

EXECUTIVE SUMMARY

- This document provides operational guidance to country-level partners and UN staff to facilitate the next phase of the country-level consultative process on scaling up towards universal access to prevention, treatment, care and support services. It concerns the setting of ambitious targets for the national HIV response to achieve by 2008 and 2010, and builds on previous guidelines.
- Targets need to be ambitious in order to achieve the universal access goals. Analysis by UNAIDS of existing national targets and rates of scaling up indicates that current efforts are inadequate to achieve universal access in the near future.
- The process of countries setting their own targets will promote partner alignment to national priorities, strengthen accountability and facilitate efforts by countries and international partners to mobilize international support and resources.
- Targets should have political and social legitimacy. The consultative process should be multi-sectoral, include full civil society participation, lead to consensus on the targets, and formal approval of these targets before the end of 2006.
- This guidance does not suggest a new, parallel process, but encourages revisiting and revising existing strategies and work plans.
- The guidelines refer to the UNAIDS *Towards universal access* assessment report¹, which reiterates:
 - the *basic principles* for universal access, namely that services have to be *equitable, accessible, affordable, comprehensive* and *sustainable* over the long-term;
 - national target setting and tracking should be *standardized through global guidance* and based on a small set of core and recommended indicators, but determination of the levels of coverage achievable by the end of 2010, i.e. the *national targets*, must be a country-level process that takes into account the specific country context; and
 - the *major requirement* for reaching targets is overcoming obstacles identified during the recent country and regional consultations.
- The principles for setting national targets include:
 - *Country ownership and participation*
 - *Building on past efforts*
 - *Review of existing data and data collection systems*
 - *Reviewing existing indicators*
 - *Setting targets as part of national strategic plans*
 - *Identifying and overcoming obstacles to scale up*
 - *Human rights, gender and the greater involvement of people living with HIV and AIDS (GIPA)*
 - *Quality of and equity in access to services*
 - *Setting priorities and overcoming obstacles*

¹ *Towards universal access: assessment by the Joint United Nations Programme on HIV/AIDS on scaling up HIV prevention, treatment, care and support*, UN General Assembly document A/60/737, 24 March 2006

- *Limiting the number of targets*
- *Using targets to mobilize resources*
- These operational guidelines describe the consultative process of target setting and ways to facilitate a dialogue among all relevant stakeholders, including networks of people living with HIV and other civil society organizations
- Steps for setting ambitious targets should include:
 - Review the status and transmission dynamics of the HIV epidemic
 - Define and prioritize the interventions to be included in the national response
 - Estimate the size of populations in need
 - Review the current coverage rates and historic rate of scaling up, and project the potential achievements by 2010
 - Determine the resources available, the current coverage capacity and what would be required to overcome identified obstacles
 - Estimate the impact on rate of scale up that would result from investments in overcoming specific obstacles
- A set of 11 existing indicators—seven core indicators and four recommended indicators—should be used for this target-setting process, but in special circumstances, additional targets can be set.
- Reporting on progress towards targets should occur within existing country-level monitoring mechanisms and information sources, as countries should measure their own progress and address problem areas that may be identified.
- There is also a need for international reporting on the setting of national targets and progress towards their achievement. UNAIDS will therefore regularly collect, analyze and review information from routine reporting processes in countries.
- Under the guidance of UN Resident Coordinator, the Joint UN Team on AIDS or the UN Theme Group on HIV/AIDS in each country will facilitate the target-setting process. Support will be provided by the UNAIDS Regional Support Team and the UNAIDS Secretariat and WHO headquarters in Geneva.
- Among the UNAIDS Cosponsors, clear responsibilities for the provision of technical advice and follow-up support should be agreed to, in line with the UNAIDS Technical Support Division of Labour.
- The UNAIDS Country Coordinator will serve as a focal point for facilitation and advice provided by the United Nations.
- Additional assistance and technical guidance can be drawn from a wide range of UN organizations, bilateral donors and others.

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1. Introduction

1.1. What are these guidelines for?

This document provides operational guidance to country-level partners and UN staff to facilitate the next phase of the country-level consultative process on scaling up towards universal access to prevention, treatment, care and support services. It concerns the setting of ambitious targets for the national HIV response to achieve by 2008 and 2010. At the High Level Meeting on AIDS, held at the UN General Assembly on 2 June 2006, national governments committed themselves in the *Political Declaration on HIV/AIDS*² to set these targets by the end of 2006. The Programme Coordinating Board of the Joint UN Programme on HIV/AIDS (UNAIDS) in turn committed UNAIDS to supporting this process³. This process is based on the *Declaration of Commitment on HIV/AIDS*, as agreed during the United Nations General Assembly Special Session on HIV/AIDS in June 2001⁴

The guidelines provide a set of principles for an inclusive target-setting process as well as an approach to setting ambitious yet realistic targets. They refer to the UNAIDS *Towards universal access* assessment report⁵, which reiterates:

- the *basic principles* for universal access, namely that services have to be *equitable, accessible, affordable, comprehensive* and *sustainable* over the long-term;
- national target setting and tracking should be *standardized through global guidance* and based on a small set of core and recommended indicators, but determination of the levels of coverage achievable by the end of 2010, i.e. the *national targets*, must be a country-level process that takes into account the specific country context; and
- the *major requirements* for reaching the targets are overcoming the obstacles identified during the recent country and regional consultations.

