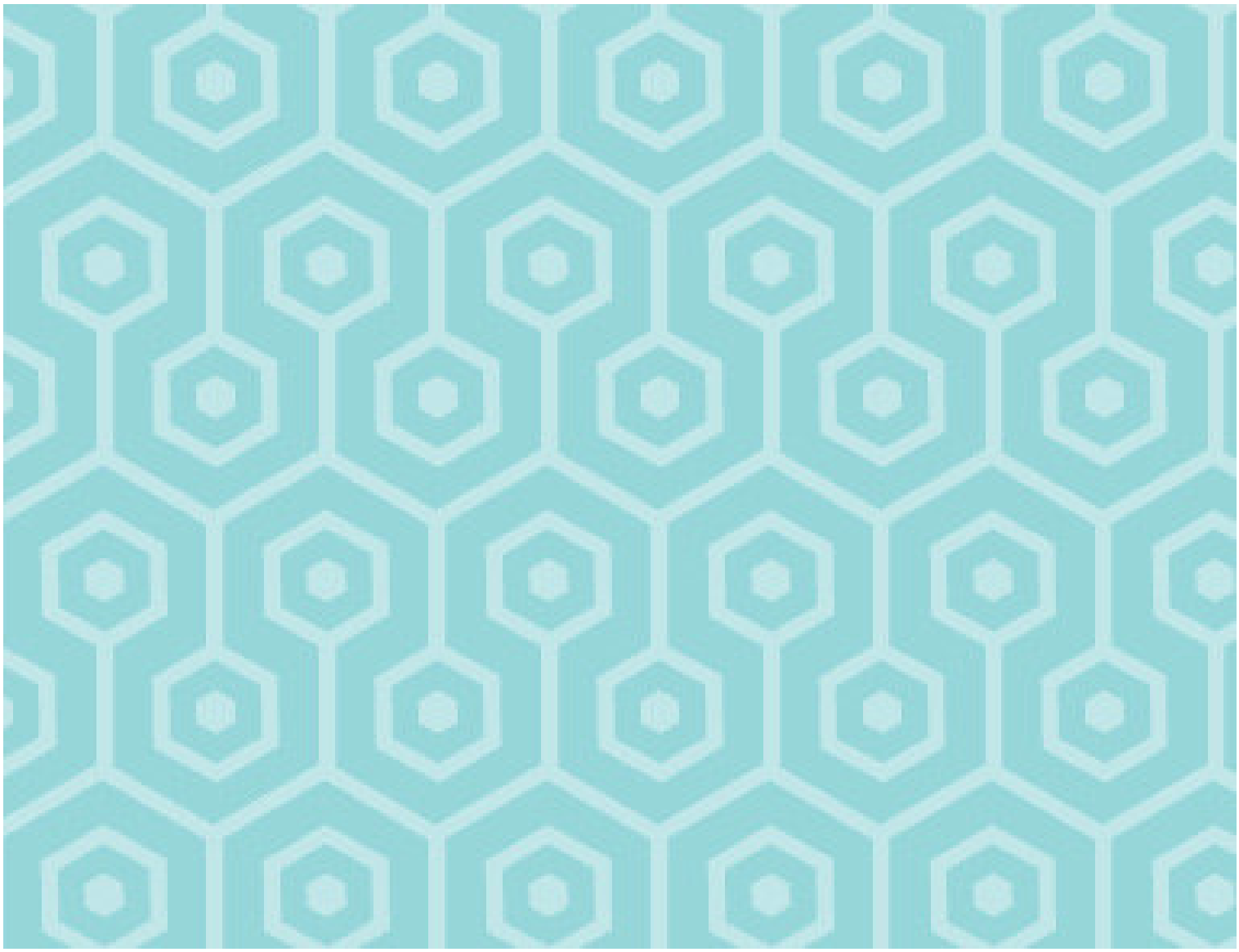
Frequently Asked Questions

The Global AIDS Monitoring 2017



Contents

Global AIDS Monitoring

Purpose of this FAQ

This document provides answers to questions that have been received frequently from UN staff, their national counterparts, and the global reporting focal points. For more information on the Global AIDS Monitoring, please visit our website (www.unaids.org/aidsreporting), or email us at aidsreporting@unaids.org.

General questions

Why is UNAIDS requesting country progress reports in 2017?

