Monitoring the UNGASS Declaration on HIV/AIDS

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Introduction

In an unprecedented show of political unity against a threat to global public health, leaders from virtually all countries have made two profound and comprehensive statements at the level of the United Nations on what they intend to do in order to fight HIV/AIDS effectively. The initial statement from June 2001 – *Declaration of Commitment on HIV/AIDS: Global crisis-Global action* – holds 66 paragraphs that detail one or more interventions against AIDS (UN 2001). The follow-up statement from June 2006 – *Political Declaration on HIV/AIDS* – lists a number of recommittments from the 2001 statement as well as additional commitments in a set of 36 paragraphs (UN 2006). Some of these commitments are broad and sweeping, whereas others are more narrowly defined and precise. One central commitment is to allow for recurring monitoring of country performances against a set of core indicators, a form of scrutiny that is seen as essential in order to ensure effective national and global responses.

Since 2003, UNAIDS has overseen three rounds of monitoring on a complete set of indicators (reported in 2003, 2006 and 2008) and two rounds on a sub-set of indicators (reported in 2005 and 2007). This reporting on the UNGASS core indicators is a national responsibility. In the course of this process, the set of indicators has changed somewhat as some indicators have been refined and others have been replaced. The current 25 core indicators are grouped under the following four headings: (A) National Commitment and Action Indicators; (B) National Programme Indicators; (C) Knowledge and Behaviour Indicators, and; (D) Impact indicators. In addition to these core indicators, there is an additional set of four indicators called Global Commitment and Action Indicators for which UNAIDS is responsible for collecting the information, with some input from national stakeholders (UNAIDS 2007).

The purpose of this paper is twofold. Firstly, to analyse whether there are any gaps between, on the one hand, the two statements of commitments and, on the other, the 25 core indicators. Secondly, to suggest additional indicators to cover any such gaps, and discuss strengths and weaknesses in the suggested indicators in terms of availability and validity of data.

The main findings from this research can be summarised as follows. The 25 core UNGASS indicators cover the large majority of commitments made in the two political declarations. Some are captured by indicators 3-25, but most are captured more or less by some element of the two wide-ranging indicators on National Commitment and Action. Further precision in the monitoring could be gained if additional response options were provided in the National Composite Policy Index so as to allow reporting of specific elements of the response. Two broad but central commitments are not at all or not sufficiently captured by any of the core indicators: the commitment to act against structural and cultural drivers of the epidemic in terms of poverty and patriarchy, and the commitment to act against global inequalities in the political economy of the production and distribution of antiretroviral medication as well as the retention of health system staff in the most affected countries. Whereas the latter gap could be addressed by including revised versions of the first and second Global Commitment and Action Indicators among the core indicators, the second is more sensitive politically as it confronts several aspects of poor political governance in some of the most affected countries.
Identifying the gaps

This paper will not report a detailed ‘forensic audit’ of instances when it can be argued that there is a gap between commitments and indicators. It is recognized that the translation of political commitments into measurable indicators can never be perfect or precise. Therefore, while the fit between some commitments and indicators will be detailed, they are highlighted mainly to make a more general point. In addition to comparing the documents mentioned above, ‘gaps’ will also be identified by taking into account the actual reports that countries have submitted to UNAIDS through the UNGASS reporting process.

The 2001 Declaration of Commitment on HIV/AIDS

The many paragraphs in the initial declaration represent a comprehensive set of commitments, most of which are covered by an indicator. However, the analysis has identified the following three types of gaps between stated commitments and indicators that monitor those commitments effectively:

- **Conceptual** – when the commitment is vague or holds internal contradictions;
- **Practical** – when the reporting format is too blunt to capture different elements of the commitment;
- **Denial** – when countries deny the relevance of an indicator due to prejudice.

