PLANNING GUIDE FOR THE HEALTH SECTOR RESPONSE TO HIV
ACKNOWLEDGEMENTS

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<td>ABC</td>
<td>Activity-Based Costing Model</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARVs</td>
<td>Antiretroviral drugs</td>
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<td>ASAP</td>
<td>AIDS Strategy and Action Plans</td>
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<td>CCM</td>
<td>Country Coordinating Mechanisms</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<td>IDU</td>
<td>Injecting drug use</td>
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<tr>
<td>IHP+</td>
<td>The International Health Partnership and Related Initiatives</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MoH</td>
<td>Ministries of Health</td>
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<td>MTEF</td>
<td>Medium-Term Expenditure Framework</td>
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<td>MTR</td>
<td>Mid-term Reviews</td>
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<td>NHPS</td>
<td>National Health Policies, Strategies and Plans</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Fund for AIDS Relief</td>
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<td>PITC</td>
<td>Provider-Initiated Testing and Counselling</td>
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<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
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<tr>
<td>RNM</td>
<td>Resource Needs Model</td>
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<td>SWAps</td>
<td>Sector-Wide Approaches</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>UHM</td>
<td>Unified Health Model</td>
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ABOUT THE PLANNING GUIDE

This guide sets out basic principles, processes and steps relating to strategic and operational planning for the health sector response to HIV. It takes into account recent developments in understanding the response of the health sector to HIV and in significance of national health strategies. The guide should be complemented by other tools on specific aspects of HIV strategic and operational planning developed by WHO, UNAIDS, the World Bank and other technical partners.

The guide is divided into 11 chapters as follows:

Chapter 1: Background
Chapter 2: Health sector planning context
Chapter 3: Planning for results
Chapter 4: Preparing for planning
Chapter 5: Situation analysis
Chapter 6: Setting priorities
Chapter 7: Monitoring and evaluation
Chapter 8: Implementation, Systems and Management
Chapter 9: Costing and budgeting
Chapter 10: Finalizing a strategic plan
Chapter 11: Operational planning

The Guide is intended to be used by and for individuals and entities involved in planning and managing the response of the health sector to the HIV epidemic. It is primarily aimed at national level planning, but can also be used for other levels such as regional/province or district. The audience includes Ministries of Health, other government sectors, nongovernmental organizations, private sector, academic institutions and other civil society organizations. The Guide will also be of value to donors and international organizations which provide financial and technical support for HIV/AIDS programmes.
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Countries have been involved in planning for the response to HIV from the onset of the epidemic. There has recently been renewed attention to the need for countries to develop sound national strategies and plans that aim towards bringing about the greatest health benefits. Such plans should be based on evidence, focus on priority issues and be implementable. Sound national strategies and plans also facilitate better cohesion of national and international efforts in addition to informing sound investment decisions.

Ambitious global goals for responding to HIV and health have been defined in various international commitments such as the Millennium Development Goals\(^1\), Declaration of Commitment on HIV/AIDS, Universal Access Targets\(^2\), the UNAIDS\(^3\) Strategy 2011-2015 and the Global Health Sector Strategy for HIV 2011-2015\(^4\). These goals and targets are realized as they are translated into national policies, plans and action. Strategic and operational planning is a tool that for defining priorities, allocating resources and defining measures of progress in the response to HIV. It is therefore an important element to meeting the national and international HIV and health goals.

The health sector response to HIV is part of a wider global and national multi-sectoral response to HIV. In 2010 UNAIDS developed a new Division of Labour\(^5\) to consolidate ways in which the UN family works collectively to advance the agenda set out in the UNAIDS Strategy 2011-2015. One of the fifteen areas of the Division of Labour is to support strategic, prioritized and costed multisectoral national plans. The World Bank takes the lead in this area.

The World Bank hosts and manages the AIDS Strategy and Action Plans (ASAP)\(^6\) service. ASAP supports countries to elaborate multi-sectoral HIV strategies and action plans that are informed by evidence and are costed. ASAP mobilizes UNAIDS Cosponsors and builds on the synergy of collaboration throughout the planning process, including harmonization with the broader development plans and health strategies.

WHO, as a UNAIDS Cosponsor, supports the inclusion of HIV concerns in National Health Policies, Strategies and Plans (working with ASAP and other multi-partner processes such as the International Health Partnership and Related Initiatives (IHP+). WHO does this through technical cooperation, normative work and providing and tools for developing and costing of strategic and operational plans for the health sector response to HIV. WHO also works closely with other development programmes such as those of the Global Fund to Fight AIDS Tuberculosis and Malaria and the President’s Emergency Plan for AIDS Relief (PEPFAR) to strengthen and align AIDS planning efforts.

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1. UN Millennium Declaration, 2000 at http://www.un.org/millennium/declaration/ares552e.htm
A robust multi-sectoral response to HIV will result from a strengthened response of individual sectors all working in synergy towards common priorities. Strong sectoral responses result in a stronger multisectoral response. WHO will work to ensure that the health sector response to HIV, which is at the core of the multisectoral response, is strong, builds on synergies with other sectors and is well integrated into the health system and national health strategies. Figure 1.1 shows the health sector response to HIV relative to the national AIDS response.

Figure 1.1: National Framework for Health Sector Response to HIV

This planning guide addresses issues relating to strategic and operational planning for the health sector response to HIV. It outlines basic principles and steps in planning. It highlights some common tools for aspects of the planning process. The guide is principally aimed at national level planning. It can however, also be used for planning at subnational levels, where appropriate. The end product of the planning process described in the guide will vary depending on the national context. Ideally, it will be presented as a detailed description of the health sector component of multisectoral AIDS plan and the HIV component of the national health plan.
2. HEALTH SECTOR PLANNING CONTEXT

The health sector is at the core of the national response to HIV, in some cases accounting for as much as 60% of its cost. The health sector also plays an essential supportive role to other sectors, informing their actions, and when extending testing, diagnostic and treatment services to settings under their control.

The health sector encompasses organized public and private health services, ministries of health, nongovernmental organizations, community groups, professional associations, industries, research institutions, as well as other institutions that directly input into the health-care system. The health sector response to HIV takes place within the health system, should operate in synergy with other health programmes, and strengthen the health system.

Figure 2.1 below shows the main elements of a strong health system and how the HIV programme contributes to them.

To foster political commitment the HIV programme should liaise with the individuals and institutions which inform the decision made by the country leadership, provide evidence on the impact of HIV on health and on the health system, and provide guidance on cost-effective interventions to reverse the epidemic and mitigate its impact. In health system governance the HIV programme should support situation analysis to inform its own planning, and contribute to health sector situation analysis to inform national planning for health. It should align its planning with the national planning for health, and include all relevant stakeholders in doing so. The HIV programme should provide inputs to and source inputs from critical subsystems such as human resources, financing, information systems, infrastructure, technology and pharmaceutical products and systems to ensure that its goals can be reached.

The HIV programme should contribute to health service delivery by providing guidance on cost-effective interventions and by adapting service delivery models to ensure the cost effective delivery of its clinical and public health interventions. The HIV programme should promote that its interventions be part of a comprehensive, integrated, continuous and people centred service delivery package, and be delivered through close-to-client service delivery networks.

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Figure 2.1: Major Components of a Strong and Sustainable Health System

- **Health and health security**
  - Including MDGs 4, 5 and 6

- **Health equity**
  - Including MDGs 4, 5 and 6

- **Social inclusion and participation**
  - Including MDG 3

- **Trust in health authorities**
  - Fairness
  - Protections
  - Competence
  - Accountability

- **Outcomes**
  - Comprehensive, integrated, continuous and people-centred
  - Cost-effective and safe interventions: clinical and public health
  - Universal access to close-to-client networks, responsible for a defined population

- **Service delivery**
  - Provide guidance on cost-effective interventions
  - Adapt service-delivery models

- **Critical subsystems**
  - Financing
  - Workforce
  - Information
  - Pharmaceuticals technology infrastructure
  - Including MDG 8
  - Provide balanced inputs to support health systems

- **Governance**
  - Policy dialogue
  - Policy directions
  - Strategic plans
  - Regulations and management
  - Assist situation analysis
  - Align programme plans with national health plan
  - Include stakeholders

- **Country leadership**
  - Health, equity, solidarity, social justice valued
  - Individual and institutional capacities

- **Political commitment**
  - Ownership
  - Alignment
  - Harmonization
  - Accountability

- **Effective aid**
  - Provide guidance on cost-effective interventions

Source: WHO 2010
2.1. Global Health Sector Strategy on HIV


The two overarching goals of the strategy are:

- to achieve universal access to comprehensive HIV prevention, treatment and care
- to contribute to achieving Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) and other health-related Goals (3, 4, 5 and 8) and associated targets.

The Strategy proposes four strategic directions to achieving the above goals. The strategic directions are as follows:

The strategy outlines four strategic objectives for health sector action to achieve the above goals.

- **Strategic direction 1: Optimize HIV prevention, diagnosis, treatment and care outcomes.** Integrate and improve the quality, effectiveness and coverage of HIV-specific interventions and approaches, and identify new HIV interventions as evidence emerges.
- **Strategic direction 2: Leverage broader health outcomes through HIV responses.** Strengthen linkages and synergies between HIV and other related health programmes, notably for sexual and reproductive health, maternal, newborn and child health, tuberculosis, drug dependence and harm reduction, emergency and surgical care and nutrition.
- **Strategic direction 3: Build strong and sustainable systems.** Build effective, efficient and comprehensive health systems in which HIV and other essential services are available, accessible, affordable and sustainable.
- **Strategic direction 4: Reduce vulnerability and remove structural barriers to accessing services.** The health sector must reduce risk and vulnerability by removing structural barriers to achieving equitable access to HIV services and protecting and promoting the human rights of key populations.

These four strategic directions guide and align global, national and WHO responses towards achieving the goals outlined above. The strategic directions become progressively less HIV-specific but contribute increasingly to the achievement of a sustainable response and health equity (see Figure 2.2).

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2.2. National Health Policies, Strategies and Plans (NHPS)

Most countries have used National Health Policies, Strategies and Plans for decades to give direction and coherence to their efforts to improve health. The process for building comprehensive national health policies, strategies and plans is as much a political as a technical one. WHO has a long track record of supporting countries to develop and utilize National Health Strategies and Plans. This has mostly been done through technical cooperation, facilitating national policy dialogue, promoting inter-country exchange, high level international policy frameworks and through normative work. A wide range of other agencies – domestic as well as external – are also involved in this endeavour.

However, there is often a disconnect between planning for disease-specific programmes, such as HIV, and the national health policies, strategies and plans. This leads to fragmentation and increased transaction costs in implementation of health programmes. The causes of this disconnect include:
(i) inadequate situation analysis of and priority setting in programme and system issues; (ii) the disconnect between the operational planning by the various programmes and the policy dialogue on national health policies, strategies and plans: they are often conducted by different constituencies with different planning cycles; (iii) donor practice to earmark funds, and demand reporting for their - and theirs only - contributions; iv) competition for available scarce resources, and; v) imbalances in national priority setting.

Coherence requires that each programme’s concerns are reflected in the comprehensive national health policy, strategy and plan, while programme plans should be informed by realistic assessments of how they can draw on and contribute to shared resources and capacities.

2.3. Harmonization and alignment
The Paris Declaration on Aid Effectiveness of 2005\textsuperscript{10} provides a set of principles to guide the international community in reforming the way aid is delivered and managed with the aim of increasing aid effectiveness and accelerating progress towards the Millennium Development Goals (MDGs). The five main principles of the Paris Declaration are as follows:

**National ownership:** Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions.

**Alignment:** Donors base their overall support on partner countries’ national development strategies, institutions and procedures.

**Harmonization:** Donors’ actions are more harmonized, transparent and collectively effective.

**Managing for Results:** Managing resources and improving decision-making for results.

**Mutual Accountability:** Donors and partners are accountable for development results.

Various efforts have been made by developing countries, bilateral agencies, multilateral agencies and nongovernmental organizations working individually or collectively, to implement the principles of the Paris Declaration. Some approaches to applying these principles include the following:
2.3.1 *The Three Ones*

An approach developed by UNAIDS to improve coordination and harmonization of national and international HIV efforts is the “Three Ones”. This requires all concerned actors align their programmes to one national strategic framework, one coordinating authority and one monitoring and evaluation system.

- **One agreed national AIDS action framework**: This provides the basis for coordinating the work of all partners working on HIV. The framework should be evidence-based and should translate to annual priority action plans and budgets.

- **One national AIDS coordinating authority**: This has a broad-based multisectoral mandate. In many countries coordination is undertaken through the National AIDS Council or Commission. In some countries it is through the Ministry of Health.

- **One agreed country level monitoring and evaluation (M&E) system**: This requires all stakeholders and partners to use one reporting system. Countries are now developing an M&E framework alongside the national AIDS strategic framework.

2.3.2 *International Health Partnership (IHP+)*

The International Health Partnership and related initiatives (IHP+) seeks to achieve better health results by mobilizing donor countries and other development partners around a single country-led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Launched in September 2007, the IHP+ aims to better harmonize donor funding commitments, and improve the way international agencies, donors and developing countries work together to develop and implement national health plans.

IHP+ facilitates better coordination and increased financing for health based on country-led processes for improved results by rallying partners to support and take forward one costed, validated, results-oriented national health plan through the signing of country compacts. At the centre of any compact is the national effort to plan strategically for health. This must be led and owned in country, and uses existing coordination and in-country management mechanisms.

The plan will be clear on how it intends to scale up coverage so as to achieve the national targets in the areas covered by the health MDG, and should involve all the major national and international stakeholders, including civil society.

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12 International Health Partnership http://www.internationalhealthpartnership.net/en/home
2.4. Joint Assessment of National Strategies (JANS)\textsuperscript{13}

Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy. There has recently been renewed interest Joint assessment of national strategies, or JANS. This has been due to an increasing number of international health actors willing to support a single national health strategy or plan. A joint assessment can help to strengthen national health strategies and increase partner confidence in those strategies, thereby securing more predictable and better aligned funding. It may also reduce transaction costs arising from multiple separate agency assessments.

The following are some principles which should guide joint assessment of national strategies:

- Country-demand driven and country led
- Build on existing in-country processes and experience
- Have a strong independent element in the assessment team
- Inclusive, involving civil society and other stakeholders in the health sector.

A Working Group of the International Health Partners (IHP+) defined attributes of sound national strategies. The Five groups of attributes in the JANS tool are as follows:

- Situation analysis, and coherence of strategies and plans with this analysis (‘programming’)
- Process through which national plans and strategies have been developed
- Financing projections and strategies; financial management and auditing
- Implementation and management arrangements
- Results, monitoring, review and dialogue mechanisms

2.5. National Strategy Applications

A number of donors, in particular the Global Fund to Fight AIDS Tuberculosis and Malaria, have moved to implement national strategy applications. This allows countries to apply for funding using a national disease or health sector strategy or plan which has been assessed as sufficiently robust. The plan is jointly assessed by a multi-stakeholder team using the same principles and attributes of JANS as described above. PEPFAR is also increasingly moving towards the national strategy or plan as the basis for developing its country programme and partnership compact. Other financing institutions such as the GAVI Alliance are moving towards national strategic applications for their areas of focus.

\textsuperscript{13} Joint Assessment of National Strategies (JANS) http://www.internationalhealthpartnership.net/en/about/j_1253621551
Planning should ensure that priorities are set, resources allocated and actions undertaken to bring about results to reduce HIV transmission, improve quality of life of people living with HIV and mitigate impact of HIV on society. National plans are not always oriented towards achieving results. There are a number of reasons for this:

(i) plans tend to be developed as a routine organizational requirement rather than specifically aiming at addressing the epidemic; (ii) plans are not based on evidence but rather are developed as continuation of what has been done before; (iii) plans focused more on what is to be done rather than what is to be achieved; and (iv) there is little coherence between policy and strategy on the one hand and operational details on the other.

3.1. Characteristics of Results Based Planning

Main characteristics of results based planning are as follows:

- Based on the best available evidence for situation analysis and effectiveness of interventions.
- Defines clear and measurable results to be achieved.
- Is adequately resourced to produce the defined priorities.
- Defines appropriate implementation arrangements.
- Provides a framework for accountability.

Planning that focuses on achieving results has a number of direct and indirect benefits, including the following:

- **Accelerates progress**: It is more likely to show good progress in the response to HIV at all levels and the country is more likely to meet its HIV, health and development objectives.
- **Improves efficiency**: Results based planning necessitates aligning resources activities and other inputs with results. This would entail reallocating resources and undertaking actions that directly contribute to producing results. This would in the long term lead to more efficient use of resources.
- **Promotes accountability and transparency**: Defining clear results for the programmes enables implementers and to be more accountable to themselves and to others. It also promotes transparency as there will be interest to know why a programme might not be meeting its goals.
- **Generates support**: If a programme can demonstrate that it is making progress towards achieving defined results it is more likely to win the support of the public, policy makers and donors. A results oriented plan is, therefore, an important tool for mobilizing resources. Even where a programme fails to achieve its goals, a plan that clearly describes what it wants to achieve is more likely to gain sympathy and support that one which does not.
3.2. Hierarchy of Results

A result is an end-state that follows development interventions in a cause-and-effect relationship. A result can be intended or unintended, positive or negative. The essence of results based planning is to deliberately working for change that will generate positive outcomes intended by the programme.

