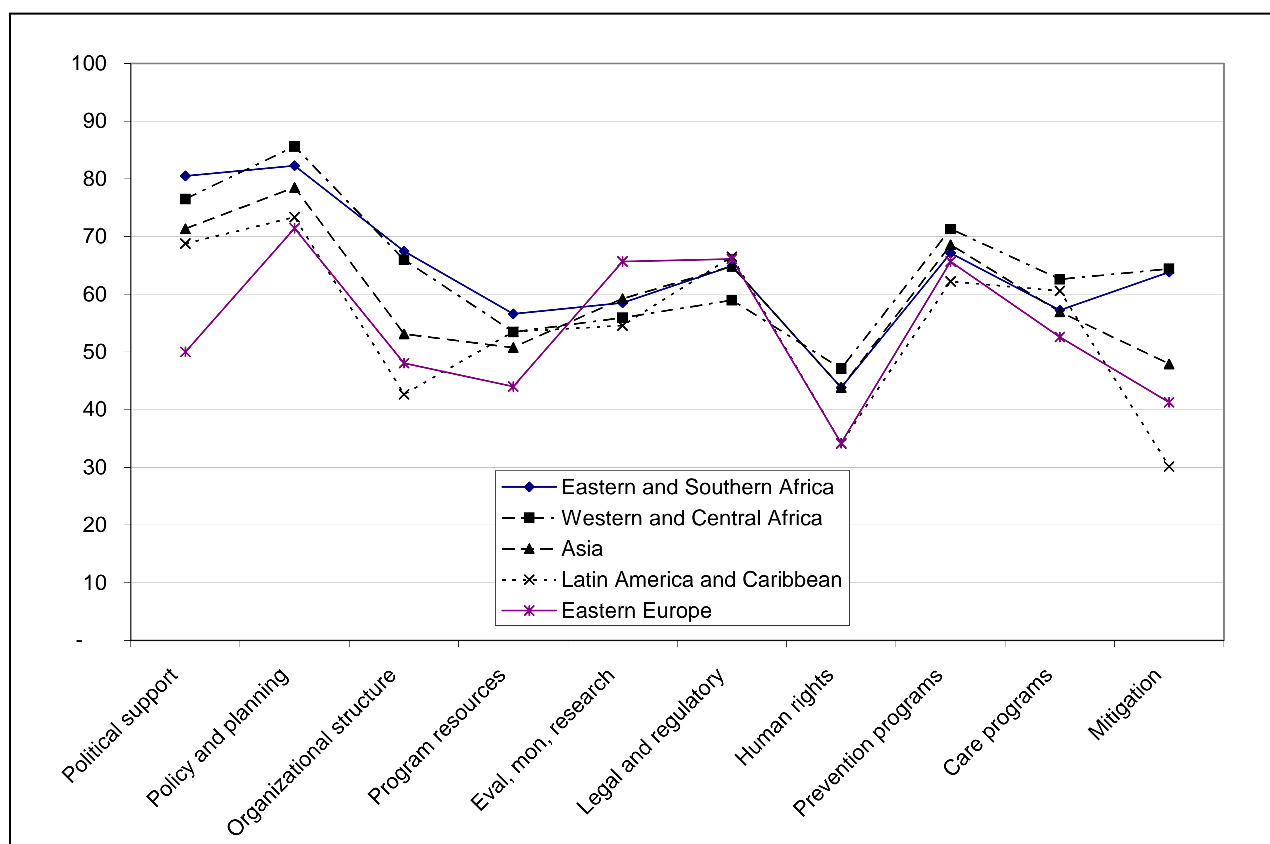
The purpose of the API is not to congratulate countries with high scores and call attention to those with low scores. The low scores may result from low effort, from higher expectations by national respondents, or from less severe epidemics. The purpose of the API is to provide information to countries about how they believe they are doing across a spectrum of key program elements. National programs will be able to use this information as part of their regular efforts to assess their strengths and weaknesses and develop programs to improve on areas of weak effort. Comparisons with other countries or regional averages should inform this process.

Although the API scores are not intended to rank or grade countries on their effort, the scores are useful as profiles of effort at the regional and global levels. These profiles can indicate to international agencies and donors where past efforts have led to improvements and where greater emphasis may be required in the future.

Profile of Program Effort

The average scores by component and region are shown in Figure 2. All five regions show a similar pattern of effort by component. The only deviations from the global pattern are the low level of political support in Eastern Europe, the greater attention to the formal organization of the program in sub-Sahran Africa and the difference in mitigation efforts between sub-Saharan Africa where HIV prevalence is the highest, and the other regions which have much lower prevalence. The detailed API scores by component and country are given in Appendix A.

Figure 2. AIDS Program Effort Index by Component and Region, 2003



- **Policy and planning** received the highest scores. Almost 80 percent of countries report that they have a favorable national policy on HIV/AIDS, and all but one country has a strategic plan. Most of the policies and plans address all the key elements contained in the questionnaire. Overall, countries report meeting 87 percent of the policy and planning criteria in the questionnaire. The summary score was somewhat lower, at 72 percent, indicating that respondents recognize that the implementation of the policies and plans is not as strong as it should be.

- **Political support** received the second highest scores. Most countries report that senior officials speak about HIV/AIDS regularly and have established National AIDS Commissions to coordinate the national response and involve civil society. Almost three-quarters of the countries of Eastern

and Southern Africa have declared AIDS a national disaster. Similar declarations have been made in one-quarter of the countries in Western and Central Africa, one-third of countries in Asia, and almost one-half of countries in Latin America. None of the countries in Eastern Europe has made this declaration. Overall, countries report meeting 76 percent of the political support criteria in the questionnaire. The summary score were somewhat lower, 69 percent, indicating that respondents recognize that actual political support is not as strong as the formal indicators indicate.

- **Prevention programs** ranked third overall. The programs most often implemented included blood safety (93 percent of countries), school-based education (85 percent), social marketing for condoms (84 percent), voluntary counseling and testing (VCT) (84 percent), behavior change communications (BCC) (80 percent), and safe injections (80 percent). The proportion of countries implementing prevention programs for vulnerable populations ranged from 69 percent for sex workers to 27 percent and 29 percent for men who have sex with men (MSM) and injecting drug users (IDUs). Programs for the prevention of mother-to-child-transmission (PMTCT) were reported by 71 percent. It should be noted that these figures refer to the percentage of countries that include these interventions to any degree in the prevention programs. It does not refer to the coverage they have achieved. In fact, although over 84 percent and 71 percent of countries report that VCT and PMTCT are part of their prevention programs, the percentage of the population reached by these programs is only about 12 percent and 5 percent, respectively (WHO, 2002)

- The **legal and regulatory environment** ranked fourth. Most countries have laws and regulations in place that support prevention activities, such as STI treatment, condom provision, information programs, and blood screening. Only about 60 percent have legislation that protects consumers, regulates condom quality, and ensures access to information and supplies. While confidentiality is protected in most countries, only two-thirds outlaw pre-employment screening for HIV. Only one-third of countries have laws and regulations to ensure access to effective and safe medication at affordable prices and only one-quarter provide legal support for harm reduction programs for IDUs. Overall, countries reported meeting about 75 percent of the specific criteria in the questionnaire. In the qualitative assessments, however, the legal and regulatory structure was rated at 56 out of 100, and the efforts to enforce the existing laws and regulations were rated at only 44 out of 100. Clearly, there is much work to be done to translate the legal and regulatory structure into real protection for the population.

- **Care and treatment** programs ranked fifth. Almost all countries reported providing treatment for opportunistic infections and STIs. Palliative care, psychosocial support, universal precautions, and TB treatment are also provided by most countries. The lowest scores were for antiretroviral therapy and treatment of difficult opportunistic infections and HIV-related malignancies. Overall, about 70 percent of essential programs are implemented. But the qualitative ratings of coverage and quality of care were much lower, at only 45 out of 100.

- **Organizational structure** ranked sixth overall. Almost all countries had participation in the HIV/AIDS program from health and education sectors. However, participation of other governmental sectors was reported in only about half of the countries. Although all countries have some formal structure to address HIV/AIDS, only about half reported that they have adequate staff and structure at the national level and only one-third at the district level.

- **Evaluation, monitoring, and research** ranked seventh out of the 10 components. A full-time evaluation officer is in place in about two-thirds of the countries. Most reported that they have AIDS case reporting and that they conduct surveillance among pregnant women and STI patients. Only about one-third conduct surveillance among MSM and IDUs.

- The **availability of resources** ranked eighth. In general, resources are lacking for orphan care, antiretroviral treatment, palliative care, prophylaxis for opportunistic infections, human rights, research, and evaluation. The best funded programs are blood safety, condom provision, and policy development.