This document compliments previous guidelines, particularly the *Considerations for countries to set their own national targets for HIV prevention, treatment, and care and support*⁶ sent out earlier this year. It also builds on the UNAIDS staff guide, *Supporting effective scaling up towards universal access*⁷, which provided direction to the earlier country consultations. This document will also inform technical guidelines expected to be available shortly, such as UNAIDS *Practical Guidelines for Intensifying HIV Prevention*⁸; WHO guidelines for establishing targets for antiretroviral treatment, testing and counselling, prevention of mother-to-child transmission, harm reduction for injecting drug users; and guidelines for national strategic and annual action planning developed by the AIDS Strategy and Action Plan (ASAP) service hosted by the World Bank on behalf of UNAIDS. These will provide more detailed technical guidance on target setting and planning.

² http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

³ http://data.unaids.org/pub/Report/2006/PCB_18_06-finaldecisions0628_en.pdf

⁴ http://data.unaids.org/pub/Report/2002/JC668-KeepingPromise_en.pdf

⁵ http://data.unaids.org/pub/InformationNote/2006/20060324_HLM_GA_A60737_en.pdf

⁶ http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf

⁷ http://data.unaids.org/pub/Report/2006/2006-UA-Staff-Guide_en.pdf

⁸ These guidelines will be finalized by the end of November. In the meantime, a draft can be obtained by contacting UNAIDS Senior Adviser for Prevention and Public Policy, Dr. Anindya Chatterjee at chatterjee@unaids.org.

These operational guidelines describe the consultative process of target setting and ways to facilitate a dialogue among all relevant stakeholders, including networks of people living with HIV and other civil society organizations. The National AIDS Coordinating Authority is expected to take the lead. Civil society must have a verifiable and meaningful involvement in national target setting, along with government and other stakeholders. Civil society groups are encouraged to share information, to undertake consultations with their members, and to mobilize and engage widely during target setting and follow-up. The UNAIDS Cosponsors and Secretariat will offer facilitation and advice, and where necessary, assist in the identification of financial and technical assistance.

Finally, these guidelines affirm the need to establish credible systems for monitoring and evaluating the implementation of these national plans, using the recommended indicators.

1.2. Why national targets?

Rather than setting new global targets, the 2006 Political Declaration calls on all countries to set ambitious national targets on HIV prevention, treatment, care and support by the end of 2006 that reflect their commitment to move towards the goal of universal access by 2010. Clear national targets—including interim or process targets for 2008, and outcome targets for 2010—will promote partner alignment to national priorities and hold countries directly accountable for reaching the targets they set themselves. They will also facilitate efforts by countries and international partners to mobilize international support and resources. The target-setting process will offer a critical framework for assessing national commitments, assist efforts by governments to tailor their responses to the particular nature and needs of their epidemics, and encourage broadly inclusive approaches.

1.3. Many countries have already set targets

To date, target data on the proposed outcome indicators have been received from 79 countries. The data show that 40 of these 79 countries have already set outcome targets for all three programmatic areas (prevention, treatment, care and support). The data also reveal that 67 of these 79 countries have set treatment targets, 60 have set outcome targets for at least one prevention intervention, and 38 countries have set targets for coverage of orphans and vulnerable children.

1.4. How to use these guidelines

This guidance does not suggest a new, parallel process. Instead it encourages countries to revisit and revise if necessary existing targets, strategies and work plans in order to ascertain:

- What coverage of services for prevention, treatment, care and support has already been achieved?
- Which affected populations are not being sufficiently reached?
- What are the major obstacles to reaching these populations?
- What are the strategies to overcome these obstacles?
- What financial, technical and human resources are currently available?
- How can budgets and programmes be adjusted to address these obstacles?

- What process and outcome targets will help move the response forward and help measure success?
- What additional resources will be required to move significantly towards the goal of universal access by 2010?

These guidelines do not advise countries on the specific level of targets to be set, as this is context-specific and dependent on the country's ability to overcome obstacles. Nor do the guidelines aim to provide guidance on how addressing obstacles to implementation will impact on the pace of scaling up, because many obstacles are interdependent and impact may vary according to the local situation.

2. What are the principles for setting national targets?

In addition to the above considerations, there are a number of principles that should be applied when reviewing targets and establishing new ones.

