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## List of Acronyms

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<thead>
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<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AAI</td>
<td>AIDS Accountability International</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>CRAG</td>
<td>Country Rating Advisory Group</td>
</tr>
<tr>
<td>ECDC</td>
<td>European Centre for Disease Prevention and Control</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Intravenous drug user</td>
</tr>
<tr>
<td>MARP</td>
<td>Most-at-Risk Population (in UNGASS defined as IDUs, MSM and sex workers)</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NCPI</td>
<td>National Composite Policy Index</td>
</tr>
<tr>
<td>OHCHR</td>
<td>Office of the United Nations High Commissioner for Human Rights</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Other Vulnerable Children</td>
</tr>
<tr>
<td>PLWH</td>
<td>Person living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
</tr>
</tbody>
</table>
1. AIDS Accountability International (AAI) is an independent nonprofit organization established to increase accountability and inspire bolder leadership in the response to the AIDS epidemic. The AIDS Accountability Country Scorecard is a rating of the degree to which governments are fulfilling the commitments they have made to respond to the epidemic. Without an evaluation of performance, there is no means to encourage governments that are succeeding, put pressure on those that are failing or stimulate constructive debate about what more needs to be done and how.

2. A comprehensive set of commitments were made by UN Member States in the Declaration of Commitment on HIV/AIDS in 2001 about how countries should respond to AIDS and how responses should be monitored and progress reported to the UN. These commitments were restated in 2006. Together with other global commitments for strengthening global public health, there are now definite targets in terms of universal access to ARV treatment by 2010 and reduced levels of HIV prevalence by 2015.

3. UNAIDS makes information and data from country reports available as narrative reports and large data files, neither of which allow for easy overview or specific exploration of the material by interested stakeholders. The AIDS Accountability Country Scorecard, for the first time, presents this information in an aggregated, transparent and analytical format that allows stakeholders to compare responses on several key issues across countries.

4. The Country Scorecard is the result of a comprehensive consultative process involving global experts in the fields of monitoring and evaluation of global public health and development of policy ratings, as well as civil society representatives from across the world. The Scorecard will be issued annually and developed and improved continuously as more and better data become available.

5. In this first phase, the Country Scorecard reflects how governments rate their own responses to AIDS through the UN process. Subsequent versions of the Scorecard will improve on this by encouraging independent validation of the data and the inclusion of additional elements. It is hoped that by the UN target date of 2010 the Scorecard will be a valid and comprehensive monitoring tool for rating country performance and will help guide rating and monitoring efforts into the future.

6. The Country Scorecard includes assessment of eight key elements required for an effective national response to AIDS: Data Collection, Focus on Most-at-Risk Populations, Treatment, Prevention, Coordination, Civil Society, Financing and Human Rights Mainstreaming. The assessment is based on 2008 data reported by 190 countries against the core indicators used for monitoring the United Nations Declaration of Commitment. The final element of the Country Scorecard, known as the AIDS Reporting Index, notes whether countries have failed to provide any data at all on one or more elements.

7. The development and analysis of the Country Scorecard motivates three general conclusions. First, there is a need to strengthen the validity of the data that countries submit. Country progress reports to UNAIDS reflect how national governments, and to some extent civil society, rate their country’s response to AIDS, and whereas these reports may be a genuine attempt to reflect the various components of their response, there is currently no way of knowing which data may be flawed or biased. Whereas UNAIDS scrutinizes epidemiological and behavioural
data, it has no mandate to question the reporting of other, more political indicators. A process must therefore be developed to establish validating mechanisms for the data and ensure a correct understanding of strengths and weaknesses in reporting country responses to AIDS.

8. The second conclusion is that whereas more countries reported to the UN in 2008 than in 2006, far too many countries still do not report on one or more of the required indicators. A failure to report is a failure to live up to a central principle of the Declaration of Commitment: the need for transparency and effective monitoring. Without data, it is impossible to monitor and evaluate country progress, and hold governments accountable for their promises.

9. The final conclusion is that the 25 indicators used in the UN reporting system are necessary but insufficient. Additional indicators need to capture the quality of policy implementation, particularly in relation to gender, youth and human rights. The uncertain quality of current data and the failure of countries to report on many aspects of the response are major obstacles to holding governments accountable.

10. AAI will develop more detailed country profiles for all countries (a select set is already available for download on the AAI website). These profiles will also draw information from countries’ narrative reports, any shadow reports that have been submitted to the UN by civil society stakeholders and analyses that are undertaken independently of the UN monitoring process.

11. The Country Scorecard is a dynamic tool that will be developed in different ways as more and better data become available and the methodology is improved. AAI intends to make the Scorecard more comprehensive by adding elements such as gender and youth, once the appropriate data and methodology have been identified. AAI is also interested in assessing the quality of a country’s response in terms of care and support and the quality of national health systems more generally. AAI also intends to add data to its analyses that can complement the information contained in the UN data, such as human rights.

12. The UN monitoring of AIDS is gender sensitive in that the majority of core indicators require countries to report data separately (disaggregated) for males and females. However, the UN reports this data only where it is available, and there has been no systematic accounting of which countries report on it across the relevant indicators. Gender disaggregated monitoring and reporting are essential to identifying and addressing women’s specific vulnerabilities to AIDS, and a failure to do so undermines claims by governments to a strong national response. In order to facilitate transparency and accountability, AAI will develop a Gender Reporting Index to be presented in 2009. The rating will detail which countries report gender disaggregated data adequately and on the basis of what indicators.
Introduction

Looking back at 25 years of the global AIDS epidemic it is clear that governments have not mobilized sufficient resources in the response to AIDS. If this had been done at the right time, tens of millions of lives could have been saved and AIDS would no longer devastate families, households and communities across the world at the scale it does today. In order to halt and reverse the epidemic, and to provide adequate care, support and treatment to those already infected and affected by HIV and AIDS, the world needs political determination and concrete action at a level not yet seen. While there are several complex reasons for why such political leadership has been lacking, a core problem has been that governments have gotten away with poor performance. There has been a lack of accountability for country responses to AIDS.

In order to accelerate the global response to AIDS, key stakeholders must translate their commitments into action. Only by going beyond promises and statements of intent to holding key stakeholders accountable for the results they do – or do not – achieve, can we stimulate real progress. Unless we assess and compare performance on a regular basis, there is no way to applaud leaders who are succeeding, put pressure on those who are failing or stimulate constructive debate about what more needs to be done and how.

The Declaration of Commitment

Governments have made extraordinary commitments to respond to HIV and AIDS. Political leaders from all 189 United Nations Member States gathered in New York in June 2001 in an unprecedented show of support for global action against a unique threat to global public health. The UN General Assembly Special Session on HIV/AIDS (UNGASS) is a milestone in the response to AIDS. For the first time, world leaders recognized AIDS as a global crisis that required concerted individual and collective action by all countries. UNGASS resulted in the Declaration of Commitment on HIV/AIDS, signed by Heads of State and representatives of government.

The Declaration of Commitment consists of a comprehensive set of concrete and time-bound targets to reverse the spread of HIV and mitigate the impact of AIDS. Governments also agreed to report on their responses through a biannual process of monitoring and evaluation. On the basis of a UN Secretary-General report in 2006 that took stock of progress and obstacles after five years, all UN Member States restated their commitment to the UNGASS Declaration and added ambitious targets for universal access to comprehensive HIV prevention programs, antiretroviral (ARV) treatment and care and support by the year 2010 (UNGASS, 2006). The most recent reporting on country responses to AIDS was submitted to the UN by governments in January 2008.

With the Declaration of Commitment, countries have clearly stated what they intend to do in response to AIDS. The Declaration thus provides a benchmark for performance evaluation against which governments can be held accountable.
Objective

The objective of the 2008 AIDS Accountability Country Scorecard is to reflect back to country and global stakeholders what governments reported to the UN system about their responses to AIDS. The purpose of this is to increase the transparency of country reports to the UN monitoring system, and make critical information accessible to stakeholders that want to hold governments accountable for flawed reporting and poor responses.

Developing the rating methodology

After the launch of the Country Rating Initiative in 2006, AAI commissioned a series of background papers reviewing indicators and methodologies used in other rating initiatives. The names of all individuals who took part in various stages of this process can be found in the Annex on page 47. A rating development team was identified and they presented a Country Rating Pilot in 2007.

This initial model, called the "relative response model", was based on statistical regression analyses that controlled for a series of context variables, and rated country performance on three different aspects of service delivery. Following an independent review of this model, feedback from members of AAI's Country Rating Advisory Group (CRAG) and extensive consideration of other ratings, indices and scorecards, AAI decided to instead adopt a more comprehensive scorecard approach that would cover a broader range of elements in the response to AIDS. For some elaboration on the methodology used in the relative response and scorecard models, see pages 42-44 under 'Methodological Considerations'.

