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Ranking countries' responses to HIV/AIDS: Ranking what and how?

Background Paper on the AIDS Accountability Country Index

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Ranking what and how?

The development of a measure to assess and then hold countries accountable for their responses to HIV/AIDS is a difficult task. The lack of clarity on exactly what should be done means that any measure of progress must implicitly or explicitly make assumptions relating to what is considered an appropriate response. This requires assumptions relating to the relative importance of the various components of a response, evaluating treatment demands against prevention and care and support, as well as other broader aspects of responses. Difficulties therefore arise at the very first step of the assessment: defining the scale against which assessment can be made. The second step of deciding who or what to rate against also requires some thought. Responses come not only from the state, but also from the private sector and broader civil society. It is important to consider if it is the state or the national response that is being measured. The third step of collecting and analysing data so that measurement can take place is as troublesome as either of the first two.

The task may not be an easy one, but the potential benefits are great. It is not possible, given the obstacles faced, to develop a perfect tool, if only because there will always be an element of subjective assessment and value judgment on which it will be impossible to find consensus. However, while perfection may not be possible, the development of a justifiable and useful ranking process is. This paper seeks to examine first the problems in the development of any measure regardless of data considerations. It is important to understand the difficulties at this stage if the end-product is to be meaningfully interpreted. Following a discussion of the problems of scale development, practical suggestions will be put forward towards providing a useful approach for ranking, given limited data. These suggestions are not put forward as the answers but rather as the basis for further discussion. It is hoped that, with some refinement, these measures will be useful or that they will at least help the process move in the direction of finding an acceptable solution.

Before moving on to consider the problems of measuring and the potential solutions relating to ranking, a few cautions and key issues warrant a mention. Firstly, when ranking countries it is of great importance that the work does not appear to be viewing the problem as a solely national issue. Certainly it is a national issue and requires governments and citizens to take responsibility, but more than that it is a global issue and requires global solutions. Any ranking process needs to stress both the national and international responsibilities associated with this challenge.

In addition to being a global concern, HIV/AIDS is also a long-term problem. In the short term, the responses to HIV/AIDS centre around prevention, treatment, and care and support. In addition to these immediate focal points, there has been increasing interest in mitigation and mainstreaming responses. These, however, are all short-term, symptomatic responses, which, while important, do not address the fundamental social problems that lie at the root of the epidemic. A ranking approach that focuses on the important short-term responses needs to be presented in such a way that it is not seen to justify the adoption of a symptomatic response alone. A successful, long-term response to HIV has to address the fundamental social problems that have allowed HIV to thrive. A ranking measure may well justifiably begin by rating the short-term response, but this must be seen in a broader context and it must be stressed that this is a ranking of only part of the response.

A ranking approach must ultimately try to incorporate the long-term considerations. This paper focuses on what can be done now in terms of ranking; though any first attempt will probably be far from the best possible approach. This is, however, seen as part of a process; with time, it is

hoped that any measure will be improved and other aspects of the response included, not least because our understanding of what constitutes an appropriate response will change.

Even in the long term, an aggregate measure will always need to be relatively simple and will miss certain aspects and subtleties of responses. This, however, is necessary if any cross-country comparisons are to be attempted. It is important to acknowledge these limitations and possibly supplement any rankings with some country-specific case studies that can begin to consider some of the detail that is lost at the aggregate level.

How to rate countries: the ideal

Data on HIV have always been an issue. The stigma and denial that have characterized this epidemic have not helped matters. As a result, the first response to any mention of rating countries is typically, and not surprisingly, that this is not possible because of the lack of data. This prevents an important and informative discussion of how countries should be ranked if data were available. It is only possible to really answer the question of what can be rated with existing data if it is at least partially clear what the rating is trying to do.

Even before a discussion on rating without data commences, it is worth clarifying what the goal or goals of the rating are. Firstly, an important definitional issue should again be mentioned: what is being referred to when talking about the ranking of a country? A country may have a very poor state response, but a very good NGO and private sector response. If considered collectively, the various aspects and their individual rating need to be clearly identifiable, so that there can be accountability. It might be easier and more sensible to focus, at least in the first instance, on state responses and in time expand to consider other sectors and their relative importance in determining a national ranking. Even with this issue clarified, there are, from the outset, two competing questions:

- How well are countries responding to HIV/AIDS?
- How well are countries responding to HIV/AIDS, given the context in which this response is occurring?

These are two very different questions. The first concerns only the quality of the response. The second suggests that the quality of response needs to consider the context in which it is implemented. This second formulation would seem, at least at first glance, to be the more appropriate. If ranking countries is the objective, it would not seem fair to rank poor and highly affected countries' response according to quality only, as they face a far greater challenge with far more limited resources than wealthy states with a low prevalence. This may, however, result in a poor and highly affected country being rated above some wealthy, low-prevalence states even though the quality of the response, independent of resources, is lower in the poor state. This would show that the poorer state had placed a higher priority on HIV/AIDS and this is essentially what the second question suggests should be the basis for the ranking. If this approach is used, however, it may be misinterpreted as suggesting that a lower quality response is more acceptable in poor countries. In terms of accessing local responses, it is more acceptable, but, from an equity and human rights perspective, it certainly is not.

Previous discussions on the issue of rating in this context have gone some way towards addressing this conflict between the different questions by separating the response into commitment, capacity and impact. In this way, a country may do well in terms of commitment, but poorly in terms of impact; thus the cause of the poor rating could be identified. This is important for any ranking to be useful.

While dividing the ranking into component parts goes some way to addressing the conflicting demands of the different questions, this particular division does raise some problems.

Commitment is only meaningful when understood in terms of capacity. To commit one million when you have five is not same as when you have two. Separating them out as individual components is a little difficult. It is rather commitment to a given capacity and what impact this would lead to that is of interest. But this still misses something. Committing one million when you have a major problem is not the same as committing it when you have a minor one. Perhaps then it is appropriate to think of commitment in context (including capacity and scale of problem) and what impact this leads to.

A two-dimensional approach such as this may be better able to address both of the questions above. Measuring commitment in context answers the second question, while impact addresses the first. In this way, a composite of the two captures elements of both questions while allowing for the answering of both via disaggregating. This will help in understanding a country's final ranking.

Having gone some way to clarify the goal, the following discusses how the responses to HIV by countries could be rated if data were not a problem. The thinking behind this approach is that it is useful to know where we would like to be, so that we can evaluate our best efforts against this standard.

Spending: while money is not the whole story, an examination of responses would have to consider money spent. This, however, would need to be divided into various components:

- Direct spending on HIV - prevention, treatment, care and support, etc.
- Spending on mitigation - training, mainstreaming, etc.

Spending by component would need to be further divided into sources of funds: private or public sector, national or international. This introduces another layer of analysis and complicates matters somewhat. For the purposes of this discussion, the focus will be on state spending. The bias of this approach against countries with strong private sectors and the difficulties of incorporating donor assistance will not be discussed at this stage, but should be kept in mind.

Efficiency: evaluating the amount of spending alone is of little use. Spending is interesting only in so far as it has an impact. Different countries will differ in their ability to transform spending into impact. These differences will stem from both efficiency considerations and circumstantial constraints. What is of interest is the efficiency of spending given the country's circumstances.

Spending (by category) * efficiency (0-1) = Equivalent efficient spend (by category)

For the equivalent efficient spend to be meaningfully interpreted, it would be necessary to evaluate it against what should be spent. This, however, is a complicated question even where data are available, as it requires an understanding of the expected impact of spending and a value judgment of the worth of that impact. The expected impact will, however, differ according to the environment in which the money is spent. What could, however, be kept standard is an assumption about the value of the outcome. It could be assumed that the highest marginal spend (accounting for variations in efficiency) on achieving outcomes, by category, is the current best standard for that category. To take prevention as an example: the highest amount spent by any state to prevent a HIV infection could be considered the current best standard and it is against this which the highest spend of every other state should be evaluated. This approach ignores the possibility of internal discrimination. Some states may spend a great deal to prevent HIV infections in some sectors of the population or to treat some people while ignoring others, but it does represent a highest possible standard. To avoid some, but not all, of the distortion of a bias focus in prevention efforts, the average spend could be used, with the highest average being considered the highest standard.

Average spend per HIV case prevented of country being ranked (efficiency adjusted) / current best average = Index of prevention spend – of treatment spend – of care spend etc.

Such an approach would, however, not take into account the capacity of the states to respond. Essentially the above would be a ranking of quality of response with no regard for context. If average efficient spend were used and calculated as a percentage of GDP per capita, this would incorporate capacity considerations but would complicate comparison with the current best standard. An index could be used ranking countries according to average (by category) spend divided by GDP per capita. Although GDP per capita does not consider the scale of the problem, to consider both capacity and scale, the average spend could be divided by GDP per HIV positive person; this would represent a level of commitment but would not measure the adequacy of response.

Having measured commitment for a given capacity, it is necessary to reintroduce a measure of the adequacy of response. This again requires a judgement of what is adequate. This could again be considered as the largest efficiency-adjusted average spend (the denominator of the average varying depending on the category), with the shortfall between the spend of the highest existing commitment percentage and the total being presented as the international community's responsibility. That is, the exercise will be to first determine what each country spends as a percentage of what they have - this as a measure of commitment. Then to say, if each country spent the same percentage (as the country that spends the highest percentage) of what they have on HIV, how much would they still be short of the highest average spend. This would result in something like the following for each country and each category and for the categories combined if weights could be agreed.

The above approach would result in a dual ranking system, ranking countries according to their need for further domestic commitment in the form of increased spending or improved efficiency, and a second ranking of countries' need for further international support. Essentially, each component would seek to answer one of the possible basic questions.

This approach, however, would be rating solely on the basis of efficient spending. Questions of equity and non-financial commitments are thus far ignored.

Equity is a difficult issue at the best of times and with AIDS even more so, particularly in regard to prevention. Some would argue that efforts should be made to reduce the risk of everyone within a society to as low a level as possible or to as low an average as possible. The distributional differences even between these two are complicated. What then happens when you introduce the question of perceived fault, or aim to reduce the overall number of deaths? Any choice of goal would require a different distribution and therefore any ranking of distribution would require a goal as its base.

Rating non-financial commitment is also difficult. Non-financial commitment can take many forms, such as political leadership or changes in the law or policy. Identifying which is most important is a question of judgement. Some factors may reduce future spread; others may improve the survival chances of those infected or improve their quality of life. If data on all of these different components were available and weights agreed, then a rating of non-financial commitments could be developed. Further, if the relative importance of non-financial ratings compared to financial commitments could be agreed, a composite and more comprehensive ranking would be possible. If, as is assumed here, data problems did not exist, the difficulties would centre around which non-financial commitments are important and what weight they should carry in the composite ranking.

A variant or possible component of the above approach would be to evaluate how those infected with HIV within countries rate their quality of life. As a purely subjective approach, this would be of little use and may simply reflect prior expectation. If, however, a checklist of what was important and an agreed weighting system were available, data could then be generated that would allow some assessment of the quality of life of HIV-positive citizens. This would also need to consider women's rights and how the quality of life for citizens may differ by gender or ethnic group.

This hypothetical approach is still limited in one very important area. It presents HIV largely as a national issue. Although a means of ranking countries in need of further international support was outlined above, it leaves responsibility to the faceless international community. A further ranking system could be considered to rank responding countries' commitments or lack thereof. Two approaches could be taken here. Firstly, and more simply, would be to rank countries according to their contributions to fighting HIV internationally as a percentage of their GDP. This is something that has already been done by UNAIDS. This implies responsibility shaped only in terms of wealth. Some countries, however, could argue that their responsibility globally is reduced by their problems with the epidemic at home.

The second option would be to calculate the difference for each country between their GDP per HIV-positive person and the global average GDP per HIV-positive person and then calculate this difference as a percentage of the global average GDP per HIV+ person. That is:

Support score for country X = (Global avg. GDP per HIV+ person – GPP per HIV+ person in country X)/ Global avg. GDP per HIV+ person

Countries with a high negative score would, according to this standard, be expected to contribute more, given their high income, low prevalence, or both, while countries with high positive scores should be able to expect more support, given their low income, high prevalence or both. It would be interesting to examine the results of such a ranking against what is allocated as aid and what is actually received by countries.