There are several examples of gaps that occur due to conceptual flaws in the stated commitment. In terms of prevention efforts, for instance, paragraph 47 commits countries to “challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS” (my emphasis) without specifying in any meaningful and measurable way what such a challenge should amount to. Consequently, neither the sections on prevention in the NCPI, nor any of the knowledge or behaviour indicators, can effectively monitor what countries have done to emphasise the importance of counterbalancing gender prejudice in their prevention programmes. Similarly, in the section on care, support and treatment, paragraph 55 specifies that countries “in an urgent manner make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS”. Not only is the commitment as such conceptually flawed since it contains apparent contradictions between the effort being ‘urgent and progressive’ and the need for it to be ‘sustainable’. The commitment is also conceptually weak since it does not provide a definition of what a ‘sustainable’ provision of treatment would entail. Consequently, no indicator captures the urgency with which countries have moved politically or programmatically to ensure maximum treatment coverage, nor is there an indicator that captures the degree to which treatment and other care and support interventions are sustainable over time.

In some instances, the core indicators fail to monitor the commitments due to the bluntness of the reporting format that is used by UNAIDS. One example is the commitments made to responding to the needs of orphans and vulnerable children affected by HIV/AIDS. Paragraph 65 identifies a comprehensive set of interventions that would provide welfare and support for OVC. Countries commit to provide “counselling and psychosocial support, […] and access to shelter, good nutrition and health and social services”. However, when asked to report on the existence of support for OVC (indicator 10), the numerator is defined as the number of OVC who receive at least one type of support. Thus, a country might record an excellent coverage of OVC support even though it may only provide one restricted element out of the comprehensive set of interventions listed in the declaration of commitment.

The gaps in the monitoring that are caused by denial in the reporting country are most clearly exemplified in relation to commitments to respecting the human rights of most-at-risk populations and to reducing their vulnerability. Paragraphs 58 to 64 specify some such groups, and indicators 14, 19 and 23 provide further examples. The problem in this regard is, essentially, that while most-at-risk populations in any country cover a wide spectrum of people, from long-distance truck drivers to men who have sex with men and sex workers, countries report selectively on these groups due to prejudice and denial. While it may be crucial epidemiologically to monitor
prevalence and prevention programmes among sexually stigmatized groups, many African countries report ‘N/A’ (not applicable) on those indicators with the argument that certain sexual practices and forms of relationships are not legal or culturally acceptable, so they do not exist. The ‘gap’ in this regard is not so much between the commitment and the indicator, but between the spirit of acceptance and human rights inherent to the UNGASS process and the practice and prejudice of reporting countries. The result is the same, though: UNGASS indicators fail to monitor what progress have been made in realizing stated commitments.

The 2006 Political Declaration on HIV/AIDS

The above declaration from June 2006 followed upon the report from the UN Secretary-General in March that year on what progress had been made during the five years since the 2001 declaration. It is therefore natural that the 2006 declaration restates some core commitments from the 2001 declaration, while it reinforces particularly those commitments that countries had fallen short of, as reported by the SG. It also formulates a few new commitments that had emerged as critical elements of an effective response during the course of the five years since the original declaration, particularly the increasingly problematic ‘feminization’ of the epidemic. The same types of gaps that were identified above can be found also in a comparison between the core indicators and the 2006 declaration, but a new and more striking political type requires further comment.

The explicit political nature of several strong commitments made in the 2006 declaration would have provided the platform for revolutionary change to governance and the international political economy if they had been followed up with a set of corresponding indicators and if – which is no small if – there was an international power to enforce them. While the 2001 declaration also, obviously, had political content, this was stated more generally. Politics was a dimension of the response to AIDS that was more or less similar and equally relevant across all countries. In contrast, the commitments with explicit political content in the 2006 declaration clearly distinguish – albeit implicitly – between countries with resources and those without, between the global North and the global South. The following highlights will exemplify this point.