- **Mitigation** programs rank next to last. Mitigation is an important part of national programs in most of the countries with high HIV prevalence. In countries with low prevalence, there is less need for mitigation programs related specifically to HIV/AIDS. The lowest score is in Latin America where few countries see the need for mitigation activities as part of the response to HIV/AIDS.

- **Human rights** is the lowest ranked component. The questionnaire actually contains two sections on human rights. One asks about whether countries have ratified the major international human rights instruments such as the Universal Declaration of Human Rights and the Covenant on the Elimination of All Forms of Discrimination Against Women. Almost all countries have ratified these instruments. The second section focuses on the participation and rights of PWLHA, codes of conduct, mechanisms to monitor and enforce human rights compliance, and legal support services. Scores are much lower in these areas. In particular, legal support services are not available in most countries. The qualitative assessment of the enforcement of human rights was only about 40 out of 100 across all regions.

The component scores are not highly correlated with each other. The highest correlation (0.62) is between the scores for prevention programs and organizational structure. Correlations of 0.60–0.62 also exist between political support, organizational structure, resources, and prevention programs. Although the correlation between organizational structure and prevention is the strongest one of the set, the correlation between organizational structure and care is one of the weakest, perhaps indicating that the adequacy of care is more dependent on the strength of the health system than special programs to provide care for HIV.

Change in Program Effort from 2000–2001

Figure 3 shows the change in component scores by region from 2000 to 2003. It includes scores from the 2000 API application, the retrospective scores for 2001 from the 2003 application, and the 2003 scores. The human rights and legal and regulatory components were completely changed since the 2000 application, so 2000 scores for these components are not shown in Figure 3. The 2000 round also did not have a component on mitigation.

Figure 3. Change in API from 2000 to 2003 by Component and Region

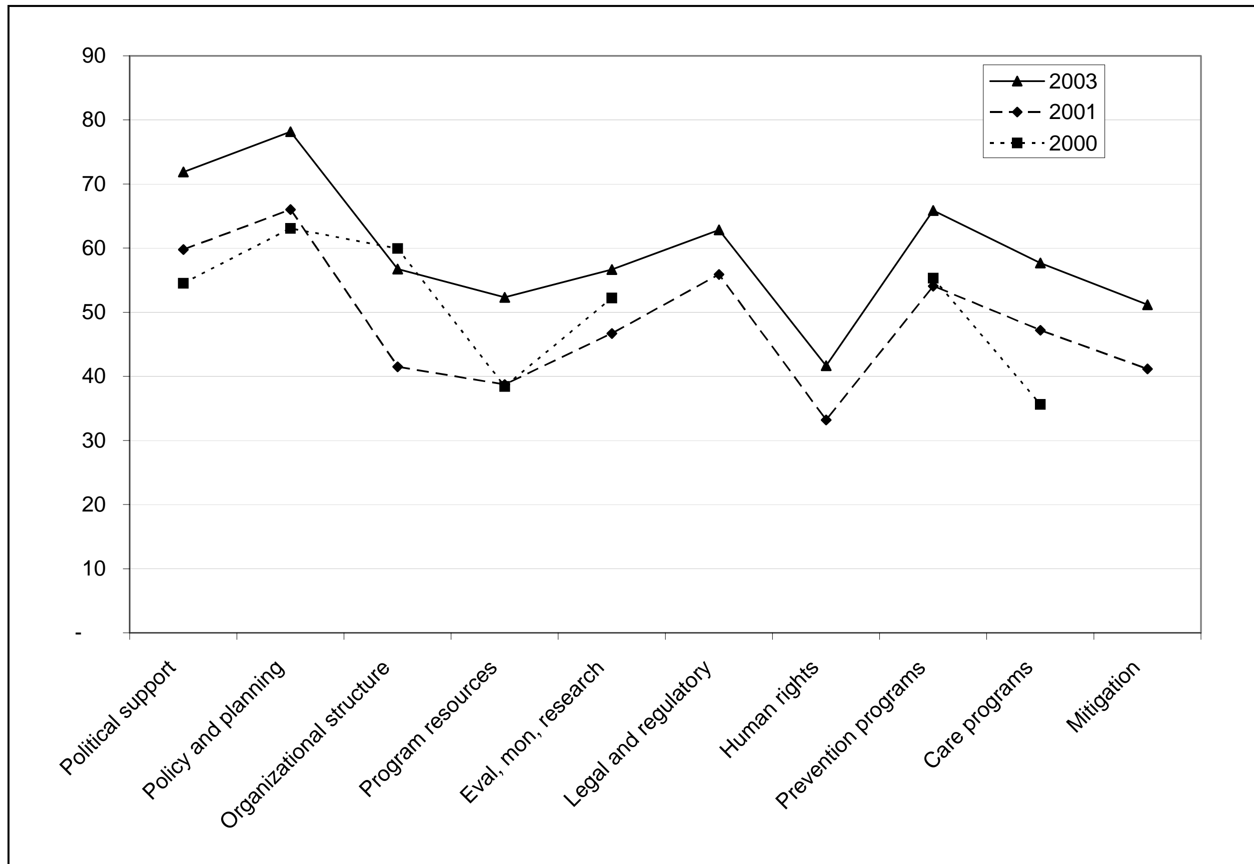


Figure 3 shows a pattern of improvement between 2000/2001 and 2003. The greatest improvements appear for political support, policy and planning, resources, and care and treatment. The increases for resources and care and treatment are particularly significant since they were the lowest rated components in 2000. The increase for the resource component reflects the greater commitment among international donors, bilateral donors, and national governments as reflected in the Abuja Declaration, the UNGASS Declaration of Commitment on HIV/AIDS, the establishment of the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria, and the increasing financial commitments by bilateral donors. The increase in care probably reflects the new emphasis on care by international donors, which had previously focused most of their efforts on prevention.

Highest and Lowest Rated Items

The API questionnaire contains 167 specific items. Some of these are implemented by all countries and some are implemented by fewer than 20 percent. Table 2 shows the 35 items that are implemented by at least 90 percent of all countries. This table shows the success of the effort by UNAIDS and other organizations to help countries develop comprehensive policies and plans. It also shows that almost all countries have ratified the major international human rights agreements. Thus, the structures are clearly in place to support effective programs. However, it should be noted that the existence of a favorable policy or plan is only the first step in effective implementation. There are many policy barriers that need to be addressed to reap the benefits of the policies and plans. Operational policies need to be developed to provide regulations and guidelines, funds need to be authorized, qualified personnel need to be available,

mechanisms to ensure accountability need to be in place, and research needs to monitor the implementation of the policies and plans and lead to changes when problems are encountered.

Table 3 shows the 19 items that have been implemented by less than 40 percent of the countries. This list identifies three major weaknesses:

- Resources for care and mitigation are inadequate, even for palliative care. Typically, care has been funded from national resources, and prevention activities have been funded from international aid. That is changing now as donors place more emphasis on care. However, it has apparently not yet affected resources available at the local level for care.

- There is a lack of attention to programs for MSM and IDUs. The global average is reduced considerably by the almost complete lack of such programs in African countries. Programs for IDUs are reported by 80 percent of Asian countries and 100 percent of those in Eastern Europe. Similarly, programs for MSM are reported by just over half of Asian countries and 75 percent of those in Eastern Europe. In Latin America, however, programs for MSM are reported by only 33 percent, and programs for IDUs are reported by only 25 percent.

- There is little attention to programs to monitor and enforce human rights regulations or to provide legal services to those who may suffer violations. The formal legal structure is in place in most countries, but the resources to make it effective in protecting human rights is still lacking.

Distribution of Total Scores

The total API score is the average of the component scores. These total scores range from a low of 35 to a high of 82 out of 100. Figure 4 shows the distribution of scores. All countries have some organized effort that contains at least one-third of the items studied. The median score is 60. Fifty percent of countries are in the range of 50–69 and eight countries are above 75. Due to the subjective nature of many of the responses, the precise scores for each country are not important, but it is useful to see the overall pattern.

