The AIDS Program Effort Index (API)

Results from the Field Test

John Stover
The POLICY Project
The Futures Group International

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Introduction

The success of HIV/AIDS programs can be affected by many factors including political commitment, program effort, socio-cultural context, economic development context, and resources available. Various approaches to measuring these factors are available. Most approaches focus on measuring low-level inputs (e.g., training workshops, condoms distributed) or outcomes (e.g., percentage of acts protected by condom use). Measures of program effort are generally confined to the existence or lack of major program elements (e.g., condom social marketing, counseling and testing).

The POLICY Project, USAID and UNAIDS have undertaken an activity to develop an HIV/AIDS/STD program effort score that will provide measures of the key high level inputs independent of program outputs. For example, program effort includes items such as the proportion of the population that has access to affordable condoms but does not include output measures such as the proportion of acts protected by condom use. There are many uses for scores that measure program efforts independent of output. At the global level, they can be used to analyze the independent contribution of program effort to outputs in a variety of social and cultural settings and the relative contribution of international organizations. At the country level they can be used to compare the national effort against that of other countries with similar settings or problems. The scores can also be used as a diagnostic tool, to indicate which program areas are weakest and which are strongest and to suggest corrective action.

A program effort score for family planning was first developed in 1972. The current version of that indicator scores countries on 30 items that are grouped into four components: policies and stage-setting activities, service and service-related activities, record keeping and evaluation, and availability of family planning methods. The score has been applied to approximately 100 countries in 1972, 1982, 1989 and 1994 (Ross and Mauldin, 1996). The results have been used for global research as well as for country applications. Among the applications are studies of:

- social marketing (Sheon et al., 1987)
- community-based distribution (Ross et al., 1987)
- access to birth control (Camp and Speidel, 1987)
- improved contraceptive method mix (Jain, 1989)
- the determinants of contraceptive use (Entwisle, Mason and Hermalin, 1986)
- political commitment and strength (Ness and Ando, 1984)
- the prospects for achieving replacement level fertility (Mauldin and Ross, 1994)
- the interactions between program effort and social setting (Casetti, 1991 and 1992)
- factors critical to overall program improvement (Bulatao, 1993)
- the recent debate on whether family planning programs have a significant impact on fertility (Bongaarts, 1990 and 1994; Pritchett, 1994, Schultz, 1994)
- a recent assessment of the sustainability of family planning programs (Knight and Tsui, 1998).

A program effort score for HIV/AIDS/STDs will facilitate provide a useful diagnostic tool for national programs, facilitate measurement of changes over time, allow the estimation of the impact of donor inputs and stimulate cross national research.

Similar scores have been developed that measure the extent to which the policy environment is supportive of effective programs. The PASCA Project has applied a policy environment score for HIV/AIDS in Central America (Murgueytio, Merino and Stover, 1997) and the POLICY Project has recently developed policy environment scores for HIV/AIDS, family planning, safe motherhood, adolescents and post-abortion care. The FPLM Project uses a similar composite index to measure the functioning and sustainability of logistics systems (Stover, 1995).

The activity to develop an AIDS Program Effort Index (API) is a joint activity of The POLICY Project, USAID and UNAIDS. It will be applied in 50 - 120 countries on a periodic basis in order to measure the level of effort and the change in effort over time. It is hoped that the API will be a useful tool to evaluate current efforts and indicate areas where improvements will enhance the efforts to address the AIDS epidemic and lead to improved outcomes. This paper reports on the results of field tests of the draft questionnaire.

The purpose of the API is to measure the amount of effort put into national HIV/AIDS programs by domestic organizations and individuals and by international organizations. The term national programs refers to the entire effort within a country, including the government-based AIDS Control Program as well as efforts of communities, NGOs, the private sector, other sectors of civil society and individuals. The API is intended to be useful for description, diagnosis and impact analysis.

Description
1. To measure the level of effort of international assistance in each country
2. To measure the level of national efforts (where national refers to all domestic inputs including central, regional and local by both governmental and non-governmental organizations)
3. To measure changes over time in national and international efforts

Diagnosis
4. To serve as a diagnostic tool to indicate areas of strength and weakness in each country program

Impact
5. To determine the effects of international assistance on national efforts
6. To determine the effects national and international efforts on outcomes

Conceptual Framework

Figure 1 shows the conceptual framework for the relationship between HIV/AIDS program effort and desired outcomes. This framework is based on one developed for family planning services by The EVALUATION Project (Bertrand, 1994)

Figure 1 Conceptual Framework of Program Effort and Outcomes
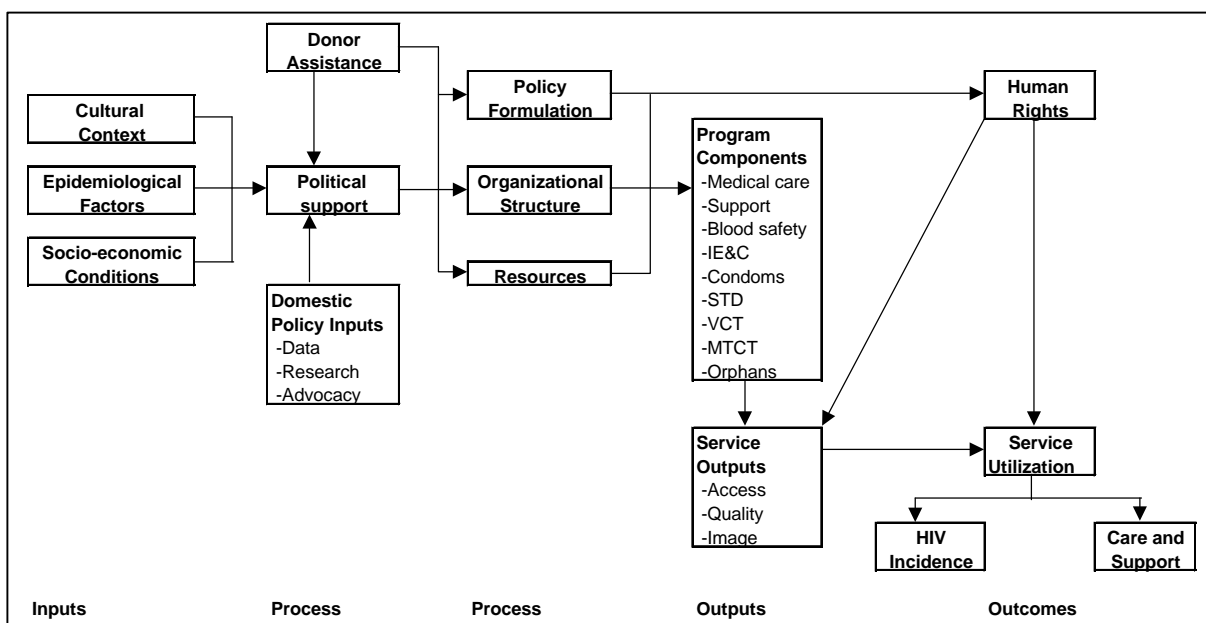
The inputs are the various social, cultural, economic and epidemiological factors that define the context of the national response to the HIV/AIDS epidemic. These factors may have a powerful influence on the epidemic and the response to it, but are outside the control of the program. The political response is influenced by these outside factors and also by various domestic efforts to define the extent and nature of the epidemic (through data collection), understand the effects of programs to combat the epidemic (through research) and influence policy makers in certain directions (through advocacy and awareness raising efforts by domestic governmental and non-governmental groups). Donor activities in policy dialogue and research also may influence the amount and type of political support for HIV/AIDS programs.

Political and donor support determines the way the response will be organized. This includes the development and implementation of national and operational policies, the structure of the program and the amount of funding and human resources that are devoted to it. These factors determine the program components, which lead directly to service outputs (access, quality and image). To the extent that these services are utilized by the

population, the program will have an effect on reducing HIV incidence and the quality and amount of care and support services provided to people living with HIV/AIDS (PLWHA) and their families.

Policy formulation directly affects the human rights of PLWHA through formal policies, laws and regulations and the environment within which these laws are implemented. Protection of the human rights of PLWHA is a desired outcome in itself. The human rights environment also may affect service outputs and utilization.

The AIDS Program Effort Index (API) is intended to measure the effort put into HIV prevention and care. It does not measure the inputs (context) of the epidemic and response nor does it measure the outcomes. Therefore the API should include all those items contained in the conceptual framework under Process and Outputs. Human Rights is also included even though it is an outcome, because it is also influences Service Outputs and Service Utilization.

Methodology

The AIDS Program Effort Index (API) is a composite indicator composed of a number of individual items grouped into key categories. Each item is scored on a scale of 0-10 by knowledgeable individuals. The item scores are averaged for each category to produce a category score that does not depend on the number of items in the category. The category scores form a profile describing the program effort of each country. The category scores are the primary indicators, however, they can be averaged to produce a total score for summary purposes.

Judgements are be provided by 15 - 25 people in each country. Respondents are selected from a variety of backgrounds, including the AIDS Control Program, Ministry of Health, other governmental organizations, NGOs (including those representing people living with HIV/AIDS), researchers, academics, major religious groups, community-based organizations and donors. Careful consideration should be given to selecting two to four individuals from each category who have a good understanding of the functioning of the national program.

Since one of the purposes of the API is to measure change, the participants are asked to rate each item twice, once for the current situation and once for the situation two years ago.

The questionnaire contains 90 individual items grouped into nine components. The components are:

- Political support, PS
- Policy formulation, PF
- Organizational structure, OS
- Program resources, PR
- Research and evaluation, ME
- Legal and regulatory, LR
- Human rights, HR
- Prevention programs, PP
- Care programs, CP

In addition, most components contain items that refer to international assistance. These items are consolidated into a tenth component:

- International assistance, IN

A copy of the draft questionnaire is included in Appendix A.

Field Test

The draft questionnaire was field tested in six countries: Cambodia, Mexico, the Philippines, Romania, Senegal and Zambia. The details of the test in each country are shown in Table 1.

Table 1. Description of Country Field Tests

Country	Implementing Organization	Date Completed	Number of Respondents	Language
Cambodia	Family Health International	June 1999	33	Khmer
Mexico	UNAIDS	July 1999	19	Spanish
Philippines	UNAIDS	February 1999	34	English
Romania	UNAIDS	November 1998	18	English
Senegal	POLICY Project	March 1999	25	French
Zambia	UNAIDS	December 1998	22	English

The results from these applications have been analyzed for two purposes (1) to see what insights we could gain from the API in actual application and (2) to understand how the questionnaire could be improved. This analysis is presented in the following sections. The first few sections focus on the substantive results while the later sections focus on methodological findings. Various summary measures are presented in the text of this report. Appendix B contains the detailed results by country, component, item and year.