In the 2016 HLM declaration (para. 76) countries agreed to "…provide to the General Assembly […]an annual report on progress achieved in realizing the commitments made in the present Declaration…". In 2017 countries are expected to assess their achievements against the targets set in 2016. The reported data are utilized for national-level reviews (including the Global Fund New Funding Model and similar reprogramming efforts), regional reviews, and global analysis. Data will be reported in UNAIDS, WHO and UNICEF reports in 2017.

Why does the indicator set look different from last year?

The indicators have been revised, and reduced in total number. This is done with the intent to reduce the reporting burden, and to make the indicators relevant to the current global AIDS response and the 2016 Political Declaration.

In addition, the former "health sector" indicators have been merged with former GARPR indicators, utilizing the Consolidated Strategic Information Guidelines (WHO, May 2015).

What is the deadline for 2017 reporting?

Country data should be submitted online no later than **March 31, 2017**.

While narrative reports are not mandatory, it is encouraged that countries submit narrative summaries by commitment area. Countries may alternatively share any narrative analysis or reports they may produce for their own national processes.

Should a submission be received after these dates, UNAIDS cannot guarantee that the data will be included in the 2017 Global Report on AIDS.

What is the recommended reporting format?

Country progress reports should be submitted online using the Global AIDS Monitoring platform. The online platform is available at https://aidsreportingtool.unaids.org, accessible as of 1st of March 2017.

Training materials and additional resources are available at http://www.unaids.org/aidsreporting.

Which internet browser should I use?

The online reporting tool is developed to work best with the latest versions of popular browsers, such as Internet Explorer, Chrome, and Firefox. With older browser versions, there may be issues in saving and viewing the data.

What information is included in a country progress report?

A country progress report submission consists of:

- A cover sheet with relevant contact information.
- Data pertaining to the indicators used globally to monitor national progress in responding to the HIV epidemic (countries can select which indicators are relevant, and for which they can provide data);
- Data responding to the National Commitments and Policy Instrument (NCPI);
- Narrative summaries by commitment area or other narrative report on progress towards the targets of the 2016 United Nations Political Declaration on HIV/AIDS (optional)

For more information, please see the 2017 Global AIDS Monitoring Guidance.

Which indicators are countries required to report on?

Countries are expected to report on all indicators as per the reporting guidelines. However, if a specific target is not a priority, or specific indicator data are not available, this can be indicated in the online reporting tool.

Progress in responding to the HIV epidemic is measured against a set of 10 global commitments and expanded targets established in the 2016 Political Declaration on HIV/AIDS. These commitments are:

1. Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

2. Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

3. Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners

4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

5. Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

6. Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

7. Ensure that at least 30% of all service delivery is community-led by 2020

8. Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

9. Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

10. Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

How can I check what my country reported in the last report?

You can view previously reported data in the following ways:

- Through the online reporting tool
- By viewing the country reports:
    - Narrative report: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2016countries
    - NCPI report: http://www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2014countries
- By viewing the data in the AIDSinfo web-page: http://www.aidsinfo.unaids.org/
- Or through the AIDSinfo Online Database: http://www.aidsinfoonline.org/
- For information on last report on indicators with regards to AIDS expenditures, please contact AIDSspending@unaids.org.

NCPI

Is the NCPI included for 2017?

Yes, it is included for 2017. The National Commitments and Policy Instrument (NCPI) was revised in 2015-2016 to respond to lessons learned over 10 years of NCPI reporting and to reflect the Political Declaration Commitments and current data needs. The WHO Policy Questionnaire has also been integrated in the revised NCPI. Countries are asked to submit the NCPI every two years, as it is expected that changes to laws, policies and regulations would occur more slowly, and the need for more frequent monitoring may be limited. The most recent reporting on the previous version of the NCPI was in 2014.

Indicator 8.1 “Total HIV Expenditure”

What does the indicator 8.1 “Total HIV expenditure” measure?

The Indicator 8.1 “Total HIV expenditure” measures the progress against the HLM commitment 8 adopted in the 2016 Political Declaration on HIV/AIDS: “Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers”. Furthermore, it reflects on the majority of the 10 global commitments in financial terms, and it is hence structured accordingly.

The indicator is designed to be the result of consistent and comprehensive data collection on financing flows and expenditures for HIV. It describes in-country resource allocation and financing sources, and can be used to monitor changes in policy priorities as well as to distinguish some of the key features of the response.

This indicator is reported by completing the National Funding Matrix template: HIV spending category by financing source, and provides critical information at both national and global levels for evidence-based policy making.

What is the primary measurement tool?