The development of the scorecard model was undertaken by the Country Scorecard Development Team. The first draft was presented at AAI’s first Rating Workshop in May 2008. Based on the feedback received at the workshop, the scorecard model was updated and again reviewed by the AAI Advisory Committee and the CRAG before being presented at a technical session at the XVII International AIDS Conference in Mexico City in August 2008. Simultaneously, a web-based scorecard evaluation tool was added to the AAI website. In addition, a gender review of the proposed scorecard was commissioned from an external reviewer. After additional evaluation by the AAI Advisory Committee and when more data was received from UNAIDS, the scorecard was updated twice more.
The 2008 AIDS Accountability Country Scorecard has thus gone through a thorough consultation process (see Figure 1), which helped AAI improve the scorecard in several ways. The Country Scorecard is now a uniquely relevant, politically legitimate and methodologically rigorous monitoring tool. But it is also a dynamic tool that will be improved further as more and better data become available. This work will commence soon after the launch. In particular, AAI will make the Country Scorecard more comprehensive, and develop a process through which the validity of country data can be assessed independently. AAI’s development plan for the Country Scorecard during 2009 is elaborated on page 45.

The next section provides a brief overview of the elements in the scorecard, followed by a section that elaborates them in more detail.

Country Scorecard Elements

The AIDS Accountability Country Scorecard captures eight “elements” of country responses to HIV and AIDS that are critical to a successful response:

Element 1: Data Collection
Element 2: Focus on Most-at Risk Populations
Element 3: Treatment
Element 4: Prevention
Element 5: Coordination
Element 6: Civil Society
Element 7: Financing
Element 8: Human Rights Mainstreaming

All data used in the Country Scorecard come from the UN’s monitoring system of the Declaration of Commitment, a process led by UNAIDS (Joint United Nations Programme on HIV/AIDS). The only exception to this is financial and census data used in Element 7. Whereas all countries are assessed on the basis of the same eight elements, the data that is used to generate the rating of Element 4, Prevention, differs between countries depending on the type of epidemic.

A total of 153 countries submitted country reports to UNAIDS in the first few months of 2008, which was an improvement from 126 in the 2006 round of reporting. UNAIDS later supplemented this information with data from additional countries and the Country Scorecard drew on data from a total of 190 countries.

The method of calculating scores differs between the elements. In the case of Element 3, Treatment, the score is based on a single percentage (those covered by antiretroviral treatment). For all other elements the score is calculated on the basis of three or more data
points. In some instances the score is based on a percentage of coverage or amount of financial resources spent. For other elements the score reflects the extent to which countries have reported the requested data. All the scores were converted to percentages and assigned a grade using a scale from A to E. This scale is elaborated in each element section.

No mathematical weighting was used in the calculation of the scores. The selection of the elements and indicators themselves is the primary weighting method used in this scorecard.

The question of how to assess countries that did not report the requested data was discussed throughout the consultation process. If country scores on a particular element were calculated based only on the data that countries submitted, this would favour countries that chose not to report data on aspects of the response they had neglected, and punish those that reported diligently on all aspects of their response (including those for which a country may have had few resources to muster a good result). However, recording non-responses could also unfairly punish countries that were not required to report on one or more elements. In the UNAIDS manual for country reporting it is stated that all of the 25 core indicators apply to all countries, with one exception. Countries with generalized epidemics are not requested to report data for indicators dealing with most-at-risk populations (MARP) unless any such group of the population experiences a concentrated sub-epidemic.

After discussing various alternatives, it was decided that non-reporting would be included in the calculation of the composite element score. Countries that fail to submit the required data for one or more of the questions or data points that make up an element receive a score of zero, which lowers their aggregate grade for that element.

Countries with general epidemics that did not report data on some or any of the questions relating to MARPs might feel that this methodology unjustly lowers their grades on two of the elements. AAI's rationale for nevertheless including these countries rests on two arguments. One is that some of these countries did report the requested data and they should be duly acknowledged for doing so. The other is that decisions to not monitor and report on these sub-groups may have less to do with epidemiology and more to do with the discrimination and sometimes condemnation that sex workers and men who have sex with men suffer in several countries with generalised epidemics in Eastern and Southern Africa. By punishing these countries for not reporting on MARPs, AAI sends the message that countries should acknowledge the existence of these groups and incorporate them fully in a constructive response to AIDS.

The final component of the Country Scorecard, known as the AIDS Reporting Index, tracks whether countries have failed to provide any data at all on the questions for one or more elements. The Index tallies up the number of elements that each country fails to report on and provides a ranking from best (all elements reported) to worst (no elements reported).
Elements of the Scorecard

Element 1: Data Collection

Indicators considered and selected

Four groups of indicators were considered for inclusion in this element:

- The extent to which appropriate and timely biobehavioural surveillance has been conducted.
- The extent to which the country in question has reported against all agreed UNGASS indicators.
- The extent to which the country in question has a quality assurance system in place for its HIV surveillance system.
- The extent to which the country has a harmonized HIV surveillance system, such as joint donor reviews.

Based on informal consultations with international experts, these groups of indicators were considered for their ability to generate information on the state of the HIV epidemic and a country’s response to it. They would also give some insight on the quality of data and the extent to which information is harmonized across development partners working in the country. In the end, a combination of indicator groups 1 and 2 was used for this element. No readily available data were found for indicator groups 3 and 4.

Data analysis and grading

Countries received a score of 1 for each of the following 15 indicators:

- HIV prevalence among the adult population (15-49).
- HIV prevalence among sex workers.
- HIV prevalence among men who have sex with men.
- HIV prevalence among injecting drug users in the country’s capital city.
- 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.
- Percentage of sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- Percentage of men who have sex with men who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- Percentage of injecting drug users who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
- Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.
- Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.
- Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.
- Percentage of female and male sex workers reporting the use of a condom with their most recent client.
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Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.

To be included, data needed to be less than 5 years old (dated from 2003 or later). Countries that did not report data received a score of zero for that indicator. Scores for all indicators were aggregated and expressed as a percentage. Grades were allocated to countries based on the following scale:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80%</td>
<td>A</td>
</tr>
<tr>
<td>61-80%</td>
<td>B</td>
</tr>
<tr>
<td>41-60%</td>
<td>C</td>
</tr>
<tr>
<td>21-40%</td>
<td>D</td>
</tr>
<tr>
<td>1-20%</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

Issues

The main issue with Element 1 is whether all countries should be expected to have data on all 15 indicators regardless of epidemic type. It could be argued that countries with an epidemic concentrated among certain subpopulations should not be expected to have data on the general population. However, many do have this information available, and several countries scored 100% across a range of geographic regions.

Similarly, it could be argued that countries with generalized epidemics should not be expected to have data for most-at-risk populations because they invest scarce resources differently. For this reason, countries with generalized epidemics are not required by UNAIDS to report such data. However, since these populations are known to be particularly at-risk and are also often neglected in responses, countries with generalized epidemics are nevertheless encouraged to monitor and report such data, and a number of them did.
Element 2: Focus on Most-at-Risk Populations

*Indicators considered and selected*

It proved difficult to identify an appropriate metric for this element. Despite broad agreement on the importance of this element and extensive consultation about how it might be measured, AAI did not receive any concrete suggestions on what indicators should be used.

*Data analysis and grading*

In the UNGASS monitoring tool, countries are required to detail their total expenditure on HIV prevention as well as their total expenditure on prevention programs for most-at-risk-populations, sex workers and their clients, men who have sex with men, and programs for harm reduction for injecting drug users. The expenditure on most-at-risk populations were then expressed as a percentage of the total expenditure on prevention, and grades were allocated based on the following scale:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;60.00</td>
<td>A</td>
</tr>
<tr>
<td>25.01-60.00</td>
<td>B</td>
</tr>
<tr>
<td>10.01-25.00</td>
<td>C</td>
</tr>
<tr>
<td>5.01-10.00</td>
<td>D</td>
</tr>
<tr>
<td>0.01-5.00</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

*Issues*

Only 49 countries reported the data that was required to calculate this element. Reporting levels may be low because the element requires countries to have disaggregated financial data. It may also be because, as with Element 1, countries with generalized epidemics tend not to report on most-at-risk populations.

Although this indicator does provide a measure of the degree to which prevention efforts are focused on most-at-risk populations, it tells us nothing about the degree of focus in other areas of response to HIV and AIDS, such as the provision of antiretroviral therapy.
Element 3: Treatment

*Indicators considered and selected*

This indicator on antiretroviral treatment (ART) captures the degree to which the supply of treatment covers the demand. The indicator is well-established and has been included in the proposed country rating since AAI began working on a scorecard.

*Data analysis and grading*

Although the construction of this element was quite simple (it is the only element based on just one figure) there were other complications. Countries were requested to report only the number of people who were receiving ART (*supply*) whereas the number of people in need of ART (*demand*) was to be modeled by UNAIDS/WHO in Geneva. The result was that many high-income countries that did not have the required data on the supply of ART disputed UNAIDS/WHO’s modeling of the demand. UNAIDS/WHO, on the other hand, criticized most country estimates of demand for not including undiagnosed cases.