- Country ownership and participation. The target-setting process needs to ensure country leadership, ownership, responsibility, accountability and transparency. Setting of targets must therefore include consensus building among all relevant stakeholders leading to formal adoption of the set targets. (See Section 3 for a more complete discussion of civil society inclusion)
- Building on past efforts. Setting of national targets should build on the 2005-2006 country consultation processes for scaling up towards universal access during which many countries reviewed national epidemics, the current status of their national response, the obstacles to scaling up, and possible solutions. Targets should also build on and help achieve existing targets, including those established in the International Conference on Population and Development (ICPD) Platform for Action, the Millennium Development Goals, and the 2001 Declaration of Commitment on HIV/AIDS.
- Review of existing data and data collection systems. Setting of national targets should build on efforts to review progress towards a country's commitments in the 2001 **Declaration of Commitment on HIV/AIDS** and on the country consultation processes for scaling up towards universal access. If baseline data for coverage of selected services, such as antiretroviral treatment, or areas like human rights or gender equality, are not available, then it is difficult to set future targets. Collecting missing baseline data and other strategic information should be a high priority. This may require the establishment of vertical data collection systems to fulfil short-term needs. However, medium- and long-term data collection should be harmonized with efforts to strengthen country health information systems.
- Setting targets as part of national strategic plans. Setting of national targets should be done in the context of national strategic planning of the HIV response, the development of Poverty Reduction Strategy Papers (PRSPs)⁹, and the Medium Term Expenditure Framework (MTEF). Where national strategic HIV plans exist in countries, the universal access target-setting process should be designed to refine the plan, including an assessment of whether the targets set are sufficiently ambitious, whether targets are supported by programmes that actually address the drivers of the national epidemic, whether sufficient resources have been mobilized for these programmes and whether sufficient data exists on which to base a target, such as coverage of antiretroviral treatment among children.
- Human rights, equity and GIPA. People living with HIV, women, young people and other most-at-risk populations, such as sex workers, men who have sex with men, drug users and prisoners, should play a major role in the setting of national targets. Targets should be considered with regard to participation, availability, affordability, accessibility and quality for all groups in need of HIV information, education and services. Coverage should be measured across different populations, with the aim of ensuring equitable

⁹ UNDP, in association with the UNAIDS Secretariat and the World Bank, is implementing a programme to assist countries to more fully integrate HIV/AIDS in PRSPs. This programme currently covers some 14 countries.

access to prevention, treatment and care and support. Data should be disaggregated by age and sex at a minimum, but also, where possible, by marital status, location (rural, urban) and ethnic background.

- *Setting priorities and overcoming obstacles.* Targets should reflect priority activities for the national programme, particularly with regard to overcoming the obstacles that block people's access to prevention, treatment care and support. They should also seek to address the true drivers of the epidemic. The recent country and regional consultations identified major obstacles in the following areas: stigma, discrimination, the inequality of women and the marginalized status of key groups (such as sex workers, injecting drug users, men who have sex with men and prisoners); lack of predictable and sustainable financing, lack of affordable commodities, lack of human resources and strong systems, and insufficient accountability mechanisms. Setting targets must be linked to efforts to overcome these obstacles. Thus, it may be necessary to shift resources to areas not adequately addressed before.
- *Limiting the number of targets.* Targets are more powerful as a catalyst for increased and more effective action if they are limited in number, tied to key national needs, very carefully considered as far as feasibility, and then actively promoted. Countries should therefore set only one or two key targets for 2008 and 2010 in each of the four major programme areas (prevention, treatment, care and support)¹⁰. These could derive from existing targets or require the setting of new, additional targets, but should be broadly representative of the country's response to their HIV epidemic.
- *Using targets to mobilize resources.* Targets should be used to mobilize increased resources in line with national needs. UNAIDS and its partners will explore different strategies to support countries with resource mobilization, including resources for civil society and other implementing partners.

¹⁰ Countries may also wish to set targets in the area of donor coordination and alignment around country systems that may lead to more efficient and effective program implementation.

3. What should the consultative process look like?

Target-setting consultations should build on the earlier consultations, held by many countries in late 2005 and early 2006, which identified the obstacles to scaling up. National targets should be set as consultation participants determine how to adjust the national response to overcome as many obstacles as possible. Expansion towards universal access requires regular review of plans and programmes, as well as the willingness and ability to shift programming and funding into areas not fully addressed, such as, gender inequality, stigma and discrimination and intellectual property issues.

If a monitoring and evaluation technical advisory group exists in a country, it should be closely involved in the target-setting process, particularly in terms of assessing the technical merits of each target and indicator, the relevance of each target to national priorities, and the feasibility of measuring the target in a regular way. Issues that should be considered include data availability and the robustness of target definitions.

To ensure targets have political and social legitimacy, the consultative process should establish consensus and lead to formal national approval of the targets. Furthermore, setting of the targets is the first step to a reiterative planning process that follows.

3.1. The role of government

UNAIDS advocates a multisectoral consultative process in defining national targets before the end of 2006. This is not only appropriate from the point of view of government ownership, accountability and transparency, it is also necessary for the target-setting process to truly address the specific dynamics of the national epidemic. From government, this would involve representatives of many sectors that often are not adequately involved in the national HIV response, but indeed are crucial if major obstacles to universal access are to be overcome, particularly in the areas of gender, stigma, discrimination, intellectual property, and financial and human resources. These could include representatives of Parliament and the judiciary, and representatives of Ministries of Interior, Justice, Gender, Trade, Finance, Development and Defence, and well as the armed forces. It would also include National Human Rights Institutions or Ombudsmen.