Results can be defined as outputs, outcomes and impact, depending on the level at which the change occurs. The results chain in the interrelations of levels of results. Figure 3.1 below shows how different levels of results are linked in a results chain. The elements at each level of the results chain must be necessary and sufficient to produce the required change at the next level. Equity must be a consideration at each step of the results chain in terms of ensuring that different groups of women and men and their specific needs, risks and vulnerabilities are addressed.

Figure 3.1: Results Chain

The results chain in the diagram shows the causal relationships between the levels of the chain, starting from the bottom and working upwards to achieve more and more significant results. Inputs and processes are the starting point of a development process. They constitute implementation to produce results. Examples of inputs include money, human resources, equipment, infrastructure and knowledge. Training and distribution and providing services are examples of processes.

Outputs refer to products and services which a programme delivers. Examples of outputs of the health sector response to HIV, also referred to as interventions, include services for HIV testing and counselling, prevention of mother-to-child transmission of HIV, antiretroviral treatment, harm reduction and male circumcision.
These services, when accessed and utilized, produce outcomes. Outcomes relate to changes in behaviour resulting from utilizing the services. Examples of outcomes include knowledge of HIV status, change of behaviour (such as regular use of condoms) and being treated.

Impact results from outcomes in addition to other contextual factors and other health programmes. Impact refers to change in health status. Examples of impact of HIV programmes include change in HIV related incidence, prevalence, morbidity and mortality and quality of life. Impact is often a result of a complex set of factors and combination of diverse efforts and not attributable to a single intervention or programme.

Figure 3.2: Relationship Between Results and Planning Elements.

<table>
<thead>
<tr>
<th>Level of change</th>
<th>Results</th>
<th>Planning elements</th>
<th>Examples</th>
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| Change at the level of health status and quality of life | Impact | Goal | - HIV prevalence in adult population reduced from 3.5% to 2%
- HIV related mortality among adults reduced by 50% |
| Change at the level of risk, behaviour and access | Outcomes | Objectives | - Increase condom uptake (utilization) among sex workers from 50% to 80%
- Proportion of male and female 15-49 year olds who know their HIV status is increased from 15% to 60%
- Proportion of most at risk populations accessing comprehensive services for HIV prevention, treatment and care increased from 50% to 80%
- Percentage of injecting drug users reached with comprehensive harm reduction programmes increased from 15% to 60%
- Increased HIV positive pregnant women receive services to prevent HIV transmission to their unborn and breastfeeding infants from 60% to 100%
- Access to ART for adults increased from 55% to 80%
| Change at the level of products and services provided | Outputs | Interventions | - Expand HIV and STI screening and treatment services for sex workers to additional 30 districts
- Increase proportion of PHC sites providing PMTCT services from 60% to 100%
- Proportion of districts with condom social marketing increased from 30% to 60%
- Sites providing T&C increased from 1600 to 3000 |

Figure 3.2 shows the relationship between level of results in a results chain and common planning elements. Results and planning elements are often used interchangeably. While results indicate what is to be achieved, planning elements denote how the results will be achieved.
3.3. Strategic Coherence

A results based plan will show strategic coherence in all its component parts. Various parts of the plan must compliment and build on each other to ensure that it delivers as one plan.

The situation analysis as a description of the prevailing context (or problem statement) should directly inform identification of programme priorities. Priorities that are not based on or consistent with the situation analysis are not likely to be the most appropriate for the programme. In turn, the indicators and data collection must be directly linked to the identified priorities. Service delivery models and implementation arrangements should be appropriate to delivering on the defined priorities. Likewise, costing of the programme should be linked to the identified priorities and capacities required to deliver and measure them. The situation analysis must include a description of the specific risks, vulnerabilities and needs of different groups of women and men and hence include indicators and data that capture the inequities experienced by these different groups.

Figure 3.3: Strategic Coherence in Planning

The operational plan must be designed to deliver the outputs of the strategic plan. To ensure coherence in the structure of a plan it is helpful to use a common codifier or numbering systems for all parts of the plan. For example, the code 1.1.1 could stand for intervention 1 of objective 1 under goal 1. The similar coding could be used in relation to indicators, costs, activities, etc.
3.4. Constructing a Logical (Results) Matrix

The log frame (results matrix or results framework) shows the relationship between different parts of the plan in graphic form. The log frame allows planners to ensure that all component parts of the plan are well aligned in a logical manner and are oriented towards producing the required results. The log frame forms the core of the plan. Adequate time and rigor should be devoted to developing coherent log frame as a basis for elaborating the rest of the plan.

Constructing a log frame should be through rigorous analysis which aims at capturing all the essential elements of the plan and ensuring that they are logically linked in strategic coherence. This process is an iterative one which often involves modifying different parts of the plan. For example, if it is not possible to deliver some interventions, it might be necessary to go back to the objectives and goals and modify them so that they are achievable or realistic, taking into account prevailing constraints.

Figure 3.4 Example of Log frame or Result Framework\textsuperscript{14}

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<th>Targets</th>
<th>Cost</th>
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<td>Objective 1.1</td>
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\textsuperscript{14} Modified from the standard logframe which has columns on indicators, means of verification and risks/assumptions.
Constructing sound logical framework is not easy; and can take a lot of attention, energy and time. But once complete, it becomes good basis for a strong strategic plan. The log-frame must be constructed such that the goals, objectives and interventions explicitly include equity considerations throughout.

<table>
<thead>
<tr>
<th>Tools for Results Based Planning</th>
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<tr>
<td>There are a number of existing tools and approaches for results-based planning which aim to assist planners to follow a systematic approach to planning to lead to achieving the desired results. Although the tools may vary in the terminology used, areas of emphasis or in approaches, they are all built around the same principles of planning which leads to results. Some of the most widely used planning methods and approaches are:</td>
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<tr>
<td><strong>Logical Framework Approach</strong>&lt;sup&gt;15&lt;/sup&gt;</td>
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<td>The Logical Framework Approach (LFA) is based on a systematic approach to analysis of the situation (problem definition) and of the options for addressing that situation. It establishes a logical hierarchy of means by which programme objectives will be reached, identifies potential risks and indicates how outputs and outcomes will be monitored.</td>
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<td>The result of this analytical approach is captured in a logical matrix (the Logframe). The matrix summarizes what the project intends to achieve and how, key assumptions, and how results will be measured.</td>
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<tr>
<td><strong>Results Based Management (RBM)</strong>&lt;sup&gt;16&lt;/sup&gt;</td>
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<tr>
<td>The RBM approach focuses on achieving and measuring results. It defines expected results based on situation analysis. It also defines a results chain (logic model) which depicts causal or logical relationships between the inputs, activities, outputs and outcomes of a programme. The product of the analysis is a results matrix, which shows the hierarchy of expected results and how they will be measured.</td>
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<tr>
<td><strong>Objective Oriented Project Planning (OOPP or ZOPP)</strong>&lt;sup&gt;17&lt;/sup&gt;</td>
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<td>The OOPP approach also provides a systematic structure for identification, planning, and management of projects. It is essentially a modification of the Logical Framework Approach. The OOPP is developed mostly in a workshop setting with involvement of principal interest groups. The main output is a planning matrix which highlights logical linkages between inputs, activities and expected results.</td>
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<tr>
<td>Although there might be some differences in approaches and terminologies in these tools, they are all based on the same principles of ensuring coherence in all elements of the plan that lead to desired results. The common feature in them is that they assist in focusing on the ‘logical chain’ that connects the levels of change in a plan and their measurement.</td>
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<sup>15</sup> The use and abuse of the logical framework approach, Sida, November 2005


Strategic planning and operational planning for a national programme is a complex process. It involves a wide range of actors, requires various types of skills, uses various types of information and requires significant amount of time and resources. It is important to prepare very well for planning. Rushing into a planning process without adequate preparation can result in a number of difficulties which could ultimately undermine the quality and credibility of the plan. Key actors might be left out or inadequately involved; parts of the process might not come together in a coherent manner; and the process is likely to be long drawn out.

Developing a national plan will require intense commitment from a number of people and institutions, a substantial budget, and will, for the core planning people involved, constitute their major work for a large part of a year at least. It is thus essential to make sure that the process has a variety of ‘allies’ – partners who support the process: people both higher in the hierarchy and lower, as well as horizontally (i.e. partners) who recognize the need for the strategic plan, see the benefits, understand the process, and are clear about the scope and scale of the exercise.

The following considerations should be made in preparing for planning:

1. How the planning process will be managed
2. Involving stakeholders
3. Methods and approaches to be used
4. Identify information required
5. Roadmap and budget

4.1. Managing the Planning Process
Establishing effective structures for leading and managing the process is essential to achieving legitimacy, ownership and efficiency for the exercise and is an essential part of the preparation. It involves defining, at the outset of planning, how the process will be led and managed. It is important to create management arrangements that involve in the planning process senior policy levels, diverse stakeholders in addition to technical competency.

Management arrangements for planning should consider the following structures:

4.1.1. Steering Group
The Steering Group will provide overall policy and strategic direction and oversight of the planning process. To develop a health sector plan for HIV, it would be comprised of senior officials in the Ministry of Health and other relevant Ministries (in particular those with significant involvement in providing health services, such as Local Government, Education, or planning them, such as Finance, Development Planning), representatives private sector organizations providing health services, of Civil Society involved in AIDS and the health sector, and academia. Efforts should be made to enable meaningful participation of women's organizations and people living with HIV.
The roles and responsibilities of the Steering Group would include the following:

- Provide overall policy guidance for the Strategic Planning Process.
- Oversee the work of the Planning Team and ensure timely reporting and submission of deliverables.
- Act as a high-level multi-stakeholder policy forum for the views of local and international policy and development partners in relation to the planning process.
- Deliberate upon and approve decisions on issues referred to it by the Planning Team, including recommendations and reports.
- Ensure that the planning process is based on a sound interpretation of the national context.
- Approve the final Draft of the Strategic Plan.
- Liaise with relevant constituents for feedback, inputs and reflect the inputs of such constituents.

The Steering Group will normally be chaired by, but not limited to, a senior official of the Ministry of Health with secretariat functions served by the HIV Department/Unit of the Ministry of Health.

Figure 4.1: Management Structures for Planning
4.1.2 Planning Team

The Planning Team will be responsible for managing and coordinating the entire planning process. The Planning Team is more technical in outlook and will be made up of people involved in planning and managing programmes in the Ministry of Health and other partners. The size and composition of the team will be determined by a number of factors such as type of plan being developed and the period covered by the plan. A comprehensive health sector plan will require a larger and more diverse team with a variety of knowledge, skills, and experience than a more focused plan.

In constituting a Planning Team, ensure that

- key stakeholders are represented. This includes relevant other ministries in order to ensure coherence of the health sector HIV plans with other sectors as well as civil society groups that include representatives of women's organizations and people living with HIV;
- there is an appropriate mix of knowledge and skills;
- the size is manageable (if it is too small it might be over-burdened with work or perceived as exclusive; if it is too large it might be unwieldy and progress slowly).

It is essential to include person(s) from other programmes such as Tuberculosis, Maternal Child Health or Reproductive Health in the Planning Team to foster synergy. It will also be useful to include the gender focal point either in the Ministry of Health or from the Ministry of Gender in order to ensure that the plan takes into account the specific issues relevant to reaching women and girls. The planning team needs to have access to other skills and expertise necessary for the planning. It is also important for the team to include or have access to writing skills.

Once the Planning Team has been constitutes is should quickly convene to:

- review its Terms of Reference;
- develop a plan of work; and
- allocate responsibilities and tasks.

The Planning Team would normally be headed by the Head of the HIV Programme in the Ministry of Health. Staff of WHO, the UN and other development partners can be members of or provide support to the Planning Team.

Roles and responsibilities of the Planning Team would include the following:

- Provide overall technical and operational guidance of the Strategic Planning Process.
- Oversee the work of the various Working Groups and Consultants and ensure timely reporting and submission of deliverables.
- Liaise with appropriate constituents to obtain feedback and ensure that it is reflected in the plan.
- Deliberate upon and endorse decisions by the Working Groups, including reports.
• Coordinate and manage the overall process and ensure timelines and budgets are adhered to.
• Make recommendations on key policy changes or inclusions necessary for an effective response in line with national priorities.
• Produce the final Draft of the new Strategic Plan.

4.1.3. Technical Working Groups
Technical Working Groups (TWG) linked to the planning process address policies, and technical and operational issues in specific areas of the response and planning. These various groups should be formally established and have clear terms of reference. Technical Working Groups could be organized to cover issues such as HIV prevention, or treatment and care, or service delivery for specific target groups, or the operation of health sector subsystems, such as information systems, supply chain management, human resource development, or leadership development.

The number of TWG will vary depending on priority issues for the country, as having too many TWG presents challenges in coordination.

4.2. Involving Stakeholders
As a national strategic and operational plan provides a common framework to ensure of all efforts in the health sector response to HIV all key stakeholders should be involved in the planning process. It is therefore necessary to define at the outset mechanisms for consulting and involving various partners. Areas which are most critical for perspectives of a wider range of partners include the following:

Early buy-in to the planning process: As soon as the decision to develop a new plan is taken, efforts should be made to involve partners in moving forward. Various stakeholders could be identified as members of or consulted over composition of the various management structures. This must include not only relevant ministries such as education, transport, gender and women's affairs, but also civil society including women's organizations, people living with HIV, research institutions etc.

Determining programme priorities: Stakeholders must be involved in validating the situation analysis, including assessment of strengths and weaknesses of the response. There should also be general consensus on the main priority areas to be addressed in the plan.

Consensus on the draft plan: Once the plan has been drafted, must get the chance to comment on both the content and presentation. Ways for doing this include circulating the draft to the stakeholders and allowing sufficient time for review and feedback. A consensus meeting could provide a forum for partners to express their views reach consensus on the plan.
4.3. Defining Planning Methods and Approaches

The Planning Team should propose the approach to be used in planning. The planning process can be top-down, bottom-up or combination of the two. Top-down planning is when all the key elements of the plan are determined at the central level and other levels follow instructions to complete the plan. Bottom-up planning is where the planning starts from the peripheral levels and becomes consolidated at the central level. A hybrid of the two approaches is probably best suited for planning the health sector response to HIV. In this approach the central level provides broad strategic guidance (e.g. in prevention, in treatment, in leadership development, …) and there is continuous iteration between the central and peripheral levels on the components of the plan such as situation analysis, priority setting, implementation arrangements and costing. The Planning Team should also define what processes will be used to carry out all aspects of planning and how different parts will come together.

The Planning Team should then develop a concept paper or detailed terms of reference that bring all the information together regarding what the planning process will achieve and how it will be conducted.

4.4. Identifying Required Information

Availability of information is a critical factor in planning as it often is the basis for taking decisions. Much of the time in the planning process is often taken up in collecting and analysing information. It is therefore necessary to ensure at the outset that the required information is easily accessible. This could be done by compiling a list of all the types of information that might be required for planning and identifying their sources. Information for planning might include, and not limited to the following:

- Epidemiological data
- Socio-economic context and determinants (e.g. harmful norms & practices, access to and control over resources by different groups, policy and legal barriers),
- Status of current response and actors
- Evidence on effectiveness of strategies or interventions
- Costs and financing

The data above must be disaggregated by relevant stratifiers (e.g. sex, age, ethnicity, SES, urban-rural etc) so that the situation analysis is able to identify the inequities in terms of gender, socio-economic status, human rights etc)

The planning process should, as far as is possible, draw from existing sources of information. Much of this information will have been obtained during programme review or programme evaluation.
Existing sources of information include:

- National AIDS Plan (Multi-sectoral)
- National Health Plan
- National SRH, gender, education and other sectoral plans
- Policy Documents on health, HIV/AIDS and socioeconomic development
- Policies and Laws related to health and HIV that can affect risk and access to or delivery of services (e.g. confidentiality laws, laws related to partner notification etc)
- Reports of epidemiological, behavioural, health services and other relevant surveys, including Demographic and Health Surveys.
- Special research studies including qualitative and quantitative studies about socio-cultural and economic context of HIV/AIDS
- Programme Reviews by government, NGOs, donors and others
- International guidelines, standards and recommendations on service delivery, M&E, health system management, and information to benchmark national performance
- Research findings
- Finding Proposals and Project Appraisal documents

It is often useful to get people to provide syntheses or extract information to be used in planning from all these sources.

4.5. Activities in Planning

The Planning Team should identify major activities that will be part of the planning process. Activities to be considered include the following:

- **Document reviews**: What kinds of documents will need to be reviewed, what will be the review methodology, what themes will be included for the analysis. Such documents reviews will become the basis for identifying the policy, legal, planning context.