Back to reality and the problems of data

The above discussion has highlighted some of the difficulties associated with ranking even before considering data limitations. It has, however, helped to clarify some of the value judgements and conceptual clarity that need to be considered when developing a measure. Keeping these issues in mind, the following presents a discussion of some practical ways forward. The discussion focuses on two approaches. The first is based on combining a few simple indicators to determine a ranking and the second considers combining a variety of different variables through a process of consultative weighting.

The purpose of the following discussion is to briefly outline alternative approaches: the suggestions are not clear-cut polished products, but rather indications of alternative methods. Following the outline of each approach, a brief sketch of how each method could be taken forward is provided. The intention is to provide a basis for discussion regarding which route to take.

The first approach mirrors the first part of the discussion of the previous section. It essentially uses spending as an indicator of commitment, adjusting it for efficiency and impact. Spending data on HIV/AIDS are limited and are of varying quality. The data limitations may mean that if such an approach were used it would only be possible to apply it to a limited number of countries for which data were available. Alternatively, it may mean it is necessary to use proxy data, a possibility that will be discussed as the variables are introduced.

As mentioned previously, the first step is to divide the response by category. In this initial outline, the responses are divided into prevention and treatment. If this approach were selected for further development, it might be possible to identify usable variables to consider other categories such as care and support. Following on from the above discussions, each category considers commitment in context and the impact.

Prevention: The first step within each category is to measure commitment. This is done in a two-stage process: measuring commitment in terms of resource context and then adjusting it to account for variations in efficiency. Adjusting for context is, however, a difficult task, as the following example will show. The example gives three options for including context; each is based on a different assumption of what constitutes commitment - the same problems faced in prior discussions. Spending here is presented as if public spending data were available. If this approach were pursued, it might limit the coverage as a result of limited availability of data. It may, however, be possible to use proxy data, such as spending on test kits, to expand coverage.
Index of prevention commitment:

Option 1 = Index [Spending on prevention / Public health care expenditure]

Option 2 = Index [Spending on prevention per HIV+ person / Per capita health care expenditure]

Option 3 = (Option 1 + Option 2) / 2

The first option measures expenditure on prevention in terms of available health care expenditure. Health care expenditure is used, as it is appropriate if state expenditure on prevention is being considered. This option measures the relative importance states attach to HIV compared to other health issues. This, however, essentially assumes that HIV should have the same relative importance regardless of context. In all countries there will be competing concerns, but these will differ as will the relative threat of HIV. Countries with low prevalence but where the state is very committed to keeping it low will be biased downward in the ranking by this approach since, as a percentage of what they have, they spend little. Relative to the scale of the problem they face, however, they spend a lot. Adjusting to redress this bias, on the other hand, has its own problems, as seen in option 2.

The second option seeks to address the differing levels of HIV. By dividing the prevention spend by the number of HIV-positive people in each country, states are assessed in terms of their efforts relative to scale. States with a larger problem, that is a larger number of HIV+ people, will be assumed to need to spend more of what they have to be considered as similarly committed. This on the surface may appear to be, and to some extent is, a little odd. Prevention arguably should be considered against the number of HIV- people, but if there are no HIV+ people, there is no risk. As anyone who studies the dynamics of epidemics knows, however, it is not the case that the more HIV+ people there are, the greater the population risk of infections. What would be more appropriate would be to divide the spending by the incidence of HIV in the absence of intervention. To do this, however, would require modelling and may be considered too controversial to be useful; though if this approach is selected for further consideration, it may be worth examining this possibility further. In the meantime, as using either the number of HIV+ or HIV- people as an adjustment is incorrect, the less biased of the two was selected. The problem with option 2, regardless of which adjustment is used, is that spending a lot per head when you do not have a major problem is not the same as spending the same per head when you do have a major problem. This approach will give a positive upward bias in the ranking to states with low prevalence.

As the biases of options 1 and 2 work in opposite direction, it may be wise to take a weighted average of the two. Option 3 is presented above as a simple average, but this may not be appropriate; the question of weights would need to be examined in some detail if this option were pursued.

Spending the same amount will not always have the same impact. It may be necessary to adjust spending according to some assessment of efficiency. The data needed to examine the relative impact of spending country by country are not available. It may, however, be possible to consider some of the impact. For example, in countries with low levels of literacy, higher rates of investment in prevention may be necessary to get the message across, considering literacy as a proxy for basic education. Similarly, more spending would be needed to have the same impact in more corrupt states. Variables like these can be combined into efficiency measures such as the following:

Prevention efficiency = literacy rate * corruption index

The above is just an example of a possible way forward to account for differential efficiency in spending to more accurately reflect commitment. It may, however, be simpler to drop this aspect and go directly to impact, as spending combined with efficiency should determine impact; so one could be dropped.

Measuring impact could be done in a variety of ways, all of which are likely to be disputed. Attempts could be made to capture impact via proxies such as the number of condoms distributed. It would, however, be more powerful to examine prevalence indicators. For example:

Prevention impact = Index [(% increase in HIV prevalence in the last 5 years)]

Alternatives to this could involve modelling expected increases in prevalence, estimating the current risk of infection or comparing similar or neighbouring countries changes in prevalence. If this approach were carried forward, these various options would have to be investigated in some detail.

Once the above have been determined, there could be a combination process to allow for a category ranking of the response.

Prevention index

Option 1 = Index [prevention (Commitment * Efficiency * Impact)]
Option 2 = Index [prevention (Commitment * Impact)]

This same exercise can then be repeated for treatment, with essentially the same problems.

Index of treatment commitment:

Option 1 = Index [Spending on treatment/public health care expenditure]
Option 2 = Index [Spending on treatment per HIV+ person/Per capita health care expenditure]
Option 3 = (Option 1 + Option 2) / 2

The above three options mirror the same concerns as were raised for prevention with similar biases introduced through the use of either option 1 or 2.

Efficiency could again be considered, this time with some form of reference to the capacity of the health sector. Any measure along these lines will be problematic, but aggregate rankings by their very nature require such simplifications.

Treatment efficiency = index of doctor population ratio * corruption index

Again efficiency could either be dropped or used along with impact. Measuring impact in regard to treatment presents a number of options, one of the most obvious of which is to consider

numbers of people on treatment. This, however, ignores any consideration of quality; measuring the number, or rather percentage, still on treatment after a year goes some way to addressing this.

Treatment impact = Index [% of patients on treatment who need it * % on treatment after 1 year]

As with prevention, there is the possibility of modelling the impact of treatment or estimating the risk of death as alternative ways of measuring impact. Again this may introduce too much controversy and focus the discussion on the models rather than the ranking.

Following the selection of the variables, the different aspects of the treatment ranking could be incorporated into a composite category ranking, either including or excluding efficiency.

Treatment index

Option 1= Index [treatment (Commitment * Efficiency * Impact)]
Option 2= Index [treatment (Commitment * Impact)]

Once indices have been developed for both prevention and treatment, there is the temptation to combine them. At least from a mathematical point of view, this would be fairly simple and could be done as follows:

Overall rating = treatment index * prevention index or average of the two

This, however, is an area of the approach that would require significant time to be spent examining the implications of this merger. The implications could only be meaningfully considered once variables for the category rankings have been finalized, but suffice to say that this will be an important part of the development of an approach like this, as it attaches relative values to prevention and treatment.

The above outline has presented the basic structure of one possible way forward in ranking countries' or rather states' responses. It requires a great deal of further development to become useful. An outline of how this development might be undertaken will be discussed shortly; first, however, it is worth noting some limitations of the approach:

- Ignores responses other than treatment and prevention - such as care and support and policy change. Although it may be possible to add these in at a later date, data would still be a problem.
- Measures commitment in terms of spending; little consideration of quality of service or quality of life for affected citizens.
- Focuses on state commitment ignoring NGO and private sector efforts.
- The approach does not immediately suggest a way of dealing with international aid to states. Should it be included as part of state commitment or should a ranking be presented with and without aid?
- It may not be possible to obtain data on state spending for many countries and as a result we will need to use proxy indicators.
- Reuses another index (corruption) and thus opens itself up to any criticism that index faces; its use, however, is only a suggestion and could easily be replaced.
- The implications of merging the two measures must be examined in detail. It may be worth keeping them separate.

While there are limitations, the approach does have some appeal. It would generate a result, one which would stimulate some debate. It does allow the results to be disaggregated to identify different aspects of the ranking, which would point to why countries received the ranking they

did. It may, therefore, be worth considering the further development of an approach along these lines.

Further development would, in the first instance, require a more concrete proposal of the variables to be used. This would require further work to be done, considering the alternative variables that could be used and working through the implications of their use. Moreover, an initial assessment of the availability and quality of the data would have to be undertaken to ensure that the proposed variables could be used. This would best be undertaken by a small group of experts in the field. Once a more definite proposal of a measure is available, this could be distributed for wider review and comments considered.

Following a wider review and the consideration of comments, the final ranking structure could be developed and data collected. It would be important to conduct a sensitivity analysis to see what differences uncertainties in the data make to the ranking.

The primary limitation of the above approach is that its consideration of what constitutes a response is very narrow. As the approach is outlined here, only prevention and treatment are considered and even these are only considered in terms of spending. There are many other aspects to a committed response and the second approach suggests a possible way of incorporating these.

The second approach outlined here starts from the assumption that there are many aspects of a committed and successful response to HIV and that a ranking should consider as many as reasonably possible. The problem, as already mentioned, is that there is not universal agreement about either what all the components of a response are or what their relative importance should be. To rank in this context requires both a decision of what should be included and its importance: different decisions – different rankings. It is likely that the decisions will cause as much discussion as the rankings and for this reason this method is suggested. Rather than push the decision aspects into the background, they are brought to the forefront and the debate that may result will not be a negative but a positive aspect of the ranking's development. The process necessary for this method to take shape is more involved than the last and the method is best explained within the context of the process.

The first stage of this process will be to draw up a list of relevant and available indicators. These indicators would need to be selected based on a review of current literature and a preliminary assessment of data quality and availability. Such a list would most likely take the form of sub-categories with indicators being divided across these. This would facilitate later weighting, as an indicator could be considered first in terms of its importance to the category and then the category's importance to the overall ranking could be weighted rather than a direct weighting. Furthermore, this first list would have to be developed in conjunction with a suggested combination structure, proposing possible transformations of the variables and how they might enter the ranking.

This would best be conducted by a small group of experts. Following the preparation of a draft list, the output could be presented to a larger group for discussion and refinement. A two-stage initial consultation is necessary because, if a larger group of experts were consulted in the first instance, there would likely be too much discussion to allow for progress. By having an initial list developed by a smaller group, some focus would be brought to the discussion.

In order to develop a ranking from the indicators gathered, they must be combined into a composite index. Such a combination requires weights to be selected for each of the variables considered. This is where the judgement factor enters the process. If this approach is followed up, it will be necessary to form an expert panel and its members asked to attach weights individually and then, following discussion, collectively. Seeking nominations for this expert

panel will be an important task in itself. It will be the respect afforded to this panel that will determine the respect the ranking will receive. The suggestion of individual weighting followed by collective ranking is made to refocus the discussion.

The weighting process required to combine indicators of different types into a composite index would at times be complicated. While an expert panel would be made up of key individuals in the field of HIV policy formation and response, they may not be familiar with the requirements of such a process. One possible way to facilitate the experts' contribution to the weighting process is to develop interactive software and distribute it to the panel members. This would provide them with a chance to conduct the weighting individually and have comparable inputs to bring to a weighting meeting. In addition to the software, each expert would need to receive a detailed review of the data that are being used as indicators. This would have to consider the quality of the data available and as such would allow experts to consider the uncertainty when attaching weights.