3.2. The role of civil society

UNAIDS advocates full civil society participation in the consultative process. This is not only appropriate from the point of view of the principles of participation and self-determination, but also entirely necessary if the process is to result in effective outcomes and legitimate targets. In many countries, civil society is the main provider and recipient of prevention, treatment, care and support services. As such civil society is well placed to comment on the feasibility, relevance and cost of proposed targets and scale up activities. People living with HIV, representatives of most-at-risk populations or those who assist them can provide comprehensive information on the specific behaviour patterns that may be driving the epidemic in a country and how best to reach their constituency with targeted and effective services.

The *full* spectrum of civil society should be involved in the target-setting process. This would include the media, faith-based organizations, human rights and legal support groups, trade unions, community-based organizations, youth, women's organizations, networks of people living with HIV and organizations working with hard to reach or most affected populations (e.g. sex workers, drug users, men having sex with men, migrants, refugees, prisoners).

Strategies for ensuring active and meaningful involvement of civil society in ambitious target setting include:

- Involvement of civil society in regional consultations on target-setting.
- Clear briefings to provide information to civil society on the envisaged national target-setting process. This needs to include communication using both printed media and electronic formats, for distribution through list serves and e-mail discussion groups.
- Provide civil society organizations with easy access to draft plans, proposed targets and other documentation, as well as a straightforward process for commenting on these documents.
- Finalization, distribution and promotion of the *Three Ones Guidelines For Engaging Civil Society* and CCM guidelines on civil society participation.
- Support to appropriate global and regional networks that can promote country-level civil society engagement and ownership in target-setting
- Identification of resources to build the capacity of civil society organizations to play meaningful roles in the setting of targets and the use of targets for advocacy. Often these skills are already possessed by certain groups, and methods should be developed to facilitate the exchange of information among civil society groups.
- Capacity-building by UNAIDS staff to maximize engagement of national civil society organizations in defining and owning national targets.

4. Setting ambitious targets

Ambitious targets are defined as targets that aim to address unmet needs for information and services, and which *can* be achieved if specific barriers to scale-up are overcome. Ambitious target setting will require a number of steps, as summarized in the box below and described in the next sections. Analysis by UNAIDS of existing national targets and rates of scaling up indicates that current efforts will be inadequate to bring many countries within reach of universal access by 2010 or the Millennium Development Goal on HIV (MDG 6) by 2015. Furthermore, many countries are dealing with the targets of individual donor organizations. Where possible, countries should be encouraged to integrate all targets into their national targets.

Steps for setting ambitious targets

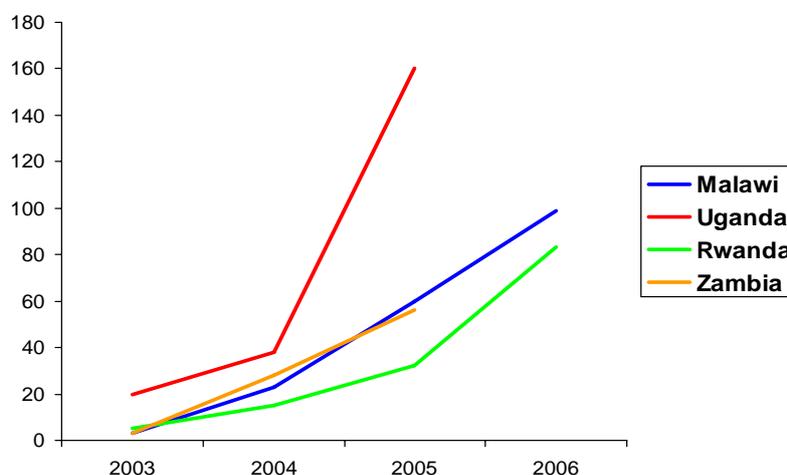
- Review the status and transmission dynamics of the HIV epidemic;
- Define and prioritize the interventions to be included in the national response;
- Estimate the size of populations in need;
- Review the current coverage rates and historic rate of scaling up, and project the potential achievements by 2010;
- Determine the resources available, the current coverage capacity and what would be required to overcome identified obstacles;
- Estimate the impact on rate of scale up that would result from investments in overcoming specific obstacles to implementation.
- Set ambitious targets and mobilize resources accordingly

4.1. “Knowing your epidemic” - reviewing the HIV epidemic and response

Before targets can be established for specific programme interventions, it is critical to understand the full dynamics of a country’s epidemic, including what factors are driving the epidemic, what is the current coverage rate and historic rate of scaling up, and what are the main obstacles to providing universal access to prevention programmes, treatment, care and support. In addition, it will provide an opportunity to review available data and identify missing baseline information.