- **Interviews**. Will there be need for interviews? What will be the purpose? Who will be interviewed? Interviews can be used assess opinions of stakeholder on particular issues.

- **Field visits**. Will there be need for field visits? What will be the purpose? Which areas should be visited? Field visits can be useful in getting the perspectives of implementers and users of services. They can help to highlight challenges and opportunities in delivering services.

- **Meetings**. What types of meetings (besides regular management meetings of the steering group, planning teams, technical working groups, etc) will be held and how many? Who will be involved? How will they be facilitated?
• **Training.** Will there be need for training? What will be the purpose of the training? Who will be trained? Sometimes it might be necessary to provide training for those that will carry out the planning. The training could be on issues such as the specific planning methods, data collection or on the use of specific tools.

• **Data collection.** Will there be a need to collect additional data? What sort of information is required? Is it feasible to collect the information during the planning period? Sometimes it might be necessary to gather evidence in particular issues before proceeding with the planning. For example, if there is low utilization of a service in some locations, it might be necessary to gather information (through small surveys) to find out why before concluding the planning, as this might influence the selection of strategies in the plan.

• **Special analyses.** There will often be a need to undertake special analyses such as estimating needs, analysing cost-effectiveness of approaches, projecting commodity, cost estimations, epidemiological analyses?

• **Technical support.** What kind of technical support will be needed? In which areas? When? Who will provide? How will it be sourced? How will it be paid for?

### 4.6. Prepare a Roadmap

The Planning Team should develop a roadmap for the planning process. The roadmap identifies the steps to be taken, the timeframes as well as roles and responsibilities. In developing the roadmap it is important to understand that some activities or steps will be taken sequentially while others can be concurrent. Figure 4.2 shows an example of a planning roadmap.

**Figure 4.2: Planning Roadmap**

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4.7. Prepare a budget

The planning process itself has significant costs. A budget must be drawn up that includes all costs that are expected to be incurred in the planning process. Once the process has been costed, the required funds must be secured before the process begins. The kinds of structures described above can be used to discuss the budget and mobilize resources.

Some of the budget items that need to be considered are:

- Working Group meeting (honoraria, snack, etc)
- Meetings and workshops (venue costs, etc)
- Secretariat costs (if this is managed separately)
- Stationary & communications (if managed separately)
- Studies (data collection, report writing, etc)
- Training (accommodation, venue, per diems, fees, etc)
- Transport (vehicle hire, fuel)
- Consultants (fees & per diems)

Resource materials


Health sector planning context


Policy and planning http://www.searo.who.int/LinkFiles/Publications_NAP_Module_2.pdf

5. SITUATION ANALYSIS

A Situation analysis is essentially about identifying the problem: what and where the HIV epidemic is, and what is being done, not being done, or could be done better to respond to it. An accurate situation analysis is a strong foundation on which the plan is constructed. It is synonymous with the dictum to “Know Your Epidemic and Know Your Response”.

A situation analysis of the health sector response to HIV draws from both situation analysis of the wider national response to HIV and situation analysis in relational to the health status of the country. It may be that either of the two situation analyses are adequate or additional analysis might be required for issues specific to the health sector response to HIV.

The situation analysis of the health sector response to HIV will include consideration of the following. It is important to emphasize that all data quantitative and qualitative where available must be presented disaggregated by sex, age and other stratifiers in order to have an accurate understanding of the equity dimensions of the epidemic from the outset of the planning process:

**Socioeconomic context:** This describes the political, social, economic and legal environment. It identifies social determinants or risk and vulnerability to HIV, and how they affect the ability of people to access health services. Social factors that impact on HIV and the ability of people with or vulnerable to HIV to access services include, but not limited to, factors such as poverty, gender relations, education, stigma, discrimination, criminalization and mobility.

**Policy and legal context:** This described the various multi-sectoral and health policies that can affect vulnerability to and access to HIV services. It should also describe the legal context (e.g. criminalization of HIV or marginalized groups, laws related to property rights, violence etc which can affect vulnerability to and uptake of services).

**Epidemiological analysis:** It describes HIV transmission, distribution, risk factors, affected population groups, and describes the needs for and coverage of treatment, care and prevention services.

**Response analysis:** This analyses the offer of services, and their effectiveness, against a background of the effectiveness of the response to HIV. It reviews progress towards addressing the prevailing prevention, treatment and care needs. It also assesses effectiveness of current strategies of the health sector response.

**Stakeholder analysis:** This identifies the key actors in the health sector response to HIV. It determines their contribution, interest and influence in the response.

**Programmatic gap analysis:** Ultimately, the situation analysis should define the unmet need for HIV prevention, treatment and care. It should also identify programmatic gaps, policy gaps and system weaknesses that need to be addressed.

A situation analysis for the health sector response to HIV does not necessarily have to be done from scratch. It can draw from other related situation analyses such as those of health in general and of the multisectoral effort. The situation analysis can also be based largely on existing information. It must also draw on special studies, research and qualitative and quantitative data
from other sectors in order to have a comprehensive situation analysis. However, it is important not to cut corners - especially not in the analysis of the response, stakeholders and gaps. Information on the performance in those areas is at times difficult to obtain, as it is often not captured in Health Information Systems, and as the interpretation of available data will at times be sensitive. It is therefore important that findings of the situation analysis are widely discussed by stakeholders and validated.

5.1. Analysis of the Socioeconomic Context
Determinants of HIV related risk and vulnerability are mainly rooted in the socioeconomic context of a society. For example, poverty can drive people to engage in high risk behaviour for money. In health sector planning their ability to access services should be a key concern.

Some of the issues to be considered in the socioeconomic context include the following:

- Political commitment to responding to HIV including commitment to funding the response.
- Population, including size, distribution (Geographic, sex, age)
- Income level, stratified by income quintiles and by sex.
- Urban-rural differentiation.
- Harmful social beliefs and practices in relation to gender, sexual orientation, people living with HIV.
- Legal environment in relation to punitive and discriminatory laws with respect to sexual orientation and most at risk populations such as men who have sex with me, injecting drug users, sex workers and prisoners.
- Policy environment in relation confidentiality, partner notification, consent etc.
- Economic activity.

Some sources of information on socioeconomic factors are:

- National Development Plan or Poverty Reduction Strategy
- National Gender Strategy and or Plan
- Human Development Report
- National Demographic and Health Surveys
- Social statistics produced by Statistical Bureaus (e.g. labour, education, violence against women, women's economic empowerment etc)
- World Development Indicators
- National Census
- Project Appraisal Reports (by Development Partners)
- Specific Surveys and Studies (Government, Academic Institutions, Development Partners)
5.2. Epidemiological Analysis

Understanding transmission, distribution, drivers and impact of HIV is at the core of the situation analysis. It is important to ensure that the most recent and best available information is used. Areas to be considered in epidemiological analysis of HIV include the following:

- **Extent of the problem:** This describes
  - the level of HIV infection in the **general population and in key populations (appropriately disaggregated)**, including at subnational levels such as regions and districts, between urban and rural areas, and in other **geographical areas** of where HIV infection might be concentrated (transport corridors, around lakes, along the coast, etc.).
  - how effectively the health sector interfaces with those populations in those areas
- The analysis should look at the rate of **new infections (appropriately disaggregated)** and where they are coming from (population groups and geographical locations), including among infants, young children and in pregnant women.
- The analysis should estimate the number of **people in need of treatment** and in need of specific HIV related services (such as PMTCT, STI treatment, hospice care) and their geographical distribution
- The analysis should describe the extent of **co-morbidities**, in particular HIV and **tuberculosis**.
- **Modes of transmission:** Determine where new infections are coming from, what is the cause, what are the modes of transmission.
- **Type of epidemic:** It might be useful to categorize the type or types of HIV epidemic prevailing in the country for the purpose of programming. The epidemic can be categorized as low level, concentrated or generalized (see Figure 5.2). The epidemic can also be described as nascent, growing or mature. It is important to understand that these categorizations are not purely for descriptive purpose only, they change from over time and various combinations might exist in one country.
Figure 5.1 Types of epidemics

**Low-level epidemic**
- HIV has not reached significant levels in populations most at risk for HIV infection as a result of high-risk behaviour.
- HIV is largely confined to people within populations most at risk for HIV infection as a result of high-risk behaviour.

**Concentrated epidemic**
- IV has spread rapidly in one or more populations most at risk for HIV infection as a result of high-risk behaviour.
- The epidemic is not yet well established in the general population.

**Generalized epidemic**
- The epidemic has matured to a level where transmission occurs in the general population, independent of populations most at risk for HIV.
- Without effective prevention, HIV transmission continues at high rates in populations most at risk.
- With effective prevention, prevalence will drop in populations most at risk before they drop in general population.

**Some sources of information on the epidemiological status of HIV include:**
- Epidemiological surveillance
- Behavioural surveillance
- AIDS Indicator Surveys
- Modes of Transmission Studies (MOT)
- Behavioural research
- Demographic and Health Surveys
- HIV incidence Studies
5.3. Response Analysis

The response analysis examines the current response to HIV and the extent to which it is achieving the desired results. The response analysis is often based on findings of programme reviews and evaluations that are undertaken periodically during or at the end of the programme cycle. Main issues to consider in the response analysis are as follows:

Outcomes and impact achieved. This analysis should include determining how much change in outcomes and impact has taken place since implementation of the outgoing plan and before. The analysis is done largely by assessing how impact and outcome indicators have changed and in which particular sub-groups, and assessing associated factors. Assessing impact includes looking at the following:

− rates of new infections appropriately disaggregated - in general population; in infants and young children; in key populations; among health care workers
− HIV related morbidity and mortality appropriately disaggregated - including HIV/TB; in sub-populations - including health care workers

Outcome areas include
− women and men and children on treatment
− knowledge of HIV status
− access to prevention services including PMTCT, harm reduction, male circumcision, PEP, safe blood and derivatives, health care worker access to protective gear and devices

Services provided. It is important to assess the types of services provided, who provided them, who were targeted and who accessed them. Were the services targeted at the right people? Were the services of acceptable quality? What were the factors influencing access to the services.

Capacity of institutions. In assessing performance of the health sector response to HIV/AIDS the focus should be on identifying factors that facilitated and constrained progress. One way of assessing overall performance is by conducting a SWOT analysis - an assessment of strengths, weaknesses, opportunities and threats.
5.4. Stakeholder Analysis

Stakeholders can be defined as individuals, groups or institutions that have vested interest in the health sector response to HIV/AIDS and who can potentially be affected by or influence programme efforts. Stakeholder can be critical to the programme achieving its goals.

A stakeholder analysis identifies the various stakeholders who have an interest in the programme. The purpose of stakeholder analysis is to develop a strategic view of the partners involved in the programme and their potential contribution to the programme.

A stakeholder analysis can help the programme to identify:

- Current and potential contribution to the HIV response
- Comparative advantage of the stakeholders in particular areas
- Potential conflicts or risks that could arise during planning and implementation
- Groups that should be encouraged to participate in the programme and
- Appropriate strategies and approaches for engaging stakeholders.

There are three steps in stakeholder analysis: 1) Identifying the key stakeholders and their interests in the programme; 2) Assessing the influence of, importance of, and level of impact upon each stakeholder; and 3) Identifying how best to engage stakeholders. Figure 5.2 shows a matrix that can be used to analyse involvement of stakeholders in the health sector response to HIV.
Figure 5.2: Stakeholder Analysis Matrix

<table>
<thead>
<tr>
<th>More Affected</th>
<th>More Influence</th>
<th>Less Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Influence</td>
<td><em>Work with them and keep them on board</em></td>
<td><em>Empower them and keep them on board</em></td>
</tr>
<tr>
<td>Less Affected</td>
<td><em>Win their support</em></td>
<td><em>Keep them informed</em></td>
</tr>
</tbody>
</table>

**Stakeholders in the health sector response include, but not limited to, the following:**

**Government**
- Policy makers
- Technical programmes
- Related institutions (e.g. regulatory) and sectors

**Service providers**
- Public
- Civil society
- Private

**Affected populations**
- Women, men and young people living with HIV
- Key populations
- Local communities

**Interest groups**
- Advocacy groups
- Professional associations
- Academia

**Development partners**
- Donors
- Technical assistance providers
5.5. Programmatic Gap Analysis

Gap analysis is the process of identifying of gaps between the current state and the future or desired state. It helps understand ‘where you are’, ‘where you want to be’ and ‘how you’re going to get there’. Gap analysis serves as a bridge between the situation analysis and priority setting. From the situation analysis, it identifies critical gaps in the current response thereby highlighting potential priority areas of consideration in the new planning cycle.

Gap analysis could include consideration of the following:

5.5.1. Unmet need

This assesses the extent of the problem which still remains to be addressed. It involves first estimating, for a particular area or the response, the total need (current and likely to arise during the period covered by the plan). The unmet need will be the difference between total need and current coverage. The areas for which unmet need is determined will depend on priority areas and issues emerging from the rest of the situation analysis. For example, the need for HIV prevention will be all those people who are at risk, while the unmet need will be those at risk who are not currently covered by effective prevention services. The unmet need can be further analysed by specific most-affected populations. Similarly, the unmet need for treatment and care should be determined. Where possible, figures of unmet need should be disaggregated in order to identify those most-in-need. Unmet need can be summarized in a simple table as follows:

Figure 5.3: Examples of Unmet Need

<table>
<thead>
<tr>
<th>Response Area</th>
<th>Total Need</th>
<th>Current Coverage</th>
<th>Unmet Need</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing and counselling among women and men</td>
<td>2,000,000</td>
<td>500,000</td>
<td>1,500,000 (75%)</td>
<td>There has been significant expansion of HIV TC sites but uptake is still very low.</td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
<td></td>
<td></td>
<td>On course to cover the need if current trend is maintained.</td>
</tr>
<tr>
<td>Harm reduction among men and women</td>
<td></td>
<td></td>
<td></td>
<td>Good progress in some towns. Nothing happening in prisons</td>
</tr>
<tr>
<td>Prevention and treatment among sex workers</td>
<td></td>
<td></td>
<td></td>
<td>High level of discrimination and social resistance associated with sex work</td>
</tr>
<tr>
<td>Prevention and treatment among MSM</td>
<td></td>
<td></td>
<td></td>
<td>Same as for harm reduction</td>
</tr>
<tr>
<td>Male circumcision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ART for adult women and men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ART for children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/TB collaborative activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The gap analysis should also describe gaps in equity in order to understand how far service delivery coverage matches the distribution of need (for prevention and care), and what kind of changes and improvements are needed in interventions and service delivery.

5.5.2. Policy, Programmatic and System Gaps
A key element of the situation analysis is identifying system weaknesses in capacity, efficiency and effectiveness of systems to deliver interventions. There is no point in rolling out ART if there isn't some kind of system to ensure the regular supply of ARV drugs, or if health care workers are not trained in their use. In setting priorities it is important to identify which system weakness can be addressed, and how; and which cannot. Based on the analysis of the health system ‘building blocks’ in the situation analysis, priorities can be set. The table suggests some examples:

Figure 5.4: Examples of System Weaknesses

<table>
<thead>
<tr>
<th>Building block</th>
<th>Identified gap or weakness</th>
<th>Priority solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery</td>
<td>• Service delivery not located in the same places where they are most needed</td>
<td>• Cannot open new services (too expensive) so support innovative approaches to delivering services where they are most needed to halt transmission – e.g. CBOs</td>
</tr>
<tr>
<td></td>
<td>• STI services separate from RH services</td>
<td>• Work to integrate STI and RH services</td>
</tr>
<tr>
<td>Health workforce</td>
<td>• Shortage of doctors who can manage ART</td>
<td>• Not feasible to increase numbers of doctors, so introduce ‘task shifting’</td>
</tr>
<tr>
<td>Information</td>
<td>• HMIS doesn’t collect HIV prevention data at community level</td>
<td>• Work to get changes in the HMIS</td>
</tr>
<tr>
<td>Medical products, vaccines and</td>
<td>• Central medical store (CMS) doesn’t have expertise in procuring and distribution of ARV</td>
<td>• Capacity building in CMS</td>
</tr>
<tr>
<td>technologies</td>
<td>drugs</td>
<td></td>
</tr>
<tr>
<td>Financing</td>
<td>• Weak systems for tracking flow of funds at district and community levels</td>
<td>• Develop a system and simple tools for recording expenditures at peripheral levels</td>
</tr>
<tr>
<td>Leadership and governance</td>
<td>• HIV Programme too vertical and separated from standard PHC service delivery</td>
<td>• Design a package of integrated HIV service delivery to be incorporated into PHC services</td>
</tr>
<tr>
<td></td>
<td>• MoH Finance Department can’t manage GF Grants</td>
<td>• Capacity building for Finance Dept.</td>
</tr>
</tbody>
</table>

Financial Gap Analysis determines the gap between resource required to implement the plan and resources available. This is addressed in the costing and resource planning part of the guide.
5.6. **Risk Assessment**

Risks are the factors that could adversely affect implementation of the plan and achievement of results. These factors can be internal to the programme or sector (such as slow pace of implementation, lack of motivation, etc). Risks could also come from outside the programme or sector (such as withdrawal of external financial support, political instability, natural disasters, etc).