The most comprehensive methodology that enables reporting granular HIV expenditure by programme and financing sources (and four other variables) is the National AIDS Spending Assessment (NASA). We recommend NASA to be used as a primary tool for HIV resource tracking and thus a subset of these results can be copied relatively effortless into the National Funding Matrix and/or the online reporting tool.

On the other hand, the System of Health Accounts-2011 - full distribution across programs - (SHA-2011) attempts to identify, for the case of the HIV programme high-level categories corresponding to the NASA-AIDS spending categories. However, depending on the study design, the System of Health Accounts 2011 may not fully inform in every case on HIV expenditures disaggregated by programme with the granularity required, both to report on the GAM indicator 8.1, or for the purpose of properly monitoring the HIV program for management purposes. The main reason is that the provider level survey recommended for comprehensive resource tracking for HIV (or the so-called “bottom-up” approach) is not applied in SHA-2011. The System of Health Accounts 2011 has additional limitations on defining reliable/repeatable estimates of the total HIV expenditure by domestic public sources in the cases where there are shared costs by more than one programme and in particular when the tracking exercise does not cover the 100% of the programmes. Indeed, it provides estimates of earmarked expenditure for HIV from central government records following a cash flow “top-down” approach; however, the HIV earmarked funds do not account for the totality of government HIV expenditures in the vast majority of countries. The bulk of the un-allocated health expenditure is then being added to HIV earmarked expenditure with an application of allocation keys.

If a country has not implemented a comprehensive HIV resource tracking exercise using the methods suggested above, an ad-hoc data collection may be undertaken to inform actual expenditure where the data is available. An ad-hoc data collection exercise needs to respond to the principles and approaches of the standard accounting methodologies even if allowing lower level of details on programme disaggregation. In those cases, countries are being asked to specify their approach in detail what was included or excluded (e.g. earmarked expenditure for HIV, commodities, service delivery, other), and potential data gaps. However, when using budget analysis to report on HIV expenditure and to fill in the National Funding Matrix, a careful assessment needs to be focused on identifying discrepancies between

budgetary allocations and actual expenditures; thus, it would be recommended that an explicit description on the scope and boundaries of what was reported.

What is required to report on the GAM indicator 8.1 using "health accounts" (SHA 2011)?

In the absence of a NASA and given the current known limitations of SHA 2011 described above, the system of health accounts is recommended as a secondary methodology to report on Indicator 8.1.

Notably, 31 countries have recently piloted SHA 2011 with full disease distribution. The findings suggest that those provide estimates on total expenditure for HIV, whereas limited data on HIV programme expenditure have been made available. The World Health Organization suggests that to date only two countries have demonstrated positive experience in HIV resource tracking with application of SHA 2011 with comprehensive findings on HIV financing flows and expenditures with programme disaggregation. However, its piloting and roll-out are still under development and results are not yet publicly available.

A recommended way forward is to embed NASA AIDS spending categories or HIV programmes as a standalone dimension into the SHA 2011 Production Tool and track expenditure for HIV accordingly. To ensure that the study design allows capturing expenditure on HIV by programme category in a comprehensive manner, provider level survey and bottom-up approach to data collection is recommended. The limitations of the top-down approach to HIV resource tracking and application of the allocation keys in SHA 2011 is described above.

If the primary data is not already available in the country information systems or it was not collected with the adequate level of granularity, the disaggregation by the core indicators and sub-indicators would need to be estimated by using an allocation key, which may produce lower reliability and validity of the estimates.

However, when the data collection and embedded in-depth analyses, such as that provided by NASA, can be aligned with the SHA-2011 exercises and the estimates have stabilized, it could allow for in-depth analysis every 3 to 5 years (using NASA), with intermediate monitoring estimates derived from SHA.

Would NASA and SHA 2011 provide necessary expenditure inputs to conduct economic evaluation and measure efficiency?

If the NASA is conducted to provide information at the level of data disaggregation following accrual accounting principles, and collecting all the six vectors to depict the financing, consumption and provision axes, the NASAs can provide entry points to conduct further analyses.

The data provided by SHA-2011 can provide useful analysis when interested in the health system as the unit of analysis instead of the programme itself.

What is the national funding matrix?

The national funding matrix is a table (spreadsheet) that enables countries to collate the HIV financing flows and expenditures according to a system of comprehensive and mutually exclusive classifications that embraces the 10 global commitments of the 2016 Political Declaration on HIV/AIDS, as well as the rest of other programme areas.

It is a double-entry table that has two basic dimensions:

HIV Spending Categories (How expenditures are allocated between different programme categories) and

Financing Sources (The origin of the funds).