Following the individual software-assisted ranking, a meeting of the experts would be required to agree on the final weights for this stage of the process. This would allow for an initial ranking to be produced and distributed. This is where the strength of the approach would show through. As already mentioned, any ranking requires a judgement as regards what is appropriate. Inevitably, whatever judgement is made, there will be disputes in terms of its validity. For this reason, the initial list could be distributed as a preliminary ranking and the software with the weights could be distributed along with it. Following such a transparent process would allow for a consultative process to flow from the initial distribution. Critics who dispute the ranking will be encouraged to examine the process followed and suggest changes where they feel a mistake has been made. By providing the software along with the ranking, this process would be made far simpler. The expert panel could, following a period of consultation, consider outside contributions and weights could be changed or variables dropped or added. This process would result in a final list of indicators and a set of weights and the publication of a final ranking for that year.

The process outlined is fairly involved and a summary may assist.

Step 1: Small group of experts review the available literature and develop an initial list of indicators and propose a combination structure.
Step 2: Initial list of indicators and structure is subject to wider review and refined.
Step 3: An expert weighting panel is nominated and formed.
Step 4: Distribution of material to expert panel.
    a) Weighting software developed and distributed to panel.
    b) Review of data conducted and distributed to panel.
Step 5: Individual members of the panel attach weights.
Step 6: Expert panel meets and agrees weights
Step 7: The ranking is distributed along with an outline of the method followed and the software. Comments and criticisms are encouraged.
Step 8: Expert panel meets and considers response. Weights, list and structure adjusted and ranking recalculated.
Step 9: Results released and consultations begin again.

The process and the method are much more complex than for the previous approach. This, however, is both a strength and a weakness. It will take more time and effort to generate a ranking using this method, but the process itself will be an intervention, hopefully stimulating debate.

Way forward

Two quite different approaches have been outlined and both have their limitations and both require further thought and refinement. The first approach will include fewer indicators and as a result require less data. It will also require fewer consultations and could be developed far more quickly. Given the nature of the problem and the scale of disagreement on how to rank, this approach may run into problems, as it does not have a built-in method of addressing criticism. The second approach may take longer but, by placing the subjective elements in such a central role and creating a space for discussion, may fare better given the environment into which the ranking will be launched.

What is necessary at this stage is for the organization to decide which approach suits its purpose and character best. This is largely an internal matter as it requires a consideration of what type of organization AAI wants to be.

Anna Mia Ekström

A Review of Existing Indicators and Methodological Aspects

Background paper on the AIDS Accountability Index

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Introduction

The overall objective of the AIDS Accountability International (AAI) initiated by Rodrigo Garay in consultation with various experts in the field of HIV, is to develop, on a global basis, an HIV/AIDS rating instrument at the country level that can increase transparency and accountability of national HIV/AIDS programs with regard to impact on the epidemic and utilization of resources, and through this also capture the attention of policy makers, multilateral bodies, national governments, NGOs, corporations and media A regularly published HIV/AIDS index could measure progress towards achieving targets, define best practise and serve as a tool to increase pressure on governments and other actors to improve national leadership and address HIV/AIDS more effectively e.g. by accelerating the provision of HIV/AIDS prevention, treatment and care.

Better accountability mechanisms that can track resources and demonstrate that resources are being used to their fullest potential are needed in the fight against the epidemic, according to several key actors in the HIV/AIDS area such as UNAIDS (Report on the Global AIDS Epidemic 2004 and 2005) and the Global Task Team which has identified accountability and empowering inclusive national leadership and ownership as critical to their task of finding ways UN system organizations and the Global Fund can rapidly improve the quality of their support to national AIDS responses, make money currently available work for people infected and affected by HIV, and support the scale-up of prevention and treatment programmes. (www.who.int/hiv/pub/advocacy/globaltaskteam/).

To hold governments accountable, their efforts and progress must be possible to monitor in a good and reliable way. In January 2003, Bill Gates announced the "Grand Challenges" a initiative focused on finding solutions to critical problems in global health, and scientists and public health experts around the world have now defined 14 Grand Challenges of which the majority relate to HIV/AIDS including vaccine improvement, vaccine development, improve drug treatment of infectious diseases, create therapies that can cure latent and chronic infections, and, possibly most critical to AAI, the development of more accurate health status assessments in developing countries (http://www.gcgh.org/),

However, existing statistical indicators and rating mechanisms have proven to be powerful tools for increasing the pressure on governments to act by facilitating for the general public and other actors to demand accountability.

To measure national progress in implementing the Declaration of Commitment from 2001, the UNAIDS applies three separate yardsticks (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.2003):

The degree of national commitment and action, as measured in terms of the amount of domestic resources devoted to HIV/AIDS –related activities and in national adoption of policies and practices set in the declaration

The degree to which commitment and action are reflected in the implementation of services that reach those who need them, increases in the level of HIV-related knowledge among key populations, and reductions in risky behaviour, and

The degree to which national commitment and action result in concrete progress in reducing the number of new infections

Concrete time-defined targets have been set in the context of the Millennium Development Goals (MDGs) (www.un.org/millenniumgoals) and UNGASS (United Nations General Assembly Special Session on HIV/AIDS). The MDG Report 2005 reveals the reality regarding the progress of countries in achieving the goals set by the UN. Of special concern is the failure by many countries to make substantial progress in reducing child mortality, improvements to maternal health and promotion of gender equality and empowerment of women. There is ample evidence that the realisation of women's and girls' rights offer the most effective route to poverty eradication and an effective and successful combat against HIV/AIDS. Therefore, indicators of women's right are suggested to be an important element in the AAI Index.

Following UNGASS, UNAIDS has initiated the National Composite Policy Index (NCPI). The aim of the index is to assess the degree to which countries have adopted and implemented the range of HIV/AIDS policies endorsed by the Declaration of Commitment in 2001. The index assesses countries' progress in achieving the goals in terms of strategic planning, prevention, human rights and care and support. The first index report (2003) shows that the strongest scores were found with respect to leadership, commitment and prevention and the lowest in human rights policies, especially regulations concerning vulnerable groups and ensuring equal access to prevention and care services for men and women. The NCPI index is based on answers from government officials with risks of bias. Moreover, the index does not measure the impact of the different policies at country level it just report if and when specific policies have been adopted. Also, in 2003 only 103 out of 189 Member States that received the Secretary-General's request for reports, submitted national reports (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.2003).

While the NCPI index is about intentions while the future AAI Index could focus on measuring progress regarding countries capacity, commitment and impact in combating HIV/AIDS. Also, an independent assessment tool measuring progress towards meeting such targets does not exist.

The AIDS Accountability Index could be such an independent assessment tool combining basic aspects of national accountability with regards to countries' HIV/AIDS response. The UNDP Human Development Index (HDI) (hdr.undp.org/statistics) is a well-known example of a composite index that has become well-established, is often cited and considered being a useful tool for advancing the debate and global agenda for human development. Vital to any composite AIDS Accountability Index is, of course, the impact of any national interventions directed against the epidemic. However, when developing a rating mechanism, the capacity and the commitment of the countries to fight HIV/AIDS would also be critical.

To begin the process of forming such an index, this paper discusses methodological aspects that need further consideration when selecting indicators for the composite AIDS Accountability Index and gives a brief overview of different existing indicators that could be composite parts of such an index, the potential advantages and disadvantages of using these indicators and what aspects regarding the selection of indicators that need further consideration and research.

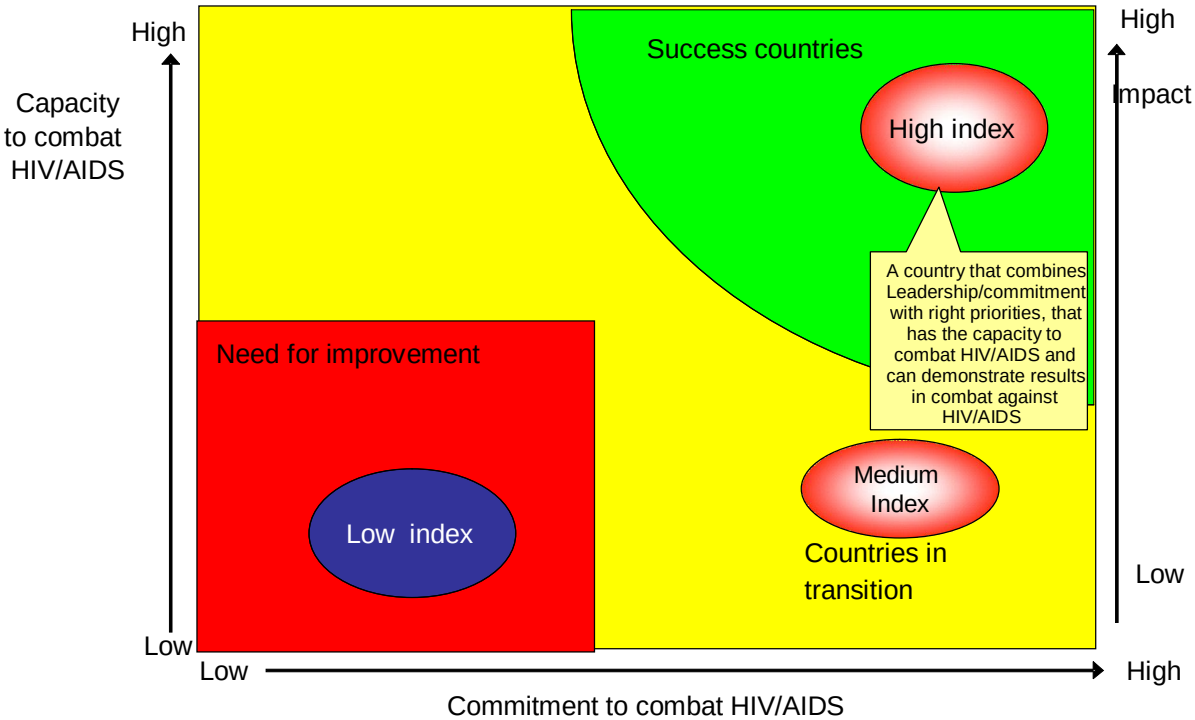
AAI- a three dimensional concept?

Three dimensions, a country's capacity and commitment to fight the epidemic and the impact national efforts have on the epidemic, have already been identified by AAI as interesting for beginning the discussion around potential indicators that could form the composite AIDS Accountability Index. Capacity can be defined as the socio-economic means that a country has to address the problem of HIV/AIDS. One way of measuring this capacity could be by using GDP per capita: rich countries have greater resources to invest in health. Capacity may extend beyond financial means to include human resources for health or the number of literate or educated men and women and measured using statistics on literacy rates or school enrolment rates. The lack of an adequate health infrastructure will also affect the capacity of a government to fight HIV-AIDS through e.g. testing and counselling as well as treatment and monitoring capacity.

Although a certain level of financial means is a prerequisite for any HIV/AIDS response, governments also need to be committed to use existing resources in a sensible way in order to impact on the epidemic. Commitment to fight HIV/AIDS could be measured e.g. by using indicators such as the percentage of government expenditure allocated to HIV/AIDS or through the National Composite Policy Index assessing the degree to which countries have adopted and implemented a range of HIV/AIDS policies. The effectiveness of any state policy would depend on institutional quality and performance as assessed by the Freedom in the World Rating (http://www.freedomhouse.org/) or the Corruption Perceptions Index (CPI) created by Transparency International (www.transparency.com). Moreover, when judging country commitment, it is also important to consider many developing countries' dependency on foreign aid and the oftentimes strong influence by donors on recipient countries' HIV/AIDS policies.

Finally, the capacity and commitment indicators must of course be linked to the size of the HIV/AIDS problem in each country and be viewed in the light of the impact on the HIV/AIDS epidemic different policies and interventions have in a specific country. Impact could be measured e.g. as changes in HIV prevalence or incidence or as the number of infected children born to HIV-positive mothers.