Total Scores

The API is intended primarily to provide information about the level of effort in each component of a comprehensive program. A total score can be calculated by averaging the component scores. It is unclear how useful the total score will be. However, the next several sections focus on the total score because this simplifies the analysis of the field test results considerably. Later in this report, the accuracy and usefulness of the total scores are discussed. In particular, it is important to note here that the low scores found for Mexico may be the result of different standards used by respondents rather than a true difference in level of program effort.

The total scores for the six countries ranged from 49 (Mexico) to 72 (Senegal). The scores and 95 confidence range for all countries are shown in Figure 2.

Figure 2. Total Scores and 95% Confidence Ranges
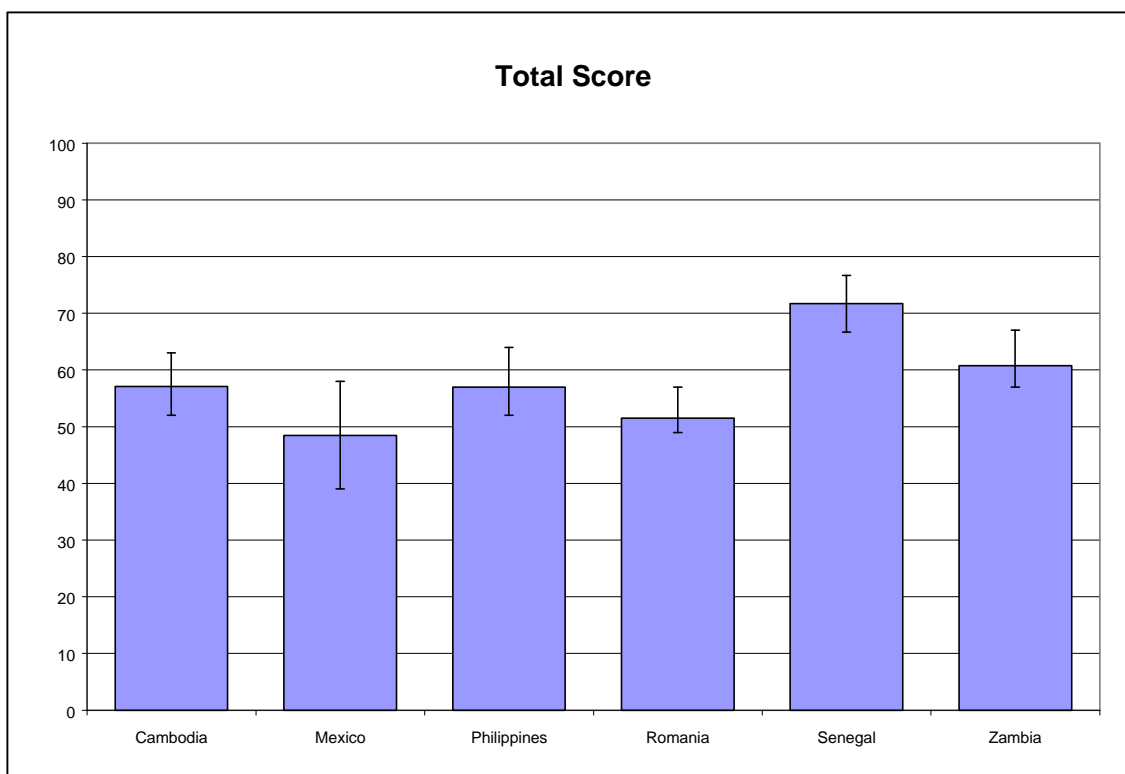
It is not surprising that Senegal received the highest score, since it is widely credited with having an effective program. It is surprising that the Mexico program ranks the lowest, below Cambodia and Romania. An analysis of variance (ANOVA) of these scores produces a significant F statistic, indicating that the country scores do differ significantly from one another. Exactly which countries differ from each other can be determined by applying a pairwise post-hoc test. The LSD (least significant difference) test is one of

these tests. It indicates that the score for Senegal is significantly larger than any of the others. The score for Zambia (the second highest score) is smaller than Senegal and larger than Romania and Mexico but not significantly different from Cambodia and the Philippines. The score for Mexico is similar to Romania but lower than all other countries. Romania's score is similar to the scores for the Philippines and Mexico. These similarity groupings are shown in Table 2.

Table 2. Country Grouping According to Total API

Group 1 (Highest)	Group 2	Group 3	Group 4 (Lowest)
Senegal			
	Zambia	Zambia	
	Cambodia	Cambodia	
	Philippines	Philippines	
		Romania	Romania
			Mexico

Change in Program Effort

The questionnaire asked respondents to rate each item twice, once for to reflect the present situation and once to reflect the situation two years ago. The total scores for both years are shown in Figure 3.

Figure 3. Change in Total Scores Over Two Years

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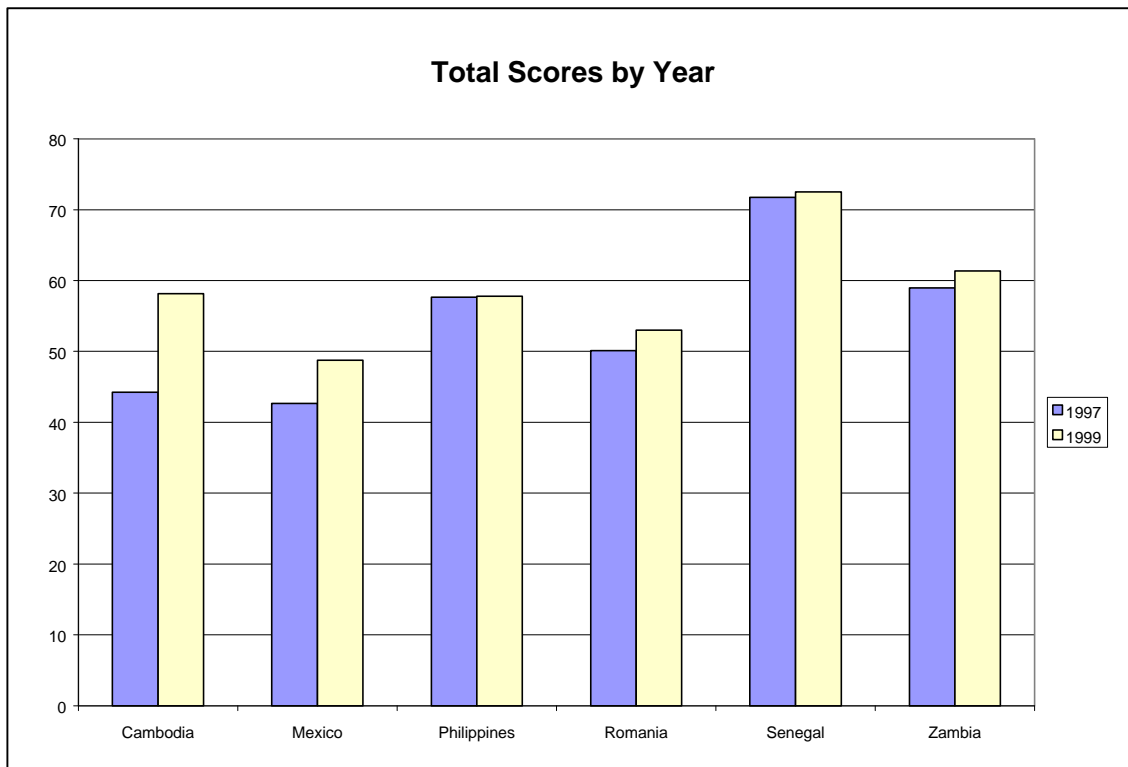
The scores increased during the last two years in all countries. The amount of change ranged from 14 points for Cambodia to 0.1 point for the Philippines. Using a t-test for paired two sample means to test for significance, the changes are significant in all countries except the Philippines. It is possible that there is a psychological tendency for most people to assume that conditions have improved over the past two years. However, respondents did not routinely assume that conditions have improved. This is shown in Table 3, which shows the distribution of estimates of change by all respondents for all items. Three-quarters of the responses indicated no change in item scores. This is evidence that respondents carefully considered the change from the previous time period, and only indicated a change in a minority of cases.

Table 3. Distribution of Estimates of Change in Item Scores from Previous Time Period

Change	Cambodia	Mexico	Philippines	Romania	Senegal	Zambia	Total	Percent
-3	8	2	0	169	4	6	189	1%
-2	17	20	0	56	5	18	116	1%
-1	19	40	0	103	13	89	264	2%
0	1141	2377	3015	630	2088	1476	10727	74%
1	520	249	1	215	96	283	1364	9%
2	546	185	3	116	26	75	951	7%
3	273	63	5	58	0	20	419	3%
>3	272	77	30	139	1	13	532	4%

Component Scores

The scores for the individual components are much more useful than the total scores. The component scores are shown for all six countries in Figure 4.

Figure 4. Component Scores
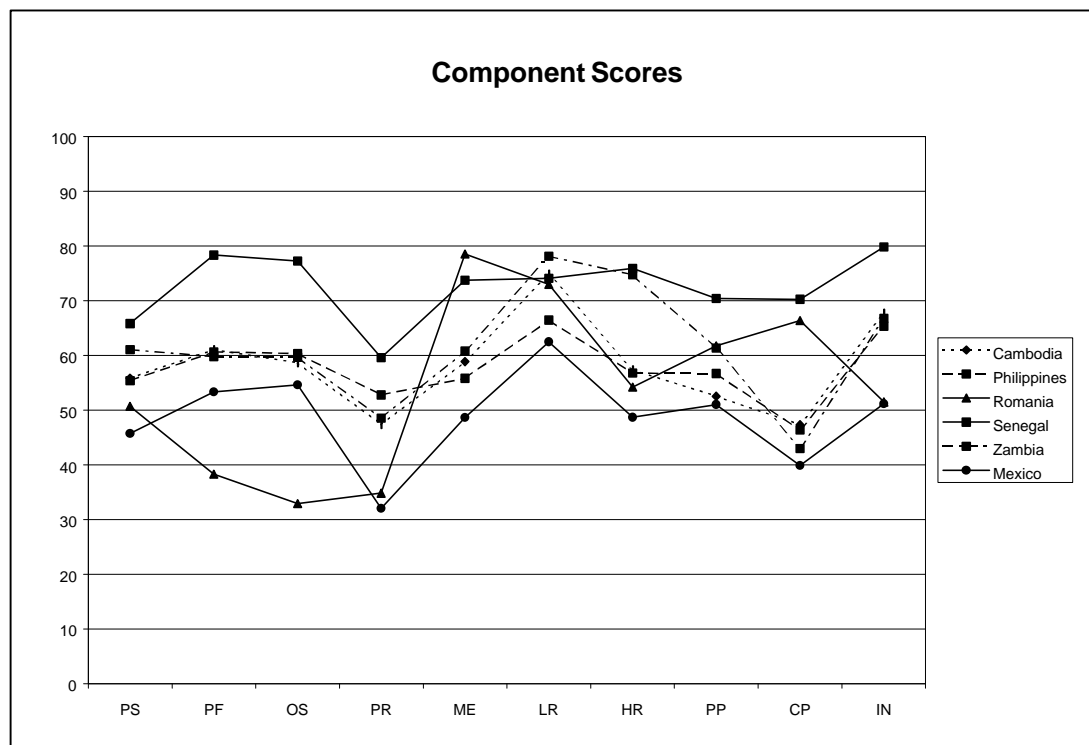
Key: PS-political support, PF-policy formulation, OS-organizational structure, PR-program resources, ME-measurement and evaluation, LR-legal and regulatory environment, HR-human rights, PP-prevention programs, CP-care programs, IN-international support.