AAI has no stake in these debates and can only use the data that is reported by the mandated UN authority, UNAIDS. Most countries report one percentage figure for the coverage, a point estimate, and a range in brackets. The point estimate was used to construct this element in the scorecard. Where no coverage figures were provided for any of the years 2004-2007, a score of zero was assigned. Grades were allocated based on the following scale:

<table>
<thead>
<tr>
<th>&gt;80</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>61-80</td>
<td>B</td>
</tr>
<tr>
<td>41-60</td>
<td>C</td>
</tr>
<tr>
<td>21-40</td>
<td>D</td>
</tr>
<tr>
<td>1-20</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

*Issues*

Element 3 currently assesses absolute performance only and could be seen as penalizing well-performing countries that are starting from a low baseline. In constructing this element, AAI explored the possibility of rating not just absolute performance from the most recent time period, but also including an assessment of how ART coverage had improved over time. Lack of data made this more comprehensive calculation impossible, however. Later versions of the scorecard may revise the methodology for calculating this element as more and better data become available.
Element 4: Prevention

**Indicators considered and selected**
The following three indicators were initially considered for this element:

- Coverage of programs to prevent mother-to-child transmission (PMTCT).
- Coverage of programs to prevent HIV transmission among most-at-risk populations.
- Behavioural indicators, such as reported condom use.

The behavioural indicators had to be dropped due to lack of data.

Since the relevance of different prevention interventions differ between types of epidemics, this is the only element that is constructed differently for different groups of countries. PMTCT coverage is particularly relevant in the generalized epidemics in Eastern and Southern Africa, and since these countries generally do not have any data on most-at-risk populations, it was decided to make PMTCT coverage the only indicator for this element. The element score for other countries in sub-Saharan Africa was calculated as the average of PMTCT coverage and the coverage of prevention efforts directed at sex workers.

It is widely recognized that prevention programs for most-at-risk populations need to be provided at scale, so measuring the coverage of these programs is important. However, there is no international consensus on what coverage means, how it should be measured or what levels need to be reached for a program to be effective. Nevertheless, figures are fairly widely available for a number of countries and to date there is no other international data set with more information on these indicators. For countries outside sub-Saharan Africa, coverage of prevention programs among sex workers, injecting drug users and men who have sex with men were used as indicators for this element.

**Data analysis and grading**
For PMTCT, the element score was based on the reported point estimate. Where only a range was provided, the midpoint of that range was taken as the coverage figure. Where no coverage figures were provided for any of the years 2004-2007, a score of zero was assigned. For programs among most-at-risk populations, the score is the average coverage among the three subpopulations. For programs among sex workers and injecting drug users, combined figures for males and females were used when available.

Grades were allocated based on the following scale:

<table>
<thead>
<tr>
<th>Coverage (%)</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80</td>
<td>A</td>
</tr>
<tr>
<td>61-80</td>
<td>B</td>
</tr>
<tr>
<td>41-60</td>
<td>C</td>
</tr>
<tr>
<td>21-40</td>
<td>D</td>
</tr>
<tr>
<td>1-20</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>
Element 5: Coordination

Indicators considered and selected

Element 5 represents an assessment of the degree to which countries have adopted the “Three Ones” approach in coordinating their response to AIDS: one national strategic framework, one coordinating authority and one monitoring and evaluation system. Information is available for countries who reported against the National Composite Policy Index (NCPI), which is one of the indicators in UNAIDS' UNGASS monitoring tool.

Data analysis and grading

For the strategic framework, scores were calculated on the basis of answers to the following 12 questions:

1. Does the country have a strategic framework?
2. Has the country had a strategic framework for more than five years?
3. Was the strategic framework based on a needs analysis?
4. Does the strategic framework include an operational plan?
5. Does the strategic framework include a clear statement of goal(s)?
6. Does the strategic framework include targets?
7. Is the strategic framework costed?
8. Does the strategic framework specify funding sources?
9. Does the strategic framework have a plan for monitoring and evaluation?
10. Did the development of the strategic framework involve civil society?
11. Has the strategic framework been endorsed by development partners?
12. Have development partners aligned their support around the strategic framework?

Questions 1-9 were scored 1 for ‘yes’ and 0 for ‘no’. Questions 10 and 12 were scored 1 for ‘fully’, 0.5 for ‘partially’ and 0 for ‘no’. Scores were then totalled out of 12 and expressed as a percentage.

For the National AIDS Coordinating Authority, scores were calculated on the basis of answers to the following 22 questions:

1. Does the country have an officially recognized national multisectoral AIDS management/coordination body?
2. Has the country had such a body for more than five years?
3. Does this body have terms of reference?
4. Does this body have active government leadership and participation?
5. Does this body have a defined membership?
6. Does this body include civil society representation?
7. Does this body include people living with HIV?
8. Does this body involve the private sector?
9. Does this body have an action plan?
10. Does this body have a functional secretariat?
11. Does this body meet at least quarterly?
12. Does this body regularly review actions on policy decisions?
13. Does this body actively promote policy decisions?
14. Does this body provide opportunity for civil society to influence decision-making?
15. Does this body strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?
16. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?
17. Does this body have terms of reference?
18. Does this body have a defined membership?
19. Does this body have an action plan?
20. Does this body have a functional secretariat?
21. Does this body have regular meetings?
22. Does this body meet at least quarterly?

Almost all questions\(^1\) were scored 1 for yes and 0 for no. Question 6 was scored 0 if there was no civil society representation, 1 if civil society representation was less than 25%, 2 if civil society representation was 25-49% and 3 if civil society representation was 50% or more. Scores were then totalled out of 24 and expressed as a percentage.

For the National Monitoring and Evaluation (M&E) System, scores were calculated on the basis of answers to the following 30 questions:

1. Does the country have one national M&E plan?
2. Has the plan been endorsed by key partners?
3. Was the M&E plan developed in consultation with civil society, including people living with HIV?
4. Have key partners aligned and harmonized their M&E requirements with the national M&E plan?
5. Does the M&E plan include a data collection and analysis strategy?
6. Does the M&E plan include behavioural surveillance?
7. Does the M&E plan include HIV surveillance?
8. Does the M&E plan include a well-defined standardized set of indicators?
9. Does the M&E plan include guidelines on tools for data collection?
10. Does the M&E plan include a strategy for assessing quality and accuracy of data?
11. Does the M&E plan include a data dissemination and use strategy?
12. Is there a budget for the M&E plan?
13. Has funding been secured for the budget?
14. Is there a functional M&E unit or department?
15. How many permanent staff are working in the M&E unit/department?
16. Are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E unit/department for review and consideration in the country's national reports?
17. To what degree do UN, bilaterals and other institutions share their M&E results?
18. Is there an M&E committee or working group that meets to coordinate M&E activities?
19. Does this group meet regularly?
20. Did this group's last meeting occur after September 2007?
21. Does this group include representation from civil society, including people living with HIV?
22. Does the M&E unit/department manage a central national database?
23. Does this database include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?
24. Is there a functional Health Information System at the national level?

\(^1\) Questions 1-5, 7-22
25. Is there a functional Health Information System at the subnational level?
26. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?
27. To what extent is M&E data used in planning and implementation?
28. In the last year, was training in M&E conducted at the national level?
29. In the last year, was training in M&E conducted at the subnational level?
30. In the last year, was training in M&E conducted including civil society?

Almost all questions\(^2\) were scored 1 for ‘yes’ and 0 for ‘no’. Questions 1, 12 and 14 earned a score of 1 for ‘yes’ and 0.5 if ‘development was in progress’. Question 4 scored 2 for ‘all’, 1 for ‘most’ and 0.5 for ‘some’. Question 15 scored 1 for ‘5 or more staff’, 0.5 for ‘1-4 staff’ and 0 for ‘no staff’. Questions 17 and 27 were scored on a scale of 0 to 5, where 0 is low and 5 is high. Scores were then totalled out of 39 and expressed as a percentage.

A composite score was generated by taking the mean of the percentage totals for each of the Three Ones. Grades for individual scores for each of the Three Ones and the composite score were allocated based on the following scale:

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80</td>
<td>A</td>
</tr>
<tr>
<td>61-80</td>
<td>B</td>
</tr>
<tr>
<td>41-60</td>
<td>C</td>
</tr>
<tr>
<td>21-40</td>
<td>D</td>
</tr>
<tr>
<td>1-20</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

\(^2\) Questions 2-3, 5-11, 13, 16, 18-26, 28-30
Element 6: Civil Society

**Indicators considered and selected**

As with Element 5, this element builds on data in the NCPI – one of the core indicators in the UN monitoring system.

**Data analysis and grading**

A numerical score was assigned based on responses to each of the following 31 questions. Most questions were scored 1 for 'yes' and 0 for 'no'. Question 1 scored 1 for 'active' and 0.5 for 'moderate'. Question 12 scored 1 for 1-25%, 2 for 26-50% and 3 for >50%. Questions 22-25 and 27-29 were graded on a scale from 0 to 5. Question 30 was graded on a scale from 0 (poor) to 10 (good). Question 31 was calculated by taking the answer from question 30 and subtracting from it the value for a similar question from 2005. Responses to this question ranged from -10 to +5, so this question was considered to have a maximum value of +5.