The risk assessment of the plan should identify the possible risks that could arise in the course of implementation of the plan. The risks should be graded according to probability of arising and the impact on implementing the plan. Risks to worry most about are those with high probability and high impact on the programme. For each risk identified it is necessary to also state the possible strategies to mitigate it.

A useful way to assess risks is to review how they might arise in the six main elements or ‘building blocks’ of a health system based on identified weaknesses of the health system. The following table can be used to summarize potential risks to implementation of the strategy.

**Figure 5.5: Example of Risk Assessment Matrix**

<table>
<thead>
<tr>
<th>Potential Risks</th>
<th>Likelihood*</th>
<th>Impact*</th>
<th>Mitigation Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership &amp; Governance</td>
<td>Declining political commitment to the HIV response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financing</td>
<td>Donors do not follow through with their pledges or major donor withholds financial support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service delivery</td>
<td>Interventions not having effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human resources</td>
<td>Exodus of trained health workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement &amp; supply chain</td>
<td>Theft of drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>Unreliable information being generated from facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*High, Medium or Low
5.7. **Steps in conducting a situation analysis**
The following steps should be considered in conducting a situation analysis:

1. Constitute a group of people with expertise in analysis of data and issues, including those relating to women and marginalized populations.
2. Identify the issues (in the five categories above) that will be included in the situation analysis.
3. Define the type of information that will be required and the sources. Identify information gaps and how they will be addressed.
4. Collect and analyse the information.
6. Call a meeting of stakeholder to discuss and validate the situation analysis. The same will also address priorities emerging from the situation analysis.

**Resource materials**


Health sector planning context


Situation analysis [http://www.searo.who.int/LinkFiles/Publications_NAP_Module_1.pdf](http://www.searo.who.int/LinkFiles/Publications_NAP_Module_1.pdf)
The response to HIV has so far yielded differing results in different countries. While significant gains have been made in recent years in scaling up HIV programmes and in understanding the epidemic there remains more to be done to reverse the trajectory of new infections and meet the treatment and care needs of people affected. It is therefore important that progress focus their attention on those interventions that will bring about the greatest required change within their epidemiological context.

A common weakness in many national programmes is that they try to implement all known interventions for prevention, treatment and care of HIV. As a consequence, their capacities become overstretched and their do not get the required results in any particular area. Sometimes programmes invest significant resources and time in interventions whose effectiveness are not proven or is minimal. Still other programmes take on approaches that have been successful elsewhere, without sufficient consideration of relevance to the local epidemiological and social context.

Setting priorities is the cornerstone of any planning exercise. It entails clear decisions on what are the most important things to do in the programme and what is not as important. A programme that sets the right priorities is more likely to achieve good results and make the best use of available resources. It is often better to identify for priority attention a limited number of areas or interventions that are likely to bring about the greatest required change. Setting priorities entails identifying results to be achieved and the best strategies or interventions to achieve those results.

6.1. Considerations in priority setting

6.1.1. Evidence
The situation analysis provides the evidence base of the HIV problem in a particular context. It describes how HIV is transmitting, who is affected and what the prevention and treatment needs are. It also describes coverage of services and performance of institutions. The situation analysis must inform the identification of results to be achieved by the programme.

Much evidence also exists on effectiveness of some interventions, while the evidence about other interventions is still being generated, or weak. Programmes should, where possible, give high priority to strategies or interventions that are supported by evidence and that have the greatest impact towards the stated goals for the least effort.

Figure 6.1: Examples of effective HIV interventions in the health sector

- Prevention of mother-to-child transmission
- Addressing needs of key populations (sex workers, MSM, IDU, prisoners)
- Antiretroviral treatment, care and support for PLHIV
- Testing and counselling
- Male circumcision
- Supporting Universal Precautions and enforcing Blood Safety

6.1.2. **Broader Development Priorities**
Priorities for the health sector response to HIV must be aligned with broader national and international health and development priorities. These priorities are elaborated in policy documents such as:

- National Development Plan or National Poverty Reduction Strategy
- National Health Policy
- The National Health Plan
- National AIDS Policy
- The National AIDS Plan
- National Gender Plans

The health sector response to HIV should also take into account international commitments and targets in setting priorities. These include Millennium Development Goals, UN Declaration of Commitment on HIV/AIDS, UN Political Declaration on Universal Access as well as the UNAIDS Strategy 2011-2015 and the Global Health Sector Strategy 2011-2015.

6.1.3. **Equity**
Priorities must also be based on an analysis of those populations that are most-in-need in relation to their risk of HIV and are least likely to be reached by key interventions. They must also be based on addressing barriers faced by such groups in accessing services. For example, in settings where young women are most-at risk for HIV, and yet may not have access to information and services because they are not youth-friendly, priorities in the planning process must take into account the inequities faced by such a group.

6.1.4. **Resources and Capacity**
There must be a link between programme priorities and available resources and capacity to deliver on them. It is futile to define priorities which cannot be met because resources or capacity fall far short of what is required to achieve them. Programmes should define ambitious and manageable priorities that allow them to make constant progress towards their long term goals. Programmes should also aim to mobilize additional resources and build capacity of the health system to reach the required level of ambition.

6.1.5. **Build National Consensus**
Building broad consensus on priorities ensures broad ownership and commitment to those priorities. It also ensures better alignment of all efforts and avoids different actors pursuing different priorities. Therefore, a wide range of stakeholders should be involved and consulted in determining priorities. Similarly, after priorities have been decided efforts should be made to get wide support from stakeholders, including the general public. Broad based support can influence the level of resources and actors committed to achieving those priorities.
**Considerations in priority setting by epidemic type**

**In all epidemics:**
- place high priority on accelerating prevention;
- start with geographic areas and populations where HIV is spreading/likely to spread most rapidly;
- focus on interventions with most proven effectiveness and impact
- plan treatment and care services that are accessible and will be used by those affected or targeted;

**In low-level epidemics:**
- recognize that affected individuals are often from marginalized populations and subject to stigma and discrimination;
- plan service delivery to match the distribution, needs and accessibility of people most-at-risk of infection and people living with HIV;
- emphasize prevention targeting populations at increased risk and their direct contacts so HIV incidence remains low.

**In concentrated epidemics:**
- target interventions to key populations, such as sex workers, transgender people, injecting drug users, and men who have sex with men and prisoners;

**In generalized epidemics:**
- select service delivery approaches able to address the high risk of infection, many new infections,
- multiple affected groups, and large numbers of people requiring treatment and care;
- decentralize HIV services to health centres and into the community;
- integrate HIV prevention, treatment and care services within primary care;
6.2. Defining Programme Goals, Objectives and Interventions

Different terms are used to describe priorities in a plan. They might be referred to as “results”, “strategic directions”, “priority areas” and various other ways depending on the national preference or planning convention. A clear understanding of the level at which the priorities are defined is more important than the nomenclature used. Most plans express priorities in terms of vision, goals, objectives and main interventions.

A vision is a political statement that communicates an ideal picture of a desired future that is aspired towards in the long-term. It should be motivating and challenging to stimulate good planning and implementation.

<table>
<thead>
<tr>
<th>Examples of Vision Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tanzania:</strong></td>
</tr>
<tr>
<td>“Tanzania united in its efforts to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus within a human rights and empowerment framework.” (United Republic of Tanzania, National Multi-Sectoral Framework 2008-2012)</td>
</tr>
<tr>
<td><strong>St. Vincent and the Grenadines</strong></td>
</tr>
<tr>
<td>The vision of the National Strategic Plan 2010-2014 is:</td>
</tr>
<tr>
<td><em>To substantially reduce the spread and impact of HIV in St. Vincent and the Grenadines through sustainable systems of Universal Access to HIV prevention, treatment, care and support, and empowerment of the population to prevent HIV infection.</em></td>
</tr>
</tbody>
</table>

A mission statement describes what a particular organization aims to achieve. A mission statement, therefore, might be more appropriate in an operational plan or a specific organization than in a national strategic plan which covers contributions of many institutions.

6.2.1. Goal(s)

A goal is a broad statement of a desired impact of the programme during the period of the plan. It is linked to impact level results. It describes desired change in HIV infections and quality of life. The goal, although broad in scope, still needs to be quantifiable and include targets. Targets are often ambitious; it is preferable, however that they stay realistic and take into account factors such as financial and human resources, institutional capacity, health systems, and the socio-political environment in the country. Goals of the health sector response to HIV need to be aligned with those of the National Health Plan and the National AIDS Plan.

Sometimes the goals defined in the previous plan might remain valid or might require to be reformulated. The planning team needs to review these in light of the recent situation and new evidence and decide whether they are still valid or need to be redefined.
6.2.2. Objectives

Objectives define what is to be done for the goals of the programme to be achieved. One or more objectives directly contribute to achieving a goal. Objectives are concerned with outcome level results. Objectives describe the change in risks and behaviour which the programme should achieve for the goals to be met. Objectives must be stated clearly or they must be SMART.

The term SMART is used to indicate characteristics of well-articulated objectives:

**Specific:** Reflect a precise or specific outcome which is linked to a rate, number, percentage or frequency.

**Measurable:** Include targets which can be measured through a reliable system.

**Achievable:** They are realistic to achieve with a reasonable amount of effort and application.

**Time-bound:** have clear start and finish date.
Example of SMART Objectives

1. **Example of objectives to optimize HIV prevention, diagnosis, treatment and care outcomes**
   - The proportion of male and female 15-49 year olds who know their HIV status is increased from 15% to 60%.
   - Proportion of most at risk populations and other vulnerable groups accessing comprehensive services for HIV prevention, treatment and care increased from 50% to 80%.
   - The percentage of injecting drug users reached by comprehensive harm reduction programmes increased from 15% to 60%.
   - Access to ART for adult women and men increased from 55% to 80%.
   - Access to ART for children increased from 20% to 60%.
   - Access to comprehensive HIV care services for women and men living with HIV increased from 40% to 80%.

2. **Example of objectives to leverage broader health outcomes through HIV responses**
   - Increased HIV positive pregnant women receive services to prevent HIV transmission to their unborn and breastfeeding infants from 60% to 100%.
   - Access to family planning services for HIV positive women of reproductive age increased from 10% to 40%.
   - Increase from 40 to 80% women and men who are HIV positive who receive services for TB prevention and treatment.

3. **Example of objectives to build strong and sustainable systems**
   - Health workers trained to provide a package of HIV prevention and treatment and care services (including HTC, PMTCT, ART, IDU) increased from 45,000 to 100,000.
   - Proportion of health facilities reporting drug stock-outs reduced from 50% to 10%.

4. **Example of objectives to reduce vulnerability and address structural barriers to accessing services**
   - HIV/STI surveillance system that allows measurement of risk behaviour for improved understanding of the magnitude and determinants of the epidemic established.
6.2.3. **Interventions**

Interventions are products and services provided to bring about specific change. Interventions represent specific action undertaken by the programme to bring about change. Programme outcomes and impact result from application of interventions. It is therefore important that interventions are effective and appropriate for the problem being addressed. They should also be delivered on sufficient scale and quality to produce the required change.

There will be one or more interventions to achieve each objective identified in the plan. WHO has identified a full range of interventions for the health sector response to HIV, in this publication “Priority Interventions HIV/AIDS prevention, treatment and care in the health sector” (http://www.who.int/hiv/pub/priority_interventions_web.pdf).

### Examples of Programme Interventions

**Objective:** The proportion of male and female 15-49 year olds who know their HIV status is increased from 15% to 60%

**Example of interventions:**

- Increase proportion of health facilities providing provider-initiated HIV testing and counselling (PITC) from 40% to 100%.

**Objective:** Increased HIV positive pregnant women receive services to prevent HIV transmission to their unborn and breastfeeding infants from 60% to 100%

**Example of interventions:**

- Increase number of health facilities providing services for prevention of HIV transmission from women living with HIV to their children from 600 to 1100.
- Number of sites providing treatment, care and support for women living with HIV, their children and families increased from 200 to 500.

**Objective:** The percentage of injecting drug users reached by comprehensive harm reduction programmes increased from 15% to 60%

**Example of interventions:**

- Extend needle and syringe programmes from 60 to 200 sites
- Introduce drug dependence treatment in particular opioid substitution therapy 5 major prisons

**Objective:** Access to HIV treatment for adults increased from 55% to 80%

**Example of interventions:**

- Provide antiretroviral therapy 500,000 people
- Implement TB-HIV collaborative activities in 70% of all health facilities
Prioritizing interventions and service delivery approaches

In all epidemics:
- place top priority on accelerating prevention;
- select prevention interventions that match current patterns of HIV transmission;
- focus on geographic areas and populations where HIV is spreading most rapidly;
- Select HIV testing and counselling approaches that will optimize entry to prevention, treatment and care;
- plan treatment and care services that are accessible and will be used by those affected or targeted (this requires designing/configuring services that are acceptable to injecting drug users, sex workers and men who have sex with men);
- select the most effective service delivery approaches for implementing the interventions—through households, communities, health centres, hospitals, or outreach to most-at-risk populations;
- ensure HIV testing, counselling, prevention, and treatment and care services include outreach services to most-at-risk populations.

In low-level epidemics:
- recognize that affected individuals are often from marginalized populations and subject to stigma and discrimination;
- plan service delivery to match the distribution of people most-at-risk of infection and people living with HIV;
- define an optimal package of services and referral linkages to reach these groups;
- emphasize prevention so HIV incidence remains low.

In concentrated epidemics:
- recognize that effective targeted interventions require information on most-at-risk populations and their access to services;
- target interventions to most-at-risk populations, usually sex workers, transgender people, injecting drug users, and men who have sex with men;
- prioritize special interventions for injecting drug use wherever the practice occurs;
- ensure adequate coverage of prevention interventions for identified most-at-risk populations;
- use outreach by peers or people trusted by the target population, self-help and community groups, and local clinics able to provide friendly services for particular populations.

In generalized epidemics:
- select service delivery approaches able to address the high risk of infection, many new infections, multiple affected groups, and large numbers of people requiring treatment and care;
- decentralize HIV services to health centres and into the community;
- integrate HIV prevention, treatment and care services within primary care;
- emphasize prevention for people living with HIV;
- recommend HIV Provider-Initiated Testing and Counselling to all patients seeking care, and to pregnant or breastfeeding women.

It is useful to develop a logical matrix that depicts the interrelationship between the goals, objectives and interventions.

### 6.3. Steps in Setting Priorities

Some steps in setting priorities are as follows:

1. **Review situation analysis.** Refer to what the situation analysis says about who is most affected, what is driving new infections, what aspects of the response are performing well, which areas are underserved, etc. So as to have a clear view of the problem.

2. **Involve stakeholders.** Ensure that processes have been defined for involving stakeholders in setting priorities. Some the key stakeholders include policy makers, major implementers, civil society, people living with HIV and donors.

3. **Define prioritization criteria.** Define the principles or approaches to prioritization. It could be that priorities defined in the outgoing plan are still valid and need to be continued. It could be that the focus this time might be on specific population groups or geographical areas. It could also be that the emphasis should be on improving the volume or quality of interventions. Addressing inequities should be a clear criteria for prioritization.

4. **Identify priority areas and set targets.** Identify clearly the priority areas to be included. It might be useful, especially where many areas have been identified, to rank the level of priority, e.g. as high, moderate or low. The ranking might entail, for example, that resources are first allocated to those ranked as high priority followed by those ranked moderate and low. For each of the priorities baselines (if known) and targets should be set.

5. **Construct log frame or results matrix.** A logical or results matrix shows how different planning elements are linked to delivering on the identified priorities. Log frames vary in the way they are constructed and the level of detail. They should show logical links to results and should provide a snapshot of the plan.

### Resource materials


The strategic plan should define how the identified priorities will be measured and how the performance of the plan will be assessed. In general, monitoring deals with assessing how well the programme is being implemented. It is concerned with tracking inputs, process and outputs. Programme evaluation or review is generally concerned with what difference the programme is making and what results are being achieved. Evaluation therefore has more to do with assessing outcomes and impact as well as understanding determinants of performance.

Monitoring and evaluation is important for:

- Programme managers and implementers, to assess how well the programme is proceeding, identify problems and find solutions
- Policy makers to provide justification for decisions made and resources allocated
- Donors to justify their investment and reassure them of commitment to follow the plan
- General public and beneficiaries to support ongoing implementation and inform on problems being experienced
- Researchers and academics to identify issues for operational and basic research.

M&E for the health sector response to HIV is part of the “One agreed M&E framework” for national response, in line with the “Three Ones” principles. It is also part of the M&E framework for the health sector as a whole. A good M&E system should clearly define what is being measured, how to measure and how to use the information obtained. It should also develop the capacity required to collect and utilize the information. There are four main components of a functional M&E system, namely: indicators; data collection, information flow; and application.
Figure 7.1 Components of an M&E System.