Figure 1. A visual example of a three-dimensional AAI, by Rodrigo Garay



Five methodological aspects have been identified as particularly important when selecting indicators that could be part of an AAI. The indicators (as well as a composite index) should have high:
Validity
Precision
Completeness
Acceptance
Comprehensibility

1. Validity

The degree to which a procedure is capable of measuring what it is intended to measure. Thus, the validity of a measure/indicator could for example be questioned when concepts meant to be measured are difficult to delineate or assess in reality, such as poverty or stigma. Comparisons between measurements within the same country and between countries may also be distorted by bias. Biases are systematic errors with constant, but often unknown, size and direction, that lead to an over-or underestimation of the true measure. This would occur for example if HIV prevalence in a country was only assessed by measuring HIV among sex workers or STI clients, which likely would result in an overestimate. In fact, using the prevalence among pregnant women seeking antenatal care, may not be representative for the whole population aged 15-49. Also, the HIV prevalence may vary 10-fold between areas and ethnic groups, meaning that the country average may not be a valid measure of the true burden of HIV/AIDS a government needs to struggle with. The indicators used must be evaluated in terms of Internal validity, meaning that there should be no or little systematic errors. This is not to be confused with the concept of "External validity", meaning that the indicator or the composite AAI index, preferably should have high generalisability and applicability.

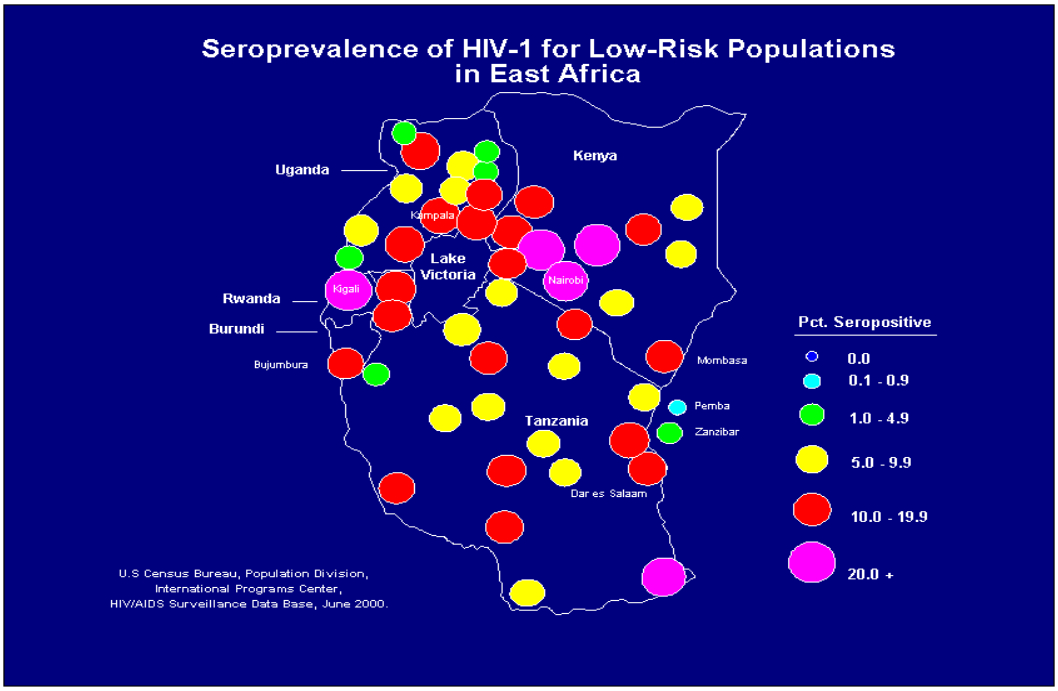


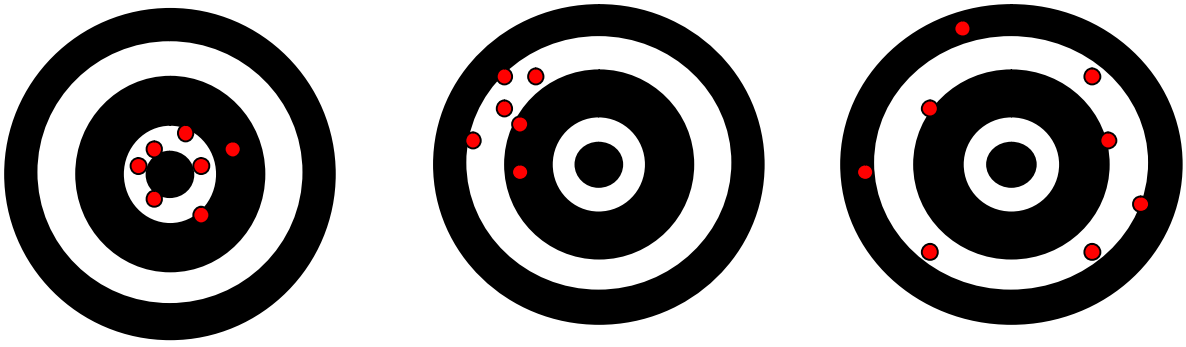
Figure 2. Validity of national averages of HIV prevalence. Source UNAIDS.

2. Precision

The precision of a measure or indicator refers to its reliability or repeatability, i.e. the extent to which the measurement procedure gives the same result when repeatedly applied to the same object. This would depend on random variation or error due to chance of random size and direction that cannot be predicted. High reliability (precision) normally means that there should be small random variation around the estimate. Such variation is often indicated by Confidence intervals or Uncertainty intervals. Traditional confidence intervals display the difference between the upper and lower confidence limits and for normally distributed statistics, the rule is, the narrower the confidence interval, the better. One way of increasing precision is to increase the sample size, i.e. the number of people included in your study/assessment. Mathematically, the interval may be halved by quadrupling the sample size.

All important health indicators are subject to more or less serious random error due to dysfunctional registration and reporting systems. This means that annual variations e.g. in mortality due to AIDS may be explained by random measurement error rather than being a result of any intervention.

UN bodies involved in annual reporting of numerous health and socioeconomic indicators such as the WHO, the World Bank, UNICEF etc often use the same sources of data, i.e. the same measurement errors get copied by all.
One technical challenge to solve is how uncertainty intervals would be accounted of rand displayed in the index.



Precise and valid

Precise (high repeatability) but invalid (does not measure what it is supposed to measure)

Valid but not precise and therefore unreliable

Figure 3. Validity vs. Precision

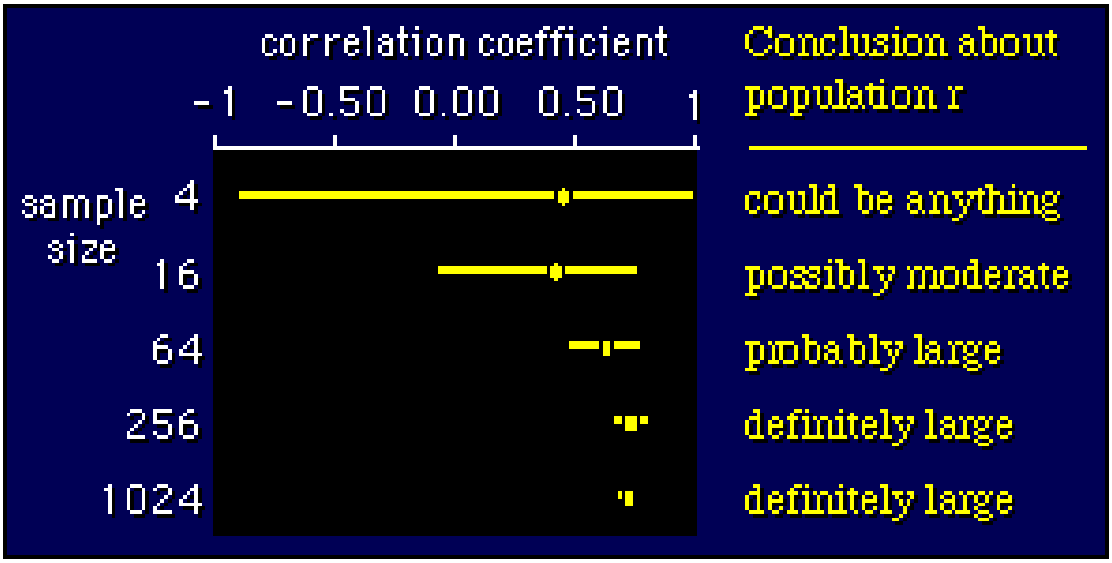


Figure 4. The relationship between the width of the confidence interval and sample size.

3. Completeness

This mainly refers to the number of countries that regularly report data the indicator in question. The accessibility of data depends on many different aspects, most often the lack of functioning reporting systems or mechanisms to systematically and reliably measure and register mortality, morbidity or socioeconomic indicators in a population, which is the case in most low-income countries and many middle-income as well. This may be at least partly compensated by well-designed and performed sentinel surveillance studies or smaller surveys sampling a representative share of the population e.g. for data collection. Around 20 low-income countries (12 in Africa, 6 in Asia and one in Latin America) also have demographic surveillance sites comprising smaller geographic areas of about 100,000 inhabitants for whom all vital events are registered (i.e. births, death, and in- and out-migration from the area in order to get the correct denominator e.g. for birth or death rates) (http://www.indepth-network.org/).

Access to data will also be influenced by countries' willingness to report data on politically sensitive indicators such as HIV prevalence or number of children born positive to infected mothers. High-income countries (including Sweden) sometimes also fail to assess and report data on basic indicators such as coverage of contraception or literacy rates where they assume themselves to be 100% successful in meeting population needs.

UN bodies often use similar mathematical models to extrapolate data when actual values are missing. For example, the straight line in infant mortality rates (IMR) over a 20 year period when Afghanistan was inaccessible to the outside world, indicates that the reported IMRs were manufactured at UN associated statistics departments. Sometimes data on morbidity and mortality rates of surrounding countries or countries with similar population and assumed disease pattern profiles are used to feed statistical models and to fill the table gaps for the annual reports produced by virtually all UN bodies. This means that even when an indicator appears to have high coverage across countries; it may in fact have little access to primary, valid and reliable data.

4. Acceptance

For an AIDS Accountability Index to be used by of policy makers, multilateral bodies, national governments, NGOs, corporations and media as is the overall objective of AAI, the indicators selected for the composite index must be known and accepted by these key actors as well as by to

the governments and country leaders to be subject to this accountability assessment. This is very important both in terms of external validity and any potential impact sought. To try to assess whether this will be the case, experts with thorough experience on the global health arena as well as country experts must be consulted.

5. Comprehensibility

For the index to be useful, not only the above-mentioned aspects must be fulfilled, but the composite index must also be easy to interpret since this will determine how wide-spread and accepted the index will become. Ideally the composite index should have an intuitive and immediate meaning to a naïve user, and be difficult to misinterpret. Most likely, this means that a quite limited number of components (3-max 5 indicators?) should be selected for the composite index.

Other methodological aspects

Composite vs "Pure" indicators

Including indicators in the AAI that are already composite indexes/indicators such as the HDI or the NCPI, will make the interpretation of the index more difficult. On the other hand, if the composite index is already accepted and includes many variables crucial to what the AIDS Accountability aims to measure, it may be an option to discuss.

Weighing

When countries are too different to be comparable on the same scale, this phenomena may be compensated by assigning countries different weights, as is done e.g. when estimating the Burden of Disease (DALYs, www.who.org/statistical annex). If weighing is an option for the AIDS Accountability Index, should commitment, capacity and impact be weighed similarly for one country? A country may have a high burden of disease but still be expected to be capable of responding adequately due to sufficient financial resources e.g. South Africa.

What dimensions should be considered during the weighing procedure? The burden of HIV, geographical region, or level of national income level (LIC, MIC or HIC) etc are possible aspects that would interact with capacity, commitment and potential impact. However, these dimensions would overlap with indicators used a an impact variables or capacity variables.
The actual weights must also be very thoroughly discussed in order to be viewed as fair and objective by all parties. Especially since a ranking of the countries may lead to some controversy.