The matrix includes, among others, 10 core HIV programme areas as outlined below, that are further disaggregated by programme category.

The 10 core HIV programme areas of the National Funding Matrix are:

- Treatment, care and support
- Prevention of vertical transmission of HIV
- Prevention (except vertical transmission of HIV)
- Gender programmes
- Programmes for children and adolescents
- Social protection
- Community mobilization
- Governance and sustainability
- Critical enablers
- TB / HIV co-infection, diagnosis and treatment

The vast majority of the programme categories in the matrix are drawn from the existing categories described in previous guidance since they have been collected for a number of years and have been part of the then existing Global AIDS Response Progress Reporting indicator 6.1.

The rows and column sub-totals can be used to report on the eight programme categories as the core expenditure indicators of the GAM 2017. These include:

8.1A Expenditure on HIV testing and counselling

8.1B Expenditure on antiretroviral therapy

8.1C Expenditure on HIV-specific laboratory monitoring

8.1D Expenditure on TB and HIV

8.1E Expenditure on the five pillars of combination prevention (further specified below)

8.1F Expenditure on preventing the mother-to-child transmission of HIV

8.1G Expenditure on social enablers

8.1H Expenditure on cash transfers for young women and girls

To illustrate alignment to the 10 global commitments, the five pillars of combination prevention (sub-indicator 8.1E) have been embedded in the reporting framework (matrix) thus enabling the accounting and estimation of “a quarter of all investments for prevention in low- and middle-income countries as a global average” (as they are not country-specific benchmarks). The following programmes represent the five pillars of combination prevention under sub-indicator 8.1E: a) Condom programmes, b) Pre-exposure prophylaxis for population groups at higher risk including the key populations, young women and adolescent girls in high prevalence countries, and sero-discordant couples, c) Voluntary medical male circumcision in high prevalence countries, d) Essential packages of services for young women and and adolescent girls; and e) Essential packages of services for the key populations, including harm reduction services and OST for pertinent subgroups of people who inject drugs.

The definitions of the core sub-indicators and associated metadata are provided in the GAM guide. Annex 2 provides a full range of HIV programme categories and the cross walk with existing NASA's AIDS Spending Categories (ASC).

Do all cells of the table (funding matrix) need to be completed?

Not all the services or financing schemes apply to all countries. Therefore, in principle, the GAM reporter in alignment with the national financing experts will select the rows and columns that are applicable. The default value for these cells will indicate that no numerical value exists for each of those cells, rows or columns. An alternative would be to fill those cells with a $0 value meaning that it is known that there were no financing flows or expenditures for that given year, financing source and service.

Out of the cells which are applicable to the country, there is a need to clearly identify which pieces can be reported on. For example, for a given service, there might be information available only for the commodities but not for the rest of the components in particular for those corresponding to service delivery, thus it is recommended only to fill the commodities rows, and leave the following row as “not available”.

On the other hand, for example, there might be services which are paid on a “per capita” basis, thus it is understood that the separate reporting of commodities and rest of the expenditure would not be reported.

Where do I find the funding matrix?

The Global AIDS Monitoring online reporting tool will provide further guidance on how to complete the reporting forms and submit expenditure indicators to UNAIDS.

Spectrum

To ensure consistency in global reporting, it is important that data elements used as inputs in Spectrum are the same as those used in the GAM online reporting tool. Similarly, it is important that the final output from Spectrum be entered in the GAM online reporting tool.

Will there be a new version of Spectrum for the estimates produced in 2017? Will there be training on the new version?

A new version of Spectrum is available for 2017. The regional estimates workshops will take place from mid-February through the end of March.

Which variables in the Global AIDS Monitoring form should match Spectrum input or output?

Table 1 describes specifically what data elements should be consistent between the Global AIDS Monitoring and your national Spectrum file.

Spectrum software can provide the denominators for indicators 1.1, 1.2, 1.4, 1.7, 2.1, 2.2, 2.3 and 3.1 (PMTCT, new infections, knowledge of status, ART and AIDS deaths). For the indicators 1.2, 1.7, 2.2, 2.3 and 3.1 Spectrum does not only provide the denominator but also the numerator and therefore the entire indicator.

In addition, the programme data entered in Spectrum should be the same as those data used in the GAM Online Reporting Tool as numerators for indicators 1.2 and 2.3.