For example, the WHO/UNAIDS ‘3 by 5’ Initiative supported target setting for scaling up treatment programmes at the country level. The figure below presents data from sub-Saharan Africa and demonstrates how countries were able to accelerate their rates of scale up in the area of treatment. This acceleration occurred because many key obstacles were overcome by, for example, dramatically increasing the number of trained health care providers and the number of facilities providing these services as well as providing more reliable access to critical commodities (e.g. antiretroviral drugs)

Country perspectives on scale-up: Rapid increase in number of ART service delivery points, Selected countries in Africa 2002-2006



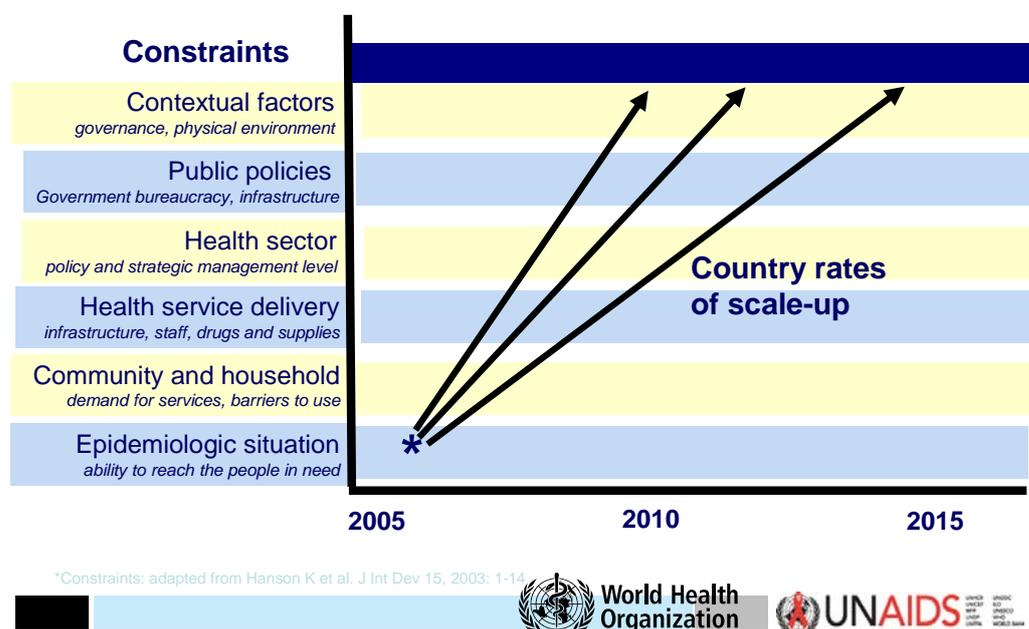
Scaling up prevention programmes is a particular challenge for countries, requiring review of the drivers of the epidemic and inclusion of interventions that reach appropriate target populations. Interventions should include individual, group, environmental and structural-level interventions in an appropriate mix for each given setting. For example, changing individual behaviour can only occur in an enabling environment, where larger social obstacles are removed or ameliorated (e.g. legislation criminalizing HIV transmission). There is also a need to address a lack of knowledge on what is working and what is not, and the need for more evaluative studies to support evidence-based decision-making.

In the document *Practical guidelines for intensifying HIV prevention at country level*, the implications of the different epidemic types on the elements and prioritization of prevention interventions are discussed. This challenge is further described in section 4.3 below.

4.2. Reviewing unmet needs and available resources

Countries are encouraged to review their unmet needs in terms of available information and services, utilizing available programmatic coverage data, including the recently collected 2005 national reports on progress towards fulfilment of the 2001 Declaration of Commitment on HIV/AIDS. Determining the magnitude of unmet needs will support the discussion on when and how to aim for reaching universal access and what ambitious targets to set to be achieved by 2010. This discussion needs to be complemented by a review of the obstacles to universal access, identified during the earlier consultations on scaling up, and the available resources to overcome these obstacles. The graph below illustrates how addressing identified obstacles can impact on the rate of scaling up, depending on the local context. The vertical axis lists examples of obstacles and constraints that are common to many countries, and the lines represent the different rates of scale up that could be achieved if one or more obstacle is addressed. The degree to which these can be overcome will help determine which of the lines representing country rates of scale up is most appropriate for target setting

Targets and Timelines



After a country has identified the most significant obstacles to scaling up, then it will need to assess the feasibility and impact of overcoming these obstacles, as well as the resource requirements. The development of ambitious targets should include a plan to overcome these obstacles so that national, regional and international partners can rapidly and harmoniously engage in overcoming them (e.g. human resources plan for the health sector).