Source: Adapted from WHO, UNAIDS, GF HIV Triangulation Resource Guide, February 2009
7.1. Indicators

Indicators are measures (metrics) of progress. One or more indicators should be selected for each of the priorities of the programme. They can be categorized as input indicators, process indicators, output indicators, outcome indicators and impact indicators, depending on the level of change they are measuring. Indicators have to be measurable.

Figure 7.2: Types of Indicators

In selecting indicators it is useful to consider the following:

− the indicator should be appropriate for the area and level of change;
− it is better to have few good indicators than many weak ones;
− it should be possible to collect the data required to generate the indicator;

Where a suitable indicator does not exist or is difficult to measure a proxy or indirect indicator can be identified instead. For example, incidence is appropriate measure of new infections. However, not many countries are able to conduct incidence studies. Instead, they could use prevalence of HIV in young people (11-24 years) as a proxy indicator of new infections in a generalized epidemic.

Defining indicators can be complicated. It is strongly recommended that the countries select indicators from standardized list from existing sources. Standardized indicators often represent a significant amount of work gone into defining them and are also more likely to have corresponding data collection tools already developed. It is also important to do this to facilitate the alignment of all stakeholders, including the donors, with country planning. UNAIDS, WHO and other Cosponsors have developed a comprehensive registry of HIV/AIDS indicators from which countries can draw. Some indicators proposed for country consideration in the Global Health Sector Strategy are shown in Figure 7.3. All indicators must be appropriately disaggregated by sex, age and other variables as recommended in the International UNAIDS and WHO guidelines.

Figure 7.3: Core Indicators Proposed for Country Consideration

<table>
<thead>
<tr>
<th>Strategic direction</th>
<th>Core indicators&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
</table>
| 1. Optimize HIV prevention, diagnosis, treatment and care outcomes | 1.1 Percentage of young people aged 15-24 years who are HIV infected  
1.2 Number of deaths associated with HIV  
1.3 Number of new HIV infections among children 0-4 years of age  
1.4 Percentage of men and women aged 15-49 years who received an HIV test in the previous 12 months and know their results  
1.5 Percentage of adults and children with advanced HIV infection who receive antiretroviral therapy  
1.6 Number of HIV-positive individuals who receive trimethoprim-sulfamethoxazole prophylaxis according to national guidelines  
1.7 Percentage of estimated HIV-positive incident tuberculosis cases that received treatment for HIV and tuberculosis |
| 2. Leverage broader health outcomes through HIV responses | 2.1 Unmet need for family planning  
2.2 Maternal mortality ratio  
2.3 All-cause mortality rate among children aged 0-4 years  
2.4 Proportion of tuberculosis cases detected and cured under directly-observed treatment, short course |
| 3. Build strong and sustainable systems | 3.1 Recommended core indicators from the Monitoring Health Systems Strengthening Handbook of Indicators and Related Measurement Strategies<sup>20,21</sup> |
| 4. Reduce vulnerability and remove structural barriers to accessing services | 4.1 Completion of the National Composite Policy Index  
4.2 Completion of the People Living with HIV Stigma Index<sup>22</sup>  
4.3 Availability of service-delivery points providing appropriate medical, psychological and legal support for women and men who have been raped or experienced incest |

<sup>a</sup> Indicators recommended for monitoring implementation of the Declaration of Commitment on HIV/AIDS are shown in italics, and indicators used for tracking progress towards the Millennium Development Goals are shown in bold.

All indicators are to be sex- and age-disaggregated, as appropriate, and analyses should be conducted to determine whether the response adequately addresses key social determinants of HIV vulnerability and risk, including gender inequality, and takes the necessary steps to achieve equitable access to services. Working towards equity involves analyses of differences within and between groups, within and across countries, using a series of summary measures.

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<sup>21</sup> For example, most countries will find it useful to track changes in availability of medicines at service delivery level, using the following core indicator: percentage of facilities that have all tracer medicines and commodities in stock, which is described in the Handbook.

<sup>22</sup> This includes consideration of stigmatization and discrimination in the health services, as measured by the percentage of respondents who report that they were denied health services, including dental care, in the last year because of their HIV status.
7.2. **Data Collection**

The main sources of data for indicators to measure programme performance should be identified. Main sources of data for monitoring and evaluation of the health sector response to HIV include the following:

- **Routine reporting:** This includes management information that tracks resources and activities. It also includes facility data and vital statistics. Routine sources provide information mostly for assessing inputs, processes and outputs.

- **HIV surveillance:** Second-generation HIV surveillance combines routine tracking of biological and behavioural markers of HIV infection. This is usually the mainstay for estimating HIV prevalence in the general or specific populations. It contributes to assessing outcomes and impact.

- **Population surveys:** Assess coverage and utilization of services. They also assess behaviour change, prevalence of risk factors and quality of life. Population surveys are often the source of information on programme outcomes and impact.

- **Operational research:** Helps set out a learning agenda for the programme. Methods can vary from case studies to quasi-experimental. Examples of questions for operational research include the following: What are the determinants of uptake of testing and counselling? What are opportunities and challenges to scaling up ART? Does the HIV programme contribute to provision of other public health services?

In addition to identifying information from these sources required to measure progress of the programme, it is also important that the necessary to identify the skills and capacities required to carry them out.

7.3. **Information Flow**

The flow of information for M&E includes consideration of how the data are managed as well as how they are analysed and synthesized. This all takes place in the context of the national health information system.

The aim is to have a strong M&E system in place for the HIV plan which is integrated into and contributes to the national health information system that includes other disease programmes and health systems. The system should generate information and streamline information requirements for national and international reporting. Managing information needs to be supported by appropriate information communication technology. The M&E system should also include skills needed to analyse and synthesize the information. The system should also enable reporting, analysis and use of data that are disaggregated in order to ensure that equity can be monitored and corrective actions can be taken to address inequities.
7.4. **Application**
M&E related information is generated for a number of uses. It is primarily intended to improve programme management and planning. M&E is the basis for assessing programme performance. It also forms the basis for situation analysis of succeeding plans. Policy makers, managers and implementers use M&E to make decisions on how to modify implementation, making changes to an existing plan (reprogramming) and developing a new plan.

Other uses of M&E include:

- Informing decisions on resource allocation for the health sector and the response to HIV.
- Produce reports to meet both national and international reporting obligations, including reporting to donors.
- Informing the formulation of health or HIV policy.
- Communicating with the general public through the media and other advocacy channels.
- Inform further research and in estimates and projections of needs.

7.5. **Programme Reviews and Evaluations**
Periodic programme reviews and evaluations are an important element in programme management and accountability. Programme reviews often involve key stakeholders in the response and look at how well the programme is performing at various levels.

**Annual reviews** focus on whether programme implementation is on track according to the national plan. They are generally considered ‘light’ reviews that focus on the progress of implementation by reviewing national indicators related to inputs, activities and outputs. They will also assess outcomes, where information is available.

**Mid-term reviews (MTRs)** are typically conducted at mid-term and/or close to the end of a ‘strategic’ multi-year programme cycle. In addition to assessing inputs and outputs, mid-term reviews also seek to assess outcomes and impact.

**Specific reviews.** In addition to assessing progress of the health response to HIV/AIDS as a whole (as in annual and mid-term reviews), reviews can also focus on specific aspects of the programme. They could be limited to specific interventions or services, such as treatment, prevention of mother-to-child transmission, services for injecting drug users or community service delivery models. They could also be carried out for specific donor-funded projects, such as those supported by the Global Fund to Fight AIDS, TB and Malaria, the World Bank or other multilateral and bilateral institutions. Sometimes, programme reviews might be limited to specific geographical areas.
A national country health systems surveillance (CHeSS) platform is needed to bring together the monitoring and evaluation work in disease-specific programmes, such as TB, HIV/AIDS and immunization, with crosscutting efforts such as tracking human resources, logistics and procurement, and health service delivery (Figure 7.4). It also includes a contextual component that describes health systems in a systematic manner. The main goal of CHeSS is to improve the availability, quality and use of the data needed to inform country health sector reviews and planning processes, and to monitor health progress and system performance. It is the platform for subnational, national and global reporting, aligning partners at country and global levels around a common approach to country support and reporting requirements.

Figure 7.4: National Platform for Country Health System Surveillance (CHeSS)

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7.6. Steps in Elaborating Monitoring and Evaluation of the Plan

- **Put together a team.** The team should consist of people who are familiar with M&E.

- **Define indicators.** Define the most appropriate indicators for each of the defined programme priorities.

- **Identify data sources.** Review the existing sources of data for the indicators. Identify both existing sources and new sources or methods to be developed.

- **Identify capacity needs.** Identify the capacity requirements to improve (access and quality) existing sources of information and to develop the new sources. This includes people, skills, technology and equipment.

- **Identify clients and uses.** Define the type of reports to be produced. Who will use the information and for what purpose.

**Resource materials**


Once priorities (goals, objectives and main interventions) of the programme have been identified, the planning team should proceed to define how the programme will be implemented. This includes identifying appropriate approaches and models of service delivery; system and capacity requirements and management and coordination arrangements. The programme and identified priorities are more likely to be implemented when sufficient attention is paid to defining the implementation and capacity requirements.

8.1. Service delivery

Approaches to service delivery will vary depending on the type of services being delivered, the population groups to benefit from those services and the type of service delivery system existing in the country. For example, approaches to delivering the same types of services might differ slightly between urban and rural areas. Similarly, systems for delivering services to, say, pregnant women would vary from those for injecting drug users. Some of the issues to consider in service delivery are as follows:

- **Channels:** Will the services be delivered through general or specific channels. General channels include, for example, health facilities, which can be accessed by the general population. Specific service delivery channels include those designed to reach specific populations such as sex workers, MSM, youth, IDU or mobile populations.

- **Providers:** It is necessary to consider who are involved in service delivery and which services they are best placed to deliver and to which population groups. Service providers often include the public sector, private sector, nongovernmental organizations, communities, religious organizations and others.

- **Levels:** Considerations for service delivery should also take into account the appropriate levels of the health for delivering various services. Usually first line services provided directly to clients will be delivered at district and community levels. While provincial and national levels complement, provide referral or backup support, or provide more specialized services.

- **Integration:** Consider possible synergies in service delivery. This includes identification of opportunities where (i) specific channels or approaches can be used to deliver multiple HIV interventions, (ii) other programmes (such as tuberculosis, maternal child health, reproductive health, adolescent health and others) can incorporate HIV services, and (iii) HIV services can contribute to advance progress in other programmes.

Service delivery for a national programme will consider various combinations of all the above. It is necessary to ensure that the most appropriate service delivery approaches for defined priorities are clearly identified and included in the service delivery system.
8.2. Systems strengthening

HIV-related services for the health sector response are delivered by the health system. The health system is defined as "the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to legitimate expectations of the people and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health."\(^{24}\) Health systems in most developing countries are generally weak and not able support the level of scale-up of HIV services necessary to achieve universal access. Building capacity of health systems is therefore an important to attaining the goals of the HIV response. While some health system strengthening actions will be specific to the HIV programme most, however, cut across programmes and concern the health system as a whole.\(^{25}\) Critical subsystems for health system strengthening include the following:

- **Human resources.** Consider the type, numbers and skill of health workers required to deliver the defined programme. Where workforce numbers are insufficient, plan to support the training, recruitment and retention of more health-care workers, the shifting of tasks from more- to less specialized health workers, and the introduction of systems to support and recognize the contribution of health workers in difficult locations. Plan to support the involvement of community organizations and lay workers in the delivery of HIV services. Ensure access HIV services for health workers and others concerned.

- **Financing.** Ensure that adequate funding will be available in a timely manner to meet the requirements of implementing the plan. Mobilize resources from domestic or external sources, address financial barriers to accessing service and offer protection from catastrophic health expenditure.

- **Medicines, diagnostics and other commodities.** Consider how to ensure continued access to the medicines, diagnostics and other commodities needed for the HIV response, and that are affordable and of acceptable quality. This involves paying attention to appropriate forecasting, procurement, storage, distribution, utilization and regulation for the required medicines, diagnostics and commodities.

- **Information systems.** Strengthen information systems for HIV programmes within the context of more robust, integrated and harmonized overall national health information systems.

- **Infrastructure.** Plan for expansion of the health infrastructure to meet the requirements for HIV prevention, treatment, care and support. This might involve construction of new health facilities, renovation of existing structures, establishment/expansion of mobile services, outsourcing to organizations with access to previously underutilized infrastructure, and reorganization of service delivery to optimize the use of existing facilities.

8.3. Role of Ministry of Health
Some of the functions of the Ministry of Health are to provide policy guidance, regulation, ensuring accountability for health, health intelligence and building partnership across all health actors. The Ministry of Health should also ensure that public health services are of quality and are equitable. The Ministry of Health must play these critical roles in the health sector response to HIV, also, and in particular, when it is not a major provider of health services. The AIDS Programme of the Ministry of Health should provide technical leadership and coordination of the health sector response to HIV. The AIDS Programme Manager should serve as a leader, manager, facilitator and innovator and should liaise regularly with other health programmes and other health and HIV actors.

8.4. Decentralization levels
The approach to planning can be either top-down, where priorities are defined at the central level and have to be translated at the subnational levels. Bottom up planning is where the national plan reflects the sum of results from the subnational levels. More countries are adopting various combinations of the two approaches to allow both national coherence and local relevance.

To be effective national strategic plans must be linked to sub-national operational plans, at the regional or district level. The degree of linkage depends on the level of detail in the national strategic plan, as well as on the level of autonomy different levels have to define their own strategies.

Some countries tend to choose a more centralized approach with an explicit and tight linkage between national strategic plans and sub-national operational plans: this has the advantage of coherence between local operational plans and the national strategic plan, but may be overly controlling and provide insufficient adaptation to context.

Other countries go for a more decentralized approach with a looser link between national strategic plans that offer guidance, but leave much more liberty of interpretation at more decentralized level: this allows for flexibility and creativity at the operational level, but may lead to contradictions with the national strategic plan.²⁶²⁷

8.5. Coordination
As the response to HIV involves a wide diversity of actors, coordination at various levels of the system becomes important to ensure coherence and cohesion of efforts. The AIDS Programme Manager should ensure effective coordination (a) with other health programmes, (b) between the HIV activities in the health sector and those in other sectors, and (c) for the implementation of the HIV activities in the health sector, between the different levels of the health system (national, regional and district).

Other mechanisms for coordination which currently exist include the following:

- **National AIDS Council (NAC).** This is the primary mechanism for multisectoral coordination in many countries. It ideally includes representation from key actors in the national response to HIV including various government ministries, nongovernmental organizations, people living with HIV, faith-based organizations, private sector and development partners. The National AIDS Council or Commission is usually a stand-alone institution, with a governance body (Council) and an operational body (the Secretariat). The NAC might be situated in the Office of the President, Prime Minister or in a ministry, usually the Ministry of Health.

- **Coordination in the Health Sector.** Various coordinating mechanisms and processes exist within the health sector. Countries might have high level mechanism such as health sector steering committee in the context of sector-wide approaches (SWAps). Such committees might be chaired by senior officials in the ministry of Health and provide general guidance to the health sector. Technical level coordination between health programmes might occur through technical working groups.

- **Donor Coordination Mechanisms.** Some funding agencies, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria have established Country Coordinating Mechanisms (CCM) to guide and align Global Fund investments within a given countries. The President’s Emergency Fund for AIDS Relief (PEPFAR) and other donors might have other types of mechanisms for coordinating their in-country efforts.

The health sector is involved and often a key member of these coordinating mechanisms and should always work to ensure consistency and harmonization of all these processes.

Steward and Advocate for the AIDS response in other sectors: The health sector is often in a position to provide the evidence necessary to leverage action for HIV in other sectors. The Ministry of Health has a crucial role in using its stewardship and advocacy power to ensure that HIV issues are addressed in all policies. This includes engaging ministries of education, social development, gender, transport etc.
9. COSTING AND BUDGETING

Any plan will bring with it the need to use resources. The proper management and allocation of resources requires planners to have a good overview of expected physical resource requirements, availability and gaps.

The use of resources to implement a plan always requires financial expenditures. Money is needed to purchase physical resources such as staff time and training, buildings and infrastructure, supplies and equipment, medicines, and skills. Therefore, a good plan requires a complete and accurate view of how much money will be required, for what, when, and by whom. It also requires a good estimate of how much money will be available to ensure that expenditures are adequately financed.

There are several compelling reasons to develop a clear and accurate picture of how much money is required and how much is available to implement a plan:

- To give guidance to the relevant ministries and political decision-makers on the financial consequences of approving the plan and allocating funds.
- For strategic planners to know whether sufficient financial resources are available to implement the plan. A shortfall may indicate that the plan needs to be revised within the financial limitations that exist.
- To highlight areas where additional investments need to be made in order to ensure the effective implementation of the plan - e.g. to scale up the health workforce, build additional capacity or improve physical infrastructure.
- To secure funding for the national strategy, e.g. from Ministries of Finance, International Organizations, bi- and multilateral donors and international NGOs. Donors and Ministries of Finance may be extremely reluctant to allocate funds without detailed and accurate financial estimates.

