National HIV Strategies for Impact

A Guidance Note for Getting to Zero

ZERO

NEW INFECTIONS
DISCRIMINATION
AIDS RELATED DEATHS

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UNAIDS
National HIV Strategies for Impact

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Purpose of this guidance paper

This document provides updated guidance for developing new and more robust national HIV strategies. Development of this updated guidance was called for by the UNAIDS Strategic Planning Advisory Group convened by the World Bank in close collaboration with the UNAIDS Secretariat. It builds on previous guidance, bringing together a number of hard-learned lessons and evidence-based good practices, integrating arguments for critical shifts in national responses as well as incorporating updated global strategies, targets, and approaches. This guidance is intended for (1) national development planning partners; (2) national programme partners such as AIDS authorities, national coordinating entities, and sectoral ministries; (3) civil society organisations; (3) United Nations teams; and (4) global development partners. It aims to provide these stakeholders with a common updated reference point for developing, assessing and implementing national HIV strategies and a common understanding of how new instruments and tools for national strategies fit together.

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1 A national strategy is considered robust when it is nationally owned, evidence-based, prioritised and realistic, costed based on a gap analysis and reflects areas where impact can be maximised.


3 Guide to the strategic planning process for a national response to HIV produced by the Joint United Nations Programme on HIV (UNAIDS) in 1998
What is a national HIV strategy?

A national HIV strategy is an authoritative framework for a national HIV response, in the context of the Three-Ones Principles. A national HIV strategy:

- describes the context (i.e., epidemiological, political, cultural, social and institutional) for the national HIV epidemic;
- articulates the longer-term goals and prioritised mid-term results to be achieved, the essential services to be provided, available and required resources to achieve those results and linkages between priorities, resource flows and outcomes/results in order to ensure accountability;
- addresses the linkages between the HIV strategy and other health programmes, such as TB and Reproductive, Maternal, Neonatal, and Child Health, as well as broader health, poverty-reduction and development strategies, and associated partnership arrangements;
- charts a path for engaging civil society organisations and the private sector in service delivery and other key aspects of the response; and
- provides a framework for external support agencies to commit themselves to and align their efforts with national processes.

A national HIV strategy is an instrument to align national stakeholders around ends and means—what society collectively agrees to seek to accomplish with limited financial, human and technological resources. It helps society make the trade-offs with competing priorities for limited resources. A national strategy also defines the accountability mechanisms that should be in place, for regular joint reviews and consultations that include all partners to monitor and report on progress towards achieving national strategy targets.

Development partners including the UNAIDS family, the United States President’s Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight Aids, Tuberculosis and Malaria (Global Fund)—have reaffirmed their support for country-led national strategies. Under its most recent legislative authorization, PEPFAR funds services “aligned with the national plans of partner governments and integrated with existing health care delivery systems.” The Global Fund “strongly encourages countries to base funding requests on quality national strategic plans and through national systems.”

By early 2014, some 164 countries had developed unique national HIV strategies, reflecting the complexity and heterogeneity of national epidemics as well as the diversity of efforts to organize effective national responses. Currently, some countries are embarking on, or

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4 The Three Ones Principles for concerted action at country level have been recognized by international organisations and national governments as the guiding principles to ensure effective coordination of national responses to HIV and AIDS. The principles are: One agreed HIV Action Framework that provides the basis for coordinating the work of all partners; One National HIV Coordinating Authority, with a broad-based multi-sectoral mandate; One agreed HIV country-level Monitoring and Evaluation (M&E) System.

5 http://www.aidstar-one.com/focus_areas/prevention/resources/national_strategic_plans

6 http://www.theglobalfund.org/en/fundingmodel/process/ “Where a country does not have a national strategic plan, or where one is no longer current, then an investment case may be presented in the concept note in support of the funding request.”
preparing to embark on, the development of their new generation of national HIV strategies, rising to the challenge of shared responsibility, investing smartly and adapting national responses to new challenges and opportunities.