Figure 4. Distribution of Countries by Total Score

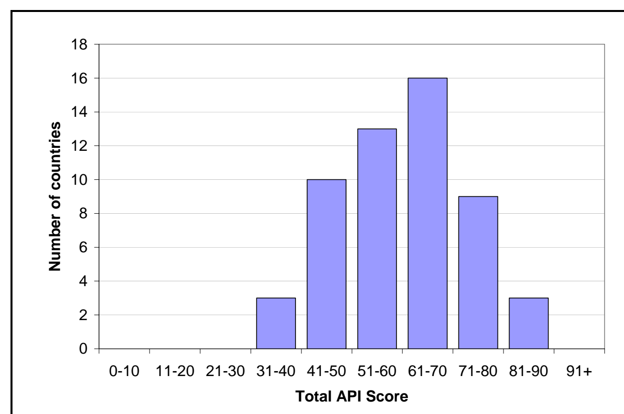


Table 2. Actions Taken by at Least 90 Percent of All Countries

Component	Item
Political support	High government officials speak publicly and favorably about HIV/AIDS issues at least twice a year.
Policy and planning	There is a national strategic plan. The national strategic plan includes: • Formal program goals • Detailed budget • Multisectoral strategies The national policy addresses: • PLHA involvement • Condom promotion and distribution • STI prevention and treatment • VCT • Youth • HIV testing • Information, education, and communication (IEC) • Safe blood • Research and surveillance
Organizational structure	The following government ministries are actively involved in the HIV/AIDS program: • Health • Education
Evaluation, monitoring, and research	Annual HIV surveillance among pregnant women
Legal and regulatory environment	Public health legislation and policies require that blood/tissue/organ supply is free of HIV and other blood-borne disease. Public health and other legislation and policies authorize and empower public health authorities to provide comprehensive prevention and treatment services, including: • HIV/AIDS information and education, for the general population and for targeted populations • VCT • STI and sexual and reproductive health services • Condoms, as a means of HIV/AIDS prevention
Human rights	The government has ratified: • The Universal Declaration of Human Rights • International Covenant on Economic, Social and Cultural Rights • International Covenant on Civil and Political Rights • Convention on the Elimination of All Forms of Discrimination Against Women • Convention on the Rights of the Child • International Convention on the Elimination of All Forms of Racial Discrimination • Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
Prevention	Blood safety programs
Care and treatment	HIV screening of blood for transfusion Treatment of common HIV-related infections: pneumonia, diarrhea, oral thrush, vaginal candidiasis, and pulmonary TB STI prevention (including condom use) and care

Table 3. Actions Taken by Less than 40 Percent of All Countries

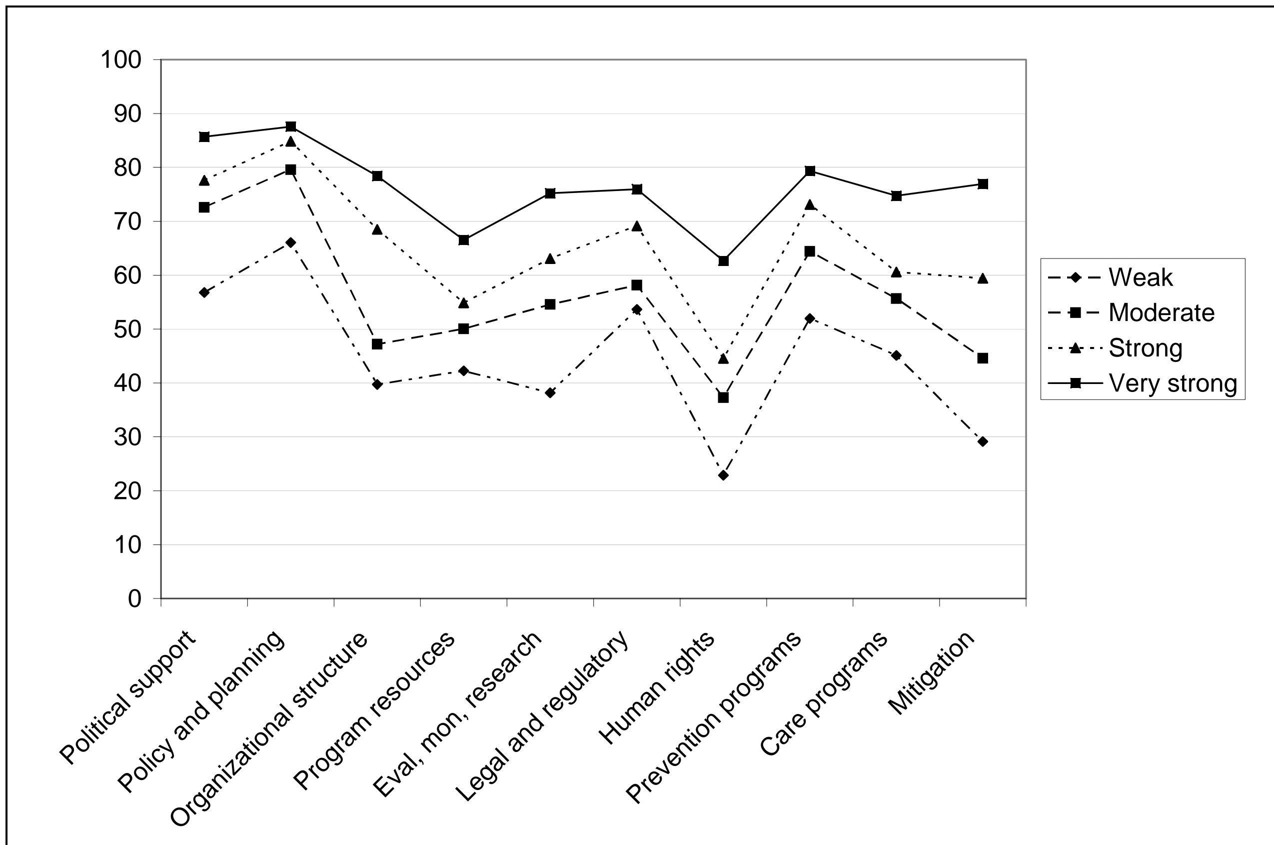
Component	Item
Organizational structure	Adequate administrative structure and staff at the district level Active involvement in the HIV/AIDS program by: • Ministry of Human Resources • Ministry of Minerals and Energy
Resources	Availability of adequate resources for: • Palliative care • Antiretroviral therapy • Orphan care
Evaluation, monitoring and research	Annual surveillance among: • MSM • IDUs
Legal and regulatory environment	Legislation, policies, and programs support reducing the risk of HIV transmission among IDUs by providing HIV-related care and treatment for IDUs, such as authorization or legalization and promotion of needle and syringe exchange programs, including prosecution protection for intermediaries dispensing such needles and syringes
Human rights	Mechanisms are in place to monitor and enforce: • Collection of information on human rights and HIV/AIDS and use of this information as a basis for policy and program development and reform • Establishment of focal points within governmental departments to monitor HIV- related human rights abuses • Development of performance indicators or benchmarks for compliance with human rights standards Legal support services: • State support to private sector laws firms to provide free or pro bono legal services to PLHA in areas such as anti-discrimination • Legal aid systems specializing in HIV/AIDS casework Codes of conduct or ethical standards that address human rights in the context of HIV have been developed for insurance professionals
Prevention	Special programs for the prevention of HIV among: • MSM • IDUs
Care and treatment	Advanced treatment of HIV-related malignancies Diagnosis and treatment of HIV-related infections that are difficult to diagnose and/or expensive to treat, such as atypical mycobacterial infections, cytomegalovirus infection, multiresistant TB, toxoplasmosis, etc.

Profiles of Weak and Strong Programs

The API component scores represent a profile of effort for each country. It is useful to ask whether countries with the strongest effort have higher scores across all components than those with the weakest effort or whether their higher overall scores are due to better effort in a few components. Figure 5 shows the profile of effort for countries by effort category. Countries are categorized has having "weak," "moderate," "strong," and "very strong" effort on the basis of their total API score: weak is 36–50, moderate is 52–60, strong is 61–69, and very strong is 70–82. This classification puts 15 countries in the moderate category and 13 in each of the other three categories.

As Figure 5 shows, countries with stronger effort have higher scores on every component than those that are weaker. Countries with strong effort do not just do better in a few areas but put more effort into all aspects of their programs. However, the difference is particularly large in four components: mitigation; human rights; organizational structure; and evaluation, monitoring, and research. These are among the most difficult areas and, with the exception of evaluation, perhaps the least likely to be bolstered by strong donor support.