Senegal received the highest scores in almost all the components while Mexico received the lowest scores in almost all. Romania shows the most differentiated pattern with very low scores on the policy-related components (political support, policy formulation, organizational structure and program resources), very good scores on evaluation and legal and regulatory and medium scores on the rest. This diversity is encouraging. It indicates that respondents are not just scoring all the items in the basis of an overall impression of the total program.

The lowest scores were recorded for the components of program resources and care and support. All countries scored relatively high on the legal and regulatory environment, but this did not necessarily carry over to good scores on human rights.

The lowest score for any component was near 30 while the highest score was almost 80. This 50 point gap is encouraging since it indicates that the API can reflect rather wide ranges in program effort.

Service Availability

The API questionnaire also includes questions on service availability. These questions asked respondents to indicate the proportion of the population with access to various services. Separate questions were asked for males and females. The results are shown in Figures 5 and 6.

Figure 5. Percent of Males with Access to Services
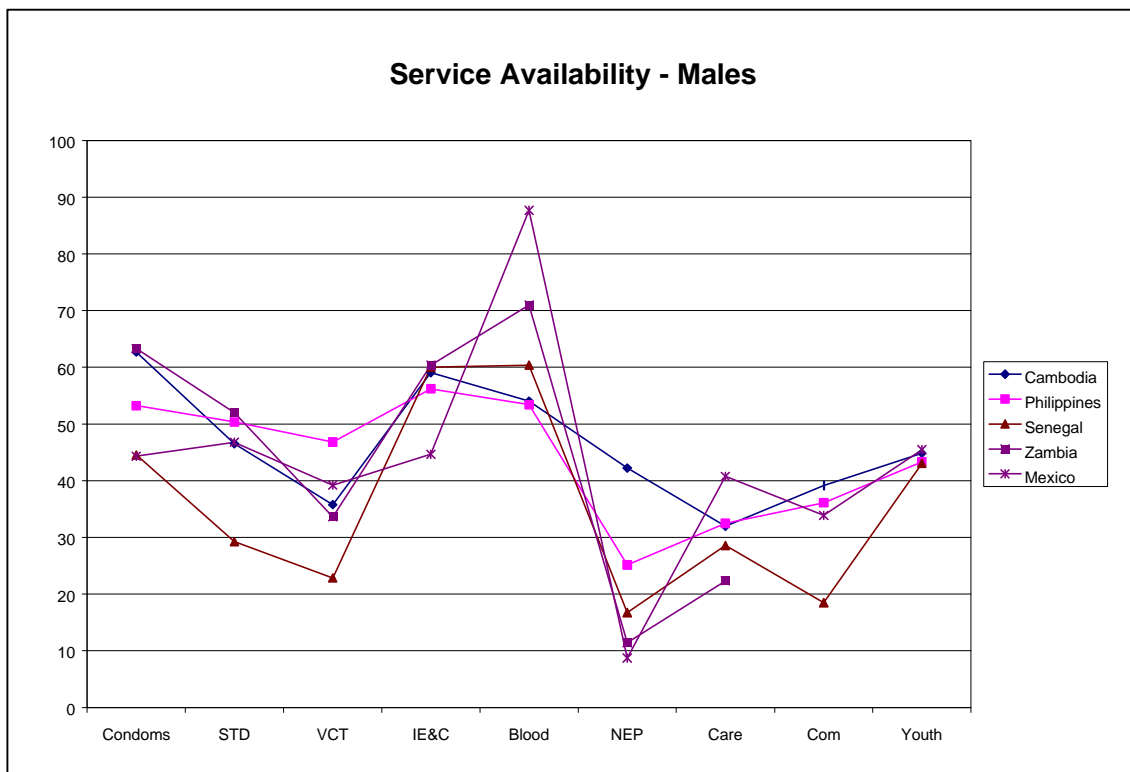
Key: Condoms-condoms, STD-treatment for sexually transmitted diseases, VCT-voluntary counseling and testing, IE&C-information, education and communications, Blood-screened blood for transfusions, NEP-needle exchange programs, care-quality medical care programs for HIV-related problems, com-family and personal support to cope with the effects of HIV, youth-information for youth about safe sexual practices

Figure 6. Percent of Females with Access to Services
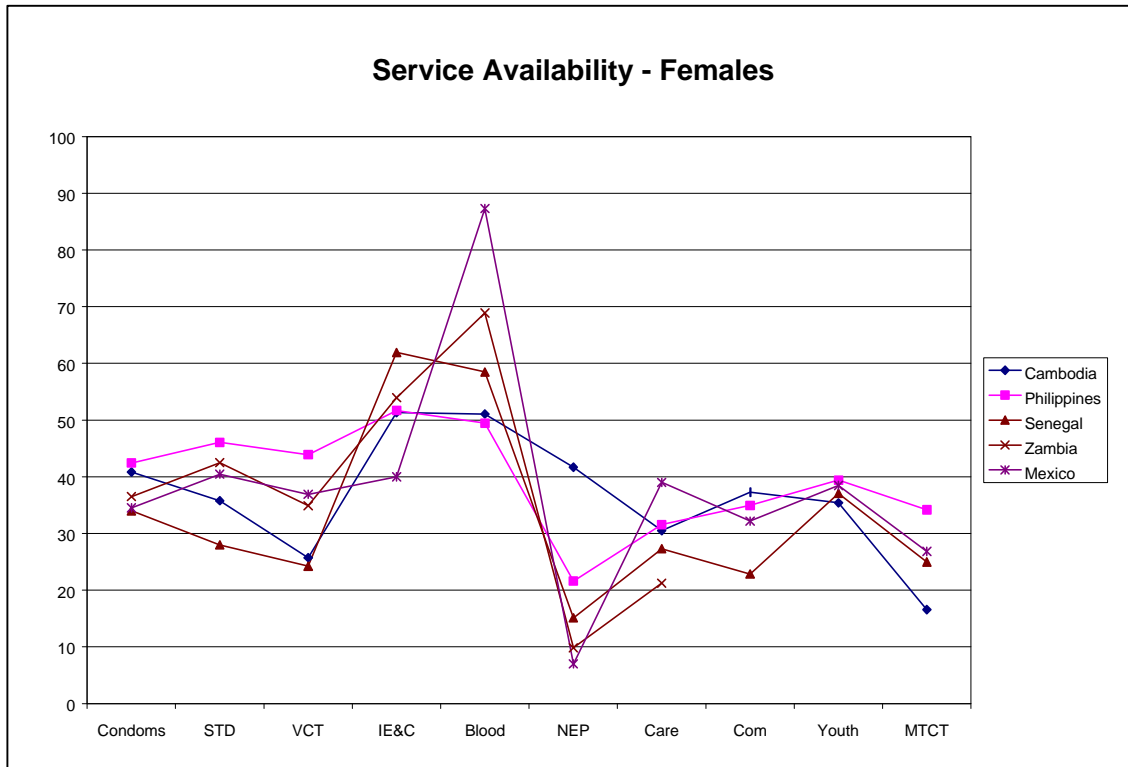
Service Availability - Females

Key: Condoms-condoms, STD-treatment for sexually transmitted diseases, VCT-voluntary counseling and testing, IE&C-information, education and communications, Blood-screened blood for transfusions, NEP-needle exchange programs, care-quality medical care programs for HIV-related problems, com-family and personal support to cope with the effects of HIV, youth-information for youth about safe sexual practices, MTCT-programs to prevent mother-to-child transmission

The respondents felt that males had more access to condoms and STD services than females. Access to other services was judged to be similar. The highest access score was for safe blood, as expected. The lowest score was for needle exchange programs. This item was intended to represent needle exchange programs for users of injected drugs. However, since none of these countries have such programs, it is clear that many respondents interpreted this item to mean clean needles for medical injections.

The item on MTCT for females received a much higher score than anticipated. The item asked respondents "What percentage of women have access to programs to prevent mother-to-child transmission of HIV?" None of these countries provide AZT treatment for pregnant women on a routine basis. They all have some recommendation on breastfeeding but do not provide breastmilk substitutes. Therefore, it appears that some respondents interpreted this to mean information for women about the dangers of transmitting HIV to new born children.

The information on service availability could be used in two ways. First, it could be used by itself to indicate the proportion of the population with access to key services. This

could help to indicate existing problems, track changes in availability over time and contribute to analyses of the effects of the API components on service availability.

Second, the service availability scores could be used to modify the API component scores. For most of the components, the respondents are rating the existence and strength of certain programs. However, for the "prevention program" component and the "care and support" component it is important to know not only whether a program exists and functions well but the proportion of the population reached. The service availability scores could be used to discount the scores for these two components. One approach would be to discount the "prevention program" component score by the average availability score for the prevention items (condoms, STD treatment, VCT, IE&C, blood screening, needle exchange and MTCT) and to discount the "care and support" component by the average availability score for the care items (quality medical care for HIV-related problems and family and personal support to cope with the effects of HIV). For example, the average availability score for the prevention items in Cambodia is 45 percent and for the care items it is 35 percent. Discounting the prevention component score (56) and care component score (47) by these amounts for Cambodia would produce new scores of 25 for prevention and 16 for care. As the questionnaire is currently written this approach would produce some double accounting, since some respondents undoubtedly gave low scores to some items on the basis of poor coverage. However, a revised questionnaire could separate the judgements of existence and quality from those of coverage.

The service availability questions probably should be revised to better reflect the target population. The question used in the field test was "What percent of the population has access to the following services?" However, the target population is not always all adults. The revised target populations that should be used are shown in Table 4.

Table 4. Target populations for access to services

Service	Target Population
Condoms	Sexually active adults
STD treatment	Sexually active adults
Voluntary counseling and testing	Sexually active adults
IE&C programs on HIV prevention	All adults
Screened blood for transfusion	Total population
Needle exchange programs	IV drug users
Quality medical care for HIV-related problems	HIV-infected adults
Family and personal support to cope with the effects of HIV	HIV-infected adults
Youth information about safe sexual practices	Youth
Programs to prevent MTCT	Pregnant women

The Effect of International Assistance

The questionnaire contains items in most of the components asking about the impact of international assistance on the local program. These items can be combined into a single score for international assistance and used to estimate the international contribution by component. Figure 7 shows the international contribution by component and country.