9.1. Principles of Costing

The process of estimating the cost of a plan is referred to as “costing” the plan; when the costs have been estimated we can say that we have a “costed” plan. Costing a plan requires planners to estimate the financial expenditures that will be required to achieve the results set out in the plan.

Cost estimations provide valuable input into the planning process. Cost estimates reinforce priority-setting by highlighting resource constraints. They provide guidance to decision-makers on the feasibility of a plan and the most cost-effective means to achieve results. Perhaps most importantly, cost estimates can be matched to available funds to identify funding gaps and mobilize additional resources from the national budget or international sources.
9.1.1. Costing for results
A critical aspect of costing is to ensure that costs are correctly linked to the results framework. Every result in the results framework must have a cost allocated to it (unless there really is a ‘no-cost’ result – but this is very unlikely), and all costs must be allocated to results. At the operational level, costs must be attributed to individual interventions and activities.

9.1.2. Direct and indirect costs
In costing a plan, planners must take care to include all the costs associated with the achievement of a particular result or implementation of an activity. Some of these costs will be direct costs and others may be indirect costs. Direct costs are the obvious costs that can be attributed directly to the provision of a service, implementation of an activity, and so on. Indirect costs are the less obvious additional costs that cannot easily be attributed to provision of a given service or activity.

For example, the direct cost of providing ART to one person per year would include the cost of the drugs themselves, required tests, and so on. It might also include some additional costs for the time of the health worker who examines the patient and prescribes the drugs. The indirect costs might include the cost of operating the clinic where the visit occurred, including some portion of the rent, utilities, maintenance, administration, etc., some proportion of programme management and administration, training of health workers, managing the procurement and supply system for the distribution of drugs, operating costs of laboratories, etc.

Often indirect costs are assumed to be covered under another budget and may be considered “free” in terms of a particular service. This is incorrect; in calculating costs it is extremely important to include both direct and indirect costs. Any resources used in the provision of a service, implementing and activity, etc., must be accounted for somewhere in the budget.

9.1.3. Attribution of costs
Much of the challenge in costing is trying to work out indirect or ‘hidden’ costs, and deciding which proportion of shared costs should be allocated to which result. For example:

- The Central Medical Stores (CMS) may be responsible for procurement and distribution of ARV drugs: how much of the CMS’ operating costs should be allocated as a ‘cost’ of providing treatment to each patient in addition to the actual costs of the drugs?
- A UN agency may provide TA for the plan: how much of the UN agency’s operating costs should be included, additional to the actual technical assistance costs?
- What are the costs of supporting community-based organizations to provide typical outreach activities? Is it just the formal ‘capacity building’ costs? Or does it include continuous supervision and support?
9.1.4. **Average and marginal costs**

Average cost is the total cost, on average, of producing one unit of a given output. It is normally defined as the total cost of a programme or of delivering a service or intervention, divided by the number of units delivered (C/Q). Average costs are important in costing as they are often used as "unit costs" in estimating the cost of delivering on a target in a plan.

Marginal costs are the incremental cost of producing one additional unit of an output. These are defined as the change in total costs divided by the change in the number of units produced. Often marginal costs are lower than average costs when a programme is in the process of scaling up. Marginal costs can be important when the goal is to "add" a service or intervention to existing services.

9.1.5. **Efficiency and effectiveness**

Efficiency is described as the condition in which no productive resources are wasted in the delivery of a certain product or service. Technical efficiency is when a given output is produced at minimum cost, or alternatively, when the maximum level of output is achieved for a given level of cost. Allocative (Pareto) efficiency occurs when the outcomes achieved with the available resources match the priorities of society. The definition of Pareto efficiency is that no person in society can be made better off without making someone else worse off.

Effectiveness addresses the question of how well a given intervention delivers the desired result relative to the cost of the intervention. The results are usually described in terms of lives saved, life-years gained, infections averted or some other measure of the effect of a given intervention. An intervention is said to be cost-effective if it delivers the maximum effect at a given level of cost, or if cost is minimized for a given effect.

9.1.6. **Recurrent vs. capital expenditures**

Recurrent costs are those operating costs that occur on a regular basis, e.g. salaries, disposable supplies and equipment, utilities, etc. Capital costs are those costs which involve a significant one-time investment on infrastructure or equipment which can be used over a long period of time, e.g. buildings, vehicles, sophisticated laboratory equipment, etc. Planners must decide how the costs of capital expenditures will be handled. One way is to attribute all the costs in the period in which they occurred. The alternative is to amortize the cost on a yearly basis over the useable life of the investment.

This concept is closely linked to the notion of fixed and variable costs. Fixed costs are usually capital costs - i.e. they are costs that cannot be varied depending on the level of output. Variable costs are similar to recurrent costs - i.e. they can be varied or even eliminated by reducing the level of a service.
9.1.7. Economic vs. financial costs

Economic cost differs from financial cost in that it includes the notion of opportunity cost. Opportunity costs are simply the cost of allocating resources to one alternative rather than another alternative. For example, if a doctor spends 50% of his time providing treatment to AIDS patients, he is unable to spend that time providing treatment to patients with other conditions. The economic cost of a programme or activity thus includes both the cost of the chosen intervention and the benefit that the best alternative would have provided if it had been chosen. Normally strategic plans are costed using financial costs and not economic costs.

9.2. Approaches to Costing

Plans can be costed using either a top-down or a bottom-up approach, as illustrated in Figure 9.1. Normally a strategic plan is costed using a top-down approach, while implementation plans may be costed using a bottom-up or inputs-based approach. Thus strategic costing tends to be a more general estimate of costs, while operational costing is more detailed and usually more accurate. Costings developed using the two approaches may not always be consistent with one another, so there may be a need for reconciliation between costings at the strategic and operational levels.

9.2.1. Top-down costing

The top-down approach to costing a strategic plan is normally carried out using data on the population who are the subject of the results to be achieved, coverage targets, and the average cost of providing one standardized unit of a service or intervention (unit cost).

Total costs are derived by first multiplying the population in need by the coverage target, and then multiplying that number by the cost of providing the service for one year. Thus, $C = P \times T \times U$ where:

$C = \text{total cost}$

$P = \text{population}$

$T = \text{coverage target}$

$U = \text{unit cost}$

A complete costing exercise would need to take account of changes in the three variables (population, coverage, unit cost) over the life of the plan. Populations in need can change over time as the epidemic evolves. Coverage targets also evolve as a country advances towards the ultimate coverage targets for the planning period. Changes in unit costs can occur for a number of reasons, including economies of scale as programmes are expanded, or broader economic changes such as inflation, exchange rate changes, rising salaries and so on.
For example, a country may expect the epidemic to evolve in a linear fashion, with an increase of 5000 people per year who are in need of treatment. The coverage targets also evolve towards the ultimate target of 50% and the unit cost of providing ART to one person per year may be expected to decline slightly over time. The resulting costs might resemble the matrix in figure 9.2 below:

Figure 9.2: Simple Costing Based on Population and Coverage Targets

<table>
<thead>
<tr>
<th>Year</th>
<th>Population in Need</th>
<th>Coverage Target</th>
<th>Unit Cost</th>
<th>Yearly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>100,000</td>
<td>20%</td>
<td>400</td>
<td>8,000,000</td>
</tr>
<tr>
<td>Year 2</td>
<td>105,000</td>
<td>25%</td>
<td>380</td>
<td>9,975,000</td>
</tr>
<tr>
<td>Year 3</td>
<td>110,000</td>
<td>30%</td>
<td>360</td>
<td>11,880,000</td>
</tr>
<tr>
<td>Year 4</td>
<td>115,000</td>
<td>40%</td>
<td>340</td>
<td>15,640,000</td>
</tr>
<tr>
<td>Year 5</td>
<td>120,000</td>
<td>50%</td>
<td>320</td>
<td>19,200,000</td>
</tr>
<tr>
<td>Total years 1-5</td>
<td></td>
<td></td>
<td></td>
<td>64,695,000</td>
</tr>
</tbody>
</table>

This simple example does not consider other issues which may affect costs, such as treatment failure and rates of switching to second-line treatment, etc. These will need to be taken into account to provide an accurate costing.

By the time the plan has reached this stage, most of the data necessary to cost the plan should already be available. The estimation of populations in need should have been done during the situation analysis and coverage targets will have been set during the target-setting phase of developing the plan. Only the last element, unit costs, needs to be determined to allow for an accurate costing.

9.2.2. Bottom-Up Costing

A country may decide to cost the plan by constructing costs of results from their individual components. This is the bottom-up, or inputs-based approach to costing. This approach requires a compilation of the inputs, or detailed activity components, for each output. The cost of each component of an output is estimated, and the sum of the component costs is the cost of the output. For example, we can anticipate that a training activity will include costs such as honoraria for trainers, travel and subsistence allowances for participants and faculty, rental of a venue, and so on. The cost of each of these individual inputs can be estimated with a reasonable degree of accuracy. The sum of the costs of these detailed activity components will be the cost of one training course. The cost of each sub-activity can be estimated in this way, and costs for the activity can be estimated as described in the above paragraph.

This method is illustrated in figure 9.3. Note that for each sub-activity component we must specify a unit of measurement as well as the cost per unit and the quantity of units that will be consumed in producing the activity. This step is important, because without a careful definition of these variables it is easy to confuse what is being costed and how much is required. To illustrate, suppose the unit of measurement for the cost of the venue rental for the training courses is...
not specified. If no unit of measurement were specified, we would not know whether the cost estimate refers to a daily rate or the rate for the entire 5 days of the workshop. This small error would have led to a discrepancy of $120,000 in the cost of the sub-activity. This is an error of almost 25% in the cost estimate, and could seriously undermine the accuracy of the budget.

Figure 9.3: Inputs-Based Costing by Sub-Activity

<table>
<thead>
<tr>
<th>Objective 1: Increase the number of people who know their HIV status from 100,000 in 2010 to 5 million in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention 1.1: Increase coverage of provider-initiated testing and counseling from 5% in 2010 to 50% in 2015</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Main Activity 1.1.1: Train 1000 health workers on provider initiated testing and counseling</td>
</tr>
<tr>
<td>Frequency of sub-activity</td>
</tr>
<tr>
<td>(A)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Sub-activity 1.1.1.1: Development of training materials</strong></td>
</tr>
<tr>
<td>Consultant to develop training modules</td>
</tr>
<tr>
<td>Editing and layout</td>
</tr>
<tr>
<td>Printing</td>
</tr>
<tr>
<td><strong>Sub-activity 1.1.1.2: Training of trainers</strong></td>
</tr>
<tr>
<td>Expert consultant</td>
</tr>
<tr>
<td>Consultant - travel costs</td>
</tr>
<tr>
<td>Consultant - daily subsistence</td>
</tr>
<tr>
<td>Venue rental</td>
</tr>
<tr>
<td>Participant travel</td>
</tr>
<tr>
<td>Participants - daily subsistence</td>
</tr>
<tr>
<td><strong>Sub-activity 1.1.1.3: Training workshops</strong></td>
</tr>
<tr>
<td>Trainer</td>
</tr>
<tr>
<td>Trainer - travel costs</td>
</tr>
<tr>
<td>Trainer - daily subsistence</td>
</tr>
<tr>
<td>Venue rental</td>
</tr>
<tr>
<td>Participant travel</td>
</tr>
<tr>
<td>Participants - daily subsistence</td>
</tr>
</tbody>
</table>
Bottom-up costing is usually very detailed and can accommodate different input costs for different service providers. The main challenge with this approach is to ensure that all the necessary inputs to produce the outputs get identified. A common problem with the bottom up approach is to cost only the obvious inputs, and to miss out important indirect or ‘hidden’ inputs that are required to achieve an output.

9.3. Unit costs

Unit costs are an expression of the total direct and indirect costs of providing one “unit” of a given “output” or service over a given time period. Unit costs are normally identical to the average cost of delivering a service or intervention.

Examples of unit costs might include the following:

- The cost of providing ART to one person for one year
- The cost of performing one male circumcision
- The cost of procuring and distributing 1000 condoms
- The cost of testing and counselling one person
- The cost of screening one blood donor for HIV
- The cost of performing one CD4 count

Unit costs for some services (e.g. ART) need to be expressed in terms of a time-frame because they are recurrent. Other services (e.g. male circumcision) are delivered only once and need not be expressed in terms of a time-frame.

In calculating unit costs it is important to include both direct and indirect costs. As mentioned above, direct costs are those costs that can be directly attributable to the provision of a service, or implementation of an activity, e.g. cost of medicines, tests, doctor’s time, etc. Indirect costs are those costs not directly attributable to the provision of the service, such as the cost of shared infrastructure, programme management, procurement and supply systems, etc.

Unit costs can be derived from data on the costs of previously providing the relevant intervention in a country. Given aggregate data, it should be possible to calculate an average, or “unit” cost of providing the service. For example, in 2006 it was estimated that the cost of providing ART in Mozambique was US$ 19,522,780 and the number of people on ART was 44,100\(^{28}\). The unit cost of ART can be calculated by dividing the total cost of ART by the number of people receiving ART to obtain a unit cost of $442.

Countries are encouraged to use existing data on programme costs and services delivered to calculate unit costs whenever possible. A number of tools are available to help countries collect and analyse such information. The National AIDS Spending Assessment (NASA) has also been developed by UNAIDS and provides a framework for undertaking a comprehensive analysis of actual expenditures for HIV&AIDS. It can be applied to any HIV/AIDS related activity (health

\(^{28}\) UNAIDS, NASA Report for Mozambique
and non-health) and used to calculate unit costs for many interventions. The NASA expenditure categories, however, are generic programme categories, and do not necessarily fit with specific country strategic frameworks. They must therefore be adapted in each case to country realities. (See details at: http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp)

Determining unit costs may be challenging where different service providers have very different costs, depending on their administrative costs, overheads, staff salary levels, etc. In many countries international NGO, for example, have much higher costs in providing services than local NGOs or government. Adjustments must be made in the costing exercises for the different proportions of services provided at such different costs.

Accurate unit cost data will not always be readily available for many interventions. In such cases, other methods may be required to estimate unit costs. One option is to refer to data from other countries with similar cost structures, or to data in the published literature. The Resource Needs Model, discussed below, often relies on such data to estimate unit costs.

Another approach is to approximate unit costs by estimating the cost of inputs needed to deliver the intervention. This can be done at a macro (or top-down) level by estimating the total cost of providing the service and dividing that total cost by the number of service units provided. For example, suppose in a previous period that ART had been provided to 20,000 people through a network of 100 HIV clinics. The total cost of ARV medicines was $7.3 million, the operating costs of each clinic averaged $24,000 per year, and salaries averaged $38,400 per year at each clinic. It is estimated that 25% of the resources of the clinics were devoted to providing ART and monitoring patients on ART. A simple unit cost calculation could be performed by multiplying the total cost of running the clinics by 25%, adding the cost of ARV medicines, and dividing by the number of patients served\(^{29}\) to obtain a unit cost of $438. Note that the unit cost is significantly higher than the simple cost of purchasing the ARV medicines ($7.2 million divided by 20,000 = $360). This is due to the additional costs associated with delivering the medicines to each person over the course of the year.

Estimating unit costs can also be done at a micro (or bottom-up) level, by estimating the input costs of a given intervention provided to one person. In this case, it is necessary to define a unit of measurement for each input, a cost per unit, and the number of units used by each patient in a given time-period (usually one year). For example, suppose the typical person on ART is receiving an ARV regimen that costs $1.00 per day. The medicines are delivered during a clinic visit each month. The operating costs of a clinic are estimated to be about $200 per day and the time of a health worker is valued at $20 per hour. Each visit takes about 10 minutes, and the clinic sees an average of 80 patients per day. A simple unit cost calculation can be done by converting the costs into units attributable to each patient. The cost of the antiretroviral drugs is wholly attributable to the patient and 30 units are provided each month. The cost of the health worker’s time is estimated at about 20% of one hour per visit (i.e. 12 minutes) for a total of about 2.4 hours per year. The overhead costs of the clinic are calculated at the daily rate ($200)

\(^{29}\) \(\frac{(100 \times (24,000 + 38,400) \times 0.25 + 7.2 \text{ million})}{20,000}\)
divided by the number of patients seen each day (80) to arrive at a utilization rate of 0.013 units per visit or a cost per visit of $2.50. The total cost per patient per year is estimated to be $438 as illustrated in Figure 9.4 below.

**Figure 9.4: ART Unit Cost Estimate**

<table>
<thead>
<tr>
<th>Cost item</th>
<th>Unit of Measurement</th>
<th>Cost per Unit</th>
<th>Units per Visit</th>
<th>Visits per Year</th>
<th>Cost per Patient Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARV Medicines per day</td>
<td>1.00</td>
<td>30</td>
<td>12</td>
<td>360</td>
<td></td>
</tr>
<tr>
<td>Health worker's time per hour</td>
<td>20.00</td>
<td>0.200</td>
<td>12</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Clinic overhead costs per day</td>
<td>200.00</td>
<td>0.013</td>
<td>12</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>438</strong></td>
</tr>
</tbody>
</table>

To assist in calculating unit costs, WHO provides simple unit cost estimators for a number of common interventions. The AIDS Medicines and Diagnostics Service (AMDS) also provides extensive data on the costs of antiretroviral drugs and other commodities commonly used in HIV/AIDS programmes. The WHO CHOICE data-base is another potential source of useful cost data on the unit costs of various health sector inputs, as well as some tools to collect and analyse cost data at programme, hospital and facility levels. While these tools are not specific to HIV/AIDS, they can provide general health sector input to HIV/AIDS plans.