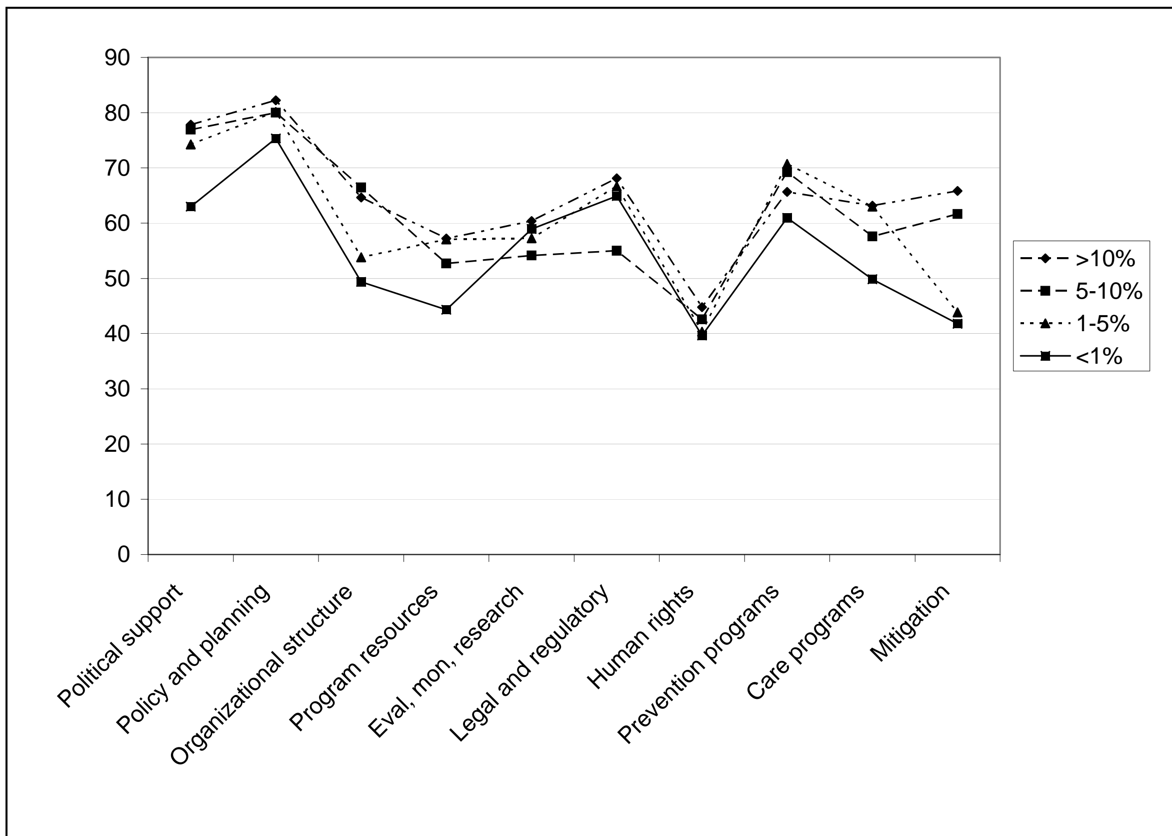
Figure 5. Program Effort Profiles by Overall Level of Effort



Program Effort and Prevalence

HIV/AIDS programs are a response to the epidemic. Therefore, it is logical that stronger programs might be organized in countries with the most serious epidemics. But strong programs also require political commitment, human and financial resources, and organizational capability. Countries with strong economies and stable governments may have a better foundation for a strong HIV/AIDS program. Figure 6 shows the profiles of program effort by adult HIV prevalence. Overall, there is not a strong relationship. Countries with prevalence under 1 percent do have weaker efforts in many components, particularly political commitment, program resources, and mitigation. Countries with prevalence above 1 percent have very similar profiles except for mitigation. For countries with prevalence above 1 percent, factors other than the seriousness of the epidemic determine the level of effort put into the response. There is no relationship between effort and national wealth as measured by Gross National Income per capita. Social, cultural, and personal factors must play a large role in determining national effort.

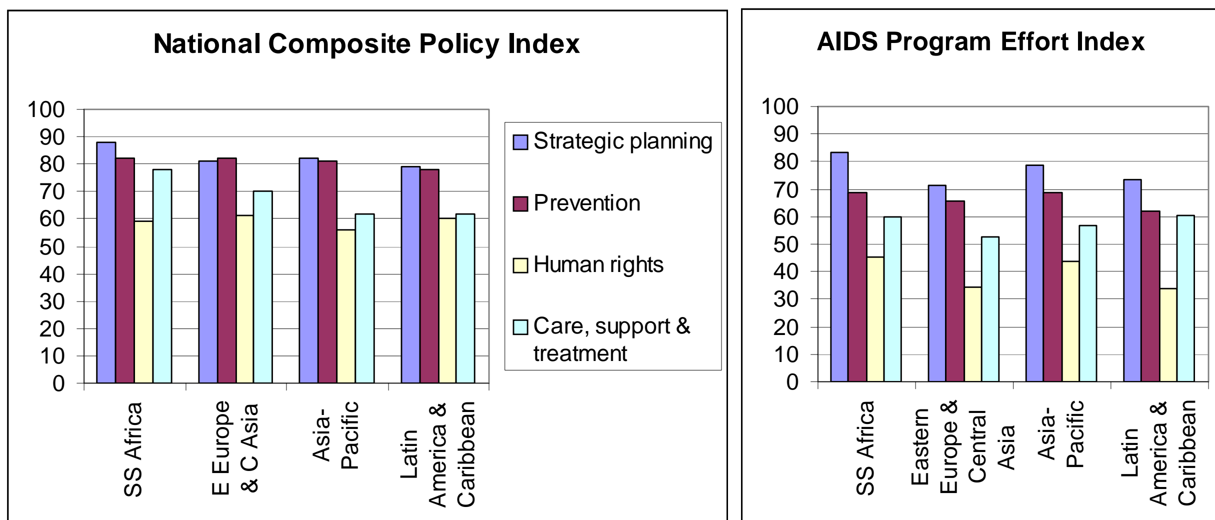
Figure 6. Program Effort Profiles by Level of Adult HIV Prevalence



The AIDS Program Effort Index and the Declaration of Commitment on HIV/AIDS

The Declaration of Commitment on HIV/AIDS adopted by UNGASS contains a number of specific goals. A set of core indicators has been developed to measure progress toward these goals. One of the indicators of national commitment and action is the National Composite Policy Index. This index records whether countries have policies or regulations in 20 specific areas grouped into four categories: strategic planning, prevention, human rights, and care and support. While the API does not include most of the specific policies addressed in the National Composite Policy Index, it does provide information on these four categories. In general, the results of the API confirm the findings of the National Composite Policy Index as shown in Figure 7. The pattern is similar across regions. Efforts in strategic planning and prevention are stronger than for care, support, and treatment. Human rights is the weakest area.

Figure 7. Results from the National Composite Policy Index Compared with the AIDS Program Effort Index



CONCLUSIONS

1. All countries studied have organized at least some reasonable effort. No country received a total score (averaged across all components) lower than 35. On the other hand, no country received a total score higher than 82 and the average score was just 61. Thus, there is considerable room for improvement in all countries.

2. Respondents judged that the best efforts have occurred in the areas of policy and planning and political commitment. Most national governments now recognize the seriousness of the HIV/AIDS epidemic and have committed themselves to address it. Donors have stressed the need for good policies and plans and have provided support for their development where it was required. Favorable policies and plans are in place in most countries. These factors do not always lead to strong effort in other areas, however. Many operational policy barriers exist and commitment to fight the epidemic does not always translate into effective programs and use of resources.

3. There is a lack of attention to programs for MSM and IDUs. Very few countries in sub-Saharan Africa have programs for MSM and coverage is low in Latin America and the Caribbean. Programs for IDUs are reported by just 25 percent of countries in Latin America.

4. One of the weakest areas is resources. Respondents felt that the resources devoted to HIV/AIDS programs are inadequate to support an effective response. Respondents did report that resources have increased significantly in the past few years. Greater national commitments, increased funding from international and bilateral donors, and new mechanisms, such as the Global Fund, have all contributed to this increase. However, considerably more resources are required, particularly for care, treatment, and mitigation.

5. Human rights is the weakest area. Although most countries have ratified the international conventions on human rights, effective implementation of these agreements and national legal structures to protect human rights is weak.

6. In 2000, care was the lowest-rated component, but its score has increased since then. International donors have placed more emphasis on care, and national programs have recognized the increasing need. Although the WHO-led “3 by 5” program to increase access to antiretroviral therapy has not yet resulted in large increases in the number of people on antiretroviral therapy, it has helped to place increased emphasis on the need for care and treatment.

REFERENCES

Bulatao, Rodolfo A. and John A. Ross. 2002. "Rating Maternal and Neonatal Health Service in Developing Countries." *Bulletin of the World Health Organization* 80:721–727.

Nuñez, Cesar A., Patricio Murgueytio, and John Stover. 1999. *The AIDS Policy Environment Score: Measuring the Degree to Which the Policy Environment in Central America Supports Effective Policies and Programs for HIV/AIDS Prevention, Treatment and Care: 1998 Follow-up Results.* Glastonbury, CT: Futures Group International.

Ross, John A. and John Stover. 2001. "Family Planning Program Effort: The 1999 Round." *International Family Planning Perspectives* 27(3):119–129.