Figure 7. The Importance of International Assistance by Component and Year
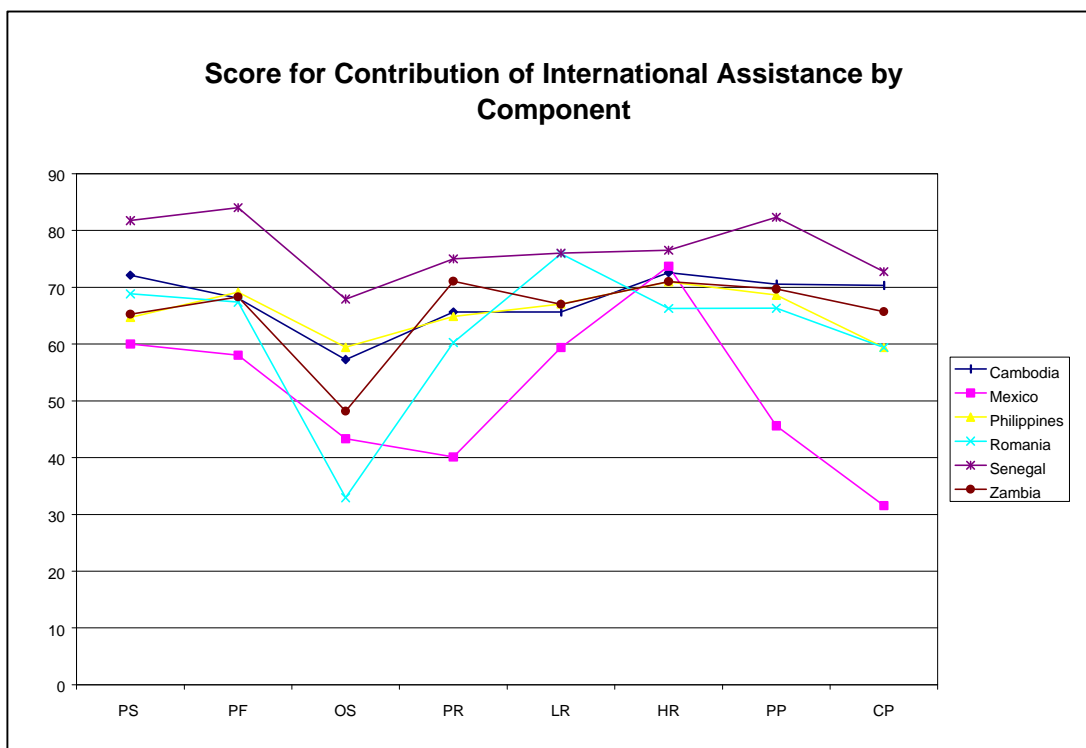
In general the scores for international assistance are high, averaging around 70 percent. However there are two exceptions to this pattern. Most of the scores are lower for organizational structure. The exact item scored is "There is good coordination between activities of the national government, local government, NGOs, private sector and international donors." So this item is not purely an assessment of the international contribution. The other exception is Mexico. Mexico scores lower than the other countries in almost all categories except human rights and has very low scores for program resources, prevention programs and care programs.

Figure 8 shows the international score, averaged across all six countries, for 1997 and 1999. Respondents estimated that the influence of international assistance had increased, by about five points, over the two-year period.

Figure 8. International Assistance Score in 1997 and 1999

Average International Score in 1997 and 1999
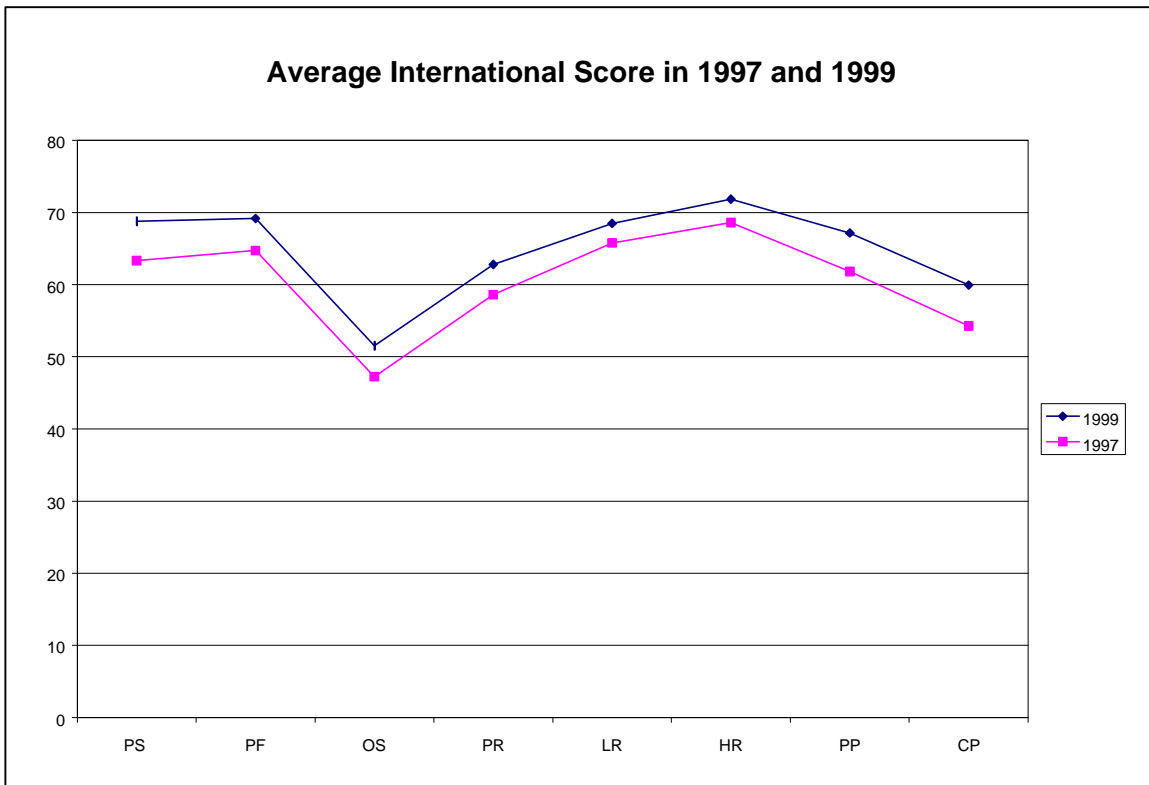
Country Scores

The primary purpose of the field test was to evaluate the questionnaire and approach. However, useful information about the participating countries was gathered. Those working with the program in each country will best interpret the results. However, here we offer a few comments on program effort in each country based on the results obtained. Table 5 provides statistics profiling the health situation in each country.

Table 5. Profile of Countries Involved in the Field Test, circa 1997

Indicator	Cambodia	Mexico	Philippines	Romania	Senegal	Zambia
Population (Millions)	10.5	94.3	73.5	22.6	8.8	9.4
Health expenditure (% of GDP)	7.2	4.7	2.4	NA	NA	4.7
Measles vaccination (% of infants)	68	97	83	97	65	73
Births attended by skilled health staff (%)	31	75	53	99	47	47
Adult HIV prevalence (%)	2.40	0.35	0.06	0.01	1.77	19.07
National expenditure on HIV per HIV+ person	$0.47	NA	$38.79	$302.40	$4.69	$0.25

Sources: National expenditure on HIV and Adult HIV prevalence: *The level and flow of national and international resources for the response to HIV/AIDS*, 1996-1997" UNAIDS and Harvard School of Public Health, 1999. All other indicators: *World Development Indicator: 1999*, World Bank, 1999.

Cambodia

Perhaps the most surprising result of the field test is the relatively high score achieved by Cambodia. Its total score is less than Senegal and Zambia, but virtually the same as the Philippines and it ranks ahead of Mexico and Romania. This pattern is roughly consistent across all the components. Cambodia scores highest in Policy Formulation and Legal and Regulatory Environment. Regarding Policy Formulation, respondents felt that Cambodia had a favorable national policy and formal goals and had realistic strategies to meet those goals. In Legal and Regulatory, Cambodia received high marks for encouraging condom distribution. Cambodia ranked the second lowest on prevention programs. In prevention, Cambodia received below average scores for mother-to-child transmission, needle exchange, family life education, blood safety, incorporating people living with HIV/AIDS into the prevention program, working with the media, targeting programs to high risk groups and STD drug logistics. It received average scores for the percentage of the population served by various services, ranging from 30 to 50. These scores seem high given the difficulty of providing services in the rural areas. Respondents estimated that program effort in Cambodia had increased substantially, by 13 points, from 1997 to 1999. This was the highest increase registered by any country.

Mexico

Another surprising result was the low scores received by Mexico. Its total score is the lowest of all six countries, it received the lowest score in eight out the ten components and the second lowest score in the other two components. It may be that people in Mexico demand and expect more from the program, so that respondents gave it low scores because it did not live up to their expectations, rather than because Mexico is actually failing in so many areas. Respondents also felt that international assistance was less effective in Mexico than elsewhere, particularly in the areas of resources, prevention and care. If Mexico has actually received its fair share of attention from international donors, then this may be another indication that the Mexican respondents were using stricter criteria to judge the program than respondents from other countries. If this is the case, then the questionnaire needs to be improved by providing more concrete examples to guide the respondent in choosing appropriate scores for each item. Interestingly, respondents did report that Mexico had improved its program effort, from 42 to 48, between 1997 and 1999.

Philippines

The Philippines received scores placing it in the middle of the group, on par with Cambodia and lower than Senegal and Zambia. A score of 57 indicates that respondents felt that the Philippines was doing a lot of things right, but had considerable room for improvement. The Philippines was squarely in the middle on all the component scores as well. The policy environment was judged to be relatively favorable, although there is little support from political parties and religious organizations. The program received good marks for using available funding appropriately but low scores for the amount of funding available for prevention, care and mitigation. Care Programs received the lowest score of all the components. Respondents felt more needed to be done to provide adequate care to people living with HIV/AIDS. This was reflected in the service availability score for care, which was only 30 percent. The Philippines was the only country where the respondents felt that program effort had not improved from 1997 to 1999.

Romania

Romania had the second lowest total score. It received very low scores on the components relating to the policy environment: political support, policy formulation, organizational structure and program resources. Political support was deemed to be low across the board and particularly low for political parties, religious organizations and the private sector. Some of this may simply be a reflection of the fact that HIV prevalence is quite low in Romania. Program resources were also judged to be inadequate in all aspects except the professional capabilities of the program staff. The program in Romania received much higher scores for the other components, particularly research and evaluation (the highest of all six countries), legal and regulatory environment and care. The total score did increase from 1997 to 1999, but only from 49 to 51.