Ranking vs score

Scoring countries with regards to their output measured as different indicators or as a composite index is one thing, but ranking countries according to the score is something else. As pointed out for example by Transparency International, a change in rank may depend on the number of countries participating in the surveys that year, i.e. the completeness or accessibility of data.

There are also important lessons to be learnt from the ranking made in the year 2000, world Health Report, where the WHO ranked countries according to health system performance based on five indicatorsa publication which became so controversial, that it to be thoroughly revised to be acceptable (http://www.who.int/whr/2000/en/index.html).

Existing indicators of interest for the composite AIDS Accountability Index

This section gives an overview of existing indicators that could be classified under the three dimensions of primary interest, i.e. capacity, commitment and impact. However, the selection of these indicators is subjective and by no means complete since the number of potential indicators approach infinity. Also, some indicators may describe two or all three dimensions.

Capacity

- Gross Domestic Product (GDP) per capita (US$ or PPP)
- Total population (million) to estimate human capacity and actual numbers in need of care
- Population living < $1-2/day (1990 PPP US$), i.e. poverty rate
- Per capita total expenditure on health (PPP or US$)
- Funding gap=Resource requirements vs funds committed for ARV therapy
- Physicians per 100,000
- Births attended by skilled health personnel
- Service Availability Mapping (SAM tool, computerized geographical mapping of range and coverage of available services including those providing ART and VCT by district, as well as the availability of health workers, laboratories and infrastructure)
- Female/Male adult literacy rate Female/Male combined school enrolment 1o, 2o and 3o
- Female/Male (15-24 yrs) unemployment (% of labor force)
- Gender-related development index (GDI)2
- Female economic activity rate (as % of male rate, age 14+)
- Ratio of estimated female to male earned income
- Seats in parliament held by women
- % of 1-year olds fully immunized with DPT/measles indicates health infrastructure capacity
- Staff trained for HIV/ART (WHO 3 by 5, new alternative sources must be researched)
- Population health indicators measuring development and human capacity:
- Female/Male life expectancy at birth (years)
- Under-5 mortality rate (per 1000 live births)
- Burden of Disease measures (DALYs, DALEs),
- Maternal mortality per 100,000 live births
- Infant Mortality Rate (per 1000 live births)

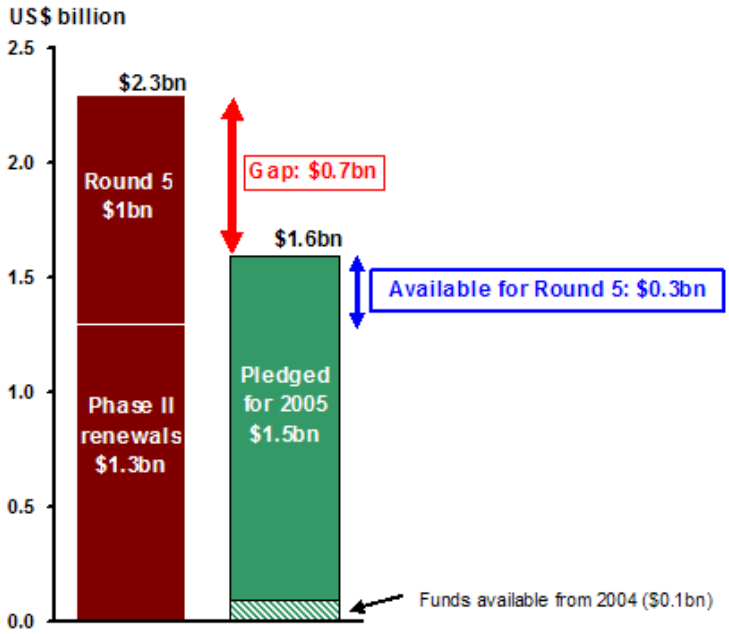


Figure 5. The funding gap. Source the Global Fund 2005.

Commitment

- General government expenditure on health as % of total expenditure on health
- Amount of national funds spent by governments on HIV/AIDS (UNGASS/UNAIDS)
- National Composite Policy index (UNGASS/UNAIDS Progress report on the Global Response to the HIV/AIDS Epidemic 2003. Follow-up to the 2001 UNASS on HIV/AIDS.2003)

A. Strategic Plan

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

B. Prevention

- Country has a general policy or strategy to promotes information, education and communications (IEC) on HIV/ASIDS
- Country has a policy or strategy promoting reproductive and sexual health education for young people
- Country has a policy or strategy that promotes IEC and other health interventions for groups with higher or increasing rates of HIV infection
- Country has a policy or strategy that promotes IEC and other health interventions for cross border immigrants
- Country has a policy or strategy to expand access, including among vulnerable groups, to essential preventive commodities
- Country has a policy or strategy to reduce MTCT

C. Human Rights

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

D. Care and Support

- Country has a policy or strategy to promote comprehensive HIV/AIDS care and support with emphasis on vulnerable groups

- County has a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups
- Country has a policy or strategy to address the additional needs of orphans and other vulnerable children
- AIDS Programme Effort Index (in addition to NCPI)
- Political Support
- Policy Formulation
- Organizational structure
- Evaluation. Monitoring and Research, Legal and Regulatory Environment
- Human Rights
- Prevention
- Mitigation

Global Fund performance indicators

- Prevention, coverage of:
- Condom distribution
- Program for specific groups
- PMTCT
- VCT

Care and Support (increased #s trained to deliver a service, #s service points, #s reached):

- Palliative Care
- Support for orphans
- HIV/TB
- OVC

Treatment (increased #s trained to deliver a service, #s service points, #s reached):
ARV
OIs

Supportive Environment (increased # trained to deliver a service, # service points, # reached):

- HS Strengthening
- IEC
- Procurement and Supply Management

Freedom House Rating 2005 (www.freedomhouse.org)

The freedom house rating is based on score related to Political Rights and Civil Liberties which are weighed together resulting in a Freedom Status. Political Rights and Civil Liberties are measured on a one-to-seven scale, with one representing the highest degree of Freedom and seven the lowest. Countries whose combined average ratings fall between 3.0 and 5.0 are "Partly Free, and those between 5.5 and 7.0 are "Not Free." Countries are then classified both according to

score and in these categories.

Freedom House is an independent NGO with annual publications including *Freedom in the World*, an assessment of the state of political rights in 192 countries and 18 related and disputed territories based on The *Freedom in the World* survey, an annual evaluation of the state of global freedom as experienced by individuals according to two broad categories: political rights and civil liberties. The survey includes both analytical reports and numerical ratings. Each country and territory is assigned a numerical rating, which is calculated based on the methodology described below, on a scale of 1 to 7. A rating of 1 indicates the highest degree of freedom and 7 the least amount of freedom. The survey findings are reached after a multi-layered process of analysis and evaluation by a team of regional experts and scholars. Although Freedom House acknowledges the element of subjectivity inherent in the survey findings, they emphasize that the ratings process is based on intellectual rigor, balanced and unbiased judgments. The survey does not rate governments or government performance per se, but the survey ratings generally reflect the interplay of a variety of actors, both governmental and nongovernmental. (Freedomhouse Methodology at www.freedomhouse.org/)

Failed States Index ((www.fundforpeace.org)
The Fund for Peace and Foreign Policy has launched a new index that measures the world's 60 most at-risk countries according to 12 social, economic, political and military indicators.

The Transparency International Corruption Perceptions Index (CPI) (www.transparency.com)
Corruption is defined as the perceived abuse of public office for private gain. Data is derived from 16 polls and surveys from 10 independent institutions, business people and country analysts, both resident and non-resident. Experts rather than the public is used to reflect grand rather than petty corruption. Public opinion on corruption is measured through the "Global Corruption Barometer", also developed by TI. The CPI ranges between 10 (highly clean) to 0 (highly corrupt).

Transparency International is a coalition against corruption which publishes a corruption perceptions index every year based on a composite survey, reflecting the perceptions of business people and country analysts, both resident and non-resident. For a country to be included it must feature at least 3 polls. As a result, a number of countries- including some which could be the most corrupt- are missing because not enough survey data is available. 159 countries were included in 2005. Corruption is defined as the perceived abuse of public office for private gain. Reliability differs between countries. A large difference in scores between different sources within a country is reflected by a wider confidence interval
Ranking countries enable TI to build and index, but the score is a much better measure of the actual perceived level of corruption.. Over-time comparisons or trends should only be compared by scores on a country basis and not by a country's ranks. But scores are also unreliable since different sources and methodology and survey sampling are used may be used different years and scores are based on data from the last 3 years. (Transparency International Corruption Perceptions Index 2005. www.tranpserency.org).

Impact

- WHO 3 by 3 indicators.
- Estimated number of people receiving ARV therapy (low-high estimate)
- Estimated number of people 0-49 years needing ARV therapy
- ARV therapy coverage (%)
- Change in Funding gap=Resource requirements vs funds committed for ARV therapy
- Change in Service Availability (SAM tool, computerized geographical mapping of range and coverage of available services including those providing ART and VCT by district, as well as the availability of health workers, laboratories and infrastructure)
- Integration of treatment and prevention and integration of service deliveries (drug rehab programs/TB care/STI care/ANC/primary health care)

- Participation of People Living HIV/AIDS

UNAIDS Epidemic Update indicators

- Burden of HIV/AIDS and STIs
- Estimated number of adults 15-49 living with HIV/AIDS (low-high estimate)
- Estimated number of children 0- 15 living with HIV/AIDS (low-high estimate)
- Estimated number of women 15-49 living with HIV/AIDS (low-high estimate)
- Estimated number of death due to AIDS, adults and children (low-high estimate)
- Estimated number of orphans who have lost their mother or father or both parents to AIDS and who are alive and under age 17
- HIV prevalence (%) in different populations (pregnant women, sex workers, injecting drug users, STI patients, men who have sex with men, tuberculosis patients; outside vs in major urban areas)
- STI syndromes
- Syphilis prevalence women
- Estimated prevalence of curable STI among female sex workers

Health service and care indicators

- % of population with access to health service (total, urban, rural)
- Contraceptive prevalence rate (%)
- Percentage of contraceptive users using condoms
- Change in % of 1-year olds fully immunized with DPT/measles
- % of ANC clinics where HIV testing is available

Knowledge and Behaviour

- Knowledge of HIV prevention methods (identifies two ways of preventing HIV transmission and reject three misconceptions about HIV transmission)
- Proportion of young people (young people 15-24) reporting the use of a condom during sex with a non-regular partner
- Ever-used a condom
- Age-mixing in sexual partnerships among young women (sex in the last 12 months with partner who is 10+ years older than themselves)
- Reported non-regular sexual partnerships
- Adolescent pregnancy
- Age at first sexual intercourse (proportion of 15-19 year olds who have had sex before age 15)
- Adolescent pregnancy (% of teenagers 15-19 who are mothers or pregnant with their first child)

Prevention Indicators

- Condom availability (nationwide distribution divided by the total population 15-49 years of age)
- Prevention of mother to child transmission (MTCT) nationwide (% of women counselled during ANC for their most recent pregnancy who accepted to test and received their test result, of all women pregnant at any time in the preceding two years)
- Screening of blood transfusion nation-wide

UNGASS/UNAIDS

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

- Percentage of large enterprises/companies that have HIV/AIDS workplace polices and programmes
- Percentage of patients with STI at health care facilities who are appropriately diagnosed, treated and counselled
- Percentage of HIV-infected pregnant women receiving a complete course o ARV prophylaxis to reduce the risk of MTCT
- Percentage of people with advanced HIV infection receiving ART
- Percentage of IDUs who have adopted behaviours that reduce transmission of HIV
- Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (target 90% by 2005, 95% by 2010)
- Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular partner
- Ration of current school attendees among orphans to that among non-orphans aged 10-14

National Impact Indicators to asses the effectiveness of national measures

- Percentage of young people aged 15-24 who are HIV-infected (target 25% reduction in most affected countries by 2005; 25% reduction, globally, by 2010)
- Percentage of HIV infected infants born to HIV infected mothers (Target 20% reduction by 2005, 50% reduction by 2010).
- % of adults and children with HIV still alive 12 months after initiation of
    - antiretroviral therapy

Millennium Development Goals

4: Reduce by two thirds the mortality rate among children under five
5: Reduce by three quarters the maternal mortality ratio
6: Halt and begin to reverse the spread of HIV/AIDS

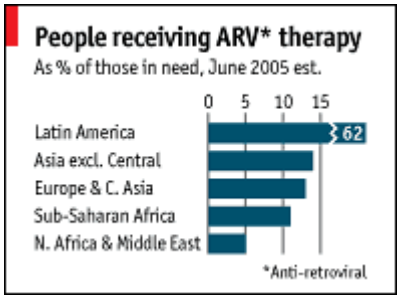


Figure 6. The treatment gap, Source the Economist July 2005

Added value- how to make the AAI useful?