Questions 1-19 were answered by government officials. Questions 20-31 were answered by representatives of civil society.

1. Has the country ensured full involvement and participation of civil society in the development of the multisectoral strategy/action framework?
2. Does the national multisectoral AIDS management/coordination body include civil society representatives?
3. Does the national multisectoral AIDS management/coordination body include people living with HIV?
4. Does the national multisectoral AIDS management/coordination body provide opportunity for civil society to influence decision-making?
5. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?
6. Does this body have terms of reference?
7. Does this body have a defined membership?
8. Does this body have an action plan?
9. Does this body have a functional secretariat?
10. Does this body have regular meetings?
11. Does this body meet at least quarterly?
12. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?
13. Does NAC provide information on priority needs and services to implementing partners, particularly civil society organizations?
14. Does NAC provide technical guidance/materials to implementing partners, particularly civil society organizations?
15. Does NAC procure and distribute drugs/supplies to implementing partners, particularly civil society organizations?
16. Does NAC coordinate with implementing partners, particularly civil society organizations?
17. Does NAC build capacity of implementing partners, particularly civil society organizations?

Notes:

- Questions 2-11; 13-21; 26
18. Was the national M&E plan developed in consultation with civil society, including people living with HIV?
19. Does the M&E committee or working group include representation from civil society, including people living with HIV?
20. Has the government involved most-at-risk populations in governmental HIV policy design and programme implementation?
21. Does the ethical review committee (for research) include representation of civil society and people living with HIV?
22. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?
23. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS?
24. To what extent are services provided by civil society included in both the National Strategic Plans and national reports?
25. To what extent are services provided by civil society included in the national budget?
26. Has the country included civil society in a national review of the National Strategic Plan?
27. To what extent is the civil society representation in HIV-related efforts inclusive of its diversity?
28. To what extent is civil society able to access adequate financial support to implement its HIV activities?
29. To what extent is civil society able to access adequate technical support to implement its HIV activities?
30. To what extent were efforts being made in 2007 to increase civil society participation?
31. How has this changed from 2005?

The maximum overall total score was 74. Of this, 21 (28%) came from questions answered by government and 53 (72%) from those answered by civil society. The element score expressed the total score as a percentage. In addition, percentage scores were available for question 30 and the equivalent value for 2005, questions answered by government (1-19) and those answered by civil society (20-31).

Grades were allocated based on the following scale:

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80</td>
<td>A</td>
</tr>
<tr>
<td>61-80</td>
<td>B</td>
</tr>
<tr>
<td>41-60</td>
<td>C</td>
</tr>
<tr>
<td>21-40</td>
<td>D</td>
</tr>
<tr>
<td>1-20</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

**Issues**

A key issue in assessing this element is whether to accept only governmental or only civil society perspectives on this issue, or to take a combination of the two. If a combined perspective is taken, it is unclear what relative weight should be given to each perspective. The current approach in this element is determined by the number of questions and the scoring system within NCPI. This weights the element towards civil society perspectives.
Element 7: Financing

**Indicators considered and selected**
Initially, a number of possible financial indicators were suggested for this element. After much discussion it was decided to use the following three indicators based on data from three sources:

- Total expenditure on HIV/AIDS per person living with HIV in the country.
- Total expenditure on HIV prevention per capita.
- Domestic spending on HIV per person living with HIV as a proportion of Gross National Income per capita.

The first two indicators consider both domestic and donor funds. The first considers total spending on HIV and AIDS and compares it to the total number of people living with HIV in the country. It could be argued that this should be considered a proxy for the cost of providing treatment, care and support for people living with HIV. The second considers total spending on prevention and compares it to the total number of people living in the country. The third indicator is for domestic spending only and can therefore be considered a measure of domestic government commitment to responding to HIV and AIDS. However, the ability of countries to fund the response varies enormously so this figure is compared to a widely-accepted measure of national wealth: Gross National Income.

**Data analysis and grading**
For some countries, UNGASS data contain financial information from a number of different years. In such cases, the most recent financial data has been used. Units for indicators 1 and 2 are US$ per person. Indicator 3 is a percentage.

**Indicator 1**
Total spending per person with HIV is graded as follows:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;$5000</td>
<td>A</td>
</tr>
<tr>
<td>$2501-$5000</td>
<td>B</td>
</tr>
<tr>
<td>$1001-$2500</td>
<td>C</td>
</tr>
<tr>
<td>$501-$1000</td>
<td>D</td>
</tr>
<tr>
<td>$1-$500</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>
Indicator 2
Total spending on HIV prevention per person in the country is graded as follows:

<table>
<thead>
<tr>
<th>Total spending</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;$5.00</td>
<td>A</td>
</tr>
<tr>
<td>$1.01-$5.00</td>
<td>B</td>
</tr>
<tr>
<td>$0.51-$1.00</td>
<td>C</td>
</tr>
<tr>
<td>$0.26-$0.50</td>
<td>D</td>
</tr>
<tr>
<td>$0.01-$0.25</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

Indicator 3
Domestic spending on HIV per person living with HIV as a proportion of Gross National Income per capita is graded as follows:

<table>
<thead>
<tr>
<th>Domestic spending</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;100%</td>
<td>A</td>
</tr>
<tr>
<td>26-100%</td>
<td>B</td>
</tr>
<tr>
<td>11-25%</td>
<td>C</td>
</tr>
<tr>
<td>6-10%</td>
<td>D</td>
</tr>
<tr>
<td>1-5%</td>
<td>E</td>
</tr>
<tr>
<td>0/No data</td>
<td>No data</td>
</tr>
</tbody>
</table>

A composite score was calculated by assigning the following numerical scores to grades:

<table>
<thead>
<tr>
<th>Numerical score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>A</td>
</tr>
<tr>
<td>8</td>
<td>B</td>
</tr>
<tr>
<td>6</td>
<td>C</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
</tr>
<tr>
<td>2</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

Mean scores for the three indicators were then aggregated without weighting. The total score was graded as follows:

<table>
<thead>
<tr>
<th>Total score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;8</td>
<td>A</td>
</tr>
<tr>
<td>6.1-8.0</td>
<td>B</td>
</tr>
<tr>
<td>4.1-6.0</td>
<td>C</td>
</tr>
<tr>
<td>2.1-4.0</td>
<td>D</td>
</tr>
<tr>
<td>0.1-2.0</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

It is possible to have a figure larger than 100% because this indicator is comparing the amount spent per person with HIV and AIDS against the gross national income per person.
Issues

Although the scoring system implies that higher spending per person with HIV and AIDS is beneficial, it is possible that high costs of antiretroviral drugs in developed countries are distorting the figures and that these high scores are actually a reflection of high drug prices rather than more committed governments.

As with all UNGASS data, there are issues of data availability and quality. However, information is currently available for each of these indicators for more than 80 countries.
Element 8: Human Rights Mainstreaming

*Indicators considered and selected*

This element has been reviewed in some detail throughout the consultation process. On balance, it was decided to base this element on responses from civil society representatives as part of reporting on core indicator 2 in the UNGASS monitoring tool, the National Composite Policy Index (NCPI).

The NCPI is divided into two parts. Part A is to be completed by government officials and covers strategic planning, political support, prevention, treatment, care and support and monitoring and evaluation. Part B is to be completed by nongovernmental stakeholders and covers human rights, civil society participation, prevention, and treatment, care and support.

Historically, reporting on NCPI through the UNGASS process has not been strong. In 2003, it was completed only by government and resulted in high scores as most countries ticked most boxes. In 2005-06, civil society responses were needed but analysis proved difficult and results were not highlighted in the overall UNAIDS report on progress towards UNGASS. In 2008, 136 countries submitted national NCPI reports and these are available on the UNAIDS website. Data from NCPI reports is referred to throughout the UNAIDS 2008 report on progress towards reaching UNGASS commitments. However, there is no section or annex presenting systematic analysis of NCPI data.

*Data analysis and grading*

A numerical score for NCPI was assigned based on responses to each of the following 40 questions. Most questions were scored 1 for ‘yes’ and 0 for ‘no’. Questions 10-17 scored -1 for ‘yes’, 1 for ‘no’ and 0 for no response. An overall score was calculated as a percentage.

Does the country have laws and regulations that protect people living with HIV against discrimination?
Does the country have nondiscrimination laws or regulations which specify protections for vulnerable subpopulations?
Does the country have nondiscrimination laws or regulations which specify protections for vulnerable women?
Does the country have nondiscrimination laws or regulations which specify protections for young people?
Does the country have nondiscrimination laws or regulations which specify protections for IDU?
Does the country have nondiscrimination laws or regulations which specify protections for MSM?
Does the country have nondiscrimination laws or regulations which specify protections for sex workers?
Does the country have nondiscrimination laws or regulations which specify protections for prison inmates?
Does the country have nondiscrimination laws or regulations which specify protections for migrants/mobile populations?
Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable subpopulations?