For the numerator for indicator 2.3, Spectrum also has a category titled *dual ARV*. This category is referring to the 2006 WHO recommended regimen that provides women with AZT plus one other ARV. This is similar to Option A. However, we count the two regimens separately. Option A recommends that women start the regimen earlier in their pregnancy and provides prophylaxis throughout the breastfeeding period. In the online reporting tool, women who received dual ARV should be listed in the “Other” category and, in the comments

box, a note should be made on the number of women receiving the dual ARV (2006 WHO recommended regimen).

Table 1.
Data elements that should be identical in the GAM tool and Spectrum

	GAM online tool	Equivalent Spectrum variable name (Variable name, location in Spectrum)
Treatment cascade and AIDS mortality		
1.1 Denominator	Estimated number of people living with HIV (select respective sex and age group)	HIV population (select respective sex and age group)
1.2 Numerator	Number of people on antiretroviral therapy at the end of the reporting period (select respective sex and age group)	Adult ART (Dec 31) (select respective sex) Child ART (Dec 31)
1.2 Denominator	Estimated number of people eligible for ART under national guidelines (select respective sex and age group)	Total need for ART (15+) (Dec 31) (select respective sex and age group)
	Estimated number of children eligible for ART under national guidelines (select respective age group)	Children needing ART (Dec 31)
	Estimated number of people living with HIV (select respective sex and age group)	HIV population (select respective sex and age group)
1.2 Indicator	Percentage of adults and children on antiretroviral therapy among all adults and children living with HIV at the end of the reporting period	Percent of people living with HIV receiving ART (select respective sex and age group)
1.4 Denominator	Estimated number of people living with HIV (select respective sex and age group)	HIV population (select respective sex and age group)
1.7 Numerator	Number of people dying from AIDS-related causes in 2015 (select respective sex and age group)	AIDS deaths (select respective sex and age group)

1.7 Denominator	Total population regardless of status (select respective sex and age group)	Total population (select respective sex and age group)
1.7 Indicator	Total number of people who have died from AIDS-related causes per 100 000 population (select respective sex and age group)	AIDS mortality per 100 thousand (select respective sex and age group)
PMTCT		
2.1 Denominator	Number of HIV-positive pregnant women giving birth in the last 12 months	Mothers needing PMTCT
2.2 Numerator	Estimated number of children newly infected with HIV from mother-to-child transmission among children born in the previous 12 months to women living with HIV	Number of new child infections due to mother-to-child transmission
2.2 Denominator	Estimated number of children delivered by women living with HIV who delivered in the previous 12 months	Mothers needing PMTCT
2.2 Indicator	Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	Final MTCT rate, including breastfeeding
2.3 Numerator	Number of pregnant women living with HIV who delivered and received antiretroviral medicines during the past 12 months to reduce the risk of the mother-to-child transmission of HIV during pregnancy and delivery	Mothers receiving PMTCT
	Newly initiated on antiretroviral therapy during the current pregnancy	ART started during pregnancy (either <4 weeks of >4 weeks before delivery)
	Already receiving antiretroviral therapy before the current pregnancy	ART started before pregnancy
	Maternal triple antiretroviral medicine prophylaxis (prophylaxis component	Option B – triple prophylaxis

	of WHO option B)	
	Maternal AZT (prophylaxis component during pregnancy and delivery of WHO option A)	Option A - maternal
	Single dose nevirapine (with or without tail) only	Single dose nevirapine
	Other	Dual ARVs – see note above
2.3 Denominator	Estimated HIV-positive pregnant women in the past 12 months	Mothers needing PMTCT
2.3 Indicator	Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	PMTCT coverage (effective regimen)
HIV incidence		
3.1 Numerator	Number of people newly infected during the reporting period (select respective sex and age group)	Number of new HIV infections (select respective sex and age group)
3.1 Denominator	Total number of uninfected population (or person-years exposed) (select respective sex and age group)	Total population *minus* HIV population (select respective sex and age group)
3.1 Indicator	Number of people newly infected with HIV in the reporting period per 1000 uninfected population (select respective sex and age group)	Incidence per 1000 (select respective sex and age group)

What is the timeline for the review and submission of Spectrum files?

Countries are requested to share draft Spectrum files with UNAIDS by 10 April 2017. Feedback will be provided within two weeks. The final files should be submitted by 14 May 2017.

Since the final Spectrum estimates will only be available after the GAM deadline, countries who opt to take the data from their final Spectrum file should leave the data elements specified in Table 1 blank in the GAM tool. An option will be provided in the online tool to import data extracts from Spectrum and populate those data elements.

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