Senegal

Senegal received the highest total score and the highest scores in eight of the ten components. It was second highest in research and evaluation (after Zambia) and third highest in legal and regulatory environment. The items judged most in need of improvement by the respondents included support from political parties, funding for care, involvement of the private sector in prevention and care and addressing inheritance laws that discriminate against women. Senegal scored particularly high in establishing a supportive policy environment. The total score improved slightly, from 71 to 72, between from 1997 to 1999. Senegal scored less well in service availability. It received the lowest service availability scores for availability of condoms, STD prevention and treatment, voluntary counseling and testing, care and community support. According to respondents, Senegal has done extremely well in establishing an enabling policy environment but lags in providing access to prevention and care services to the majority of the population.

Zambia

Zambia has the worst epidemic of all the countries studied here, according to HIV prevalence. Its response to the epidemic received the second highest total score, after Senegal. According to the respondents, it has a relatively good policy environment and a very good legal and regulatory structure and human rights situation. Prevention programs also compare well with other countries. Zambia scores less well on care programs and resources. It received low scores on most resource items and for the availability of drugs for palliative care and to treat opportunistic infections. Its program effort has increased marginally, from 58 to 60, during the last two years. Zambia received some of the best scores for availability of condoms, STD treatment and IE&C, but low scores for voluntary counseling and testing and care. The low score for care is probably related to the large number of people needing care in Zambia.

Calculation of Total Scores

The total API is calculated by averaging the scores for the individual components. This procedure implicitly assigns equal weights to each component. We considered the possibility that the components should have different weights in the determination of the final score. To test this idea, the respondents in the field test were asked to indicate the importance of each of the components to an effective HIV/AIDS program. Components were scored on a scale of 1 to 10. The results for all countries combined are shown in Figure 9.

Figure 9. Importance by Component
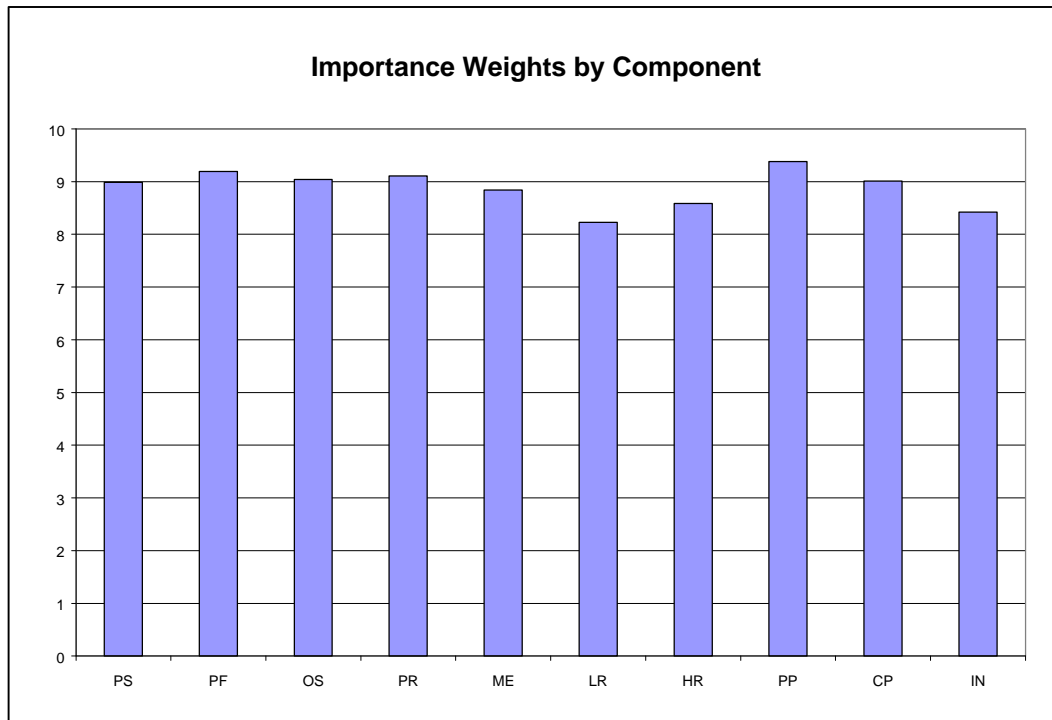
Importance Weights by Component

Key: PS-political support, PF-policy formulation, OS-organizational structure, PR-program resources, ME-measurement and evaluation, LR-legal and regulatory environment, HR-human rights, PP-prevention programs, CP-care programs, IN-international support.

The component weights vary from a low of 8.2 for Legal and Regulatory to a high of 9.4 for Prevention Programs. An analysis of variance shows that the component weights do differ significantly from each other. However, if the component weights are used to re-calculate the total scores, the differences are small. Table 6 shows the unweighted and weighted scores and the percent difference due to weighting. Only in Romania is the difference very large. This is due to a much wider variation in the component scores than in the other countries.

Table 6. Unweighted and Weighted Total Scores

Country	Unweighted Score	Weighted Score	Percent Difference
Cambodia	57.1	56.9	0.4%
Mexico	48.5	48.4	0.3%
Philippines	57.0	57.7	0.4%
Romania	51.5	54.3	-5.4%
Senegal	71.7	71.7	0.1%
Zambia	60.8	60.5	0.4%

In general, the differences between the weighted and unweighted scores are quite small. The use of weighted scores is not worth the extra effort to collect the importance estimates and explain the weighting system.

Adjusting for Expertise

The API methodology assumes that all respondents are equally knowledgeable. Many reviewers have questioned whether this is a reasonable assumption. While it is unlikely that all respondents are equally knowledgeable, it may not be easy to find a methodology to account for differences in expertise. The existing questionnaire contains a crude form of discounting by allowing respondent to leave blank any item that they do not feel qualified to answer. As shown in Figure 10, only about 8 percent of all items were left blank. Undoubtedly some respondents felt compelled to answer all items, while other were more thoughtful about what they did and did not know.

Figure 10. Percent of All Items Left Blank by Respondents
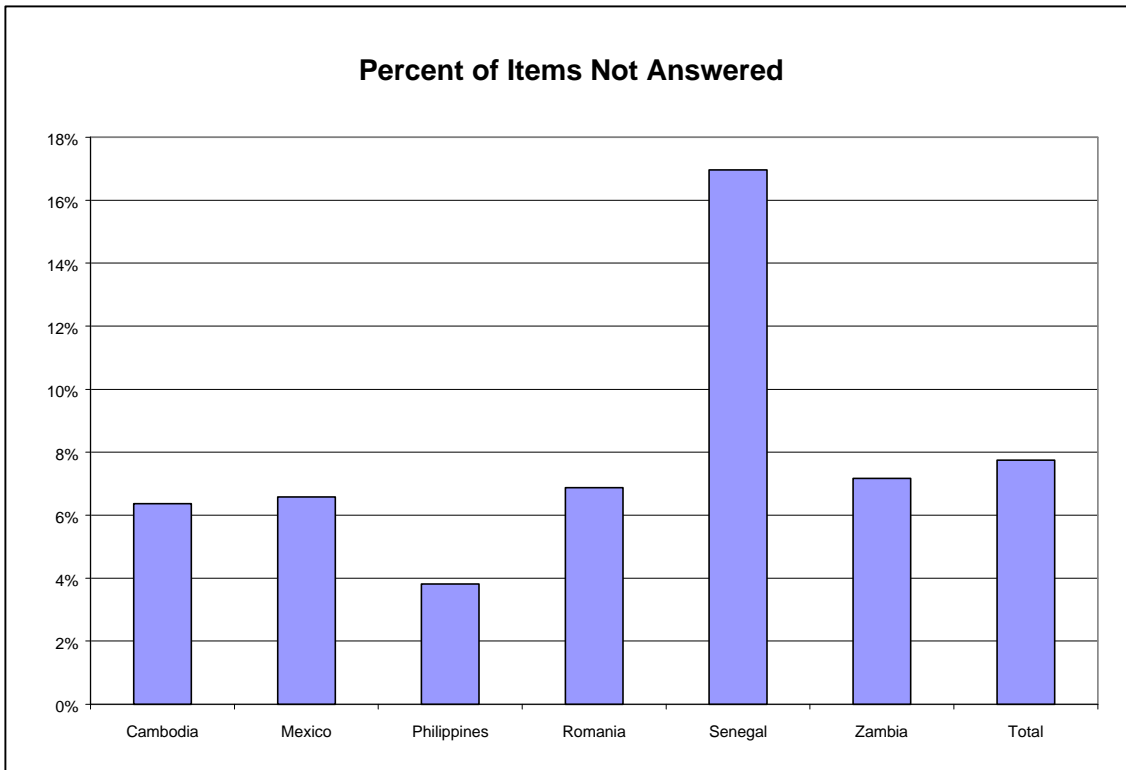
Eight percent seems a rather low figure. It seems likely that most respondents felt that they should do their best to answer all items. It would probably be useful in a revised questionnaire to give more emphasis to the possibility of not answering items where the respondent lacks expertise. It has been suggested that respondents should be asked to consider each component carefully and only answer items in those components for which they have good knowledge.

Another approach would be to weight respondents by their level of expertise. However, this requires an independent assessment of expertise. Of course, respondents can be asked to evaluate their own expertise, but there is little experimental evidence that this approach is useful.

Another approach would be to assume that expertise can be determined by the position of the respondent. For example, respondents who work in the AIDS Control Program may be assumed to be more knowledgeable about most items than those that work in universities or the private sector. Figure 11 shows the total scores by respondent type for the four countries where respondent position was available (Mexico, Philippines, Senegal and Zambia). There is some difference in scores by respondent type. A one-way ANOVA produces a significant F-statistic indicating that the differences among the groups are significant.