---


7 Questions 1-9, 18-40
Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for women?

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for young people?

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for IDU?

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for MSM?

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for sex workers?

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for prison inmates?

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for migrants/mobile populations?

Is promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

Has the government involved most-at-risk populations in governmental HIV policy design and programme implementation?

Does the country have a policy of free services for HIV prevention?

Does the country have a policy of free services for ART?

Does the country have a policy of free services for HIV-related care and support?

Does the country have a policy to ensure equal access for women and men to prevention, treatment, care and support?

Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Does the country have a policy prohibiting HIV screening for employment purposes?

Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Does the ethical review committee include representatives of civil society and people living with HIV?

Does the country have independent national institutions for the promotion and protection of human rights?

Does the country have independent focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment?

Does the country have performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts?

Does the country have performance indicators or benchmarks for reduction of HIV-related stigma and discrimination?

Have members of the judiciary been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Does the country have legal aid systems for HIV and AIDS casework?

Does the country have private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV?

Does the country have programmes to educate and raise awareness among people living with HIV concerning their rights?

Does the country have programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS?

Does the country have programmes through the media designed to change societal attitudes of stigmatization associated with HIV and AIDS?
Does the country have programmes in schools designed to change societal attitudes of stigmatization associated with HIV and AIDS?

Does the country have programmes involving personalities regularly speaking out designed to change societal attitudes of stigmatization associated with HIV and AIDS?

Grades were allocated based on the following scale:

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80</td>
<td>A</td>
</tr>
<tr>
<td>61-80</td>
<td>B</td>
</tr>
<tr>
<td>41-60</td>
<td>C</td>
</tr>
<tr>
<td>21-40</td>
<td>D</td>
</tr>
<tr>
<td>1-20</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>

AIDS Reporting Index

A widespread lack of transparency is one of the key factors hindering accountability in responses to AIDS, and assessment of performance is impossible unless countries provide the required data. The final element of the Country Scorecard, known as the **AIDS Reporting Index**, notes whether countries have failed to provide any data at all on the questions for one or more elements. The Index tallies up the number of elements that each country fails to report on and presents a ranking from best (all elements reported) to worst (no elements reported).

Grades were allocated based on the following scale:

<table>
<thead>
<tr>
<th>Score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>A</td>
</tr>
<tr>
<td>7/8</td>
<td>B</td>
</tr>
<tr>
<td>5-6/8</td>
<td>C</td>
</tr>
<tr>
<td>3-4/8</td>
<td>D</td>
</tr>
<tr>
<td>1-2/8</td>
<td>E</td>
</tr>
<tr>
<td>0</td>
<td>No data</td>
</tr>
</tbody>
</table>
Results

Element 1: Data Collection
The amount of data countries reported on key epidemiological and behavioural indicators.

More countries reported on this element than any other – 177 in total. The mean score varies for different subgroups of countries. High-income countries have a lower score than low-income countries, which suggests they are worse at monitoring and/or reporting on the fundamentals of their epidemics and their responses. Countries that face more problematic types of epidemics appear to spend more effort on monitoring and reporting. Countries with concentrated epidemics have the highest score followed by those with generalized epidemics.
Table 1. Mean scores, Element 1.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>all</th>
<th>low</th>
<th>low/con*</th>
<th>con*</th>
<th>gen**</th>
<th>low</th>
<th>middle</th>
<th>high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting countries/total</td>
<td>177/190</td>
<td>59/61</td>
<td>11/19</td>
<td>67/68</td>
<td>39/39</td>
<td>51/53</td>
<td>84/90</td>
<td>40/42</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>4.9</td>
<td>4.3</td>
<td>3.6</td>
<td>5.7</td>
<td>5.0</td>
<td>5.4</td>
<td>5.4</td>
<td>3.4</td>
</tr>
</tbody>
</table>

*concentrated (con)  
**generalized (gen)

The high number of countries reporting on this element suggests that the large majority of countries do monitor at least some fundamental aspects of their respective epidemics. However, the relatively low scores achieved overall show that this monitoring and reporting to the UN is far from satisfactory. Most countries do not appear to know their epidemics as well as they should.
Element 2: Focus on Most-at-Risk-Populations

The share of total funds for HIV/AIDS that was spent on prevention efforts directed at most-at-risk populations.

Country reporting on this element is highly problematic. Only 49 countries (26%) reported some or all of the data for this element and 141 countries reported no data at all. Of the countries that did report, investment in reaching most-at-risk populations was greatest in countries with low-level epidemics and least among countries with generalized epidemics. In countries with low-level epidemics, high scores on this element were strongly linked (in terms of statistical correlation) to high scores on data collection (Element 1). This suggests that countries with rigorous monitoring also have more effective policy implementation.
Table 2. Mean scores, Element 2.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>all</td>
<td>low</td>
</tr>
<tr>
<td>Reporting countries/total</td>
<td>49/190</td>
<td>13/61</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>4.1</td>
<td>5.7</td>
</tr>
</tbody>
</table>

* concentrated (con)  
** generalized (gen)

The main finding related to this element is that a large majority of countries fail to report any data at all on prevention efforts for subgroups that are particularly vulnerable to HIV infection. This may indicate a lack of respect for the human rights of individuals in these groups, as well as a lack of understanding of how HIV may spread from these groups into the general population.
Element 3: Treatment

The coverage of antiretroviral (ARV) treatment.

This element is the third most reported, with 69% of countries providing the necessary data. The mean score varies greatly between groups of countries. Not surprisingly, coverage reflects country income levels: the mean score of high-income countries is more than twice that of low-income countries. It is noteworthy, however, that this high score for high-income countries is based on only 38% of those countries reporting – a very poor showing. This leads to a clear and unfortunate conclusion: many of the high-income countries that provide funding for antiretroviral treatment in the poorer countries, and for which they demand precise monitoring and reporting, do not themselves live up to the standards they set for others. Measuring progress towards the target of Universal Access to HIV treatment by 2010 will not be possible unless countries drastically improve their monitoring and reporting of ARV coverage.

Table 3. Mean scores, Element 3.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>all</td>
<td>low</td>
</tr>
<tr>
<td>Reporting countries/total</td>
<td>132/190</td>
<td>29/61</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>4.8</td>
<td>4.6</td>
</tr>
</tbody>
</table>

*concentrated (con)
**generalized (gen)
Element 4: Prevention

The coverage of HIV prevention programmes.

Since prevention is critical to a successful AIDS response, it is highly problematic that only 48% of countries provided any data on this element. The mean score on prevention coverage does not appear to be affected by the type of epidemic, but it is significantly lower among high-income countries. Monitoring and/or reporting is poor among high-income countries, with only 12% reporting some data.

The only relatively strong association for this element is with ARV coverage (Element 3) in generalized epidemics. This would appear to reflect global policy recommendations that strong treatment and prevention policies should complement each other in an effective response to AIDS, especially in countries with generalized epidemics.

*Table 4. Mean scores, Element 4.*

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>all</td>
<td>low</td>
</tr>
<tr>
<td>Reporting countries/total</td>
<td>91/190</td>
<td>17/61</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>4.1</td>
<td>3.8</td>
</tr>
</tbody>
</table>

*concentrated (con)*

*generalized (gen)*
Element 5: Coordination

The extent to which countries coordinate their responses through the so-called "Three Ones" approach. Whereas such coordination is considered essential to an effective institutional response to the AIDS epidemic, the element does not tell us anything about the efficiency of those institutions.

Of all the elements, this was the one that the 136 reporting countries gave themselves the highest overall mean score. Countries with generalized epidemics gave themselves the highest grade of all – close to a full score. High-income countries are, again, the worst at reporting on this element and have the lowest mean score. Given that a good monitoring system is included in the score for this element, one would expect an association with a strong score on data collection (Element 1). This, however, is not the case, implying that the institutional arrangements in place might not be so effective.
While the data suggest that countries have taken on the Three Ones approach quite well, reporting on this element may be particularly susceptible to political bias for two reasons. First, funding is to some extent conditional on the adoption of this policy blueprint. Second, this element is the clearest example of governments commenting on their own institutional structures.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>low</td>
</tr>
<tr>
<td>Reporting countries/total</td>
<td>136/190</td>
<td>31/61</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>8.2</td>
<td>7.8</td>
</tr>
</tbody>
</table>

*concentrated (con)
**generalized (gen)
Element 6: Civil Society

The extent to which civil society is able to play an active role in the response to AIDS.

Close to three quarters of all countries reported on this element, and the relatively high mean score did not vary significantly on the basis of country income levels or type of epidemic. While this would indicate that civil society participation in the response to AIDS has been widely accepted, the singular element score hides some discord between what is reported by government and what is said by civil society stakeholders in some countries. The reporting process also does not assess the extent to which civil society participation represents a broad spectrum of political affiliations and public interests.