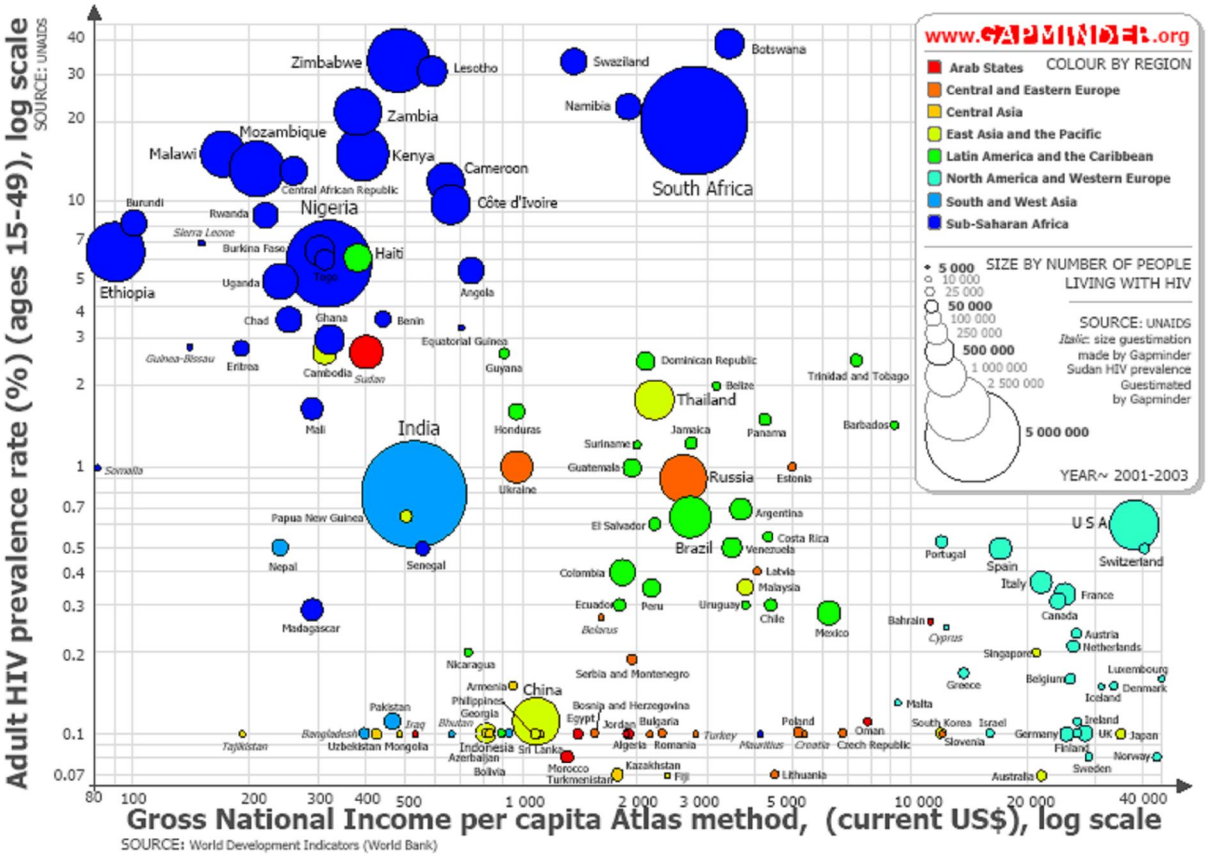
Finally, for the AIDS Accountability to be widely used, countries must see an added value in doing so. How do we make the index useful in the field/ for policy makers and implementers? Should a certain rating score be linked to funding? Since money talks, one way would be linking it for example to the evaluations made by WHO for renewal of "3 by 5" funding or the similarly to the current evaluation indicators used by the Global Fund funding.

While awaiting such a process, a quicker way linking accountability to money could be to develop a software where countries could test how much they would gain in terms of reduced loss of GDP if they for example strengthened HIV prevention and reduced the number of new HIV infections by 50%. Theoretically, existing statistical and economical models such as those used by Chris

Murray, Jeffrey Sachs and Anne Mills for making predictions on the economic consequences of the HIV/AIDS epidemic in different countries could be further adjusted and developed for each country to make it possible for leaders on how much countries need to strengthen their commitment to HIV interventions in order to achieve a certain level of impact, in turn linked to economic gains. In such a model, impact, commitment and capacity could be adjusted along the axes of a flexible visual computer graph for example the already widely available free-of charge software developed by Gapminder (www.gapminder.org).

Macroeconomic impact of HIV/AIDS

"In North Africa , it is estimated that economic growth equivalent to 35% of today's GDP would be forfeited by 2025 compared o a situation where HIV/AIDS was not present and the annual GDP loss per capita is 1,2 % in Mozambique and 3.2 % in Botswana. Increasing condom use by 30% or safe needle use by 20% could reduce the GDP loss by 20% by 2025. Delaying these intervention only by a few years, will make these interventions much less efficient". The estimated cost benefit ratios of preventing new HIV infections range between 40-50 (Mills A, Shillcut S. communicable Diseases. Summary of Copenhagen Consensus on communicable diseases Challenge Paper, 2004). .



Principal issues to discuss in addition to the methodological aspects:

- Are the three proposed dimensions the most pertinent?
- Capacity, commitment and Impact are inter-dependent and somewhat overlapping concepts. Greater capacity could affect commitment; capacity and commitment may largely affect impact; a large impact may have a positive feedback effect into capacity and

commitment. These interrelationships need to be developed and explored to ensure the analytical foundations of the rating instrument.

- Definition of Impact? Could be a direct measure of HIV/AIDS but prevalence has a large margin of error where change may be very difficult to assess, or a process indicator such as % receiving PMTCT or other % with access to VCT.
- As HIV treatment/ART becomes more available also in high-prevalence low-income countries, a country's HIV prevalence will no longer be a valid and useful measure of HIV incidence since prevalence is a result of both incidence (new cases) and duration of disease (prolonged with ART). This is already the case in all high-income countries, and good and ethically sound methods for monitoring HIV incidence are still lacking in most parts of the world.
- In addition, just measuring coverage of ART will not be enough since, also long-term follow-up i.e. % still on ART after 1 year follow-up, will be a much more important measure of the potential for resistance development in combination with the use of single-dose nevirapine for PMTCT.
- Definition of Commitment? Intentions and/or commitments met through actual interventions/funds dispersed etc.
- Is a composite index the most appropriate way to develop the rating mechanism?
- To take into account a degree of uncertainty in the data, would it not be suitable to define the resultant composite index along a range of values?
- New indicators?
- Considering the paper on existing indicators elaborated for this preparatory meeting by Anna Mia Ekström, is it adequate to just use existing data and indicators or should we consider the development of new indicators from the beginning?
- Weighing?
- The epidemic is driven by different factors in different regions, how should this be accounted for in the index? Different variables in different regions or weighed differently?
- Instead of rating?
- List of good and bad examples rather than rating?
- List of the 5-10 most prioritized areas according to the Copenhagen consensus or Freedomhouse?

Per Strand

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 recommitments 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*.(1) 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).(2)

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.(3)

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 prizes 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.

1. 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.

2. 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.
3. The paragraph is rephrasing somewhat the formulations by AAI in the *Terms of Reference* for this research.

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An overview and comparative analysis of HIV/AIDS Declarations and Commitments

Background Paper for AIDS Accountability International

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I. Introduction

This background paper reviews past and contemporary declarations on HIV/AIDS. These documents represent a call for renewed political commitment in the response to an epidemic with global ramifications. The first part of the comparative study will focus on goals, areas covered and strategy and provide some analysis of the same. The second aspect of the study is to compare the monitoring and evaluation framework of the different declarations focusing on substantive content.

The UNGASS Declaration of Commitment on HIV/AIDS (hereinafter the Declaration (2001)) receives special attention in this paper and will be discussed in some detail throughout the study. This leading declaration on HIV and political commitment will be compared to other commitments on the right to health and HIV/AIDS, including but not limited to: The Abuja Declaration and Framework for Action for the fight against HIV/AIDs, tuberculosis and other related infectious diseases in Africa of 2001 (hereinafter Abuja (2001)); the Alma Ata Declaration of 1978 (hereinafter Alma Ata); the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia (hereinafter Dublin (2004)); the Caribbean Regional Strategic Framework for HIV/AIDS (2002-2006) (hereinafter the Caribbean Framework (2002)); and the General Assembly's Political Declaration on HIV/AIDS (hereinafter the Declaration (2006)).

The Declaration (2001) is divided into twelve major themes and actions, namely: (i) Global crisis; (ii) Leadership; (iii) Prevention; (iv) Care, support and treatment; (v) HIV/AIDS and human rights; (vi) Reducing vulnerability; (vii) Children orphaned and made vulnerable by HIV/AIDS; (viii) Alleviating social and economic impact; (ix) Research and development; (x) HIV/AIDs in conflict and disaster (xi) Resources and (xii) Follow up. These headings articulate the major issues surrounding the response to HIV and they appear in slightly modified form in the major HIV/AIDS commitments predating and following the Declaration (2001). These themes will be used within this paper in order to frame the descriptive and comparative study. Some themes will be subsumed within other themes, for example, (iii) prevention will be subsumed under the headings of vulnerable groups, in this case children, women and girls.

A brief introduction clarifying the usage of terms in this paper and the binding or non-binding nature of declarations follows:

HIV/AIDS

HIV/AIDS is referred to as HIV or AIDS throughout this paper and both variations are intended to refer to both conditions. People living with HIV or AIDS will be referred to as PLHIV.

The UN General Assembly

Established in 1945 under the Charter of the United Nations (hereinafter the Charter), the General Assembly occupies a central position as the chief deliberative, policy-making and representative organ of the UN. Comprising all 192 Members of the UN, it provides a forum for multilateral discussion of international issues covered by the Charter and plays a significant role in the process of standard-setting and the codification of international law.

The (binding) nature of declarations

The International Court of Justice (hereinafter the ICJ) is the principal judicial organ of the United Nations, it was established in 1945 by the Charter. The Statute of the ICJ provides the principal

sources of international law and these include: international conventions (treaties); international custom, as evidence of a general practice accepted as law; the general principles of law recognized by civilized nations. It has been argued that General Assembly resolutions and declarations must be considered representative of general state practice, and representing binding international law. However, this position is still debated by international jurists.

A look at the Universal Declaration of Human Rights (hereinafter the Universal Declaration (1948)), the most well known product of a UNGA resolution, sheds light on the potential of declarations to take on a moral and even legal weight in the international legal order. It was initially drafted as an exercise of moral suasion, a statement of goals and aspirations and not justiciable and binding (M. Glen Johnson: 69). However, since its adoption the Universal Declaration (1948) has directly influenced the development of subsequent human rights treaties. In particular, the UN Covenant for Civil and Political Rights (1966) (hereinafter 'CCPR') and the UN Covenant on Economic Social and Cultural Rights (1966) (hereinafter 'CESCR') greatly elaborated on the principles and protections laid down by the UDHR, and together the three documents are referred to as the International Bill of Rights.