A national HIV strategy aims to chart broad strategic direction for the national response. Accordingly, it is not to be confused with an operations or implementation plan, which is typically the result of a separate and sequentially subsequent planning exercise building on the national HIV strategy.

Changing global AIDS context

Building on scientific evidence and lessons learned from the past 30 years of the HIV response, this updated guidance integrates a series of critical shifts in the HIV response:

- **A shift beyond the previous generations** of National Strategic Plans, (i.e., from the 1980s to the early 1990s, when HIV was addressed exclusively within the health sector; from the mid-1990s, when HIV was addressed as a broader multi-sectoral concern with increased funding, albeit coupled with limited prioritisation and allocative efficiency).

- **A shift in vision**, from managing AIDS to achieving the three zeroes and ending the AIDS epidemic;

- **A shift away from the AIDS ‘exceptionalism’** and stand-alone AIDS architecture, integrating the HIV response in broader multi-sectoral health, development, social justice and human rights agendas;

- **A shift in the mindset about resourcing** the future of the response – adopting strategic investment thinking and improving understanding that resources for HIV and AIDS are investments in national well-being, not merely costs;

- **A shift in the content and package of interventions** – focusing on evidence-based programme activities and critical enablers, while maintaining a rights-based and gender equality approach that guarantees that the needs of all affected populations are addressed;

- **A shift in population targeting** – advocating for better targeted and less generic interventions to focus on and engage with affected and vulnerable population groups and geographical areas; 

- **A shift in those who can help finance** – increasing use of domestic resources to enhance country ownership and mutual accountability, while encouraging continued international

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7 Key populations as groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In all settings, men who have sex with men, transgender people, people who inject drugs, sex workers and their clients and people in prisons and closed settings are at higher risk of HIV than other groups. Each country, in partnership with communities and civil society, need to define additional specific populations that are key to their epidemic and response.

8 The financial circumstances of countries most affected by AIDS have changed in the last decade. In 2000, 70% of people living with HIV resided in countries classified as low-income. In 2010, this proportion dropped sharply to 37% and is projected to reduce even further to just 13% by 2020. For the first time, in 2011, domestic AIDS investments exceeded international investments in low and middle-income countries such as South Africa, Brazil, India and China. More countries are rising to the challenge of filling the AIDS investment gap and sustaining the response by identifying alternative domestic sources of investments.
investments commitment in line with shared responsibilities and global solidarity, and financing by new partners;

- A shift from planning to implementation – making planning processes lighter and more strategic while focusing resources on achieving results and ‘maximising efficiency’.

These shifts reflect the rapidly changing AIDS environment, particularly over the past decade. In the late 1980s and 1990s, AIDS was a major global crisis that required an emergency response. Today, in a number of key respects, the global AIDS response is being transformed from a sprint to a marathon, where systematic and sustained efforts are required.

In 2012, an estimated 2.3 million [1.9–2.7] people were newly infected with HIV in 2012—about a million fewer new infections than a decade earlier. The estimated number of AIDS-related deaths in 2012 was 700 000 lower than in 2005. The HIV response is saving lives, in large part due to a record-breaking 9.7 million people receiving antiretroviral treatment (ART) in low- and middle income countries, with the number of people receiving ART increasing by 1.7 million in 2012 alone.

Expanded treatment availability and improvements in treatment regimens and service delivery strategies are transforming HIV infection into a chronic condition. AIDS is increasingly perceived less as a ‘global public health emergency’ and more as an important public health challenge in many countries. Yet despite significant progress in the response, the epidemic is far from over. Millions of new HIV infections continue to occur, including 2.3 million in 2012 alone, while AIDS remains the leading cause of death globally among women of reproductive age. In many places, the maturation of the epidemic has exacerbated the burden on fragile health systems ill-equipped to provide the needed long-term care for patients on HIV treatment. It is unacceptable that only 34% (32-37%) of people eligible to treatment in 2013 were receiving it. In some regions, inadequate access may be compounded by low retention—it has been estimated that only 65% of people remain in care after three years in sub-Saharan Africa.