Figure 11. Total Scores by Type of Respondent

Total Score by Respondent Type
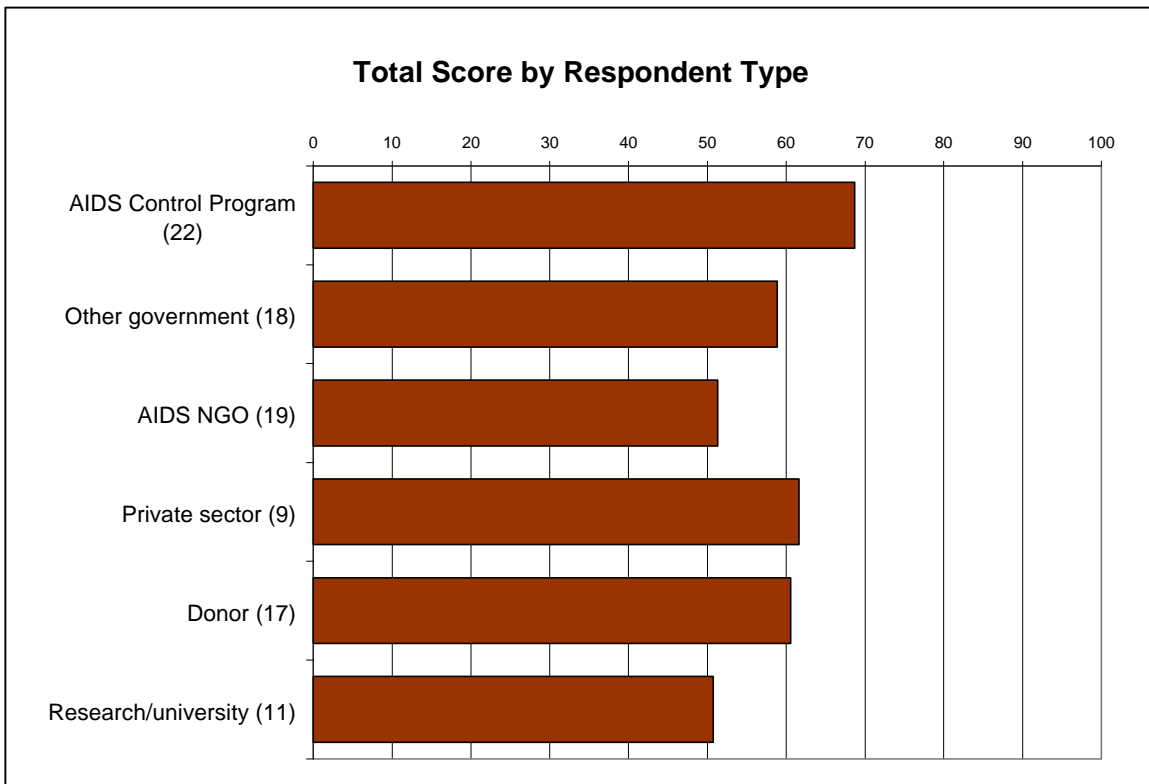
To test whether respondent weighting would produce significantly different scores, we conducted an illustrative calculation using the respondent weights shown in Table 7.

Table 7. Illustrative Respondent Weights

Respondent Type	Weight
AIDS Control Program	1.0
Other government	0.5
AIDS NGO	0.8
Private sector	0.2
Donor	1.0
Research/university	0.7
Other	0.5

These weights produce the revised scores shown in Table 8.

Table 8. Unweighted and Weighted Total Scores

Country	Unweighted Score	Weighted Score	Difference
Mexico	47.2	48.1	-1.9%
Philippines	57.0	56.9	0.2%
Senegal	71.8	73.3	-2.1%
Zambia	60.7	60.4	0.4%

The largest difference is only 2.1 percent in Senegal. The reason for the small difference is that the highest scores are provided by the highest weighted group (respondents from AIDS Control Programs), the lowest scores are from respondents with AIDS NGOs, who are also assumed to have good knowledge of the program. Given such a small difference, there seems little value in adjusting the scores by some measure of expertise. Another argument against weighting is that the respondents with the best knowledge of the program, such as members of the National AIDS Control Program, may be biased to give high scores, while those will less knowledge may be biased to provide lower scores if they assume that anything they do not know about is not being done. All in all, there seems to be little value or basis for weighting responses.

Scoring System

The questionnaire used in the field test asked respondents to use a 0 to 10 scale to score each item. Other similar instruments have used difference scales, such as 1-4, 1-5 and 0-4 and 0-5. The larger scale used here provides for greater differentiation. However, if the scale is too large it can lead to random differences if, for example, respondents cannot distinguish between 7 and 8. We decided to use a large scale for this field test and then examine the results to see if it was necessary.

Figure 12 shows the distribution of responses by score for all items and all respondents. The sawtooth pattern of the distribution shows that all eleven possible responses on the 0-10 scale are not needed. Response categories 1, 4, 6, and 9 are clearly less frequently used than the others. Categories 2 and 8 are also chosen less than the others. This suggests that a six point scale, 0-5, would be appropriate.

Figure 12. Distribution of Responses by Score across All Items and Respondents

Distribution of Item Scores
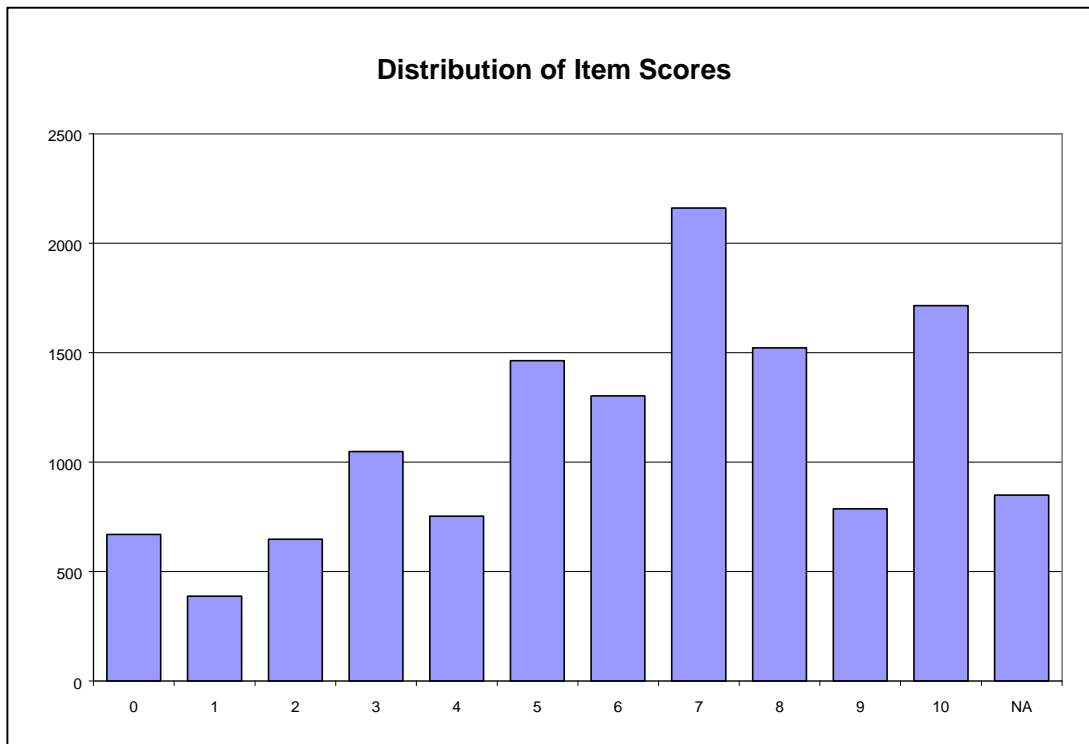
Clarity of Questionnaire

The field test results can indicate whether certain items were not clearly understood by respondents. Items that are poorly worded will be interpreted differently by respondents and increase the variation in the scores without contributing to the analysis of program effort. There are three ways in which confusing items might be identified: comments from respondents, items left blank and items with high variance within countries.

Respondents did mention a few items that seemed confusing. The most common comment was that items stated in the negative were hard to understand. The items in the questionnaire are all constructed such that a high score is better. Thus, for the item "Condom advertising is allowed" a high score is better. For some items, particularly in the human rights component, this approach requires wording most items in the negative, such as "There is no discrimination in access to health services". Several respondents mentioned that these items were confusing. All of these respondents were in Mexico, so it may be that the translation to Spanish caused some of the concern. However, it is also true that the Mexican respondents commented much more frequently on the construction of the questionnaire than did respondents from other countries.

Respondents were encouraged to leave items blank if they did not know enough about an item to answer. Respondents may have also left items blank if they did not understand the item. In the field test, the service availability items were most likely to be left blank. On average, these items were left blank by one-quarter of the respondents. Most likely, these respondents did not have trouble understanding the question, but did not feel comfortable estimating what percentage of the population had access to these services.

Table 9 shows the other items that were left blank 15 percent or more of the time. Most of these items are simple and clear. It seems more likely that these items were left blank because respondents did not know enough to answer, rather than that they were confused by the meaning of the item.

Table 9. Items Most Often Left Blank

Item	Percent of Responses Left Blank
HR 7.10 There is no discrimination in access to insurance.	24%
LR 6.7 Inheritance laws that discriminate against women have been addressed.	23%
PP 8.13 Needle exchange programs.	19%
HR 7.11 There is no discrimination in access to housing.	18%
PP 8.10 Family life education for youth.	18%
PR 4.3 Current funding can be used flexibly to support effective new programs.	17%
LR 6.3 There are no restrictions on the importation of STD drugs.	16%
LR 6.5 NGO registration procedures are clear, straightforward and fair.	16%
PR 4.2 Resource allocation decisions are based on considerations of the cost-effectiveness of interventions.	15%
HR 7.7 There is no discrimination in the application of criminal and civil law.	15%

If some items were confusing, those items should have higher variations in responses than those that were not confusing. Of course, greater variation could also result when items are difficult to answer, even though the wording may be clear. Table 10 shows the items with the highest variation. The variance scores are the standard deviations for all respondents within a country, averaged across all countries.

Table 10. Items with Highest Standard Deviation of Responses

Item	Standard Deviation
PP8.10 There is family life education for youth.	3.6
HR7.10 There is no discrimination in access to insurance.	3.0
HR7.1 Anti-discrimination laws and regulations exist.	2.9
PP8.11 There are programs to prevent mother-to-child transmission.	2.8
LR6.7 Inheritance laws that discriminate against women have been addressed.	2.8
HR7.11 There is no discrimination in access to housing.	2.8
LR6.6 Rape, sexual abuse and domestic violence are perceived as serious offenses and are adequately prosecuted.	2.8
HR7.5 There is no officially condoned harassment of high risk groups (CSW, MSM, IVDU).	2.8
PP8.13 There are needle exchange programs.	2.8
HR7.3 Confidentiality of HIV-status test results is protected in law and regulations.	2.7
HR7.6 There is no mandatory reporting of HIV test results.	2.7
HR7.12 There are no restrictions on movement (mandatory declaration, testing, exclusion) on the grounds of HIV status.	2.7
HR7.8 There is no discrimination in access to health services.	2.7
ER5.3 Mechanisms and structures for monitoring and evaluation, such as a formal evaluation unit, exist within the program.	2.7
PR4.9 The program is organized to enhance long-term sustainability.	2.6
PR4.11 International organizations have provided a significant portion of funding for care programs.	2.6
PP8.1 Universal blood screening.	2.6
PS1.3 The main political parties support effective policies and programs.	2.6
HR7.9 There is no discrimination in access to social welfare benefits and programs.	2.6
HR7.2 There are no mandatory testing requirements for employment, marriage, travel or access to health care.	2.6

For most of these items the wording is clear and straightforward. Therefore, the variation is likely due to the difficulty of answering the question rather than poor wording. Several of these items are from the Human Rights component where most items are stated in the negative. The comments from several Mexican respondents indicated that these items may be difficult to interpret.

The application in Cambodia included a small set of separate questions to respondents about the survey itself. One question asked respondents "How easy is the questionnaire to

understand?" The responses are shown in Table 11. Most respondents found the items easy to understand.

Table 11. Responses from Cambodian Participants to the Question "How easy is the questionnaire to understand?"