In a sixty year period, more than 40 emerging States explicitly incorporated the Universal Declaration into their constitutions. Regional intergovernmental organisations in Europe, Africa and the Americas, have incorporated the Universal Declaration into their charters or resolutions. And finally, the UN and many of its specialised agencies have repeatedly invoked the Universal Declaration in resolutions and declarations, including those relating to HIV/AIDS. To all intents and purposes, the Universal Declaration has come to be regarded by all states as legally binding and authoritative. ((M. Glen Johnson, 1994: 76).

Declarations and resolutions establish standards for governments to measure their policies and actions against and can lay the foundation for the development of related treaty law. The Declaration (2001) and the Declaration (2006) are cases in point.

2. Comparative Analysis

2.1 Global crisis

The Declaration (2006) allows States to reaffirm their commitment to implementing the Declaration (2001) on HIV/AIDS and related documents arising from all major UN conferences and summits, the Millennium Development Goals and the goal of achieving universal access to reproductive health by 2015 as set out in the International Conference on Population and Development.

The Declaration (2001) refers to the devastating global impact of HIV/AIDS on all peoples irrespective of age, gender and race. Stating the global impact of HIV has the political objective of rousing political commitment and support on a global scale, at the international, regional, national and community levels. This global positioning is not so recent when one looks back to the International Conference on Primary Health Care in Alma-Ata, Kazakhstan, in 1978, which brought together 134 countries and 67 international organizations. Nearly all member states of the WHO and UNICEF signed the document. It issued a call for 'health for all' by the year 2000. Its core strategy was primary health care, comprising essential elements ranging from safe water to basic health care services. Alma Ata described the existing gross inequality in health standards between developed and developing countries as well as within countries as politically, socially and economically unacceptable and therefore, of common concern to all countries.

In keeping with Alma Ata and its concern for conditions in developing countries, the Declaration (2001) also situates HIV as predominantly affecting developing countries, specifically Sub Saharan Africa, the Caribbean, the Asia-Pacific region and Latin America. The global proportions of HIV as well as its disproportionate impact on Africa and African peoples is affirmed in all major declarations, including Abuja (2001) and Dublin (2004). The Caribbean Framework expresses its concern that regionally AIDS is the leading cause of death in the 15-44 year age group.

HIV/AIDS and human rights

The Universal Declaration (1948), CCPR and CESCR predate the HIV/AIDS global crisis, however, observance of the human rights identified in the respective treaties is central to an effective response to HIV/AIDS. The rights defined within these documents that can be directly compromised by HIV include but are not limited to: the right to non-discrimination and equality; the right to health; to liberty and security of the person; to privacy; to seek receive and impart information; to marry and found a family; to work; and the right to freedom of movement, association, and expression. Alma Ata defined health as 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, and a fundamental human right.

The first WHO Global Strategy on HIV launched in 1987 incorporated among its key strategies the protection of individuals and societies against the impact of HIV, including discrimination against people affected or infected by HIV. The strategies initially focused primarily on the health sector to respond to HIV manifestations. In the 1990s as understanding of the roots of the epidemic deepened, it was seen that societal and structural factors influenced and even determined the degree of individual risk and vulnerability. The extended response to HIV began to include, human rights principles and instruments as a practical framework of analysis and action, reminding states of obligations under international and national law. The 1996 UNAIDS Global Strategy Framework was built around these principles giving rise to the Health and Human Rights movement (Tarantola: 2008).

The Declaration (2001) links a poor human rights culture to high incidences of HIV. HIV is presented as a formidable challenge to the enjoyment of human rights and dignity. The Declaration's position is in tune with the conclusions of the Vienna Declaration and Programme of Action adopted at the World Conference on Human Rights in 1993 which affirmed that all rights are indivisible, interrelated, universal and interdependent. Regarding indivisibility and interdependence the Declaration (2001) and Declaration (2006) emphasise economic, social and cultural rights and specifically, those areas in which they can be impacted: access to education; employment; health care; social and health services.

The International Guidelines on HIV/AIDS and Human Rights (hereinafter the International Guidelines (1996)) predate the two Declarations (2001 and 2006) and tie governments' obligations to respond to HIV/AIDS to their commitment to observe international human rights law. The 12 guidelines take existing human rights norms and mould them into a series of practical concrete measures that states can respond to respond to the epidemic. They emphasise the interdependence of public health on human rights.

Dublin (2004) was adopted at the conclusion of the conference 'Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia' that brought together representatives of States and Governments together with invited observers in Dublin, Ireland in February 2004. Dublin (2004) repeats the Declaration's (2001) position that the promotion and protection of human rights is essential to an effective response to human rights. There is an emphasis on the right to health care, and ending discriminatory practices against PLHIV, particularly those in the category of vulnerable groups. This position is mirrored in the Caribbean Framework (2002)

which emphasises HIV as an assault on human rights, particularly of vulnerable groups. The Caribbean Framework, however, (like Abuja 2001) also refers to the HIV epidemic as a major development problem for the region.

In contrast to these (human rights) approaches, Abuja (2001) makes no explicit reference to human rights, nor does it attempt to make human rights protection and promotion by States and governments central to the formulation of an effective response to HIV. An implicit reading of human rights in this document could be made, for example, a reference to 'millions of orphans and disrupted family structures' is a denial of the enjoyment of the right to family. Further, Abuja's acknowledgment of the role played by poverty, poor nutritional conditions and underdevelopment in increasing vulnerability could be viewed as an acknowledgment that in those African States (where infection rates are highest) have failed to meet the economic, social and cultural rights of people, such as, the right to development, and the right to food. Abuja places education as the capstone of an effective response to HIV but does not use the human rights language adopted so boldly in the Declaration (2001), Alma Ata or Dublin (2004). A right to information as well as a right to education could have been stated, but this approach is not taken.

However, a human rights agenda can be inferred because of Abuja's endorsement of the African Consensus on Leadership (hereinafter African Consensus (2000)) which provided specifically that 'people living with HIV/AIDS are human beings in full possession of their human rights', and called on States to ensure the dignity of PLHIV. It may be inferred that by acknowledging 'the special importance of the African Consensus' Abuja (2001) accepts the provisions and commitments to human rights therein. Abuja (2001) also affirms a commitment to all relevant decisions, declarations and resolutions in the area of health and development and on HIV/AIDS, particularly the Lomé Declaration on HIV/AIDS in Africa and the Decision on the adoption of the International partnership against HIV/AIDS adopted in Algiers, (2000) and the Algiers Declaration (1999), all of which use a rights based approach to the HIV response.

Vulnerability and prevention for women and girls

The Declaration (2001) repeatedly emphasises the impact of HIV on girls and women they are described as 'the most vulnerable' throughout the document. At the national level, governments are urged to integrate a gender perspective as they implement and design national strategies and financing plans for combating HIV. The empowerment of women, the role of women as bearers of children, as mothers caring for the young, women as primary caregivers of PLHIV, the situation of women in armed conflict and disasters, women experiencing partner violence, these are all gendered experiences and realities highlighted within the Declaration (2001) to show women's position in society and the impact this has on vulnerability to HIV. Women and their multiple roles are referred to specifically in no less than nine of the twelve thematic headings in the Declaration (2001).

The Declaration (2001) uses the language of human rights denial to describe women's relationship to HIV: Discrimination based on gender and inequality are placed at the centre of women's increased vulnerability to HIV. Rape, domestic violence and other forms of gender based violence are described as egregious human rights violations contributing to the spread of HIV/AIDS. There is also a focus on economic and social rights, including: the right to education, inheritance, employment and healthcare for women as imperative human rights that would reduce women's vulnerability to sexual abuse and exploitation and empower them to avoid risk taking behaviour and exercise control over sexual autonomy and reproductive health.[1]

[1] Although the Convention against all forms of Discrimination against Women is not referred to in the Declaration (2001) its General Comment elaborating on women and health should be regarding as setting the standard for placing women's rights into the HIV: 18. The issues of HIV/AIDS and other sexually transmitted

Abuja (2001) recognises that poverty, poor nutritional conditions and underdevelopment increase vulnerability to HIV – however, no gendered analysis of these conditions is provided. In this way, the feminisation of poverty (referred to as such by the Declaration 2006), or the link between food shortage and prostitution by women are obscured by the gender neutral tone of the document. Women are primarily referred to by Abuja (2001) in the role of expectant or lactating mother and the health concern rests with the unborn child vulnerable to mother to child transmission. This is comparable to Alma Ata which referred to women primarily in the context of maternal and child health care paying no attention to women's subordinate status in most societies and the impact this had on women's sexual autonomy, sexual reproductive health and child health care. This approach (Abuja and Alma Ata) to HIV results in the impression that women's exposure to HIV is not an issue of gender hegemonies and systemic discrimination on grounds of sex and gender but rather solely on women's biological make up. Abuja (2001) makes only a passing reference to economic and social inequalities that subordinate women, but ultimately, the document is 'gender neutral'.

Abuja (2001) misses the opportunity to apply a gender analysis to its commitment and strategy. For example, trafficking in human beings and its impact on HIV is referred to, without specific reference to the trafficking of women for sexual exploitation, a surprising omission considering its prominence in organised crime discourse in Europe and the US. This omission is further emphasised when taking into account that the African Consensus (2000) specifically refers to commercial sex workers and women forced by economic conditions to engage in survival sex: States are reminded of their obligations to specifically protect these women through laws and law enforcement officers, access to education and access to condoms and medical facilities. The African Consensus (2000) goes as far as stating that perpetrators of sexual and domestic violence must be prosecuted in the courts and further that women and girls must be empowered in their homes, workplaces, schools and communities, and provided with the cultural, legal and material means of protection from sexual abuse. Abuja (2001) also evades reference to harmful traditional practices such as early marriage and female genital cutting which increase girl's vulnerability to HIV. The Declarations (2001&2006) specifically refer to such practices. The Caribbean Framework (2002) is as vocal as the African Consensus in its denunciation of gender inequalities and discriminating attitudes that permit violence against women and other denials of human rights, which enhance vulnerability to HIV.

Dublin's (2004) position on women lies somewhere between Abuja (2001) and the Declaration (2001). There is reference to the promotion of equality between men and women and a perfunctory acknowledgment of women and girls vulnerability to HIV. However, overall the document leaves the impression that in the European and South East Asian context, women are not regarded as a vulnerable group, except in the case of trafficked women and sex workers. Heterosexual men and women are viewed as belonging to the 'general population' an area that is as yet unexposed to HIV/AIDS.

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disease are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases. States parties should ensure, without prejudice and discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, including those who have been trafficked, even if they are not legally resident in the country. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality. Committee on the Elimination of all Forms of Discrimination against Women, General Recommendation No. 24 on women and health (1999).

Children orphaned and made vulnerable by HIV/AIDS

The Declaration (2001) calls on families, communities, the private sector2 as well as governments to protect orphans, girls and boys affected and infected by HIV/AIDS. Children's economic and social needs are emphasised and states are called on to ensure that they receive counselling, schooling, housing and food.

The Caribbean Framework (2002) gives a comprehensive analysis of the gendered threat that girls face. Economic circumstances are presented leading to sexual activity and exposure to HIV. What is referred to as survival sex in the African Consensus is referred to as transactional sex or exchange for school fees and other necessities by the Caribbean Framework (2002), for example, girl's sexual partners are most likely to be older men whose chances of being HIV positive are higher than their younger counterparts. Social conditions that coerce girls into early sex are also identified. Coercive sex in the forms of incest, rape, domestic violence and sex tourism targeting girls are also named as challenges girls confront and which expose them to infection.

Reference is made in Abuja (2001) to the special role families can play in reducing vulnerability, however, the negative role family can play is not touched upon – for example in arranging early marriages or other harmful traditional practices for girls.