Considerable challenges remain in preventing and treating HIV infection, especially in vulnerable communities that are also socially and politically marginalized in many countries. Stigma and discrimination persist as major barriers to an effective response, most acutely where legal frameworks offer few protections and both reflect and reinforce intolerant attitudes and law enforcement practices. Gender inequality undermines the effectiveness of the response by increasing vulnerability, exacerbating stigma and discrimination and affecting clinical outcomes and the experience of people living with HIV. Interventions will be more effective if they adequately capture and respond to the dynamics of gender inequality through pro-active, gender-sensitive programming and policy formulation.

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11 This represents the percentage receiving ART in 2013 according to the 2013 guidelines where it is estimated that 28.6 million were eligible to treatment in that year. Source 2013 Global report.
Without the efforts of civil society, the global AIDS response would be indescribably weaker. Civil society has played a central role in the AIDS response since the earliest days of the epidemic. It has been—and continues to be—actively involved in every phase of the response, across the continuum of care, from advocacy to service delivery, from policy to programme design and implementation to monitoring and evaluation. In the context of national HIV strategies, civil society organisations need to be recognized and supported as essential national partners in strengthening community systems, giving a voice to those most marginalized, and helping advance human rights.

In the next development era, strong progress is needed for millions of people living with HIV and the people who newly contract HIV every day. Failure to continue and build on recent gains in the response will particularly affect large segments of the population (the poor, women, girls, and children) already vulnerable, at greater risk, less able to access services and at increasing risk of being left behind. At similar risk of losing out on the historic gains being made against HIV are marginalized and stigmatized key populations at higher risk of HIV exposure (men who have sex with men, sex workers, people who use drugs, transgender people and prisoners).

Lessons learned about programming

*Tailor programmes and solutions to different contexts* – Since the earliest national HIV strategies were developed, much has been learned about how to harness our collective energies and resources to maximum effect in the response to HIV. The most fundamental insight is that each national or indeed sub-national or micro-epidemic is shaped by a unique social and cultural context, conditioning its modes of transmission as well as the intervention approaches that will be most effective. This means that each national framework for action or strategy needs to be different, designed around the unique social, cultural and institutional context in which the response will unfold. It means one cannot take a cookie cutter approach, replicating strategies and plans from one context to another. A corollary is that strategies cannot be rigidly fixed over long periods but must be adaptable and resilient in the face of changing social, cultural and institutional contexts. It also means that it is only possible to assess the quality of a national HIV strategy in its own context, that is, within the unique social, cultural and institutional context of the country.

*Better data for better programmes* – Routine monitoring, sentinel surveillance and comprehensive epidemiological studies have added to national and international understanding of the complex causes and determinants of HIV infection. Since the late 1990s, simpler HIV testing technology means that individuals can learn their HIV status more quickly, and therefore make more informed choices about staying healthy. Focusing on the areas where the HIV epidemic is highly concentrated, identifying the places where services are lacking and reaching the people in need of prevention services, testing, treatment and support are the first steps towards achieving more efficient and effective programmes. More and more countries are collecting and analysing data that enable these locations and key populations to be identified, understood and served. Data collection is expanding, and new methods are being used to identify where localized epidemics may be emerging, where specific populations are carrying the highest burden of disease and where vital HIV services are deficient or absent. Countries are combining these data in innovative ways, including with geographical information, to produce more detailed and vivid understandings of the HIV epidemic, all the way to the district.
and subdistrict levels. Disaggregating data by sex and age wherever possible needs to be routine. While innovations in producing better data are urgently needed, it is essential to ensure that people, rather than technologies, drive decision-making regarding data collection activities and that ethical standards, including confidentiality, are fully respected. Key populations must be involved in the design, implementation and evaluation of any monitoring or surveillance activities among them. Taking a more focused and innovative approach to data collection makes it possible to focus HIV programmes more precisely and effectively and to offer or adapt services to reach greater numbers of people in need.