### 9.4. Resource Estimation and Allocation

The next critical step involves estimating what resources are available, or will become available, from all sources, over the course of the strategic plan period. Resource estimates can be based on national budgets, donor funding and pledges, expectations from the Global Fund, etc, as well as estimates from other partners and implementers. A simple format as shown in Figure 6-5 is a useful starting point to get an overall picture.

Points to remember in compiling this table are:

- The importance of spreading it across all the years of the Plan: much of the funding may be only available for some years.
- The need to avoid duplication: where PEPFAR funding, for example, goes to International or local NGOs, it needs to be put either in the PEPFAR row in the table and not in the NGO row, or vice versa.
- It may be difficult to extract funding specific to HIV in the health sector from larger grants or allocations.

---


Compiling an estimate of resources in is only the first step. The next step is to allocate this available funding against the strategic results framework. For each intervention, allocate funds available from the various donors to build a comprehensive picture of what funds are available for what planned results. Often funding will be restricted by donors to certain result areas or interventions, and will have to be allocated accordingly. More flexible funding can be allocated to other areas to try to achieve a balance between results.

Figure 9.5 provides an example of such an allocation for one year. Note that the funds are allocated to interventions and summed up by objective. The total for the goal is the sum of the funds allocated to the objectives and so on.

Figure 9.5: Resource Estimation

<table>
<thead>
<tr>
<th>Source of Funds</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. National Budget</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Ministry of Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGOs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Multilateral Donors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GFATM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNITAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World Bank</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>United Nations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Bilateral Donors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEPFAR</td>
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</tr>
<tr>
<td>USAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European Commission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DFID</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>CIDA</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AusAID</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. International Foundations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinton</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Civil Society</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FHI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WVII</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARITAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Allocation of Funds

#### Year 1

<table>
<thead>
<tr>
<th>Planning Element</th>
<th>Interventions</th>
<th>Funding Available</th>
<th>Source of Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1</strong></td>
<td>Reduced HIV related mortality and morbidity by 50%</td>
<td>69,385,298</td>
<td></td>
</tr>
<tr>
<td><strong>Objective 1.1</strong></td>
<td>Access to HIV treatment for adults increased from 55% to 80%.</td>
<td>43,618,870</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.1.1</td>
<td>Antiretroviral therapy</td>
<td>4,461,000 USG</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.1.2</td>
<td>Managing opportunistic infections and co-morbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention 1.1.3</td>
<td>Tuberculosis prevention, diagnosis and treatment</td>
<td>2,729,414 UN</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.1.4</td>
<td>Co-trimoxazole prophylaxis</td>
<td>1,797,000 UN</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.1.5</td>
<td>Palliative care</td>
<td>4,805,815 GF-R 7</td>
<td></td>
</tr>
<tr>
<td><strong>Objective 1.2</strong></td>
<td>Access to ART for children increased from 20% to 60%.</td>
<td>25,766,428</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.2.1</td>
<td>Pediatric antiretroviral therapy</td>
<td>1,770,000 UN</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.2.2</td>
<td>Treatment preparedness and adherence support</td>
<td>45,000 UN</td>
<td></td>
</tr>
<tr>
<td>Intervention 1.2.3</td>
<td>Managing malnutrition</td>
<td>1,320,000 USG</td>
<td></td>
</tr>
</tbody>
</table>

Points to consider in this exercise are:

- If the results framework is new (i.e. from a new strategic plan), many partners will not use the new framework for their allocations; it may take time for all partners to be able to show how their existing funding is allocated against the new results framework.
- Some partners, indeed, may have funding which does not relate at all to the strategic framework: deciding how to handle this is a difficult issue.
- Again, it is very important to avoid duplication.
- Some (new) areas may not have any funding allocated to them.
In the final step this table should be matched with the first one, so that the funding is shown by timeframe as well as by strategic allocation. This will then allow the calculation of the gaps in funding.

### 9.5. Financial Gap Analysis

A budget allows expected income to be matched against expected expenditures to enable a financial gap analysis. During the development stage, budgets will often be in deficit as plans may be too ambitious for the funds available. But even a “balanced” budget may have gaps if funding is inflexible and not allocated to the right activities, or if funding comes too late in the planning cycle. A gap analysis will identify where such imbalances occur and highlight where adjustments may be required to make the plan realistic.

To determine the financial gaps the costing and the resource estimation must be put together. Figure 9.7 provides an example of how this could be done. The table shows a hypothetical analysis for a hypothetical plan (only years 1 and 5 are shown for simplicity).

Overall the gap for planning period is $498,000. Note that some interventions are fully funded for some years while others have no funding for some years. Intervention 1.1.3 is fully funded for the entire plan, while intervention 1.2.3 has no funding. Intervention 1.1.3 if fully funded for the entire planning period, so the gap is equal to zero. Intervention 1.1.2 and 1.2.2 have negative gaps because the funds available exceed the funds required.

**Figure 9.7: Financial Gap Analysis**

<table>
<thead>
<tr>
<th>Planning Element</th>
<th>Year 1</th>
<th>…</th>
<th>Year 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost</td>
<td>Funding</td>
<td>Gap</td>
<td>Cost</td>
</tr>
<tr>
<td>Goal 1</td>
<td>770</td>
<td>606</td>
<td>164</td>
<td>996</td>
</tr>
<tr>
<td>Objective 1.1</td>
<td>230</td>
<td>120</td>
<td>110</td>
<td>555</td>
</tr>
<tr>
<td>Intervention 1.1.1</td>
<td>100</td>
<td>80</td>
<td>20</td>
<td>400</td>
</tr>
<tr>
<td>Intervention 1.1.2</td>
<td>50</td>
<td>83</td>
<td>-33</td>
<td>125</td>
</tr>
<tr>
<td>Intervention 1.1.3</td>
<td>80</td>
<td>80</td>
<td>-</td>
<td>30</td>
</tr>
<tr>
<td>Objective 1.2</td>
<td>540</td>
<td>486</td>
<td>54</td>
<td>540</td>
</tr>
<tr>
<td>Intervention 1.2.1</td>
<td>120</td>
<td>105</td>
<td>15</td>
<td>200</td>
</tr>
<tr>
<td>Intervention 1.2.2</td>
<td>300</td>
<td>381</td>
<td>-81</td>
<td>300</td>
</tr>
<tr>
<td>Intervention 1.2.3</td>
<td>120</td>
<td>-</td>
<td>120</td>
<td>40</td>
</tr>
</tbody>
</table>
The information that a financial gap analysis reveals is critically important. At the most obvious level, it shows where there are gaps, either because of insufficient funding, or possibly because an intervention area is new has not been funded yet. The gap analysis also highlights whether resources are currently being allocated against the right results, or whether a reallocation of resources is required. The gap analysis is also useful to show where there is duplication of effort - i.e. where several donors all funding the same interventions, leading to over-funding. Finally, it shows the contributions that various partners are making, so that accountability can be clearer.

The financial gap analysis is important to allow planners to:

- Reallocate funding from areas that are over-funded to those that are under-funded
- Prioritize interventions and objectives - some areas my need to be scaled back or eliminated while others may be scaled up.
- Adjust the scale and scope of a plan to make it financially feasible
- Focus resource mobilization efforts on those areas in most critical need of funding

9.5. Cash flow analysis

Cash flow analysis is a technique that allows planners to manage inflows and outflows of funds and identify where short-term cash problems might occur. It is closely related to gap analysis because it indicates where gaps might occur in the budget due to the relative timing of expenditures and income receipts.

Figure 9.8 shows a simple cash-flow projection. For each year the projection includes an opening balance, planned expenditures and income, and a closing balance. The closing balance in year 1 becomes the opening balance in year 2 and so on. A positive closing balance for any period represents a positive cash flow. A negative closing balance indicates a gap in financing for that period. Negative cash flow results need to be addressed through reducing expenditures or increasing income (possibly through borrowing) to ensure that the programme is adequately financed.

Cash-flow analysis can be done for any period - yearly, monthly, quarterly, or even daily.

Figure 9.8: Cash-Flow Analysis

<table>
<thead>
<tr>
<th>Cash Flow Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Year 1</strong></td>
</tr>
<tr>
<td>Opening Balance</td>
</tr>
<tr>
<td>Planned Expenditures</td>
</tr>
<tr>
<td>Expected Income</td>
</tr>
<tr>
<td>Closing Balance</td>
</tr>
</tbody>
</table>
9.6. Budget Presentation

A budget can be presented in a number of different ways. Frequently government budgets are presented as a list of expenditures on line items such as staff salaries and benefits, premises rental and maintenance, travel and transportation, supplies and equipment, computers, training, depreciation, and so on. Such budgets are not particularly useful for managing results-based strategic plans. For managing a strategic plan, it is necessary to use a budget format that describes what will be done and what funding will be required at each level of planning. Such a budget is referred to as a results-based or strategic budget because it provides the financial basis for the strategic plan. Increasingly governments are also being called upon to present their budgets in ways that the resources allocated for and spent towards on interventions and programmes that meet the needs of women and girls. In the recent report of the Accountability and Information Commission on Women and Children's health, there is a specific recommendation requiring countries and donors alike to be able to present such information in order to track resource flows towards the health of women and children. Therefore, it may be important to be able to present budget information to explicitly demonstrate expenditures that go towards women and girls. Gender-responsive budgeting provides such tools to do so.

A strategic budget does not simply summarize income and expenditures by cost category; it provides a comprehensive financial framework in which to design and implement the strategic plan. A good strategic budget will itemize expenditures by goal, objective and intervention, and will allocate funds against the expected cost of implementing a strategic plan.

9.6.1. Strategic Budgets

The principles outlined above may be readily applied to the development of a budget for a strategic plan. Costing a strategic plan will normally require a top-down approach. Targets will have been set as part of the SMART goals objectives and interventions, so all that is left is to define appropriate unit costs to do the costing. In many cases the country may have unit costs available from implementation of previous programmes or from a NASA exercise. In the absence of such information, unit costs may be estimated.

A strategic plan may be costed at the level of goals, objectives or interventions, depending on what data is available and the preferences of the countries. However, costing at the level of goals and objectives will tend to be difficult, as it may not be possible to get accurate unit costs at that level. As a general rule, it is recommended to cost strategic plans at the level of interventions. This is where differentiation occurs between the various inputs needed to reach an objective, and should result in the most accurate costing.

Resources can be estimated on the basis of past experience, government budgets, donor pledges, or other relevant information. The strategic budget should present expected income and expenditures by goals, objectives and interventions, and should be oriented around the achievement of the results set out in the plan. Ideally the budget will include estimates of both expenditures and income for each year and each expected result.
A gap analysis should be performed during the development of the budget and used to make any necessary adjustments. Ideally, the final budget should be balanced - i.e. planned expenditures should match expected income for each intervention, for each year and for the entire planning period. If the budget is in deficit, the budget presentation should include information on how the deficit will be financed. (Normally a strategic plan will be accompanied by a resource mobilization plan designed to fill any remaining gaps in the budget)

It should also include an indication of where financial gaps occur to allow planners to adjust the plan or to focus resource mobilization efforts on the appropriate areas.

A simplified example of a possible budget presentation is given in figure 9.9. Expenditures and funds available are allocated by intervention and summed to the level of objectives and goals. In this example, the budget is slightly in deficit, which would frequently be the case in actual strategic plans. This budget would need to be accompanied by an explanation of how funds will be raised to finance this deficit.

**Figure 9.9: Simple Budget Presentation**

<table>
<thead>
<tr>
<th>Planning Element</th>
<th>Costs</th>
<th>Funds</th>
<th>Costs</th>
<th>Funds</th>
<th>Costs</th>
<th>Funds</th>
<th>Costs</th>
<th>Funds</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1</td>
<td>770</td>
<td>630</td>
<td>850</td>
<td>740</td>
<td>...</td>
<td></td>
<td>1095</td>
<td>1040</td>
<td>2,715</td>
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<tr>
<td>Objective 1.1</td>
<td>230</td>
<td>230</td>
<td>320</td>
<td>310</td>
<td>...</td>
<td></td>
<td>555</td>
<td>550</td>
<td>1,105</td>
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<tr>
<td>Intervention 1.1.1</td>
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<td>...</td>
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<td>400</td>
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<td>650</td>
</tr>
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<td>75</td>
<td>...</td>
<td></td>
<td>125</td>
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<td>0</td>
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<td>40</td>
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</tbody>
</table>
9.6.2. **Operational Budgets**

Operational plans exist at several different levels. At the most general level, a national operational plan may consist of a general framework to guide more detailed plans at a sub-national level, such as different geographical regions, line ministries, or implementing agencies. Each implementing entity will itself develop an operational plan. For the purposes of this guide, the national operational framework is called an operational plan, and the plans of implementing agencies are referred to as implementation plans.

National operational plans should be derived directly from the national strategic plan. The national operational plan will normally take a one or two year “slice” of the strategic plan and break the targets and budgets down to the operational level. Individual targets and indicative budgets would then be assigned to each implementing agency.

Because the operational budget is based directly on the strategic budget, there should be no need for a separate costing of the operational budget. The strategic budget for one year would be broken down to an operational level and an indicative budget figure assigned to each implementing agency.

9.6.3. **Implementation Budgets**

Implementation plans are developed by implementing institutions (e.g. MOH, individual NGOs, provincial or district health authorities) within the context of the operational plan. The implementation plan will normally define a set of activities that the institution will implement in order to deliver on the results and targets it has been assigned in the national operational plan.

The budgets for implementation plans will not be developed in the same way as for strategic plans. Funding for the implementation budget will often come from a variety of sources and are generally well-known in advance, either from the Medium Term Expenditure Framework (MTEF) or from donor commitments.

Implementation plans will also not be costed in the same way as strategic plans. Since the implementation plan consists of activities, the costing should be done at the activity level. Just as Implementation Plans need to be far more detailed about actual inputs and activities, and who will implement, and where and when, the budgets of implementation plans need to be detailed, as they are the basis for the release of actual funding, and tracking and accounting for expenditure. This usually implies a bottom-up and detailed approach to costing.

The most important requirement of implementation budgets is that they do in fact allocate resources to achieve results – i.e. produce outputs. They must be completely linked to the implementation plans, and their outputs and targets, described above. There should be nothing in the implementation budget that is not linked directly to the results in the implementation plan; and all activities in the implementation plan must be budgeted.
Once the activities have been costed, they can be put together in an implementation budget. It is recommended to establish the budget on a monthly or quarterly basis to provide for adequate cash flow management. Detailed activity components do not necessarily need to be included in an implementation budget; it should be sufficient to include only the sub-activities with their unit costs - assuming a robust costing/budgeting exercise has taken place and can be substantiated.

9.6.4. Reconciling the strategic and implementation costings

In theory the sum of all the implementation budgets should equal the operational and strategic budgets for any given planning period. Frequently, however, strategic and implementation plans will have been 'costed' using different methods. Often the strategic plan will have been costed using unit costs at the objective or intervention level (a top-down approach); while the implementation plans will have been budgeted using detailed inputs at the activity or sub-activity level (a bottom-up approach).

These different approaches may yield different cost estimates for a given year in the planning cycle. Over the course of the strategic planning cycle, these discrepancies may become quite important.

Unless very reliable unit cost data is available for use in costing the strategic plan, implementation budgets are likely to be more accurate than those done at the strategic level. When a discrepancy occurs, it is usually best to assume that the detailed implementation plans have the most accurate costing. Countries may wish to update their strategic plans periodically to reflect better cost data generated during the operational phase.
## Resources and Tools for Costing

### UNAIDS manual and workbook for costing HIV facilities and services\[^{32,33}\]

The manual, together with the accompanying Workbook for collection of Cost Information of HIV Services, have been produced to provide standardized guidance for countries to collect cost data in their facilities that provide HIV prevention or treatment services. They aim to provide policymakers and implementers with the tools to provide robust and contemporary strategic data, which can inform their national strategic plans. This includes financial information on expenditure and costs to help the planning, implementation, monitoring and evaluation of HIV services that are sustainable in the long term.

### Resource Needs Model (RNM)\[^{34}\]

The Resource Needs Model (RNM) is often recommended for cost estimation in strategic planning. This tool combines epidemiological and demographic data with unit costs to project populations in need, set coverage targets, and estimate resource needs. The tool is based in Microsoft Excel and contains three sub-models: the prevention models, which calculate the cost of 12 generic prevention interventions; the care and treatment models, which estimates the cost of five types of generic care and treatment programs; and the orphan support model, which calculates the cost of three generic interventions to support children orphaned by AIDS. The RNM applies the same service classification for HIV/AIDS interventions as NASA, which provides for an easy use of NASA unit cost estimates in the model. The RNM can calculate unit costs for some interventions, but requires completed unit costs as inputs to other interventions.