The major declarations on HIV unfortunately do not explicitly endorse3 the Convention on the Rights of the Child or General Comment no. 3 (2003) formulated by the Committee on the Rights of the Child which states that HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights - civil, political, economic, social and cultural. It gives a detailed analysis of those rights which are most compromised by HIV and stresses that adequate measures to address HIV/AIDS can be undertaken only if the rights of children and adolescents are fully respected.4

Other groups

Apart from women, the youth and children the various declarations identify other vulnerable groups. Dublin (2004) identifies: drug injectors and their sexual partners, men who have sex with men, sex workers, prisoners, ethnic minorities and migrant populations. Abuja (2001) expresses leaders' concern over the vulnerability of the youth and in particular when under the influence of mind altering drugs and alcohol. Abuja (2001) also refers to situations of forced movement as a result of armed conflict in Africa and increased vulnerability to HIV in such situations for groups such as refugees and internally displaced populations.

Dublin (2004) reminds us that a gender perspective should involve women as well as men. It recognises that a focus on the role of men and boys in combating HIV/AIDS and in the promotion

[2] Except for Alma Ata all current HIV declarations include the private sector as a key actor and even leader in the response to HIV.

[3] The Caribbean Framework does however, note that it has consulted various international and regional human rights instruments including the Women's Convention and the Convention on the Rights of the Child.

[4] The most relevant rights…are the following: the right to access information and material aimed at the promotion of their social, spiritual and moral well-being and physical and mental health (art. 17); the right to preventive health care, sex education and family planning education and services (art. 24 (f)); the right to an appropriate standard of living (art. 27); the right to privacy (art. 16); the right not to be separated from parents (art. 9); the right to be protected from violence (art. 19); the right to special protection and assistance by the State (art. 20); the rights of children with disabilities (art. 23); the right to health (art. 24); the right to social security, including social insurance (art. 26); the right to education and leisure (arts. 28 and 31); the right to be protected from economic and sexual exploitation and abuse, and from illicit use of narcotic drugs (arts. 32, 33, 34 and 36); the right to be protected from abduction, sale and trafficking as well as torture or other cruel, inhuman or degrading treatment or punishment (arts. 35 and 37); and the right to physical and psychological recovery and social reintegration (art. 39). Children are confronted with serious challenges to the above-mentioned rights as a result of the epidemic. Article 6, Committee on the Rights of the Child, General Recommendation 14, (2003).

of gender inequality will benefit society and that engaging men and boys as partners will encourage them to take responsibility for their sexual behaviour and to respect the rights of women and girls. This position is taken but with less emphasis in the Declaration (2001) which encourages the active involvement of men and boys in challenging gender stereotypes against women and gender inequalities in relation to HIV/AIDS.

Although Abuja (2001) is silent on this point, it can be inferred from a reading of the African Consensus (2000) which states that men must be a target for educational efforts with a view to their being important allies in the fight against HIV/AIDS. Interestingly, a very masculine institute, the military (and other uniformed services) is given special mention, within the African Consensus (2002), as a vulnerable and affected group, as a group that can spread HIV as well as a group that can be called on institutionally to prevent HIV. The military is called on to; confront the reality of high levels of HIV prevalence among soldiers and provide for soldiers who are living with HIV; take a leading role in HIV/AIDS control programmes and; take steps to eliminate the high level of sexual violence against women and girls, particularly during conflicts, and ensure that those responsible are prosecuted and punished. The Caribbean Framework (2002) also refers to the provision of appropriate prevention and care policies designed for uniformed populations but does not indicate their enhanced vulnerability or propensity to transmit HIV.

The Caribbean Framework (2002) is in line with Dublin (2004) when it challenges the media, faith based organisations, court system and school systems as central to modifying the ways in which boys are socialised and reared and subsequently behave towards women. Male prostitutes are also cited as groups made vulnerable to HIV, a working group that is ignored in other HIV declarations. The Caribbean Framework (2002) gives special attention to men-to-men transmission and admits that homosexual (and bisexual) sex is a chief means of communicating HIV in the region. Extreme homophobia, a form of discrimination and indeed a human rights violation are cited as increasing men's vulnerability to HIV.

2.2. Leadership

Political commitment can be described as the decision of leaders to use the power of the State as well as their own official powers, influence and personal involvement to ensure that HIV/AIDS programmes receive the visibility, leadership, resources, and ongoing political support that is required to support effective action to limit the spread of HIV and mitigate the impacts of the epidemic…Political commitment in the widest sense means leadership commitment (The Policy project 2000: 4). The Joint UN programme on HIV/AIDS Report on the Global HIV/AIDS Epidemic (June 2000) drew some of the common features of effective national responses: First on the list was political commitment.

Alma Ata called on governments to work towards an acceptable level of health for all the people of the world by 2000. They were to achieve this by formulating national policies, strategies and plans to action to launch and sustain primary health care as part of a comprehensive national health system and coordination with other sectors…mobilising country resources and exercising political will…and through cooperation and a spirit of partnership. Alma Ata urged governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care.

The Declaration (2001) calls for leadership at the national, regional and global levels. However, it is clear that the national level is seen as bearing the primary responsibility for responding to the challenges of HIV/AIDS. With respect to the national level a pronouncedly legalistic language is used and positive action called for, for example, States must ensure development, address gender dimensions, and eliminate discrimination. And a concrete action plan is set out for the national level.

A key provision in the Declaration (2006) focuses on political commitment and cooperation between States and the following: UN, INGOs, people living with HIV and vulnerable groups; medical, and academic institutions, NGOs, the business sector including pharmaceutical companies, trade unions, the media, parliamentarians, foundations, community organisations, faith based organisations and traditional leaders.

Abuja (2001) reflects a regional commitment to the response to HIV as the 'leaders of the Continent' take the lead in strengthening current successful interventions and developing new and more appropriate policies, practical strategies, effective implementation mechanisms and concrete monitoring structures at national, regional and continental levels with a view to ensuring adequate and effective control of HIV/AIDS, TB and other related diseases on the Continent. The African Consensus is referred to by Abuja (2001) as setting the standard it will follow for leadership. It (African Consensus) elaborates greatly on a multi-level type of leadership necessary for an effective response to HIV. 1. Personal leadership; 2. Community leadership; 3. National leadership; 4. Regional leadership and; 5. International partnership. Personal leadership includes (i) Every citizen, leader, wife, husband, parent, child, youth, adult, worker, or employer, must be ready to speak openly about sexual relations and the unequal power relations within sexual relationships; (ii) Every person should embrace people living with HIV/AIDS as fellow members of their families, communities and nations/

Dublin (2004) also places leadership at the centre of its response. Government is envisaged as bearing the primary responsibility in formulating a response to HIV. Other actors are identified and encouraged to take on strong leadership including; the private sector; civil society; HIV partnership forums; PLHIV; institutions of the EU; the Council of Europe; the Organisation for Security and Cooperation in Europe; UNAIDS and the Global fund to fight AIDS, TB and Malaria.

The Caribbean Framework lists its seven priority issues and strategy, for each issue, a primary leader is named. These include: CARICOM; UNAIDS; Red Cross, Caribbean Federation of Youth, University of West Indies, Caribbean Regional Epidemiological Centre and the Caribbean Network of People Living with AIDS are the most prominent organisations delegated leadership. Unlike Dublin's focus on government's The Caribbean Framework places a regional and institutional leadership role at the heart of its response to HIV. The Caribbean Framework articulates those specific opportunities and challenges common to most of the countries across the region. Though not a substitute for national level action, the Framework identifies priorities that can be best addressed collectively at a regional level to the benefit of all, while identifying key issues for national level focus that will advance the regional fight against HIV/AIDS.

Monitoring and evaluation

Abuja (2001) does not prescribe a monitoring and evaluation framework for national governments. It issues a general call to the OAU Secretary General, in collaboration with ECA, Africa Development Bank, WHO, UNICEF, UNDP, ILO, UNFPA, FAO, UNESCO, UNIFEM, IOM, UNDCP and other partners to follow up on the implementation of Abuja (2001) and submit a report to the Ordinary Sessions of the Assembly.

As mentioned above, Abuja (2001) endorses the African Consensus (2000) and this should include its well formulated framework for evaluation and monitoring which include (national level): Each country should hold a representative national workshop by mid-February 2001, to determine how the Consensus and Plan of Action can be turned into action at the country level; all governments should prepare reports for the Special Summit of the OAU on HIV by mid-March which should include concrete action on national initiatives at the highest level and resource

allocation; civil society organisations, especially PLHIV and youth, should strengthen their cooperation, evaluate their experience, and prepare for their contribution to the OAU Special Summit; by the end of 2001, each country should ensure that it has in place a National AIDS Commission (or equivalent) and a strategic plan, backed up by appropriate legislation, modalities for the involvement of PLHIV and other stakeholders, and mechanisms for regular monitoring of progress.

At a regional level, the African Consensus encourages regional organisations to ensure that HIV is mainstreamed into the agendas of all meetings of African leaders including Heads of State, at regional, sub regional and supraregional levels. This has been observed quite diligently by states parties to the present day. Already at the follow up meeting (to Abuja) in Lusaka, member states made several declarations demonstrating their internalisation and application of the Abuja principles. For example, the Prime Minister of Lesotho stated that:
'We find the Abuja Framework document in line with our National AIDS Strategic Plan of Action, which aims at controlling the spread of HIV/AIDS in the country, and mitigate its impact on all vulnerable groups, individuals, families and the nation in line with the Abuja Framework Plan of Action…We established the Lesotho AIDS Programme Coordinating Authority to coordinate all HIV/AIDS control efforts through all sectors at national and international level as well as mobilizing resources for the fight against the disease.'

The Declaration (2001) is an extensive document making specific and far reaching action plans for an effective response to HIV. As a first step to establishing an evaluative framework, the document includes time bound targets, particularly at the national level, for example in order to meet certain internationally agreed targets before a specified period. Other targets include: by 2005 strengthen the response to HIV in the workforce; by 2003 implement universal precautions in health care settings to prevent transmission of HIV infection; by 2005 reach an overall target of annual expenditure on the epidemic of between 7 and 1 billion US dollars in low and middle income countries.

A framework for evaluation and monitoring is provided for at multiple levels: at the national level periodic reviews by governments are called for, with the participation of civil society, particularly PLHIV, vulnerable groups and caregivers. The reviews are required to identify progress achieved in realising the many commitments contained in the Declaration (2001). The Declaration (2001) provided for annual reviews by the General Assembly of progress in implementing the Declaration's provisions, with discussions each year to be informed by a substantive report prepared by the Secretary General. These annual reviews have been maintained and are essential to the review and evaluation of commitments made in the Declaration.

With the Declaration (2001), as with Abuja (2001), evaluation and monitoring of HIV responses is expected to remain an ongoing subject on the agenda of regional meetings at the ministerial, head of State and Government level. Regional organisations are also called on to collate data and processing to facilitate periodic country reviews. Within the Political Declaration (2006) the General Assembly decided to undertake comprehensive reviews in 2008 and 2011 of the progress achieved in realising the Declaration (2001). This is an important development and the results of the 2008 review are an important precedent for other HIV declarations (the deadline for the submission of country reports was 31 January 2008).

The Report by the Secretary General on progress in implementing the Declaration of Commitment on HIV/AIDS is essential to the monitoring and evaluation of progress under the Declaration (2001). It precedes the General Assembly review and provides a comprehensive report on progress achieved and remaining challenges in the global AIDS response. Countries are encouraged to submit reports on national progress to help inform the Secretary General's report.

With funding provided by UNAIDS the World AIDS Campaign commissioned an evaluation of a Civil Society Task Force. With the aim of better involving meaningful civil society in future AIDS reviews in 2006 a necessary condition to pressure governments to meet their obligations.

Dublin (2004) like the Declaration (2001) includes many time bound targets including: By 2010 eliminate HIV infection among infants in Europe and Central Asia; by 2005 provide universal access to effective, affordable and equitable prevention, treatment and care including safe anti-retroviral treatment to PLHIV. The follow up or framework for monitoring and evaluation is a rather broad and general statement when compared to the African Consensus and Declaration (2001): We commit ourselves to closely monitor and evaluation the implementation of the actions outlined in Dublin (2004) and the Declaration (2001). Dublin (2004) leaves it to the EU and other relevant regional institutions to establish a framework for reviewing and monitoring realisation of the actions stated.

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