Stover, John. 1999. *The AIDS Program Effort Index (API): Results from the Field Test*. Washington, DC: POLICY Project, Futures Group International.

Tsui, A.O., A.I. Hermalin, J.T. Bertrand, J. Knowles, J. Stover, and K.J. Stewart. 1993. "Evaluating Family Planning Program Impact: New Initiatives on a Persisting Question." *Demography India* 22(2):133–154.

UNAIDS. 2003. *Progress Report on the Global Response to the HIV/AIDS Epidemic, 2003: Follow-up to the 2001 United Nations General Assembly Special Session on HIV/AIDS.* Geneva: UNAIDS.

UNAIDS, USAID, and POLICY Project. 2001. *Measuring the Level of Effort in the National and International Response to HIV/AIDS: The AIDS Program Effort Index (API)*. Geneva: UNAIDS.

World Health Organization (WHO). 2002. *Coverage of Selected Health Services for HIV/AIDS Prevention and Care in Less Developed Countries in 2001*. Geneva: WHO.

Wynter, Newton, Karen Hardee, and Pauline Russell-Brown. 2003. *The Policy Environment Score: Measuring the Degree to Which the Policy Environment in Jamaica Supports Effective Policies and Programmes for Adolescent Reproductive Health: 2002 Round*. Kingston: Jamaica Adolescent Reproductive Health Project.

Appendix A. The AIDS Program Effort Index Results

	Political support	Policy and planning	Organiza-tional structure	Program resources	Eval, mon, research	Legal and regulatory	Human rights	Prevention programs	Care programs	Mitigation	Total
Eastern and Southern Africa											
Angola	49	72	42	38	28	34	38	63	36	30	43
Botswana	95	100	77	69	88	73	55	73	88	80	80
Burundi	79	88	68	64	56	58	27	78	69	85	67
Ethiopia	95	68	55	50	35	50	32	66	31	85	57
Kenya	73	90	57	43	29	71	17	55	28	23	48
Lesotho	68	73	28	49	25	35	12	22	45	30	39
Madagascar	90	95	84	50	56	75	48	70	33	20	62
Malawi	90	93	71	64	73	78	73	81	61	90	77
Mozambique	79	74	82	61	72	75	53	72	50	65	68
Namibia	78	73	66	62	48	78	68	71	79	75	70
Rwanda	89	93	90	64	78	85	70	83	79	78	81
S Africa	79	69	90	71	76	70	58	86	78	75	75
Swaziland	78	81	50	67	62	61	15	61	59	68	60
Tanzania	79	83	82	49	67	63	35	68	46	58	63
Uganda	94	83	95	61	78	69	74	70	64	70	76
Zambia	73	78	82	49	57	60	32	73	68	85	66
Zimbabwe	80	79	39	52	60	70	37	48	67	75	61
Average	**80**	**82**	**68**	**57**	**58**	**65**	**44**	**67**	**58**	**64**	**64**
Western and Central Africa											
Benin	89	95	79	66	51	63	40	77	55	68	68
Burkina Faso	100	95	92	79	76	87	53	82	72	80	82
Cameroon	71	90	85	73	65	77	59	77	68	63	73
Chad	75	66	42	45	48	43	28	63	42	63	52
Congo	61	79	47	31	18	45	28	44	61	58	47
Congo, D.R.	59	91	47	44	65	48	42	68	45	30	54
Cote d'Ivoire	73	85	48	27	68	70	58	68	68	63	63
Ghana	90	88	82	68	70	68	55	73	56	85	73
Mali	64	81	44	50	35	61	40	77	72	73	60
Nigeria	88	90	71	55	57	70	43	86	82	50	69
Senegal	89	88	84	64	83	55	63	81	82	85	77
Togo	61	78	68	40	35	20	55	56	50	58	52
Average	**77**	**86**	**66**	**53**	**56**	**59**	**47**	**71**	**63**	**64**	**64**

	Political support	Policy and planning	Organiza-tional structure	Program resources	Eval, mon, research	Legal and regulatory	Human rights	Prevention programs	Care programs	Mitigation	Total
Asia											
Cambodia	79	93	61	70	63	75	42	81	66	45	67
China	50	67	42	53	67	73	73	39	66	53	58
India	71	75	74	62	51	66	45	86	46	10	59
Indonesia	84	79	49	42	60	35	47	63	55	28	54
Myanmar	66	63	47	42	52	46	13	68	24	20	44
Nepal	78	98	34	40	56	60	43	62	55	78	60
Philippines	55	73	60	45	65	85	61	81	88	80	69
Thailand	85	91	58	62	77	78	49	81	80	73	73
Vietnam	75	68	54	42	42	66	22	54	32	46	50
Average	**71**	**79**	**53**	**51**	**59**	**65**	**44**	**69**	**57**	**48**	**59**
Latin America and Caribbean											
Argentina	49	51	28	53	43	76	42	61	68	20	49
Brazil	100	90	62	76	74	88	78	86	93	73	82
Dominican Republic	84	82	57	63	61	85	20	72	43	25	59
El Salvador	92	93	43	52	77	48	26	45	75	42	59
Guatemala	78	60	33	50	51	65	30	86	58	10	52
Guyana	66	78	36	60	27	50	15	70	62	-	46
Haiti	71	40	38	58	56	31	13	65	57	60	49
Honduras	84	89	82	63	65	73	77	68	49	30	68
Mexico	64	79	52	65	83	62	27	77	47	50	61
Nicaragua	51	68	33	31	37	71	37	35	41	20	42
Panama	61	91	26	38	48	78	28	48	93	23	53
Peru	27	58	21	34	34	72	17	33	41	10	35
Average	**69**	**73**	**43**	**53**	**55**	**66**	**34**	**62**	**61**	**30**	**55**
Eastern Europe											
Belarus	55	84	66	52	90	83	58	85	74	75	72
Kazakhstan	63	72	50	37	66	51	30	62	42	23	50
Russia	21	47	34	31	40	51	13	43	49	40	37
Ukraine	61	82	42	56	67	80	35	72	45	28	57
Average	**50**	**71**	**48**	**44**	**66**	**66**	**34**	**66**	**53**	**41**	**54**
Global average	**73**	**80**	**58**	**53**	**58**	**64**	**42**	**67**	**59**	**52**	**61**

Appendix B. National Consultants Who Implemented the API

Country	Consultant	Country	Consultant
Angola	Antonella Anello	Lesotho	Mannete Ramali
Argentina	Dr. Claudio Bloch	Madagascar	Prof. Ranjalahy Rasolofomanana
Belarus	Svetlana Brutskaya	Malawi	Wise E. Chauluka
Benin	Guy Onambele	Mali	Aissata Cisse Diallo
Botswana	Dr. Gobopamang Letamo	Mexico	Mauricio Ramos
Brazil	Dra. Pamela Diaz	Mozambique	Dr. Joel Samo Gudo
Burkina Faso	Dr. Drabo Koine Maxime	Myanmar	Jason Copland
Burundi	Dr. Euphrasie Ndihokubwayo	Namibia	Hopolang Phororo
Cambodia	Ma. Cecilia G. Millado	Nepal	Mahesh Pradham
Cameroon	Dr. Emmanuel Ngapana	Nicaragua	Vanessa Morales
Chad	Keumaye Ignegonba	Nigeria	Martins Ovberedjo
China	Yuan Jianhua	Panama	Beatriz Lopez
Congo	M'Boussou Franck Fortune Roland	Peru	Roberto Lopez
Congo, D.R.	Pascal Milenge Kibwa	Phillippines	Arlene Ruiz
Côte d'Ivoire	Isabelle Josiane Kouame	Russia	Dr. Elena Dmitrieva
Dominican Republic	William Rafael Duke	Rwanda	Mr. Jean Muhirwa
El Salvador	Vilma Guadelupe Portillo	Senegal	Badara Seye
Ethiopia	Dr. Mesfin Haile Tefere	South Africa	Nonhlanhla Makanya
Ghana	Dr. Agnes Dzokoto	Swaziland	Jane Tomlinson
Guatemala	Outi Karppinen	Tanzania	Dr. Mathew Peter Mandara
Guyana	Dr. Morris Edwards	Thailand	Dr. Angkarb Poonnachit Korsieporn
Haiti	Eric Gaillard	Togo	Dr. Teyo A. Lawson
Honduras	Dr. Henry Andino	Uganda	Dr. Saul Onyango
India	Dr. Sashi Kant	Ukraine	Dr. Yuriy Kruglov
Indonesia	Endang R. Sedyaningsih-Mamahit	Vietnam	Dr. Hai Oanh
Kazakhstan	Dr. Venera Baisugurova	Zambia	Muriel Syacumpi
Kenya	Dr. Sobbie Mulindi	Zimbabwe	Ms. Felicity L.S. Hatendi

Appendix C. AIDS Program Effort Index Questionnaire

AIDS PROGRAM EFFORT INDEX (API) - 2003

COUNTRY:

CONSULTANT NAME:

ADDRESS:

TEL:
FAX:
E-MAIL:

DATE:

GENERAL COMMENTS:

INSTRUCTIONS

This instrument is designed to measure the amount of effective effort put into national HIV/AIDS programs by domestic organizations and individuals and by international organizations. It measures the strength of effort for program inputs, as opposed to program outputs or results such as HIV prevalence or number of condoms distributed. Your contribution will be part of a global effort to measure AIDS program effort across a number of countries. The results will be used to describe levels and patterns of program effort and as a guide to understanding the components of effective programs and the major needs to strengthen program effort worldwide.