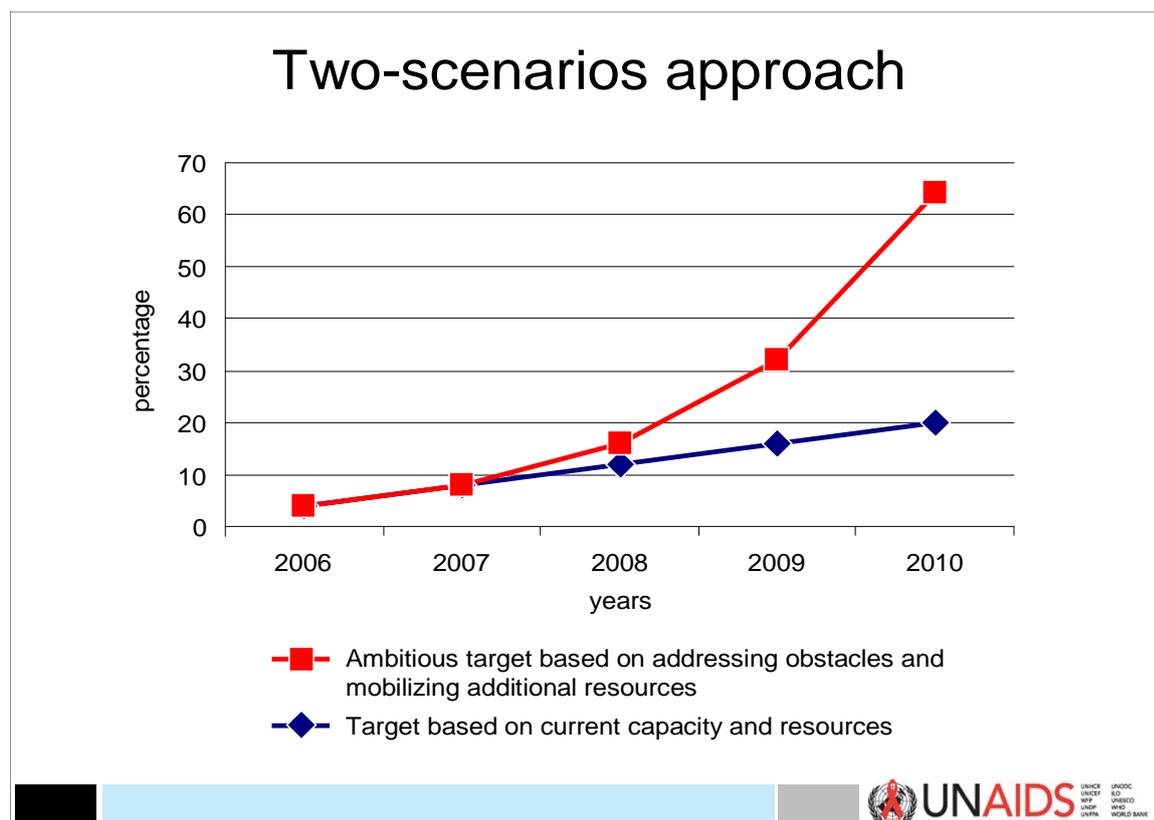
4.3. Prioritizing interventions

The target-setting process should consider the priority of programme interventions. National HIV responses are resource limited, even in high-income countries, making maximum coverage of all interventions difficult. As such, interventions need to be prioritized according to the dynamics of the epidemic and the effectiveness of the intervention, while also respecting human rights and gender equity.

Prioritization should be guided by an objective identification of the drivers of the epidemic to ensure that adequate coverage of most-at-risk populations is not compromised when trying to achieve a high coverage among large vulnerable populations. In prevention, for example, interventions for in-school youth or migrant and mobile workers are likely to be significantly more expensive and may have less impact than similar interventions for smaller populations at higher risk of HIV infections, such as sex workers or men who have sex with men. Additionally, addressing environmental and structural barriers to HIV prevention (e.g. laws prohibiting syringe exchange, the absence of legal frameworks for women's inheritance rights or protecting them from domestic violence) can significantly affect the drivers of the epidemic without a significant increase in financial resource expenditure.

4.4. The two-scenario approach to target setting

The graph below illustrates a two-scenario approach on target setting. The bottom line on the graph below represents the scale up of services based on historical information and minimal changes in capacity. The top line reflects ambitious yet realistic targets, that respond to unmet needs and anticipating additional resources for overcoming specific barriers to scale-up. Setting such ambitious targets will be country specific, and require adequate information of the baseline and trends.



The rate at which a country can move upwards from the bottom line is dependent on the efforts that will be made today to increase human resource capacity; improve health and other social sector services; address stigma and discrimination; promote and protect the rights of women and girls; ensure predictable and sustainable funding; gain access to more affordable drugs and commodities; generate political commitment and accountability for results. The setting of ambitious targets will therefore result in the revision of national strategies and costed work plans, to guide resource mobilization, domestic and external, and identification of technical support that may be required, thereby improving donor coordination and alignment around country systems.

4.5. Are there global or regional targets or standards that should be achieved?

While there is evidence pointing to minimum coverage levels required to achieve impact in some specific interventions, there is no universal formula for target setting. After consideration of technical guidance on minimum coverage levels, each target in each country must be set with reference to the circumstances within that country.

Some targets have already been set at global level, such as the target of 80% coverage of mother-to-child HIV prevention services for pregnant women to be achieved by 2010 set by the 2001 *Declaration of Commitment on HIV/AIDS*. This global target is a standard of service that all countries should aspire to. However, each country must decide for itself when and how this could be accomplished. The 2010 target may not be possible unless full resources can be obtained and significant obstacles overcome. For example, building capacity through recruiting additional service providers, training them and paying their salaries takes time, and each country is at the different level of human resource capacity. Thus, the question is not whether a country aspires to this global target, but instead, what is a timeframe that takes into account all that must be done to achieve it. Existing global targets are presented in the first guidelines document, *Considerations for countries to set their own national targets for HIV prevention, treatment, and care and support*.

Targets may also be agreed at regional level. For instance, the theme of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria, held in Abuja in May 2006 was *Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010*, and it developed a common position on universal access for members of the AU¹¹. The African Civil Society Coalition “*urged member states to adopt the Abuja 2006 common position for the continent in order to inform and strengthen their own plans of action in the framework of the 2001 Abuja Declaration and Plan of Action. In the same vein, the African Union and Regional Economic Communities should make close follow-up the development and implementation of national Action Plans of Member States and Mechanisms for Monitoring and Evaluation*”.