Table 6. Mean scores, Element 6.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>all</td>
<td>low</td>
</tr>
<tr>
<td>Number of countries</td>
<td>136/190</td>
<td>31/61</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>6.5</td>
<td>6.6</td>
</tr>
</tbody>
</table>

*concentrated (con)
**generalized (gen)
Element 7: Financing

The level of financial resources that are invested in the response to AIDS.

This element has the second lowest overall mean score, and only half of the countries reported the data. As would have been expected, there is a strong positive association between this element and ARV coverage (Element 3) in middle-income countries, and an even stronger association in countries with generalized epidemics, as countries with stronger funding can afford higher treatment coverage.
Table 7. Mean scores, Element 7.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>all</td>
<td>Low</td>
</tr>
<tr>
<td>Reporting countries/total</td>
<td>96/190</td>
<td>22/61</td>
</tr>
<tr>
<td>Mean score (out of 10)</td>
<td>3.9</td>
<td>4.5</td>
</tr>
</tbody>
</table>

* concentrated (con)
** generalized (gen)

The poor reporting on this element is problematic in light of the principle adopted in the 2005 Paris Declaration, which states that developing countries should determine themselves how donor funds are spent. Whereas local self-determination is considered to be a central element of effective national responses to the epidemic, this principle can only help strengthen the quality of governance more generally if the allocation of funds is reported appropriately. The fact that spending on AIDS is so poorly reported does not bode well for the effective use of AIDS funding.
Element 8: Human Rights Mainstreaming

The degree to which human rights have been mainstreamed into the AIDS response.

Whereas this element reflects the degree to which legal frameworks that structure the response to AIDS consider human rights, it does not measure how well these rights are respected in the implementation of AIDS policy, nor does it necessarily reflect the human rights cultures of countries more generally.
Table 8. Mean scores, element 8.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting countries/total</td>
<td>all</td>
<td>low</td>
</tr>
<tr>
<td>132/190</td>
<td>31/61</td>
<td>12/19</td>
</tr>
<tr>
<td>Mean score</td>
<td>5.4</td>
<td>5.0</td>
</tr>
</tbody>
</table>

*concentrated (con)
**generalized (gen)

With 70% of countries reporting, this element has the third highest overall mean score, with little variation in the mean score in terms of country income levels or types of epidemics. The most striking finding is that Human Rights Mainstreaming is positively linked to Coordination (Element 5) and Civil Society (Element 6). Countries with high scores on one of these elements are likely to also score well on the other two. This might suggest an interesting set of mutually reinforcing effects between a well-coordinated state response and an active civil society steeped in a human rights culture. This pattern is found in all subgroups of countries with the exception of those with generalized epidemics, where such virtuous effects between governance institutions (coordination) and governance culture (participation and human rights) would be most sorely needed.
The overall mean score on the AIDS Reporting Index is 3, meaning that countries, on average, failed to report any data on three out of the eight elements. But there is much variation between the subgroups of countries. On average, high-income countries failed to report on five elements, the lowest level of reporting. Countries with generalized epidemics are found towards the top of the rating index, with an average reporting of seven elements.

Global monitors of AIDS refer to the “red countries”, meaning the hyperendemic countries in Eastern and Southern Africa that show up in dark red on UNAIDS’s maps of global HIV infection rates. The AAI map of AIDS Reporting is the inverse of the global infection map – high-income countries with low-level or concentrated epidemics appear in deep red due to their poor reporting.

Table 9. Mean scores, AIDS Reporting Index.

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>Epidemic type</th>
<th>Income level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting countries</td>
<td>all</td>
<td>low</td>
</tr>
<tr>
<td>190</td>
<td>61</td>
<td>19</td>
</tr>
<tr>
<td>Mean score, non-reporting</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*concentrated (con)

*generalized (gen)
Conclusions

In the course of developing the first Country Scorecard and reviewing the results, AAI has identified three critical priorities that must be addressed if country progress in the response to AIDS is to be better evaluated and governments truly held accountable for their actions against stated commitments.

Need for independent assessment of the validity of data

Country progress reports to the UN indicate how governments rate their own responses to AIDS, with some influence from civil society actors. However, there is currently no way of systematically assessing how, and to what extent, reported data may be flawed or biased. Any interpretation of the scores and grades that countries receive should therefore be cautioned by a basic uncertainty about the validity of self-reported data. But such a caution does not imply that the data is worthless across the board – far from it. If the data was thoroughly corrupted, all countries would falsely report top performance on all indicators. The fact that countries do not, and that several countries actually report poor performance, increases its credibility. In addition, once countries have submitted their reports, UNAIDS spends considerable resources and time scrutinizing them and requesting further information and clarity where obvious gaps or inconsistencies exist.

What AAI is calling for and will try to contribute to is a more nuanced and finely tuned process. In developing the scorecard, it became clear that there is currently no way to tell which data had been through some process of validation and which had not. While it would seem, for instance, that UNAIDS undertakes some validation of the epidemiological information submitted by countries, no similar checks are made on the more politically sensitive information submitted through the NCPI. (But this may not be true for some countries or other sets of indicators.) The process that is outlined in the last section of this report is intended to increase the transparency of data validation that has been completed by countries and/or UNAIDS, and complement these efforts where necessary.

Need for better and more complete reporting

More countries contributed reports to the UN process in 2008 than in 2006, yet far too many countries still do not report on one or more of the required indicators. It is a concern that high-income countries are particularly poor at reporting. A failure to report to the UN is obviously a lesser problem than a failure to respond effectively to AIDS. However, the fact that countries that to a large degree fund the global response to AIDS and have great influence over the policy guidelines (UNGASS itself being one) do not themselves report adequately arguably undermines the credibility and political legitimacy of the global effort. A failure to report is a failure to live up to a central principle of the Declaration of Commitment: the need for transparency and effective monitoring. European countries appear to have woken up to the fact that data reporting is essential for effective monitoring and assessment. The 2004 Dublin Declaration sets out a process that will strengthen and develop the reporting on AIDS by countries in Europe and Central Asia by 2010.
Need for additional indicators

The 25 indicators used in the UN reporting system are necessary but insufficient. More indicators are needed if we are to better understand what is really happening with country responses to AIDS. For instance, the current reporting system reveals the existence of discriminatory laws against people living with HIV, but does not take account of whether, or how, these laws are implemented. AAI has noted in particular major weaknesses in data and indicators related to gender and human rights. We are therefore reviewing various ways to better incorporate these aspects into future scorecards.

The questionable quality of current data and data sources, the lack of independent scrutiny of much of the data and the failure of countries to report on many aspects of the response to AIDS are all major obstacles to holding governments accountable.
Methodological Considerations

An effort to measure and rate country responses to AIDS will very quickly encounter some fundamental questions and methodological challenges. Which aspects of the response are more important? What should be the scope of the rating? How can the rating be done technically? What data is available to work with? While some of these issues have been touched upon earlier in this report, this section will elaborate further on the choices AAI has made in this regard and what discussions and consultation processes preceded these decisions.

Issues and scope
AAI’s ambition has been to include in the rating as many countries as possible and to base the rating on a comprehensive set of key elements of the response to HIV and AIDS. The rating was never envisaged as an exercise initiated in the Global North to measure efforts in the South, nor to only rank countries that were facing generalized epidemics. The ambition has been to create a rating tool that matches both the AIDS epidemic itself in terms of global coverage and the necessary response in terms of comprehensiveness.

Rating model
Shortly after the launch of AAI in 2006, we commissioned a series of papers that discussed various technical solutions for developing the rating instrument. The papers weighed the pros and cons of several of the existing ratings on issues relevant to AIDS, development and governance. We decided to develop a model that would rate country efforts while taking several contextual factors into account. We called it the “relative response model”.

According to this model, countries would not be rated directly on, for instance, what level of antiretroviral treatment coverage they had achieved. Rather, their respective scores would take into account whatever obstacles they had to face in reaching a particular level of coverage. Consequently, the model might give a higher score to a poor country with severe resource constraints than to a rich and well-resourced country even though the poor country had a lower level of coverage. This was because, in the context of its resource constraints, the poor country had made a greater effort. With a sporting metaphor, the relative response model leveled the playing field on which countries compete for positions on the rating. In technical statistical terminology, the relative response model was based on the residuals in multivariate regression analyses.

The relative response model has generated a rating that has been published in a scientific journal and it presents some very interesting results (Desmond et al, 2008). However, as the research advanced, it was decided that it would not be used as the model for AAI’s global rating. The two main reasons for this were that it did not have global scope and that the set of issues on which it was based was not sufficiently comprehensive. Both these shortcomings were due to limitations in available data. AAI will nevertheless explore the relative response model as we develop our rating instruments further on the basis of new and more comprehensive data.

AAI decided to instead base the rating on a scorecard model, which does not take country context into consideration. The available data on country performance is not analysed through statistical techniques but simply summed into composite scores that place countries in a rating in direct relation to other countries. While this methodology is simple and transparent, which has definite political and strategic advantages for stakeholders who wish to use it, it is in other ways more difficult to interpret. Whereas the relative response model built context into the analysis, the informed interpretation of the scorecard model requires that readers keep context
in mind. For example, it asks whether it could be country wealth, the severity of the epidemic or dominant norms around sexual behavior that explain why countries A, B and C get better scores than countries X, Y and Z. AAI will develop analyses to assist the reader with interpreting context, and the scorecard model and the interpretation of its results will improve continuously as data is added and feedback is generated from those who use the scorecard.