Countries in the global North, with financial and other resources, countries that have much less problematic epidemics to deal with, make three commitments that would have direct and very positive effects on the ability to fight AIDS in the global South. In paragraph 29 they commit to creating international and bilateral partnerships to ensure that national health systems are strengthened in terms of resources, training and management at national as well as community levels. In particular they commit to “effectively govern the recruitment, retention and deployment of new and existing health workers to mount a more effective HIV/AIDS response”. The present level of poaching of health systems staff, doctors as well as nurses, from the South to the North is incompatible with this commitment. If resources were instead focused at making conditions of work more attractive, health systems in the South, perhaps particularly in Southern Africa, would stand stronger against AIDS. A second example is how the same countries commit to effecting previous commitments to give 0.7 percent of GNP in development aid, in paragraph 39. However, in addition to restating such donor targets, the countries commit to making sure that such funding is aligned with national strategies for fighting HIV/AIDS. This implies that countries that provide funding for fighting AIDS should not decide on the strategies for doing so. A final example is how resourceful countries, in paragraphs 43-48, commit to finding ways of ensuring that existing and future trade agreements and regulations do not prevent the rapid and sustainable development, provision and financing of ARV treatment at the necessary scale. None of these central political commitments are being monitored through the current UNGASS core indicators.

While the above section detailed some commitments that have special traction with countries in the global North, a number of explicitly political commitments were made that have particular relevance for countries in the global South. The following two examples are particularly clear. If interpreted more broadly, paragraphs 30 and 31 imply a commitment to ending patriarchy. Not only must women and girls get equal access to services and support, but countries commit to providing comprehensive information and education towards shifting gender stereotypes that fuel the epidemic. The commitment does not stop with policy, but requires the institutionalization of
equal human rights for women. The second example is how countries, in paragraph 28, commit to ensuring that sufficient levels of food and nutrition are integral to the comprehensive response to HIV/AIDS. While the provision of medication implies foreign aid, the politics of ensuring sufficient amounts of food and nutrition in terms of the response to AIDS is, for the most part, a domestic affair. It should be noted, however, that this issue too increasingly takes on global dimensions as food prices keep escalating.

The commitment to provide food and nutrition is not monitored by an UNGASS indicator at present. The strong commitments on improving the response in relation to women and girls are covered, but only partly. The problem in this instance mirrors the ‘practical’ gap discussed above, where commitments are many and diverse, but indicators are few and blunt. What can be done to improve the situation? Some suggestions are discussed in the next section.

Covering the gaps

This research has identified four different types of gaps between commitments made in the two UNGASS declarations and the set of core indicators used by UNAIDS to monitor progress: conceptual, practical, denial and political. Of these, only the ‘practical’ type can easily be corrected. Where it is the case that a commitment holds several important elements but these are not captured in full by the corresponding indicator, improvements could be made simply by adding more elements to the indicator. The clearest example of this was mentioned above. Countries that deliver on only one out of four aspects of a comprehensive response to the needs of OVC should not be reported favourably by the indicator, as is the case presently.

The gaps of a political nature that refer to commitments which primarily apply to resourceful countries in the global North may have a relatively simple remedy. In combination with the NASA tool for collecting information on the first of the core indicators (AIDS spending), the first two of the additional global commitment and action indicators would capture several aspects of the explicitly political commitments made in the 2006 declaration. If these two indicators – on bilateral and multilateral financial flows and public funds for research and development – could be ‘mainstreamed’ as part of the core indicators for which countries are responsible for the reporting, they might trigger much constructive debate among stakeholders in the state and civil society, thus putting additional domestic pressure on governments to improve their responses.

It would be considerably more difficult to find ways of covering the other gaps. The ‘conceptual’ gaps that can be found in several of the commitments are obviously no mistakes; they are there for a reason. It is not uncommon in political declarations that language is kept vague and concepts ill-defined in order to allow the process to bypass obstacles that otherwise would jeopardize the core purpose, in this case to display consensus in the UN family on how to fight AIDS. For example, it would be futile to seek clarification on the meaning of ‘sustainability’ in terms of providing treatment in order for that commitment to be monitored accurately. Research cannot provide such clarity, and politicians cannot commit public funds indefinitely.

In the case of denial, the gap is more fundamental as it refer to a gap between the ideals of a liberal human rights regime and the prejudice of sexual intolerance. Since this gap does not refer to a mismatch between commitments and the core indicators, little if anything would improve by altering the relevant indicator(s). Whatever the formulations in the UNGASS instrument, intolerant countries would still respond that, in their case, the indicators do not apply.