Response	Number of Responses
No answer	2
Very easy	0
Easy	25
Difficult	6
Very difficult	0

Length of Questionnaire

The version of the questionnaire that was tested contains 90 items in the main components, 19 service availability questions and 10 questions on component importance. The 90 items in the main components are answered for two time periods. Thus, the total number of judgments required is 209. Several respondents commented that the questionnaire was too long. This question was asked directly of the Cambodian respondents. The results are shown in Table 12.

Table 12. Responses from Cambodian Participants to the Question "What do you think of the length of the questionnaire?"

Response	Number Of Responses
No answer	2
Fine	12
A bit too long	17
Too long	2

There are several ways in which items might be identified for deletion. One approach is to find those items that have the lowest correlation to the total component score. Removing these items would cause the smallest change in the component and overall scores. These items are shown in Table 13. This approach has the advantage of causing the smallest change in the scores while still reducing the size of the questionnaire.

Table 13. Items with the Lowest Correlation to the Component Score

Item	Correlation to Component Score
PP8.6 A social marketing program for condoms exists.	0.46
PP8.13 Needle exchange programs exist.	0.46
HR7.3 Confidentiality of HIV-status test results is protected by law and regulations.	0.52
CP9.6 International research has contributed significantly to the design of care programs.	0.53
LR6.7 Inheritance laws that discriminate against women have been addressed.	0.53
PP8.7 National treatment guidelines for STDs exist.	0.53
HR7.6 There is no mandatory reporting of HIV test results.	0.56
OS3.1 The AIDS Control Program is placed high in the government structure.	0.57
PP8.1 Universal blood screening exists.	0.57
HR7.1 Anti-discrimination laws and regulations exist.	0.58
PP8.15 People living with HIV/AIDS are formally included in the program.	0.59
LR6.6 Rape, sexual abuse and domestic violence are perceived as serious offenses and adequately prosecuted.	0.60
LR6.3 There are no restrictions on the importation of STD drugs.	0.61
PP8.14 There are training programs for those engage in prevention and care activities.	0.62
HR7.5 There is no officially condoned harassment of high risk groups (CSW, MSM, IVDU).	0.62
PP8.8 There are special prevention programs for high-risk groups.	0.62
HR7.12 There are no restrictions on movement (mandatory declaration, testing, exclusion) on the grounds of HIV status.	0.63
LR6.1 Condom advertising is allowed.	0.63
PR4.8 The private sector plays a significant role in funding HIV/AIDS prevention and care programs.	0.63
HR7.2 There are no mandatory testing requirements for employment, marriage, travel or access to health care.	0.63

An alternative approach is to look at variation within countries and between countries. The "best" items would be those that have the smallest variation among respondents from the same country and the largest variation between countries. This is based on the assumption that items that help to distinguish countries are better than those that do not. Of course, some items may truly be the same across many countries. Omitting them from the questionnaire may bias the true score but will provide better discrimination between country scores.

To rank items according to this approach we calculated the standard deviation within countries and between countries for each item. We then calculated the ratio of the between to the within standard deviation. For this indicator, a high ratio is good, indicating good discrimination between countries and good agreement among respondents in the same country. The 20 items with the worst (lowest) ratios are shown in Table 14. The items relating to the impact of international assistance have been deleted from this list, since they would not be expected to vary considerably from one country to the next.

Table 14. Twenty Items with the Worst Ratios of Between to Within Variation

Item	Ratio
PS1.7 NGO leaders support effective policies and programs.	0.178
PP8.9 Confidential counseling and testing services are available.	0.262
PP8.2 Guidelines to reduce the risk of HIV transmission to health workers exist.	0.272
PS1.3 The main political parties support effective policies and programs.	0.288
LR6.3 There are no restrictions on the importation of STD drugs.	0.295
PP8.10 There are programs for family life education for youth.	0.296
PP8.14 There are training programs for those engaged in prevention and care activities.	0.308
PR4.4 There are technically competent professional staffing the program.	0.309
PP8.7 There are national treatment guidelines for STDs.	0.315
LR6.5 NGO registration procedures are clear, straightforward and fair.	0.316
LR6.8 There are no restrictions on who may receive STD services.	0.329
PP8.11 There are programs to prevent mother-to-child transmission.	0.346
LR6.6 Rape, sexual assault and domestic violence are perceived as serious and are adequately prosecuted.	0.350
PF2.6 Policy dialogue and formulation involves NGOs, community leaders and representatives of the private sector, women's groups and special interest groups.	0.350
HR7.12 There are no restrictions on the movement (mandatory declaration, testing, exclusion) on the grounds of HIV status.	0.358
PP8.13 There are needle exchange programs.	0.364
PR4.9 The program is organized to enhance long-term sustainability.	0.365
PF2.2 Formal program goals exist.	0.376
PP8.5 There is a functioning logistics system for condoms.	0.386
PS1.8 Professional associations (e.g., medical, legal) support effective policies and programs.	0.389

The comparison of between to within variation captures some of the aspects of the other methods used here to compare items (number of non-responses, variance within countries). A combination of this approach and the examination of correlation between items and total component scores is probably the best avenue to identify items that should be modified or dropped from the revised questionnaire.

Number of Respondents

The recommendation to each country was to include 20-25 respondents distributed among various categories, such as AIDS Control Program, other government, private sector, AIDS NGOs, donors, researchers, representatives of civil society and other knowledgeable individuals. The actual applications included between 18 and 34 respondents per country. A large number of respondents provides for greater diversity but requires more time and effort.

Would a smaller number of respondents provide similar results? The answer to this question depends on how "results" are defined. Since the total scores are averages of all respondents, a smaller number of respondents would not affect the total score if the respondents were randomly selected from the larger pool. A smaller number would increase the uncertainty surrounding the estimates, however. This could reduce the power of the indicator to detect significant differences between countries. For the six countries in the field test, an analysis of variance to detect significant differences in the total scores produces an F statistics of 1789, much higher than the critical level to determine significance of only 3.8. Using only have the respondents would not necessarily change the average scores, but by reducing the sample size would reduce the F statistic by about half. In this case, the F statistic is still quite large and the conclusion about significant differences would not change. However, in the case of other comparisons, such as the significance of change from the previous to the current period, the smaller sample size could reduce the ability to detect significant differences.

A more important consideration is the ability of the sample to represent all points of view. In the field test, we found significant differences in the responses from people from different backgrounds (e.g., the AIDS Control Program, AIDS NGOs, donors). If respondents are divided into at least six groups (AIDS Control Program, other government, AIDS NGOs, donors, researchers, other) and we want at least four people from each group, then the number of respondents should be at least 24. This is the most powerful argument for keeping the number of respondents in the range of 20-30.

Conclusions

Overall, the API instrument seems to work reasonably well.

- It detected significant differences between countries in both total scores and component scores.
- The component scores contained substantial variation for most countries. The lowest score for any component was near 30 while the highest score was almost 80. This 50-point gap is encouraging since it indicates that the API can reflect rather wide ranges in program effort. It also indicates that respondents were not judging all items on the basis of a perceived level of effort for the entire country.
- The score did detect change in effort during a two-year period for some countries and not for others.
- The questionnaire was generally well received by respondents.

One negative finding is that the API scores do not seem work well in cross national comparisons. Some respondents, particularly those in Mexico, seem to have used stricter standards to judge their program than other respondents. This indicates that the scoring system will need to be more precise to enhance cross country comparability or the score will not be useful for comparisons across countries.

The detailed analysis leads to a number of conclusions.

1. The total score can be calculated simply as the average of the component scores. There seems little advantage in trying to differentially weight the contributions of the components to the total score.

2. The items referring to needle exchange programs need to be elaborated to explain that these refer to programs for injecting drug users.

3. The item on MTCT should be elaborated to make it clear that it refers to testing, treatment and breastfeeding substitutes, not just the provision of information to pregnant women.

4. The component on prevention programs and the questions on service availability are somewhat redundant. We recommend dropping the service availability section and revising the description of the prevention component to indicate that the score should combine the existence of a program, the quality of the program and the population coverage. This section should also make it clear that various programs provide services to different target populations.

5. The introductions to each section should be improved with the additional of more examples of the meaning of the possible scores. This would improve the cross country comparability of the score.

6. The questionnaire should give more emphasis to the possibility of not answering items where the respondent lacks expertise. Respondents should be asked to consider each component carefully and only answer items in those components for which they have good knowledge.

7. There seems to be no value in attempting to adjust the scores by some measure of expertise.

8. The scale should be reduced from the eleven point scale (0-11) used in the test questionnaire to a six point scale, 0-5.

9. The length of the questionnaire should be reduced by dropping items that had the worst ratio of between to within variance and those with the lowest correlation to the total component score. Table 15 lists the items that should be dropped.

Table 15. Items to be Dropped to Reduce the Length of the Questionnaire

Component	Items
Political support	3. The main political parties support effective policies and programs. 7. NGO leaders support effective policies and programs. 8. Professional associations support effective policies and programs.
Organizational structure	4. NGOs are formally included in the AIDS Control Program.
Program resources	4. There are technically competent professionals staffing the program. 9. The program is organized to enhance long-term sustainability.
Legal and regulatory	3. There are no restrictions on the importation of STD drugs. 5. NGO registration procedures are clear, straightforward and fair. 6. Rape, sexual abuse and domestic violence are perceived as serious offenses and offenders are adequately prosecuted. 7. Inheritance laws that discriminate against women have been addressed.
Human rights	Combine items 3 and 6 into one item. 1. Anti-discrimination laws and regulations exist. 5. There is no officially condoned harassment of high risk groups (CSW, MSM, IVDU). 10.There is no discrimination in access to insurance. 11. There is no discrimination in access to housing. 12. There are no restrictions (mandatory declaration, testing, exclusion) on grounds of HIV status.
Prevention programs	1. Universal blood screening. 7. National treatment guidelines for STDs.

14. Training programs for those engaged in prevention and care activities.

With the modifications suggested above, the API should be a useful indicator that will contribute to our understanding of HIV/AIDS program effort. The application of this instrument went relatively smoothly in the six field test countries. It should be possible to apply it to most countries with AIDS programs to obtain a useful profile of effort in each country and across countries.

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Appendix A. Draft Questionnaire

AIDS PROGRAM EFFORT INDEX
(API)

This instrument is designed to measure the amount of effective effort put into national HIV/AIDS programs by domestic organizations and individuals and by international organizations. The API is comprised of ten categories to assess the program effort: political support; policy formulation; organizational structure; program resources; evaluation, monitoring and research; legal and regulatory environment; human rights; prevention programs; care programs; and service availability.

The API is meant to assess the current environment as well as changes over a period of two years. Many of the items will change little over a two-year period; nevertheless, this allows the same features of program effort to be systematically assessed at regular intervals. The respondent should fill in responses to both the "1999" and "1997" columns each time the questionnaire is administered.