Statistical indicators and rating mechanisms have proven to be powerful tools for ensuring accountability and advancing knowledge of good and bad practice. When Moody’s or Standard & Poor’s downgrade a country’s sovereign credit rating, investors and donors take notice, and purchasers of bonds and securities know that they will need to absorb greater risk. UNDP’s Human Development Index (HDI) and Transparency International’s Corruption Perception Index are other examples of ratings that are well-established and often cited.

The work on the scorecard model was undertaken by the Country Scorecard Development Team. A first draft of the model was presented at AAI’s first rating workshop in May 2008. Based on the feedback received at the workshop, the model was updated and reviewed by the AAI Advisory Committee before being presented at a technical session at the XVII International AIDS Conference in Mexico City in August 2008. In addition, a gender review of the proposed scorecard was commissioned from an external reviewer, Chiseche Mibenge of the Netherlands Institute for Human Rights, University of Utrecht. The scorecard was then updated twice more after additional evaluation by the AAI Advisory Committee and upon receiving further data from UNAIDS.

The main concerns that were raised during this consultation on the scorecard model can be summed up in a few points: elements, overall composite score and non-reporting.

Elements

The version of the scorecard that was presented at the AIDS Conference in Mexico had ten elements. Apart from the current eight, there was one element that was intended to assess the quality of health systems, and one called an outcomes element with data on HIV prevalence and orphan school attendance. The element on health systems was taken out partly due to a lack of data, but we hope to return to this element in 2009. The outcomes element was too different in character to be regarded as an element of the response to AIDS. Data on HIV prevalence should rather be seen as a contextual factor, and the extent to which orphans (who may or may not have been orphaned through AIDS) go to school is more a result of the response than a part of it. During 2009 we will explore analyses that test whether, for instance, any of the current Country Scorecard elements that capture the institutional character of the response can be said to explain one or more policy outcome variables. In other words, do specific institutional arrangements have a causal impact on the effectiveness of the response?

Overall composite score

Previous versions of the Country Scorecard calculated an overall composite score of the different elements. This was an attempt to capture country performance with a single figure. While such simplicity would have been advantageous in some respects, especially in the media, AAI decided that presenting the complexities of country responses to AIDS in one rating was too blunt and imprecise an assessment to be of any real value.
Non-reporting

It has already been discussed why a country's failure to report needs to influence the scores it is awarded in the rating. In previous drafts of the Scorecard, this was done in three ways. First, a failure to report on some of the data that generated the score for a particular element would lower the country score for that element. Second, a failure to report any of the data for an element gave countries an F-score for that element. Third, any such F-scores on one or more elements would lower the overall composite score for countries.

The following changes were made to this methodology and presentation of the Scorecard:

Previous F-scores were instead noted as 'no data' in order to signal that failures to report any data at all on an element were not assessed using the same scale as the other scores (which were graded from A to E) and that non-reporting represented a different sort of failure. Second, since the scorecard no longer presents an overall composite score, failure to report any data at all on one or more elements will now only affect the assessment of those particular elements. Finally, AAI generated the AIDS Reporting Index in order to clearly identify variations in the reporting to the UN.
The way forward

The process of improving and developing the Country Scorecard will commence shortly after the launch. AAI’s first tasks will be to make the Scorecard more comprehensive and to develop a process by which the validity of the data can be assessed independently.

Making the Scorecard more comprehensive

The need to somehow incorporate gender into the Country Scorecard was highlighted throughout the consultation process. However, no method or data were identified that could work for all countries. AAI has subsequently identified a method to create a Gender Reporting Index on the basis of UN data. The central importance of a gendered response to AIDS was clearly stated in the 2001 UN Declaration of Commitment on HIV/AIDS. The UN monitoring of AIDS is therefore gender-sensitive in that the majority of core indicators require countries to report data disaggregated for males and females. The UN reports this data where it is available, but there has been no systematic accounting of which countries report on it across the relevant indicators. Gender disaggregated monitoring and reporting are essential to addressing women’s specific vulnerabilities to AIDS, and a failure to do so undermines claims by governments to a strong national response. In order to facilitate transparency and accountability on the gender aspect of country responses to AIDS, AAI will develop the Gender Reporting Index for presentation in June 2009. The rating will detail which countries report gender disaggregated data adequately, and for what indicators. We will explore a methodology that would allow the extent to which countries report gender disaggregated data to influence some or all of the element scores in the Country Scorecard.

In addition to gender, the consultation process also suggested that AAI develops elements for youth, care and support, as well as health systems. We will also pursue these suggestions and welcome suggestions on what available data would be most appropriate to use.

Assessing the validity of the UN data

As has been mentioned, the 2008 version of the Country Scorecard builds exclusively on the self-reported data that countries submit to UNAIDS through the monitoring process of the Declaration of Commitment. Since the reporting from each country is ultimately controlled by government, several participants in the AAI consultative process expressed great reservations about the validity of the data. Some participants could detail problems with the reported data from one or a few countries, and others could give examples of how the process of consultation with civil society stakeholders had been biased against those who were critical of government. For these reasons, AAI does not assume that all data is valid, but at the same time it would be a mistake to regard the information gathered by UNAIDS as untrustworthy.

AAI’s ambition in this regard is to develop a process through which it can say which data already has considerable and perhaps sufficient validity, and which data does not. Where problems of validity can be identified in a particular set of countries, or in a particular set of indicators, AAI will suggest a process through which to address the problems. The main mechanism for this process will be the Country Scorecard Panel, a large group of experts and stakeholders from civil society, academia and public health experts in various development agencies.

AAI has begun working on the strategy to identify the approximately 1000 key individuals who will be invited to join this Panel. Their role will then be to assess the validity of the data reported to the UN as well as the country ratings that AAI generates. The AAI Country Scorecard Panel will be made up of people with a broad range of expertise and experience relevant to the tasks of...
the panel, stretching from epidemiology and politics to AIDS-related grassroots mobilization and service delivery. The Panel will also be representative in terms of gender and geographical regions, ensuring that women's voices from the South will be heard loud and clear. AAI is about to establish its Rating Centre in South Africa where the work on developing the Country Scorecard will be undertaken.

It is AAI's ambition that by the current UN target date of 2010, the Country Scorecard will be widely recognized as a valid and comprehensive monitoring tool and rating of country responses to AIDS. It is also hoped that the Scorecard will help ensure that governments and political leaders can be held accountable for their performance in responding to AIDS beyond the current UNGASS deadline, and sustain political mobilization for effective country responses to AIDS.
Annex: People involved in the AIDS Accountability Country Scorecard development process

This annex lists those who have been involved in developing or commenting on various drafts of the Country Scorecard or assisting AAI in other ways. It is essential to point out that the final content of any of AAI’s publications, strategies or ratings, including the AIDS Accountability Country Scorecard, do not necessarily reflect their views or opinions, and has not been explicitly certified by any of these individuals or the institutions they represent.

**AAI Board of Directors**
- Lars O. Kallings, MD, PhD, UN Special Envoy to the Secretary General for HIV/AIDS in Eastern Europe and Central Asia
- Gustaaf Wolvaardt, MD, Executive Director, Foundation for Professional Development, South Africa
- Carl-Olof Bouveng, Partner at law firm Lindahl KB, Sweden
- Rodrigo Garay, Founder & Executive Director of AAI, former CEO, International AIDS Society

**Advisers**
AAI is proud to have interacted with and received the advice of the following leading global experts in the field of HIV/AIDS, as well as global public health and development more broadly, on different strategic issues:

- Tony Barnett, Professor, London School Of Economics, UK
- Alvaro Bermejo, Executive Director, International HIV/AIDS Alliance, UK
- Pedro Cahn, President, International AIDS Society
- Nils Daulaire, President and CEO, Global Health Council, USA
- Paul De Lay, Director, Epidemic Monitoring and Prevention Department, UNAIDS, Geneva
- Bo Ekman, Chairman, Tällberg Foundation, Sweden
- Minou Fuglesang, PhD, Director, Femina-HIP, Tanzania
- Ophelia Haanyama-Orum, Senior Advisor, Global Partnership on HIV and AIDS, Sweden
- Bobby John, Member, Global Health Advocates core team, India
- Andreas Kyriacou, Professor, Departament d’Economia, Universitat de Girona, Spain
- Anders Milton, Former Chairman, Council of the World Medical Association, Sweden
- Christopher Murray, Professor, Institute Director, Institute for Health Metrics and Evaluation, University of Washington, USA
- Hans Rosling, Professor, Karolinska Institute and Founder of Gapminder, Sweden
- Thomas Scalway, Independent Consultant, South Africa
- Mary Ann Torres, Senior Program Officer, ICASO, Canada
- Thomas Tufte, Professor in Communication, Roskilde University, Denmark
- Stefano Vella, Research Director, Department Of Drug Research And Evaluation, Instituto Superiore di Sanità, Italy
- Senator Mechai Viravaidya, UNAIDS Special Representative, Chairman, Population & Community Development Association, Thailand
- Anders Wijkman, Swedish Member of the European Parliament and the Committee on the Environment, Public Health and Food Safety, Brussels
- Anne Winter, Advocacy and Communications Consultant, Geneva
- Paul Zeitz, Executive Director, Global AIDS Alliance, USA

**AAI Rating Development Teams**
Each of AAI’s rating initiatives has consisted of a Development Team of 4-8 people. The teams were
commissioned to write proposals for new rating instruments, which were reviewed by the Expert Panel and the AAI Advisory Committee.