The API is meant to assess the current environment as well as changes over a period of two years. Many of the items will change little over a two-year period; nevertheless, this allows the same features of program effort to be systematically assessed at regular intervals. Please provide responses for both the 2003 and 2001.

Each section should be completed by interviewing the two or three people most knowledgeable about that topic. In many cases this will be the Director or Deputy Director of the National AIDS Program or National AIDS Council. But in some cases you will need to consult other experts, such as in the sections on human rights and the legal and regulatory environment. Some items can be completed by the consultant before the interview and checked during the interview. The best approach is to interview all respondents for a particular section together so that a consensus opinion can be recorded. If that is not possible, please complete a separate form for each person interviewed and then combine the results into a single questionnaire. All responses are strictly confidential. No answers or comments will be attributed to any specific individuals.

Each section contains a number of specific questions about detailed items. Each section also contains a summary questions that asks for an opinion about the overall level of effort in that areas. These responses should be provided on a scale of 0 to 10. Zero means the effort in that area is extremely weak while ten means that it is optimal.

Please add any comments you may have on particular items in the margin of the questionnaire or on a separate page.

Once the questionnaire is complete, please return it by e-mail to j.begala@tfgi.com or by fax or DHL to: Jane Begala, Futures Group, 80 Glastonbury Blvd., Glastonbury, CT 06033, USA Tel: 1-860-633-3501 x 202; Fax: 1-860-657-3918; E-mail: j.begala@tfgi.com

THANK YOU FOR YOUR ASSISTANCE WITH THIS RESEARCH.

RESPONDENTS

Please list the names and positions of the people who responded to each section of the questionnaire.

Name	Position	Date interviewed
I. Political support		
1.		
2.		
3.		
4.		
5.		
II. Policy and planning		
1.		
2.		
3.		
4.		
5.		
III. Organizational structure		
1.		
2.		
3.		
4.		
5.		
IV. Program resources		
1.		
2.		
3.		
4.		
5.		
V. Evaluation, monitoring, and research		
1.		
2.		
3.		
4.		
5.		
VI. Legal and regulatory environment		
1.		
2.		
3.		
4.		
5.		

Name	**Position**	**Date interviewed**
VII. Human rights		
1.		
2.		
3.		
4.		
5.		
VIII. Prevention programs		
1.		
2.		
3.		
4.		
5.		
IX. Care and treatment services		
1.		
2.		
3.		
4.		
5.		
X. Mitigation programs		
1.		
2.		
3.		
4.		
5.		

I. POLITICAL SUPPORT

The best respondents for this section will generally be the Director or Deputy Director of the National AIDS Council or Commission and representatives of donor agencies, such as the UNAIDS Country Program Advisor, WHO Country Representative, Chairperson of the UN Theme Group on AIDS or local representatives of USAID, DFID or other bi-lateral donors.

	2003	**2001**
1. Does the head of the government, and/or other high officials, speak publicly and favorably about AIDS issues at least twice a year? Head of government Other high officials	 __Yes __No __Yes __No	 __Yes __No __Yes __No
2. Is there a National AIDS Council or Commission outside the Ministry of Health that coordinates the multi-sectoral AIDS program? If so, is the Head of the Council or Commission chaired by the President, Vice President, Prime Minister or Deputy Prime Minister? Does the Council or Commission include active participation of representatives of civil society?	__Yes __No __Yes __No __Yes __No	__Yes __No __Yes __No __Yes __No
3. Has AIDS been declared a national disaster?	__Yes __No	__Yes __No
4. Has the country submitted an application for funding to the Global Fund for AIDS, Tuberculosis and Malaria? If so, has the application been approved by the Global Fund?	__Yes __No __Yes __No	
5. Overall, how would you rate the political support for the HIV/AIDS program? 2003 No support ... Strong support 0 1 2 3 4 5 6 7 8 9 10 2001 No support ... Strong support 0 1 2 3 4 5 6 7 8 9 10		

II. POLICY AND PLANNING

If there is a national AIDS policy and a national strategic plan, you should collect copies of these documents and use them to answer the questions below. Then check the specific answers with people involved in the development of the policy and plan and have them rate the overall effort (question 3). Please list the reference for the policy and plan in the space provided below.

	2003	**2001**
1. Does a favorable national AIDS policy exist?	__Yes __No	__Yes __No
2. If a national policy does not exist, are policy statements included in the national strategic plan?	__Yes __No	__Yes __No
3. Which of the following areas are addressed in the policy or strategic plan?		
a. Human rights?	1 _____	1 _____
b. PLHA involvement?	2 _____	2 _____
c. HIV testing?	3 _____	3 _____
d. Voluntary counseling and testing?	4 _____	4 _____
e. Information and communications?	5 _____	5 _____
f. Condom promotion and distribution?	6 _____	6 _____
g. STI prevention and treatment?	7 _____	7 _____
h. Safe blood?	8 _____	8 _____
i. Prevention of mother-to-child transmission?	9 _____	9 _____
j. Breastfeeding?	10 ____	10 ____
k. Care and treatment?	11 ____	11 ____
l. Gender?	12 ____	12 ____
m. Youth?	13 ____	13 ____
n. Research/surveillance?	14 ____	14 ____
o. HIV/AIDS and poverty?	15 ____	15 ____
p. Orphans?	16 ____	16 ____
q. Migration?	17 ____	17 ____
r. Vulnerable populations?	18 ____	18 ____
Was the national policy developed in a participatory manner with significant involvement of civil society?	__Yes __No	__Yes __No
Reference for policy document: (title, date)		

II. POLICY AND PLANNING (continued)

<table>
<tr><td></td><td>2003</td><td>2001</td></tr>
<tr><td>4. Is there a national strategic plan for AIDS?

Does it include:
a. formal program goals?
b. detailed budget of costs?
c. indications of funding sources?
d. multi-sectoral strategies?
e. a monitoring and evaluation plan?

Reference for strategic plan (title, date):</td><td>__Yes __No

1 _____
2 _____
3 _____
4 _____
5 _____</td><td>__Yes __No

1 _____
2 _____
3 _____
4 _____
5 _____</td></tr>
<tr><td colspan="3">5. Overall, how would you rate policy formulation and planning in the HIV/AIDS program?

2003 Weak ... Strong
0 1 2 3 4 5 6 7 8 9 10
2001 Weak ... Strong
0 1 2 3 4 5 6 7 8 9 10</td></tr>
</table>

III. ORGANIZATIONAL STRUCTURE

The best respondents for this section will be the Director or Deputy Director of the National AIDS Council or Commission and representatives of donor agencies, such as the UNAIDS Country Program Advisor, WHO Country Representative, Chairperson of the UN Theme Group on AIDS or local representatives of USAID, DFID or other bi-lateral donors. I is important to include both national respondents and international respondents since it requires a judgment about the adequacy of the administrative structure and staff.

	2003	**2001**
1. Adequacy of administrative structure and staff. A good administrative structure with competent staff can ensure that plans are implemented, is capable of recognizing and solving problems that cause low performance, and is capable and willing to use existing resources and/or call upon higher administrative levels to obtain resources necessary to carry out plans. Is there an adequate administrative structure and staff for HIV/AIDS activities either through the national AIDS program or through the Ministry of Health? a. at the national level? b. at the provincial or state level? c. at the district level?	__Yes __No __Yes __No __Yes __No	__Yes __No __Yes __No __Yes __No
2. Are the following government ministries actively involved in the HIV/AIDS program? Please check all that are actively involved either with their own AIDS program or as active participants in the national program. a. Agriculture b. Culture, information c. Education d. Finance e. Health f. Human resources g. Labor and employment h. Military i. Minerals and energy j. Planning k. Public works l. Tourism m. Trade and Industry n. Transportation o. Youth	1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 ____ 11 ____ 12 ____ 13 ____ 14 ____ 15 ____	1 _____ 2 _____ 3 _____ 4 ____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 ____ 11 ____ 12 ____ 13 ____ 14 ____ 15 ____

III. ORGANIZATIONAL STRUCTURE (continued)

3. Overall, how would you rate the organizational structure of the HIV/AIDS program?

2003	Weak										Strong
	0	1	2	3	4	5	6	7	8	9	10
2001	Weak										Strong
	0	1	2	3	4	5	6	7	8	9	10

IV. PROGRAM RESOURCES

The best respondents for this section will generally be the Director or Deputy Director of the National AIDS Council or Commission and representatives of donor agencies, such as the UNAIDS Country Program Advisor, WHO Country Representative, Chairperson of the UN Theme Group on AIDS or local representatives of USAID, DFID or other bilateral donors.