**Focus on the right populations** – Too often, national HIV expenditures have been mismatched with national needs. This has been especially the case in countries with low-level or concentrated epidemics, where rational funding would focus primarily on HIV prevention services for populations most at risk of HIV exposure. In the Asia Pacific region, for example, key population prevention investments account for less than 6% of overall investments, even though these populations represent more than two-thirds of all new HIV infections. Countries with concentrated epidemics often opt for broad prevention programmes for the general population rather than for more cost-focused on populations most at risk. Data from countries with concentrated epidemics suggest that risk-reduction programmes focused on populations most at risk represent only 10% of overall HIV prevention spending. Meanwhile, in countries with generalized epidemics, more resources are required for treatment, care, and social mitigation.

To achieve sharp reductions in new infections, national responses need to focus on affected populations and on those who do not access treatment, recognizing these approaches as critical investments in national health and well-being. Programmes should be specifically developed to prevent HIV transmission in the most vulnerable (such as women and girls) and key populations, as defined by the country’s epidemiological situation.

**Use all available approaches and tools** – There is no single stand-alone solution to preventing new HIV infections. Evidence demonstrates that effective HIV prevention efforts involve a combination biomedical, behavioural and structural approaches that are tailored to local epidemics. For instance, randomized controlled trials in sub-Saharan Africa have found that voluntary medical male circumcision reduces the risk of heterosexually acquired HIV infection in men by about 60%. Correct and consistent use of a condom can prevent HIV infection. Treatment as prevention works in certain contexts and populations. For example, results from one treatment-as-prevention study in 2011 showed that earlier use of antiretrovirals by HIV-positive heterosexuals partnered with HIV-negative individuals (serodiscordant couples) reduced HIV transmission by 96%. When antiretroviral drugs are available as prophylaxis, rates of HIV transmission from mothers living with HIV to their infants can be reduced to less than 5%. Evidence indicates social protection, care and support, including livelihood protection, financial incentives and economic empowerment, reduce the risk of acquiring HIV. Studies show cash transfer schemes can inspire safer sexual behaviours and reduce new HIV and sexually transmitted infections in young women.

**Build a multisectoral/multidisciplinary response** – Effective national HIV strategies are built on teamwork across multiple sectors, disciplines and capacities. The array of approaches

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that comprise an effective response is vast, including direct patient support, community mobilisation, clinical support services, information management, procurement and supply chain management, planning, communication services, etc. Effective networking and capacity building across sectors and key disciplines are essential building blocks for a scaled-up and sustained response.

**Integration of HIV services** – While important lessons have been learned with respect to integrating HIV into broader health and development efforts, substantial additional work is needed to ensure an integrated, coordinated response that leverages multiple systems and accelerates progress. Integration is highly country- and context-specific, underscoring the fact that no single approach will fit all circumstances and highlighting the importance of high-quality impact evaluations. Integrating HIV services must be implemented in a way that strengthens health systems, including addressing the skills mix options and task-shifting opportunities in integrating services, to ensure that gains are secured and monitored. New integration indicators are needed to support high-quality impact evaluations.

**Invest in health systems** – HIV infection is increasingly shifting to a chronic condition, requiring longer-term, sustainable medical management strategies. While AIDS is classified as a communicable disease from a cause-based perspective, health system planners taking an effect based perspective understand conditions such as AIDS, which require long term care, whatever their aetiology, place similar demands on healthcare systems, patients, their families, and communities. Increasingly, programmatic responses to aspects of HIV treatment and care have more in common with chronic non-communicable disease programmes. As is the case for other chronic diseases, HIV treatment requires developing and protecting longer-term investments in health systems (e.g., skilled human resources, drug supply systems, information systems, financial management systems) to make the AIDS response sustainable, and to integrate it into broader health and development systems operations.