The Country Rating: Relative Response Development Team

Coordinator: Chris Desmond, Research Associate, Harvard School of Public Health, USA
Anita Alban, Executive Director, EASE International, Denmark
Anna-Mia Ekström, Researcher, Division of International Health (IHCAR), Department of Public Health, Karolinska Institute, Sweden
Evan S. Lieberman, Associate Professor of Politics & Richard Stockton Bicentennial Preceptor, Princeton University, USA

Country Scorecard Development Team

Coordinators: Jaran Eriksen, Researcher (PhD), Karolinska Institute, Sweden and Per Strand, Researcher (PhD), University of Cape Town, South Africa
Joseph Decosas, Regional Health Advisor, PLAN International, Ghana
Roger Drew, Health and Development Consultant, UK
Ulrich Laukamm-Josten, WHO Regional Office for Europe, Denmark
Marcel van Soest, Executive Director, World AIDS Campaign, The Netherlands
Jerome Uher, Communications Director, Corporation for Enterprise Development

Business Rating Development Team

Pamela Bolton, Associate Vice President, Knowledge, Evaluation & Performance, Global Business Coalition on HIV/AIDS, Tuberculosis, and Malaria, United States
Gavin George, Research Fellow at the Health Economics and HIV/AIDS Research Division at the University of KwaZulu-Natal, South Africa
Brad Mears, CEO, South African Business Coalition on HIV/AIDS, South Africa
Alyson Slater, Independent Communications and Sustainability Consultant, The Netherlands

AAI Advisory Committee

The members of this advisory committee provided feedback on the rating initiatives on a regular basis and advised AAI on the design and content of future rating workshops and on potential activities that could further strengthen the impact of our rating initiatives.

Priscilla Akwara, Advisor, Statistics and Monitoring, UNICEF, New York
Laura Ferguson, Research Manager, Program on International Health and Human Rights, Harvard School of Public Health, USA
Marianne Flink, Independent Consultant, Former CEO, Standard & Poor’s Scandinavia, Sweden
Michael Hammer, Executive Director, One World Trust, UK
Stuart Kean, Senior HIV and AIDS Policy Adviser, World Vision UK
Khadija Moalla, Regional HIV/AIDS Practice Leader & Programme Coordinator for Arab States, UNDP HIV/AIDS Regional Programme in the Arab States, Egypt
Gcebile Ndlovu, Regional Coordinator Southern Africa, International Community of Women Living with HIV and AIDS, Swaziland
Carol O’Brien, Executive Director, American Chamber of Commerce in South Africa, South Africa

Expert Panel

During 2009, AAI will establish an HIV/AIDS expert panel to assist in the validation of the self-reported data for the Country Scorecard. The panel will consist of international interdisciplinary HIV/AIDS experts, including representatives from civil society, the private sector, the UN system, donors, academia, media and people living with HIV/AIDS. Panel membership will be representative in terms of area of expertise, gender and geography. The expert panel will also be used as a critical mass of expert opinion on AIDS that will be surveyed through recurrent opinion polls of the whole
The panel or of subgroups on specific matters. The panel will also provide feedback to AAI on the rating mechanisms and serve as a key channel for the dissemination of ratings and information from AAI.

**Country Rating Advisory Group**
AAI has created the Country Rating Advisory Group (CRAG) to review country ratings. The group involves close to 100 representatives of civil society, academia, bilateral and multilateral agencies, government and the private sector from all over the world. Specific advisory groups will also be formed for other ratings, such as the donor and private sector rating. The recruitment of members to the different advisory groups is an ongoing activity.

-Zackie Achmat, Activist, Founder of Treatment Action Campaign, South Africa
-Munir Ahmed, Team Leader UNICEF HAP HIV Program, Bangladesh
-Dennis Altman, Professor, La Trobe University, Australia
-Joe Amon, Director HIV/AIDS Program, Human Rights Watch, USA
-Vardan Babayan, Programme Director Armenian National AIDS Foundation, Armenia
-Syed Mohammad Baqar, Consultant in community work, workplace responses, training of PLWA, India
-Alvaro Bermejo, Executive Director AIDS Alliance, UK
-Karoline Beronius, ICT4D Adviser, The Swedish Program for Information and Communication Technology in Developing Regions, Sweden
-Mabel Bianco, President and Coordinator, Fundacion para Estudio e Investigacion de la Mujer, Argentina
-Pedro Cahn, Director, Fundación HUESPED, Assistant Professor of Infectious Diseases at the Buenos Aires, Argentina
-Edgar Carrasco, Regional Secretary of the Latin American and the Caribbean Council of AIDS Service Organizations (LACCASO), Venezuela
-Dani Ceuninck, Attaché AIDS, Federal Public Service Foreign Affairs, Belgium
-Nada Chaya, Metrics Manager, Research & Metrics Population Services Int., USA
-Susan Chong, APCASO, the Coalition of Asia Pacific Regional Network on HIV/AIDS (the Seven Sisters), Malaysia
-Nick Corby, ActionAid’s HIV/AIDS policy officer, UK
-Naina Dhingra, Director, Advocates For Youth, Washington, USA
-Evelyne Sylvia Ehua, Directeur de la Coordination et des Appuis Techniques au Ministère chargé de la Lutte contre le SIDA, Cote d’Ivoire
-Mziwethu Faku, District Organizer, Treatment Action Campaign, South Africa
-Claudio Fernandes, AIDS activist, designer and filmmaker, GESTOS, Brazil
-Susan Fox, Project Manager, Int. Federation of Red Cross and Red Crescent Societies, Geneva
Lynde Francis, Founder and Director of The Centre, Harare, Zimbabwe
Mariangela Galvao Simao, CoDirector, National AIDS Program, Brazil
Gregg Gonsalvez, AIDS Coalition to Unleash Power (ACT UP) AIDS and Regional Coordinator, Rights Alliance for Southern Africa, South Africa
Reverend Christo Greyling, Global Adviser on HIV &AIDS and Church/FBO Partnerships HIV/AIDS, World Vision International, South Africa
Jill HanassHancock, PostDoc fellowship at HEARD, University of KwaZuluNatal, South Africa
LeeNah Hsu, Strategic planning, policy advocacy, programme management, monitoring and evaluation, transdisciplinary research and training, USA
Mark Ishaug, Board Member, Funders Concerned About AIDS, USA
Bobby John, Principal Partner & President, Global Health Advocates, India
Inoussa Kabore, Acting Director of Evaluation, Surveillance and Research, Family Health International, US/Burkina Faso
Mohga Kamal Yanni, Health Policy Adviser, Oxfam, UK
Andreas Kyriacou, Associate Professor Department of Economy University of Girona, Spain
Innocent Laison, Senior Program Manager of the African Council of AIDS organizations, Senegal
Chewe Luo, Senior Programme Adviser, HIV and Health, Health Section, Program Division, UNICEF, Zambia
Ron MacInnis, Director of Policy and Programmes, International AIDS Society, Geneva
Elizabeth N. Mataka, Global Fund Board: Developing Countries Delegation, Zambia
Elaine McKay, Independent Consultant, South Africa
Sam McPherson, Associate Director of Planning, Analysis & Learning, Int. HIV/AIDS Alliance, UK
Brad Mears, CEO South African Business Coalition On HIV/AIDS, South Africa
Sisonke MsimangWhite, Open Society Initiative Southern Africa, South Africa
Teymur Noori, Scientific Officer, European Centre for Disease Prevention and Control, Sweden
Rafael Ohanyan, Head of Prevention Department of National Center for AIDS Prevention, Armenia
Alena Peryshkina, Director, AIDS Infoshare, Russia
John Rock, National Portfolio Convener NAPWA and member of APN+, Australia
Thomas Scalway, Consultant in Communication and Mobilisation for HIV/AIDS, South Africa
Lakshmi Sundaram, Associate Director, Global Health Initiative, World Economic Forum, Geneva
John Tomaro, Director, Health Programme, Aga Khan Development Network, Geneva
Göran Tomson, Professor of International Health System Research, Karolinska Institute, Sweden
Stefaan Van der Borght, Director Health Affairs, Heineken, The Netherlands
Regina Wenzel, Project Manager, Global Health Initiative, World Economic Forum, Geneva
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