The gaps identified in relation to the broad and far-reaching commitments made in paragraphs 28, 30 and 31 could probably be monitored by linking the UNGASS process to other monitoring projects within UN agencies. A proxy for the general health status of the HIV positive population in terms of nutrition could be created by using existing data on the two relevant MDG goals. The UNDP is already reporting the percentage of the adult population which is malnourished and the percentage of children who are underweight for their age (UNDP 2006, p. 305). This data, for adults and children respectively, could be used as the denominator. The numerator would be new data on the percentages of malnourished adults and underweight children who are receiving ARV...
treatment. Since several AIDS-related diseases and some of the medication itself can cause weight-loss, it would not be simple to construct a valid numerator, but it may not be impossible. The point to note here is that data on the level of malnourishment is already available.

The monitoring of the commitments on the situation for women and girls (paragraphs 30 and 31) could rely on data gathered in the current monitoring of two international conventions: the Convention on the Elimination of all Forms of Discrimination against Women and the Convention on the Rights of the Child. Both of these are legally binding on countries that have ratified them and both would have a set of monitoring indicators, one of which could be used to monitor these UNGASS commitments. The two commitments in the 2006 declaration are stated so broadly that a non AIDS-specific indicator would still be valid.

It was argued in this section that some of the identified gaps could be covered by improving existing indicators or by introducing a few new ones. It would, however, not be an easy task to negotiate the introduction of any such additions or even edits of existing indicators. Much work is ongoing on how the M&E tools used by agencies working towards the realization of the MDGs generally and UNGASS commitments specifically can be coordinated and aligned. It would be safe to assume that there is little space for novelty in that negotiation.

Conclusions

The questions at the core of this paper assumed a somewhat legalistic reading of the commitments made by countries in the 2001 and 2006 declarations. The questions were based on the assumption that countries should live up to commitments made in a UN forum. This is the correct lens through which to read declarations of this kind if the purpose is to generate tools for holding governments accountable. However, the analysis also showed the limitation of this methodology as we identified gaps of a political nature that either stem from prejudice or the complexity of negotiating such declarations at the level of the UN.

The challenge for AAI in pursuing its agenda further is to work towards improvements in monitoring and accountability in relation to UNGASS commitments, without endangering the broad political legitimacy of a necessarily imperfect political process.

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These are: (1) AIDS spending, by category and financial source; (2) National composite policy index; (3) Percentage of donated blood units screened for HIV in a quality assured manner; (4) Percentage of adults and children with advanced HIV infection receiving antiretroviral treatment; (5) Percentage of HIV-infected pregnant women who received antiretrovirals to reduce risk of mother-to-child transmission; (6) Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV; (7) Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results; (8) Percentage of most-at-risk populations who received an HIV-test in the last 12 months and who know their results; (9) Percentage of most-at-risk populations reached with HIV prevention programmes; (10) Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child; (11) Percentage of schools that provided life skills-based HIV education in the last academic year; (12) Current school attendance among orphans and non-orphans aged 10-14; (13) Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission; (14) Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission; (15) Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15; (16) Percentage of women and men aged 15-49 who have had sex with more than one partner in the last 12 months; (17) Percentage of women and men who have had more than one sexual partner in the last 12 months who report who report the use of a condom during their last sexual intercourse; (18) Percentage of female and male sex workers reporting the use of a condom with their most recent client; (19) Percentage of men reporting the use of a condom the last time they had anal sex with a male partner; (20) Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse; (21) Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected; (22) Percentage of young women and men aged 15-24 who are HIV infected; (23) Percentage of most-at-risk population who are HIV infected; (24) Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy, and; (25) Percentage of infants born to HIV-infected mothers who are infected.

These are: (1) amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle-income countries; (2) Amount of public funds for research and development of preventive HIV vaccines and microbicides; (3) Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programmes, and; (4) Percentage of international organisations that have workplace HIV policies and programmes.

The paragraph is rephrasing somewhat the formulations by AAI in the Terms of Reference for this research.

References