A scale of 0 to 10 should be assigned to each item. In every case, a score of 10 indicates a better or more satisfactory rating. Some items may seem to require just a yes or no response, such as the existence of a program or regulation, but the 0-10 scale can be used to indicate degree. For example a score of 3 might indicate that a program exists but is poorly implemented while a score of 7 might indicate that it is well implemented. Similarly, a score of 3 might mean that a regulation exists but is rarely enforced while a 7 might indicate that it is usually enforced. Enter a "DK" in a cell when you have little or no information about it, rather than leaving it blank or using a zero.

AIDS PROGRAM EFFORT INDEX (API)

COUNTRY:

RESPONDENT NAME:

POSITION:

DATE:

GENERAL COMMENTS:

AIDS Program Effort Index (API)

I. POLITICAL SUPPORT
Please indicate the level of support that is provided by the following groups for an effective HIV/AIDS/STD policy and program. Use a scale from 0 to 10 where 0 indicates no support or active opposition and 10 indicates strong support. Numbers between 0 and 10 indicate degrees of support.

	1999	1997
1. High-level national government support exists for effective policies and programs.		
2. Public opinion supports effective programs and policies.		
3. The main political parties support effective policies and programs.		
4. Top government civil servants outside of the MOH recognize AIDS/STDs as a priority problem.		
5. Major religious organizations support effective policies and programs.		
6. Private sector leaders support effective policies and programs.		
7. NGO leaders support effective policies and programs.		
8. Professional associations (e.g., medical, legal) support effective policies and programs.		
9. There are local activities to build support for effective AIDS programs aimed at high-level political and community leaders.		
10. There is awareness among policy makers that improving women's social and economic status is important to AIDS prevention.		
11. International organizations have made a significant contribution to strengthening the political commitment of top leaders.		

II. POLICY FORMULATION

Please read the following statements and indicate the degree to which each statement is true or false. Use a scale of from 0 to 10 where 0 indicates "false", 10 indicates "completely true" and the numbers between indicate degrees. (For example, a score of 2 on item 1 would indicate that a national policy does exist but has little effect, while a score of 7 would indicate that a good policy does exist but it ignores some key elements.)

	1999	1997
1. A favorable national policy exists.		
2. Formal program goals exist.		
3. Specific and realistic strategies to meet program goals exist.		
4. A national coordinating body exists and functions effectively.		
5. Ministries other than Health are involved in policy formulation.		
6. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector, women's groups and special interest groups.		
7. International organizations have facilitated policy formulation through the provision of technical assistance and guidelines.		
8. International organizations have facilitated planning through the provision of technical assistance and guidelines.		

III. ORGANIZATIONAL STRUCTURE

Please read the following statements and indicate the degree to which each statement is true or false. Use a scale of from 0 to 10 where 0 indicates "false", 10 indicates "completely true" and the numbers between indicate degrees. (For example, a score of 3 on item 1 would indicate that an AIDS Control Program exists but is only a Unit within a Department with the Ministry, while a score of 7 would indicate that the program is two layers below the Ministerial level.)

	1999	1997
1. The AIDS Control Program is placed high in the government structure.		
2. The ACP Director is full-time and reports to an influential superior officer.		
3. A multi-sectoral approach has been implemented and functions well.		
4. NGOs are formally included in the AIDS Control Program.		
5. The private sector is formally included in the AIDS Control Program.		
6. Effort are made to enhance community participation.		
7. There is good coordination between activities of the national government, local government, NGOs, private sector and international donors.		

IV. PROGRAM RESOURCES

Please read the following statements and indicate the degree to which each statement is true or false. Use a scale of from 0 to 10 where 0 indicates "false", 10 indicates "completely true" and the numbers between indicate degrees. (For example, a score of 3 on item 4 would indicate that funding is available but does not cover all essential programs while a score of 7 would indicate that most important programs are funded but a few are not.)

	1999	1997
1. Resources are allocated according to priority guidelines.		
2. Resource allocation decisions are based on considerations of the cost-effectiveness of interventions.		
3. Current funding can be used flexibly in order to support effective new programs.		
4. There are technically competent professionals staffing the program.		
5. Adequate funding is available for public prevention programs.		
6. Adequate funding is available for care of people living with HIV/AIDS.		
7. Adequate funding is available for programs to mitigate the impacts of AIDS.		
8. The private sector plays a significant role in funding HIV/AIDS prevention and care programs.		
9. The program is organized to enhance long-term sustainability.		
10. International organizations have provided a significant portion of funding for prevention programs.		
11. International organizations have provided a significant portion of funding for care programs.		

V. EVALUATION, MONITORING AND RESEARCH

Please read the following statements and indicate the degree to which each statement is true or false. Use a scale of from 0 to 10 where 0 indicates "false", 10 indicates "completely true" and the numbers between indicate degrees. (For example, a score of 3 on item 1 would indicate that evaluation activities do exist but results are not used routinely while a score of 7 would indicate that evaluation and research are generally used in policy and planning.)

	1999	1997
1. Operational and financial plans are developed that correspond to objectives and targets.		
2. Evaluation and research results are actively employed in policy formulation and program planning.		
3. Mechanisms and structures for monitoring and evaluation, such as a formal evaluation unit, exit within the program.		
4. Special studies are undertaken as needed to improve the program.		
5. A sentinel surveillance system for HIV infection exists and functions regularly.		
6. A behavioral surveillance system exists and functions regularly.		

VI. LEGAL AND REGULATORY ENVIRONMENT

Please read the following statements and indicate the degree to which each statement is true or false. Use a scale of from 0 to 10 where 0 indicates "false", 10 indicates "completely true" and the numbers between indicate degrees. (For example, a score of 3 on item 1 would indicate that condom advertising is allowed under some circumstances while a score of 7 would indicate advertising is allowed with few restrictions.)

	1999	1997
1. Condom advertising is allowed.		
2. There are no restrictions on the importation of condoms.		
3. There are no restrictions on the importation of STD drugs.		
4. There are no restrictions on condom distribution.		
5. NGO registration procedures are clear, straightforward and fair.		
6. Rape, sexual abuse and domestic violence are perceived as serious offenses and offenders are adequately prosecuted.		
7. Inheritance laws that discriminate against women have been addressed.		
8. There are no restrictions on who may receive STD services.		
9. International conferences, documents and guidelines have made a major contribution to legal and regulatory reform		

VII. HUMAN RIGHTS
Please read the following statements and indicate the degree to which each statement is true or false. Use a scale of from 0 to 10 where 0 indicates "false", 10 indicates "completely true" and the numbers between indicate degrees. (For example, a score of 3 on item 1 would indicate that some anti-discrimination regulations exist but may not be enforced while a score of 7 would indicate that good regulations exist and are usually enforced.)

	1999	1997
1. Anti-discrimination laws and regulations exist.		
2. There are no mandatory testing requirements for employment, marriage, travel or access to health care.		
3. Confidentiality of HIV-status test results is protected in law and regulations.		
4. There is no arbitrary interference with liberty and security of person based on HIV-status, such as quarantine, detention in special colonies, incarceration.		
5. There is no officially condoned harassment of high-risk groups (CSW, MSM, IVDU).		
6. There is no mandatory reporting of HIV test results.		
7. There is no discrimination in the application of criminal and civil law.		
8. There is no discrimination in access to health services		
9. There is no discrimination in access to social welfare benefits and programs.		
10. There is no discrimination in access to insurance.		
11. There is no discrimination in access to housing.		
12. There are no restrictions on movement (mandatory declaration, testing, exclusion) on grounds of HIV-status.		
13. International conferences, documents and guidelines have made a major contribution to improving the human rights environment.		

VIII. PREVENTION PROGRAMS

Please read the following statements and indicate the degree to which the following programs are implemented. Use a scale of from 0 to 10 where 0 indicates the program does not exist, 10 indicates that is does exist and functions well, and the numbers between indicate degrees. (For example, a score of 3 on item 10 would indicate that there is a family life education curriculum but it is weak and teachers are not trained to use it while a score of 7 might indicate that good program exists but is not universally applied.)

	1999	1997
1. Universal blood screening.		
2. Guidelines to reduce the risk of HIV transmission to health workers.		
3. An active program to promote accurate HIV/AIDS reporting by the media.		
4. A functioning logistics system for drugs for the treatment of STDs and opportunistic infections.		
5. A functioning logistics system for condoms.		
6. A social marketing program for condoms,		
7. National treatment guidelines for STDs.		
8. Special prevention programs for high-risk groups.		
9. Confidential counseling and testing services.		
10. Family life education for youth.		
11. Programs to prevent mother-to-child transmission.		
12. National information, education and communications (IE&C) program.		
13. Needle exchange programs.		
14. Training programs for those engaged in prevention and care activities.		
15. People living with HIV/AIDS are formally included in the program.		
16. International programs have contributed significantly to the training of local staff working in prevention programs.		
17. International research has contributed significantly to the design of program interventions.		
18. International organizations have helped program design and implementation through technical assistance and guidelines.		

IX. CARE PROGRAMS

Please read the following statements and indicate the degree to which the following programs are implemented. Use a scale of from 0 to 10 where 0 indicates the program does not exist, 10 indicates that is does exist and functions well, and the numbers between indicate degrees. (For example, a score of 3 on item 1 would indicate that some drugs are available but not all the time while a score of 7 might indicate that most drugs are available most of the time.)

	1999	1997
1. Palliative drugs are readily available through the national health system.		
2. Drugs are available to treat the most common opportunistic infections.		
3. An active TB program exists that implements the WHO-recommended DOTS (directly observable therapy short-course).		
4. A continuum of care from hospital to outpatient to home care services is in place.		
5. International programs have contributed significantly to the training of local staff working in care programs.		
6. International research has significantly contributed to the design of care programs.		
7. International organizations have significantly helped program design and implementation through technical assistance and guidelines.		

X. SERVICE AVAILABILITY

Please read the following statements and indicate the degree to which the following are available. Use a scale of from 0 to 100 to indicate your best estimate of the percent of the population that has access to these services.

	MEN		WOMEN	
	99	97	99	97
1. What percent of adults have reasonably convenient access to the following services:				
a. Condoms				
b. STD treatment				
c. Voluntary counseling and testing				
d. IE&C programs on HIV prevention				
e. Screen blood for transfusions				
f. Needle exchange				
g. Quality medical care for HIV-related problems				
h. Family and personal support to cope with the effects of HIV				
2. What percent of youth have access to information about safe sexual practices.				
3. What percent of pregnant women have access to programs to prevent mother-to-child transmission of HIV?				

In the boxes below please indicate the importance of each of the following categories to an effective HIV/AIDS program:

Category	Importance (0-10) 0 = Not important 10 = Extremely important
Political support	
Formal policies and plans	
Organizational structure of the program	
Funding	
Evaluation and research	
Formal laws and regulations	
Protection of human rights and elimination of discrimination	
Programs that provide information and services to prevent the spread of HIV	
Programs to provide care and support for people living with HIV and AIDS	
Assistance from international organizations	

Appendix B. Detailed Results