	2003	**2001**
1. Are resources allocated according to priority guidelines including considerations of need, cost-effectiveness and available infrastructure?	__Yes __No	__Yes __No
2. How would you rate the resources available for the following programs? Use a scale of 0-3 where -0 no resources -1 limited resources -2 substantial but insufficient resources -3 adequate resources to meet needs		
a. Policy development	1____	1____
b. Human rights	2____	2____
c. Mass media	3____	3____
d. Community mobilization	4____	4____
e. Voluntary counseling and testing	5____	5____
f. Behavior change communications	6____	6____
g. Programs for vulnerable populations (CSW, MSM, IDU)	7____	7____
h. Programs for youth	8____	8____
i. Blood safety	9____	9____
j. Condoms	10___	10___
k. STI treatment	11___	11___
l. Prevention of mother-to-child transmission	12___	12___
m. Palliative care	13___	13___
n. Treatment of opportunistic infections	14___	14___
o. Prophylaxis for opportunistic infections	15___	15___
p. Anti-retroviral therapy	16___	16___
q. Care for orphans	17___	17___
r. Research	18___	18___
s. Program management and coordination	19___	19___
t. Evaluation	20___	20___

IV. PROGRAM RESOURCES (continued)

3. Overall, how would you rate the adequacy of financial resources for the HIV/AIDS program?

	Poor										Good
2003	0	1	2	3	4	5	6	7	8	9	10
2001	0	1	2	3	4	5	6	7	8	9	10

V. EVALUATION, MONITORING AND RESEARCH

The best respondents for this section will generally be the official in charge of monitoring and evaluation in the national AIDS program.

	2003	2001
1. Is there an evaluation officer responsible for monitoring and evaluation activities of the national program?	__Yes __No	__Yes __No
a. If so, what is the title of this officer?		
b. If so, is the monitoring and evaluation officer full-time on monitoring and evaluation?	__Yes __No	__Yes __No
2. Which of the following components are including in the HIV/AIDS surveillance system. Please check all that apply.		
a. AIDS case reporting	a. ____	a. ____
b. Annual HIV surveillance estimating prevalence among		
1. pregnant women	1 _____	1 _____
2. STI patients	2 _____	2 _____
3. tuberculosis patients	3 _____	3 _____
4. commercial sex workers	4 _____	4 _____
5. men who have sex with men	5 _____	5 _____
6. injecting drug users	6 _____	6 _____
7. uniformed services	7 _____	7 _____
c. Regular behavioral surveillance among key populations	c. ____	c. ____
d. Periodic national population surveys on HIV/AIDS knowledge, attitudes, beliefs and behaviors	d. ____	d. ____
3. Are evaluation and research results actively employed in policy formulation and program planning?	__Yes __No	__Yes __No

4. Overall, how would you rate the evaluation and monitoring efforts of the HIV/AIDS program?

	Poor										Good
2003	0	1	2	3	4	5	6	7	8	9	10
2001	0	1	2	3	4	5	6	7	8	9	10

VI. LEGAL AND REGULATORY ENVIRONMENT

The best people to answer the items in this section will be those with detailed knowledge of the HIV/AIDS legal and regulatory environment. These may include law reform commissioners, Ministry of Justice officials, ombudspersons, national human rights commissioners, and representatives of national human rights NGOs or legal aid centers/institutions.

	2003	**2001**
1. Public health and other legislation and policies authorize and empower public health authorities to provide comprehensive prevention and treatment services, including:		
a. HIV/AIDS information and education, for the general population and for targeted populations.	__Yes __No	__Yes __No
b. voluntary HIV testing and counseling	__Yes __No	__Yes __No
c. sexually transmitted disease services, and¸ sexual and reproductive health services.	__Yes __No	__Yes __No
d. condoms, as a means of HIV/AIDS prevention.	__Yes __No	__Yes __No
e. drug treatment, care and support for AIDS-related illnesses.	__Yes __No	__Yes __No
2. a. Legislation and policies do not authorize coercive measures such as isolation, detention or restriction of liberty or detention of persons living with HIV/AIDS, merely on the basis of their HIV status.	__Yes __No	__Yes __No
b. Where legislation authorizes the restriction of the liberty of persons living with HIV/AIDS to reduce real risk of transmission then such circumstances are prescribed within the law and due process such as the right to be heard, right to representation and the right to appeal are guaranteed.	__Yes __No	__Yes __No
3. Public health legislation and policies require that blood/tissue/organ supply is free of HIV and other blood-borne disease.	__Yes __No	__Yes __No

	2003	2001
4. Legislation and policies require that information relative to HIV and AIDS cases, known or reported through the course of employment, is subject to strict rules of data protection and confidentiality.	__Yes __No	__Yes __No
5. Criminal law or other legislation does not include specific offences against intentional transmission of HIV/AIDS. (Where appropriate, this is covered under the general criminal, public health or mental health law.)	__Yes __No	__Yes __No
6. Legislation, policies, and programs support reducing the risk of HIV transmission among injecting drug users by providing HIV-related care and treatment for injecting drug users, such as, authorization or legalization and promotion of needle and syringe exchange programs, including prosecution protection for intermediaries dispensing such needles and syringes. (If injection drug use is not a significant mode of HIV transmission in your country, please skip this question.)	__Yes __No	__Yes __No
7. a. Legislation, policies, and programs prohibit discrimination, in the private and public sectors, on the basis of HIV status.	__Yes __No	__Yes __No
b. Legislation, policies and programs contain provisions that protect from discrimination members of vulnerable groups such as women, men who have sex with men, sex workers, and prisoners.	__Yes __No	__Yes __No
8. Legislation and policies protect and promote workplace rights, including:		
a. prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits).	__Yes __No	__Yes __No
b. confidentiality of employees' medical and personal information, including HIV/AIDS status.	__Yes __No	__Yes __No
c. employment security (e.g., no unfair dismissal rules) for HIV-positive workers able to work, including reasonable alternative working arrangements, and social security and other benefits where workers are no longer able to work.	__Yes __No	__Yes __No
d. access to information and education programs on HIV/AIDS, as well as to relevant counseling and appropriate referral.	__Yes __No	__Yes __No

	2003	2001
9. Legislation and policies may regulate the quality, accuracy and availability of HIV-related goods, services and information to ensure availability of prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at affordable price. Do legislation and policies include:		
a. consumer protection against fraudulent claims; and regulatory approval for sale, distribution and marketing of pharmaceuticals, vaccines and medical devices only when they are safe and efficacious.	__Yes __No	__Yes __No
b. regulation for condom quality.	__Yes __No	__Yes __No
c. access to HIV prevention and care information, as well as to measures, such as condoms, bleach, home tests and/or rapid HIV test kits, sterile needles and syringes.	__Yes __No	__Yes __No
d. adequate, safe and effective medication at an affordable price.	__Yes __No	__Yes __No

10. Overall, how would you rate the policies, laws, regulations and structures in place relating to HIV/AIDS?

	Weak										Strong
2003	0	1	2	3	4	5	6	7	8	9	10
2001	0	1	2	3	4	5	6	7	8	9	10

11. Overall, how would you rate the effort to enforce the existing policies and laws?

	Weak										Strong
2003	0	1	2	3	4	5	6	7	8	9	10
2001	0	1	2	3	4	5	6	7	8	9	10

VII. HUMAN RIGHTS

The best people to answer the items in this section will be those with detailed knowledge of the human rights environment. These may include law reform commissioners, Ministry of Justice officials, ombudspersons, national human rights commissioners, and representatives of national human rights NGOs or legal aid centers/institutions.[2]

	2003	2001
1. a. The Government, through political and financial support, involve and engage communities infected, affected and vulnerable by the epidemic in all phases of HIV/AIDS policy design, program implementation and evaluation.	__Yes __No	__Yes __No
b. The Government ensures that community organizations are enabled to effectively carry out their HIV/AIDS activities, including as they concern human rights and law.	__Yes __No	__Yes __No
2. The Government, in collaboration with the community, promotes a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying social, cultural, political and legal prejudices and inequalities through, amongst other things, community dialogue, specially designed social and health services and support to community groups.	__Yes __No	__Yes __No
3. a. A broad range of channels (such as creative education, training, film, theater, television, radio, print, personal testimonies and posters) are used to promote respect for the rights and dignity of People Living With HIV/AIDS (PLWHAs) and members of vulnerable groups.	__Yes __No	__Yes __No
b. There are programs that are explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance.	__Yes __No	__Yes __No

[2] [2] Items included in the human rights category track two UNAIDS human rights documents to which reference should be made: (1) *HIV/AIDS and Human Rights, International Guidelines,* United Nations, 1998; and (2) *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999.