Though the concept of universal access calls for HIV information and services for all those in need, it is sometimes not realistic to set 100% coverage targets for both technical and ethical reasons. For example, not all persons are willing to be tested for HIV, and not all HIV-positive persons are willing to begin treatment services.

4.6. Recognizing the local context

In countries with high prevalence, low prevalence or concentrated epidemics, the national targets should reflect the dynamic of the local HIV epidemic. In order to ensure that services are reaching most-at-risk individuals, it is also beneficial to set targets specific to those groups. For example, in countries where HIV is concentrated among injecting drug users, a target should be included to measure access to interventions such as syringe exchange and substitution therapy.

4.7. Disaggregating data

To promote both equity of service provision and the effectiveness of interventions, it is important to disaggregate targets by age and sex at a minimum, but also, where possible, by marital status, location (rural, urban), ethnic background and other characteristics that are relevant to a country. This is particularly true in settings where the epidemic is concentrated

¹¹ ASSEMBLY OF THE AFRICAN UNION, 7th Ordinary Session of the Assembly, 1-2 July 2006, Banjul, The Gambia; Report on the Outcome of the Special Summit on HIV/AIDS, Tuberculosis and Malaria (ATM), Abuja, (Nigeria, 2-4 May 2006); Assembly/AU/5 (VII). See www.africa-union.org

in certain subsets of the population, or where subsets of the population are not afforded the same access to services as the rest of the population. For example, the majority of new infections may occur in people under the age of 25, or predominantly occur in women and girls. Similarly, many highly marginalized groups, such as sex workers, injecting drug users or men who have sex with men, may have poorer access to services than the general population. Age specific data disaggregation helps ensure that adults, young people and children are included in scale-up efforts.

4.8. Adding new targets

As the response to HIV evolves, it will be necessary to incorporate additional interventions into programmes. This is particularly true as new technologies become available, such as a microbicide. Indicators and targets should then be considered that would address these new programmatic areas.

5. Which indicators are recommended for the selection of targets?

5.1. Outcome indicators

For consistency, countries are encouraged to use the outcome indicators recommended by the universal access process' Global Steering Committee. These seven core indicators and four recommended indicators were included in the internationally approved UNAIDS guidance, *Considerations for countries to set their own national targets for AIDS prevention, treatment and care*.

It is important to note that additional outcome targets may be appropriate in specific country settings. For example, in countries with low prevalence or concentrated epidemics, coverage of prevention programmes targeting most-at-risk populations should be an additional core indicator. In other countries tuberculosis is a major killer of persons with HIV. Setting a target for the percentage of coverage for HIV testing in TB clinics may be a powerful way to ensure that these critical services are being delivered.

Seven core indicators

Treatment

1. Percentage of women, men and children with advanced HIV infection who are **receiving antiretroviral combination therapy**;

Care and support

2. Percentage of OVC (boy/girl) aged under 18 living in households whose **household have received a basic external support package***;

Prevention

3. Coverage of **preventing mother-to-child transmission**;
4. Coverage of **HIV testing** and counselling;
5. Number of **condoms** distributed annually by public and private sector
6. Percentage of young men and women who have had **sex before age 15**;

National Commitment

7. Amount of **national funds** disbursed by governments in low and middle income countries.

*The support package could include food, education, health care, family/home or community support. Currently this is one of the least well-reported indicators and special attention should be paid to it .

Four recommended indicators

Treatment

1. Percentage of adults and children on **ART who are still alive 12** months after initiation of antiretroviral therapy;

Prevention

2. Percentage of young people (15-24) or “at risk” group who correctly **identify ways of preventing sexual transmission** of HIV—including delaying sexual debut, reducing partners, and use of condoms—and reject major misconceptions (male/female);
3. Coverage of **targeted prevention programmes** in low prevalence and concentrated prevalence countries (in concentrated epidemics this should be a **core** indicator); and

National Commitment

4. Implementation of the “**Three Ones**” principles.



5.2. Interim indicators

Countries may find it useful to set a small number of mid-term process targets to guide the planning and initiation of initial scale up, such as targets for reduction of stigma discrimination and gender inequality; resource mobilization; strategic information and national planning. It is recommended to use existing indicators for tracking national progress on the 2001 Declaration of Commitment whenever possible. The following process indicators may be considered, as reflected in the *Considerations for countries to set their own national targets for HIV prevention, treatment and care*.