**Lessons learned about orientation of national strategies**

Extensive consultations have also highlighted some of the shortcomings of earlier strategies as well as promising newer approaches:

- Strategies should be focused and simplified, giving greater **consideration to what can actually be implemented**, linking interventions to expected results, and monitoring progress.

- Strategies should **aim for results, prioritise interventions and represent value for money**, determined by the effectiveness, efficiency and equity of the programmes that are

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14 Rethinking the terms non-communicable disease and chronic disease; Nigel Unwin, JoAnne Epping Jordan, Ruth Bonita (WHO); in J Epidemiol Community Health 2004;58:801.

15 Including “Third Generation of National Strategic Plans-Global Consensus Meeting” (Nairobi, June 2012) and “Coordination-Fit For purpose-striving for more effective AIDS Coordination at country level” (Washington, July 2012).
planned. In particular, strategies and implementation plans must prioritise halting HIV transmission, with an appropriate balance of investments in prevention and treatment interventions.

- National strategies should be **shorter, developed faster and aimed at a higher level**, with emphasis on planning processes that are smarter and lighter on people’s time and money, combining with existing forums and using new communication technologies to seek stakeholder inputs into planning. (This is highlighted in Box 2.)

- Strategies should have indicative medium-term **budgets with realistic costing** of major programme areas. They should ensure that the level of investment is closely aligned with evidence of what works together with scenarios for what interventions are to be prioritised in low-, medium- and high-level funding scenarios.

- Strategies should provide **details on governance and accountability structures**, and how the country will plan and manage the AIDS response to achieve results.

- National AIDS strategies need to be **coherent with and linked to wider health and development strategies**, but such coherence needs to be achieved with minimal overhead (i.e., avoiding slow, costly, and cumbersome multi-sector planning processes). Many conditions that create the underlying vulnerabilities driving the HIV epidemic remain: gender inequality; income disparities; unemployment; stigmatized and criminalized sexual behaviours and drug use. These need to be addressed as part of national development plans and programmes if we want to achieve zero new HIV infections. Areas of synergy between AIDS-specific efforts and development include sexual and reproductive health, maternal and newborn health, social protection, access to education, adequate food and nutrition, legal reform, poverty reduction, gender inequality and violence, and improvements in health, community and employment systems. Addressing social and economic inequality through social protection programmes and other national development efforts not only will help address underlying determinants but also mitigate impact, reduce risk, and enhance prevention and treatment outcomes.

**Box 1  National HIV strategy development: a faster, lighter process**

Developing a national HIV strategy has in the past taken considerable time (up to two years) and involved significant costs (sometimes in excess of US$ 1 million). The degree of formality and elaborateness of the planning process are best determined by local context, with a number of countries recently using lighter and faster, innovative processes:

- **Azerbaijan**’s new national strategy was developed through a broadly participatory, inclusive and interactive process. The situation and response analysis improved

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understanding of the strengths and weaknesses of the HIV response and enabled country partners to focus efforts to maximise impact. Consultations with national stakeholders and donors on prioritisation and costing contributed to an evidence-based strategy in line with the High Level Meeting country plan for improving response by complementing partners’ resources. The process took eight months and cost approximately US$ 50,000.

- Mauritius developed its national strategy using an innovative approach with priority setting and alignment to the High Level Meeting targets and other global commitments, including capacity building for all partners throughout. The process took six months from the development of the concept note until validation by all stakeholders. The overall cost was US$ 74 000, including local training, consultation workshops, logistics, technical assistance (experts from UNAIDS, WHO, lead consultant and costing consultant mobilised through Technical Support Facilities (TSF)). As a matter of principle and procedure, a per diem was not paid to local participants and resource persons who attended workshops.