This model uses globally standardized, generic descriptions of interventions, however, and is not structured around results. It is thus important for each country to adapt the model to fit its own results framework. This is essential, as without it the RNM produces generic estimates of costs which may be of limited use in costing a specific, country results-based strategic framework.

### Activity Based Costing (ABC) Model\[^{35}\]

When unit costs are not available, countries may wish to use the Activity Based Costing (ABC) Model developed by the World Bank for ASAP. While this model was developed for operational costing, it covers a multiple year time-frame and may be useful for a bottom-up costing of a strategic plan.

The challenge with this model is to ensure that ALL inputs necessary to achieve outputs are identified and costed accurately. Because the model does not use pre-set categories for expenditure, however, it can be easily adapted to country-specific results frameworks.

### Unified Health Model (UHM)

WHO and other partners are developing a unified health model (UHM) to cost national health strategies and plans. This model is modular and will contain a module on HIV/AIDS. The HIV module will be based to a large extent on the resource needs model and will probably be recommended to replace the RNM for costing national HIV strategies.

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ment/2011/20110523_manual_costing_HIV_facilities_en.pdf

\[^{33}\] Workbook for the collection of cost information on HIV facilities and services, UNAIDS, 2011. http://www.unaids.org/en/media/unaids/contentas-

\[^{34}\] The RNM tool and information on how to use it can be found at: http://www.futuresinstitute.org/pages/ResourceNeeds.aspx

\[^{35}\] The ABC model can be accessed at: http://web.worldbank.org/WEBSITE/EXTERNAL/TOPICS/EXTHEALTH/NUTRITIONANDPOPULATION/EXTHI-
VAIDS/0,contentMDK:30674001~menuPK:2764889~pagePK:210088~piPK:210062~theSitePK:376471,00.html
Resource materials for costing and budgeting


The different parts of the plan -- generally the products of the various technical working groups on the areas covered in the strategy -- must be brought together in a draft document which should present a coherent and complete view of the whole plan. The main plan document should be clear and succinct. It must be written with a wider audience in mind. In particular, implementing partners must be able to understand the document without much difficulty.

10.1. Consensus on the draft plan
Once the full plan has been developed, interested parties must reach consensus on the content and presentation of the overall plan. One way to arrive at consensus is through ongoing involvement of major partners in the planning process. This enables partners to provide their perspectives and assent at each step of the process. The second approach is by circulating a draft of the plan, as widely as possible, to all key partners and allowing sufficient time for review and feedback. This provides an opportunity for partners to appreciate the complete picture, raise any additional concerns, and correct factual errors. A consensus meeting could provide a forum for partners to openly express their views and for making compromises.

10.2. Assessment of the plan
Once a strategic plan has been developed, a country may wish to undertake an assessment of the quality of the plan. The purpose of the assessment or peer review of the plan is to verify that the plan demonstrates the attributes of a plan that forms the basis for implementation of a sound programme and a sound basis for domestic and international investment.

An internal assessment is undertaken by the parties directly involved in developing the plan. A joint assessment will include both internal and other interested external parties in assessing the plan. The IHP+ has developed a tool for Joint Assessment of National Strategies (JANS). The JANS tool can be used both for internal and joint assessment of national strategies. The JANS tool was developed to assess national health strategies and their constituent plans such as programme plans and system (human resource, financing, PSM, etc) plans.

10.3. Official endorsement
Once broad consensus on the plan has been reached and the plan has been assessed for quality, the plan must be formally endorsed by the relevant national authorities. A plan that is without formal endorsement will often be perceived as lacking legitimacy. Two issues are important:

- Internal legitimacy within the health sector: endorsement must be provided by the formal authorities within the health sector, with perhaps a launching by the Minister of Health, to show that it is a formal element in the overall Health Strategy.
- External legitimacy beyond the health sector: as noted earlier in the section on context, HIV strategic plans in the health sector are usually part of wider multi-sectoral AIDS strategic plans, and overall development plans. It is important that this legitimacy is explicit.
10.4. Dissemination of the plan
Once the plan has received official endorsement, the document must be promoted and distributed widely to guide the contributions of all partners (government, non-government and private sector) to the priority responses of HIV/AIDS through the health sector. In addition it is essential that the plan is distributed widely at the different levels of planning and implementation within the country i.e. to provinces or districts, to local authorities, to municipalities, etc.

10.5. Supporting plans
A number of other plans or strategy documents might be developed to expand on specific areas covered in the strategic plan. These could include

- Specific intervention plans (e.g. testing & counselling, IDU, PMTCT, ART, etc)
- M&E plan
- Financing plan
- Technical assistance plan
- Procurement and supply management plan
- Human resource plan

Some of these plans might be part of system-wide plans or specific to HIV/AIDS. For example, an HIV financing plan might be already fully incorporated in a general health financing plan or might present details in an HIV financing plan.
One of the major weaknesses with programme planning is some disconnect between strategic plans and implementation. Often strategic plans would be developed and launched, but programme implementation continued unchanged as before. It is necessary that the strategic plan is translated into a clearly defined framework for its implementation. This is done by developing corresponding operational and implementation plans. The strategic plan defines the direction in which the programme should go while the operational and implementation plans describe what to do to get there. The strategic plan takes a longer term view (generally 4-5 years or more) while implementation plans focus on shorter time segments (annually or bi-annually).

The operational or implementation plan must be linked to the strategic plan. It should define the actions that should be taken to produce outputs in a specified period of time as defined by the strategic plan. The operational plan should identify the resources required, activities to be carried out and those involved in and responsible for carrying them out.

**Rationale for operational planning**

- The operational plan facilitates a timely and effective adaptation of the response to changing dynamics of the epidemic and a changing environment.
- Provides a roadmap for linking up the SP to the health sector response, and achieving the SP results by guiding the day-to-day work of all the key stakeholders contributing directly or indirectly?
- It provides a framework for aligning and harmonizing contributions of all stakeholders to enhance coordination and efficiency in implementation efforts.
- It rationalizes allocation of resources in the process of implementing the plan.
Operational Planning concerns itself with the details of precisely:

- What needs to be done (Activity),
- By whom (People)
- By when (Time) (Scheduling)
- In what order (Sequencing)
- With which resources (Materials, Technology, Infrastructure)
- The target to be achieved (Outputs)
- Validation and Assessment

11.1. Types of operational plans

Operational or implementation plans translate the various parts of the strategic plan into a discrete set of activities that must be implemented over a specified operational time period to achieve the overall outcomes and impact of the strategic plan.

There are often several different kinds of operational and implementation plan.

11.1.1. National operational plan

This would normally be developed at the national level and derive directly from the strategic plan. It would show how all the national efforts (including all partners/stakeholders) will be organized to implement the strategic plan in a specified period. A national operational plan would normally identify the main activities, responsible institutions, allocation of resources and timelines for implementation. National operational plans are usually developed for a period of one year or two years. There could also be two year or three year rolling plans, which include projected activities of subsequent years.
11.2. Institutional Implementation Plans

Each institution involved in implementing the programme would ideally develop its own implementation plan, based on the national operational plan. For example, the Ministry of Health might develop an implementation plan for those activities that it is responsible for, and the same would go for sub-national entities such as states, provinces, regions, districts, as well as other implementers such as NGOs, private sector, academic institutions, etc. Within each implementing entity there may be workplans showing contributions of specific units. Operational plans become more detailed as they are translated into action at peripheral units, but it is important that there is a logical link in all the implementation actions taking place to the national operation plan.

11.2.1. Project implementation plans

Implementation plans can also be developed for specific interventions or sub-systems, such as for provider-initiated testing and counselling (PITC) or for procurement and supply management, etc. A grant or project implementation plan which shows what is being done by aspects of the programme that share the same funding source or other common considerations. Such plans normally outline in greater detail, how a particular intervention (e.g. male circumcision or harm reduction, etc), system (e.g. procurement and supply chain) or approach (e.g. task-shifting, Integrated Management of Adult Illness, etc) will be implemented.
11.3. Steps in Operational Planning
Operational Planning generally involves the following steps:

11.3.1. Review status of implementation
Development of an operational plan should be preceded by a quick review of the foregoing implementation experience. Reviewing the current status of implementation allows the planning team to note overall performance, and document lessons learned and implementation challenges. This review informs the development of the new operational plan.

The planning team can draw on progress reports of the previous year(s) to answer the following questions:

- Have the planned activities been implemented?
- What have been the challenges to implementation and how can they be overcome?
- How have the allocated resources been utilized?
- What is working well and needs to be continued?
- What is not working well and needs to be changed or discontinued?
- Who else needs to be involved or mobilized in implementation?

It is important as part of this component to document how implementation challenges will be addressed. For example, if the team identifies the absence of data to target a specific at-risk population, the new operational plan should include an activity to address that challenge.

11.3.2. Identify the results to be achieved during the operational period
The strategic plan would have defined annual targets with respect to the goals, objectives and interventions. During operational planning, it is important to begin by clearly identifying those targets that are to be achieved during the operational period as they form the basis of what the operational plan should achieve.

The resources, activities and implementation arrangements to be contained in the operational plan should all contribute to achieving the targets for the specified period as defined in the strategic plan.
11.3.3. Define the activities to be undertaken
An activity is the process through which inputs are turned into outputs. Activities combine resource inputs such as people, infrastructure, supplies and equipment, to produce outputs, or deliverables, such as trained health workers, peer educators, health services, and so on. Activities are the building blocks of a programme designed to achieve objectives.

Activities can exist at different levels. Some activities combine raw inputs to produce lower-level outputs. Other activities are rather high level and combine the outputs from lower-level activities to produce higher level outputs. For the purposes of this guide we define higher level activities as "main activities" and lower-level activities as "sub-activities". Typically a main activity will consist of one or more sub-activities which, together, produce the outputs defined at the main activity level.

The level of detail described for activity will depend on the type of operational plan. A national operational plan would usually contain main activities that are defined at a higher level, such as train 1,000 health workers or construct ten new clinics; institutional workplans would describe lower-level results such as hiring a consultant to develop training curriculum or preparing tenders for construction.

Activities can be linked to the goal, objective and intervention they are contributing to by using a systematic coding with common identifiers (for example, an activities identified by a code such as 1.1.2.2 will indicate that this is a second activities addressing the second intervention in the first objective of the first goal of the strategic plan).

11.3.4. Specify the timelines and sequencing of the activities
The operational plan should define timelines for implementation of activities to ensure that implementation is occurring on schedule. It is also necessary to ensure appropriate sequencing of activities as some activities can only be done following others (treatment must be preceded by drugs being available or there must be a training curriculum before rolling out training). Process indicators or implementation milestones need to be identified to track progress in implementation.

11.3.5. Develop indicators and milestones to measure progress
Indicators are quantitative measures of progress, while milestones are descriptive indications of progress. For example, a process indicator will be “number of peer educators trained in HIV testing and counselling" whereas a milestone would be “tender for condom procurement completed".

Where Annual Health Sector Reviews for HIV & AIDS are conducted, they serve as a useful mechanism for assessing and steering implementation. Reviews assess progress in implementation and the extent to which the goals and objectives of the strategic plan are being achieved.
11.3.6. **Determine costs of activities and allocate resources**
An operational plan requires a more detailed and practical costing for a one or two year period. Since the operational plan is constructed from activities, it must be costed at the activity and/or sub-activity level. A national operational plan might identify activity costs on an annual or half-yearly basis, while specific workplans might identify costs on a quarterly or monthly basis.

11.3.7. **Name the responsible entity/persons**
The operational plan should also identify the entities responsible for implementation. At higher levels, this will mean individuals who will ensure that activities are carried out or institutions involved. At lower levels, workplans identify individuals or groups who actually carry out specific tasks.

**Resource materials on operational planning**


Operations manual for delivery of HIV prevention, care and treatment at primary health centres in high-prevalence, resource-constrained settings
Indicative List of Interventions for the Health Sector Response to HIV³⁶

**Knowing HIV status**
- Client-initiated HIV testing and counselling
- Provider-initiated HIV testing and counselling
- Blood donor HIV testing and counselling
- Laboratory services for HIV diagnosis

**Prevention of sexual transmission in key populations:**
- Promoting and supporting condom use
- Male circumcision
- Detecting and managing sexually transmitted infections
- Safer sex and risk reduction counselling
- Prevention among people living with HIV

**Prevention of mother to child transmission of HIV**
- Primary prevention of HIV transmission
- Prevention of unintended pregnancies among women living with HIV
- Prevention of HIV transmission from women living with HIV to their children
- Provision of treatment, care and support for women living with HIV, their children and families

**Prevention, treatment and care among injecting drug users**
- HIV testing and counselling
- Needle and syringe programmes
- Drug dependence treatment in particular opioid substitution therapy
- Targeted information, education and communication for IDUS
- HIV treatment and care
- Promoting and supporting condom use for IDUs and their sexual partners

**HIV treatment for adults and children**
- Antiretroviral therapy
- Infant diagnosis
- Managing opportunistic infections and co-morbidities
- Tuberculosis prevention, diagnosis and treatment
- Co-trimoxazole prophylaxis
- Palliative care

**HIV/STI surveillance**
- HIV infection and AIDS case reporting
- HIV sentinel surveillance among clients attending antenatal clinics
- Integrated biological and behavioural data among most-at-risk populations
- Periodic national population-based surveys with HIV testing
- Data from HIV surveillance among TB patients


A new approach to global health - Positive Synergies

AIDS Strategy & Action Plan (ASAP)

ASAP HIV/AIDS Costing Tool v1.2 - October 2008

ASAP

Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services

Costing Process Guide


Country Health Systems Surveillance (CHeSS)

Enhancing results by applying the Paris Declaration at sector level: Progress update and Lessons Learnt from Aid Effectiveness in AIDS Responses, UNAIDS, August 2008.

Evaluating national Health System HIV Responses: Reference Guidelines for countries in the Latin American and Caribbean Region (PAHO/AMRO) (DRAFT - not yet available)

Everybody's Business - Strengthening Health Systems to Improve Health Outcomes

Financial Crisis Impact Assessment Tool for HIV/AIDS FinCIAT – HIV/AIDS (May 28, 2009 draft for comment)


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Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services http://www.wpro.who.int/NR/rdonlyres/DB0EB0E3-3ABS-4667-ACD9-E8C5DAEA53FC/0/HSI_LinkingHIVServices_March2008_FINAL.pdf


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Green, Andrew, Strategic health planning: guidelines for developing countries, Nuffield Institute for Health, 2002.

Green, Andrew; An introduction to health planning in developing countries, Oxford University Press, 1999.


Guidelines for conducting a review of the Health Sector Response to HIV/AIDS (SEARO, 2008)


International Health Partnership http://www.internationalhealthpartnership.net/en/home

Joint Assessment of National Strategies (JANS) http://www.internationalhealthpartnership.net/en/about/j_1253621551


MDGs, targets an indicators related to health http://www.who.int/mdg/goals/041222health_mdgchart_en.pdf


Policy and planning http://www.searo.who.int/LinkFiles/Publications_NAP_Module_2.pdf


Setting National Targets for Moving Towards Universal Access - Further guidance to complement
"Scaling Up Towards Universal Access: Considerations for countries to set their own national targets for
AIDS prevention, treatment, and care and support“ - Operational Guidance http://data.unaids.org/pub/

int/hq/2005/WHO_HIV_2005.05_eng.pdf

Situation analysis http://www.searo.who.int/LinkFiles/Publications_NAP_Module_1.pdf

Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic:
Handbook for Designing and Implementing HIV/AIDS Programs, Edited by: Peter R. Lamptey, MD,
DrPH, Paul Zeitz, DO, MPH and Carol Larivee, MA, Family Health International, 2001

int/publications/924154483X.pdf


Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for

EXTHEALTHNUTRITIONANDPOPULATION/EXTHIVAIDS/0,contentMDK:20974001~menuPK:275
4898~pagePK:210058~piPK:210062~theSitePK:376471,00.html

The costing process guide can be found at: http://www.who.int/hiv/topics/systems/health_financing/
en/

The HUCC http://www.who.int/hiv/topics/systems/health_financing/en/

The People Living with HIV Stigma Index: An index to measure the stigma and discrimination
experienced by people living with HIV. Can be downloaded on the following site: http://www.stigmaindex.
org/9/aims-of-the-index/aims-of-the-index.html


The RNM tool and information on how to use it can be found at: http://www.futuresinstitute.org/pages/
ResourceNeeds.aspx

The use and abuse of the logical framework approach, Sida, November 2005


Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention,
treatment, care and support http://www.who.int/entity/hiv/toronto2006/towardsuniversalaccess.pdf

UN Millennium Declaration, 2000 at http://www.un.org/millennium/declaration/ares552e.htm

MakingTheMoneyWork/chat.asp