	2003	2001
4. Codes of conduct or ethical standards for professional groups that address human rights issues in the context of HIV/AIDS (such as confidentiality, informed consent to testing, the duty to treat, the duty to ensure safe workplaces, reducing vulnerability and discrimination) and include practical remedies for breaches and misconduct exist for		
a. health care workers	__Yes __No	__Yes __No
b. lawyers and other legal professionals	__Yes __No	__Yes __No
c. insurance professionals	__Yes __No	__Yes __No
5. Effective monitoring and enforcement mechanisms are necessary at the national and community level to monitor and guarantee protection and realization of HIV-related human rights, including those of PLWHAs, their families and communities. The following mechanisms are in place:		
a. Collection of information on human rights and HIV/AIDS and use of this information as a basis for policy and program development and reform.	__Yes __No	__Yes __No
b. Creation of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons.	__Yes __No	__Yes __No
c. Establishment of focal points within governmental departments to monitor HIV- related human rights abuses.	__Yes __No	__Yes __No
d. (d) Development of performance indicators or benchmarks for compliance with human rights standards.	__Yes __No	__Yes __No

	2003	2001
6. The Government has ratified the following major international human rights instruments: (check all that have been ratified) a. The Universal Declaration of Human Rights b. International Covenant on Economic, Social and Cultural Rights c. International Covenant on Civil and Political Rights d. Convention on the Elimination of All Forms of Discrimination Against Women e. Convention on the Rights of the Child f. International Convention on the Elimination of All Forms of Racial Discrimination g. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment h. Convention on the Prevention and Punishment of the Crime of Genocide. The Government has submitted reports to the United Nations treaty monitoring bodies, including on relevant HIV/AIDS-related human rights concerns arising under the various treaties. Government institutions and non-governmental organizations cooperate with all relevant United Nations programs and agencies (e.g., UNAIDS) to share knowledge and experience concerning HIV/AIDS-related human rights issues; to ensure appropriate human rights- based responses at the international level.	a) _____ b) _____ c) _____ d) _____ e) _____ f) _____ g) _____ h) _____ __Yes __No __Yes __No	a) _____ b) _____ c) _____ d) _____ e) _____ f) _____ g) _____ h) _____ __Yes __No __Yes __No
7. Legal support services can educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues. Are the following legal support services available: a. legal aid systems specializing in HIV/AIDS casework b. state support to private sector laws firms to provide free *pro bono* legal services to PLWHAs in areas such as anti-discrimination c. programs to educate, raise awareness among PLHAs concerning their rights and or empower them to draft and disseminate their own charters/declarations of legal and human rights.	__Yes __No __Yes __No __Yes __No	__Yes __No __Yes __No __Yes __No

8. Overall, how would you rate the legal and organizational structure in place to protect human rights?

2003	Weak											Strong
	0	1	2	3	4	5	6	7	8	9	10	
2001	Weak											Strong
	0	1	2	3	4	5	6	7	8	9	10	

9. Overall, how would you rate the effort to enforce the human rights laws and regulations?

2003	Weak											Strong
	0	1	2	3	4	5	6	7	8	9	10	
2001	Weak											Strong
	0	1	2	3	4	5	6	7	8	9	10	

VIII. PREVENTION PROGRAMS

The best respondents for this section will generally be the Director or Deputy Director of the National AIDS Council or Commission or those in charge or prevention, care and mitigation activities.

	2003	2001
1. Which of the following prevention activities have been implemented. Check all programs that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations.		
a. An active program to promote accurate HIV/AIDS reporting by the media.	a. _____	a. _____
b. A functioning logistics system for condoms and essential HIV/AIDS drugs	b. _____	b. _____
c. A social marketing program for condoms.	c. _____	c. _____
d. School-based AIDS education for youth	d. _____	d. _____
e. Behavior change communications	e. _____	e. _____
f. Voluntary counseling and testing	f. _____	f. _____
g. Special programs for commercial sex workers	g. _____	g. _____
h. Special programs for men who have sex with men	h. _____	h. _____
i. Special programs for injecting drug users	i. _____	i. _____
j. Special programs for other vulnerable populations	j. _____	j. ____
k. Blood safety	k. _____	k. ____
l. Nationwide program to prevent mother-to-child transmission of HIV	l. _____	l. ____
m. Programs to ensure safe injections in health care settings	m. ____	m. ____

2. Overall, how would you rate the prevention efforts of the HIV/AIDS program?

	Poor										Good
2003	0	1	2	3	4	5	6	7	8	9	10
2001	0	1	2	3	4	5	6	7	8	9	10

IX. CARE AND TREATMENT SERVICES

The best respondents for this section will generally be those in charge of care and treatment services within the National AIDS Control Program, the Ministry of Health and the WHO and UNAIDS representatives.

	2003	2001
2. Which of the following are part of care and treatment of HIV/AIDS. Check all that apply.		
a. HIV screening of blood for transfusion	a. _____	a. _____
b. Psychosocial support for PLHA and their families	b. _____	b. _____
c. Palliative care	c. _____	c. _____
d. Treatment of common HIV-related infections : pneumonia, diarrhoea, oral thrush, vaginal candidiasis and pulmonary TB	d. _____	d. _____
e. Nutritional care	e. _____	e. _____
f. STI prevention (including condom use) and care	f. _____	f. _____
g. Cotrimoxazole prophylaxis among HIV-infected people	g. _____	g. _____
h. Universal precautions	h. _____	h. _____
i. Intensified case finding and treatment for TB, including for smear negative and disseminated TB among HIV-infected people	i. _____	i. _____
j. Preventive therapy for TB among HIV-infected people	j. ____	j. ____
k. Systemic antifungals for systemic mycosis (such as cryptococcosis)	k. ____	k. ____
l. Treatment of HIV-associated malignancies : Kaposi's sarcoma, lymphoma and cervical cancer	l. ____	l. ____
m. Treatment of extensive herpes	m. ____	m. ____
n. Post exposure prophylaxis of occupational exposure to HIV and for rape	n. ____	n. ____
o. Highly active antiretroviral therapy (HAART)	o. ____	o. ____
p. Diagnosis and treatment of HIV-related infections that are difficult to diagnose and/or expensive to treat, such as atypical mycobacterial infections, cytomegalovirus infection, multiresistant TB, toxoplasmosis, etc	p. ____	p. ____
q. Advanced treatment of HIV related malignancies	q. ____	q. ____

2. Overall, how would you rate the coverage (number of people served) of care and treatment efforts of the HIV/AIDS program? 2003 Poor Good 0 1 2 3 4 5 6 7 8 9 10 2001 Poor Good 0 1 2 3 4 5 6 7 8 9 10
3. Overall, how would you rate the quality of care and treatment provided to those receiving it? 2003 Poor Good 0 1 2 3 4 5 6 7 8 9 10 2001 Poor Good 0 1 2 3 4 5 6 7 8 9 10

X. MITIGATION PROGRAMS

The best respondents will generally be those involved with mitigation programs. This may include people from the National AIDS Commission, the Ministries of Health, Planning, Social Services, Economic Development or Children, international organizations such as UNICEF, and religious organizations and NGOs working in community support and orphan support programs.

	2003	2001
1. Which of the following mitigation activities have been implemented:		
a. Community support for orphans and other vulnerable children	a. _____	a. _____
b. Programs to pay school fees for orphans and vulnerable children	b. _____	b. _____
c. Funding of community efforts that reduce the impact of HIV infection	c. _____	c. _____
d. Specific public services that reduce the economic and social impacts of HIV infection	d._____	d. _____
2. Overall, how would you rate the efforts to mitigate the effects of the HIV/AIDS epidemic? 2003 Poor ... Good 0 1 2 3 4 5 6 7 8 9 10 2001 Poor ... Good 0 1 2 3 4 5 6 7 8 9 10		

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