POSSIBLE INDICATORS FOR “INTERIM” TARGETS IN 2008 THAT FOCUS ON OVERCOMING OBSTACLES TO SCALING UP

Sites for preventing mother-to-child transmission

- ⇒ Number of ANC sites and estimated capacity to provide PMTCT services

Sites for HIV testing and counselling

- ⇒ Number of testing and counselling sites in country
- ⇒ Number of TB clinics, hospitals which have instituted provider initiated routine offer of HIV testing
- ⇒ Number of VCT sites in country that serve defined most-at-risk populations
- ⇒ Number of programmes to train health care workers in non-discrimination, confidentiality and informed consent

Supply chain management

- ⇒ Stock out rates: percentage of facilities that experienced a stock out during a specific period or on day of facility visit

Size of risk population

- ⇒ Estimation of size and locations of most-at-risk populations
- ⇒ Number of sensitivity training programmes for law enforcement staff

Number of health care facilities for provision of ART

- ⇒ Percentage of health care facilities with basic treatment services (clinical care, laboratory capacity, and sustainable pharmaceuticals supply)

Human resource needs are estimated

- ⇒ Numbers and distribution of necessary health service staff (physicians, nurses, clinical officers, counsellors, lab technicians and pharmacists) have been estimated.

Estimating resource needs

- ⇒ Resource needs have been estimated to scale up to 2010 targets and goals.

Civil society participation

- ⇒ Percentage of members in national AIDS coordinating body (NAC) who represent sectors of civil society
- ⇒ Targets set for equitable access to key prevention, treatment, care and support interventions for defined vulnerable populations

Reducing stigma and discrimination and assuring human rights

- ⇒ A defined oversight structure to be established to monitor and report annually on the enforcement of policies to protect human rights, which includes the active and participation of people living with HIV and civil society.
- ⇒ Number of national and community campaigns to reduce HIV stigma and discrimination

Enhancing care and support

- ⇒ Number of income-generation schemes for women care-givers put into place
- ⇒ Number of legal and social support services for women care-givers and victims of sexual violence
- ⇒ Number of legal support services for people living with HIV

Reducing vulnerability to infection

- ⇒ Number of programmes to keep girls in secondary school

6. What is the reporting mechanism for national target setting and what is UNAIDS going to do with the targets?

Reporting on progress towards targets should occur within existing country-level monitoring mechanisms and information sources, using the agreed indicators, as countries should measure their own progress and address problem areas that may be identified.

There is also a need for international reporting on the setting of national targets. UNAIDS will therefore collect and analyze information from regular reporting processes in countries. To the extent possible, UNAIDS will aggregate the national targets at the regional and global level, not aiming at setting new global targets but to help assess progress and identify potential problem areas and resource needs to support the countries.

In addition, UNAIDS will review the national targets to better understand the challenges and achievements at the country level. UNAIDS then will prepare strategic information at the country, regional and global level to influence the concerned agendas.

UNAIDS will publish progress towards meeting national targets, country-by-country, on an annual basis as part of its yearly report on the epidemic.

7. Accessing financial and technical assistance and UNAIDS facilitation

7.1. Technical guidance

New technical guidance will be available in the coming months for the following areas:

- Setting targets for antiretroviral treatment (WHO)
- Setting targets for prevention of mother-to-child transmission of HIV (WHO/UNICEF)
- Setting targets for prevention of HIV transmission among injecting drug users (WHO)
- Testing and counselling (WHO)
- Strategic planning and annual action planning (World Bank AIDS Strategic Action Plan¹²)
- Setting targets for the reduction of stigma, discrimination and gender inequality (UNDP and UNAIDS Secretariat)

Most of these specific guideline documents should be available later this year. Many will include spreadsheet models to allow countries to factor the current levels of human resources, infrastructure, access to critical commodities and other key parameters that determine rates of scale up.

7.2. UNAIDS facilitation

The UN Resident Coordinator, the Joint UN Team on AIDS or the UN Theme Group on HIV/AIDS will facilitate the target-setting process, with support from the UNAIDS Regional Support Team and the UNAIDS Secretariat and WHO headquarters in Geneva.

The UNAIDS Country Coordinator¹³ will serve as a focal point for facilitation and advice provided by the United Nations. Among the UNAIDS Cosponsors, clear responsibilities for the provision of technical advice and follow-up support should be agreed to, in line with the UNAIDS Technical Support Division of Labour.

7.3. Sources for additional assistance

As countries review existing targets and establish new ones, there is often a need for technical support. There are multiple sources for such assistance and these should be utilized whenever possible. Examples include:

- UNAIDS, through the UNAIDS Country Coordinator and M&E Advisor, can identify possible technical consultants and resources to support them.
- WHO and other technical agencies.
- The Global AIDS Monitoring and Evaluation Team (GAMET¹⁴).
- Through the UNAIDS Regional Support Teams, countries can access the Technical Support Facilities and Regional Hubs.
- Bilateral donors, including PEPFAR

¹² The AIDS Strategy and Action Plan (ASAP) service was established by the Global Task Team to assist countries to enhance their HIV-AIDS strategies to make them more evidence-based, prioritized and actionable and to establish implementation action plans to “make the money work”. Details about ASAP, which is hosted by the World Bank on behalf of UNAIDS can be found at www.worldbank.org/asap

¹³ In the absence of a UNAIDS Country Coordinator, a UNAIDS National Programme Officer or the UNAIDS Focal Point should be contacted.

¹⁴ The Global AIDS Monitoring and Evaluation Team (GAMET), hosted by the World Bank on behalf of UNAIDS, assists countries to establish and maintain results-based M&E systems. Information on GAMET can be obtained through the World Bank