- Senegal led a country-owned national strategy process with wide participation from health workers, Civil Society Organisations (CSOs) and the private sector. It was built on a multi-sectoral consultation mechanism (“AIDS pool”) and promoted substantial decentralisation of the response toward the district level. In line with the High Level Meeting targets, an evidence-informed approach helped to prioritise regions that were highly affected and better target key affected heavily affected populations and regions. The process cost US$ 60,000 (covered mostly by the national partners) and took 12 months, including the Joint Assessment of National Strategy exercise that was conducted with partners, including UNAIDS and the Global Fund, and the results of which were used to inform and strengthen the strategy.

- South Africa’s National Strategic Plan (NSP) 2012–2016 was launched by South Africa’s President. It was developed through a highly participatory and consultative process involving government, civil society, people living with HIV, the private sector and development partners at national and provincial levels. Consultations were conducted through the Think Tank (which articulated the strategic vision and a bottom-up approach), the Programme Implementation Committee, the South African National AIDS Council Plenary and Sector Leaders’ Forum (both chaired by the Deputy President), the Provincial Councils on AIDS and the 5th National AIDS Conference. The process led to the adoption of the “Four Zeros”—zero new tuberculosis (TB) and HIV infections, zero new infections due to vertical transmission, zero preventable deaths associated with HIV and TB, and zero discrimination associated with HIV and TB. Independent reviews help ensure the quality the approach. The process aligned the nine provincial strategic plans, enhanced strategic partnerships by leveraging resources and promoted mutual accountability between government and development partners. The effective planning exercise took nine months (March–November 2011).
Common principles for effective national HIV strategies

Common principles fundamental to effective national strategies include:

- **Ensuring country ownership**\(^{18}\) in shaping the future of the AIDS response, taking account of lessons on national ownership that have been learned over the last 30 years to inform the process and outcomes.\(^{19}\)

- **Recognizing the role of government as the ultimate duty bearer**, and that countries and their *citizenry* are responsible for ensuring the sustainability of their AIDS response, including, among other things, diversifying funding sources.

- **Ensuring responses are evidence–informed** while respecting individual rights. For instance, HIV travel restrictions are not evidence-informed and possess no public health value in terms of preventing HIV transmission.

- Driven by the GIPA principle\(^{20}\), **enabling full engagement** of affected communities, civil society and communities at large, particularly those who are yet to be reached with prevention and treatment services, and those who are at highest risk for HIV, so that they can help shape AIDS responses and better hold governments to account.

- **Achieving/moving towards universal access** to HIV services and eliminating HIV-related marginalization. As an example, key populations often have inequitable access to HIV services due to discrimination in the health care system and inadequate accountability systems.

- **Advancing human rights and gender equality** in the AIDS response, including eliminating HIV-related stigma and discrimination, and promoting laws and policies that ensure the full realization of all human rights and fundamental freedoms for people who are living with or vulnerable to HIV.\(^{21}\) The nature of the HIV epidemic—its interaction with poverty, inequalities, exclusion, law, gender dynamics, politics, taboos and more—highlight the need for responses to directly confront the political and social determinants of risk and vulnerability.

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\(^{19}\) However national AIDS coordination evolves in the future, it needs to be decided by AIDS stakeholders together with national governments, with a view towards long-term ownership and sustainability of the country’s AIDS response and its governance. AIDS coordination needs to retain its multi-stakeholder nature while applying this particular strength to other areas of health and development.

\(^{20}\) Greater Involvement of People Living with HIV, which advocates for the active and meaningful participation of people living with HIV in the design, development, implementation, monitoring and evaluation of all policies and programmes that affect their lives.

\(^{21}\) This includes the enforcement of laws that protect sexual minorities, women against domestic violence and sexual abuse as well as aligning national AIDS strategies to government commitments and actions on women’s rights E.g., Convention to Eliminate Discrimination against Women – CEDAW.
- Recognizing the role that "critical enablers", both social and programmatic ones, need to play in support of programme interventions.

Global commitments and targets

We have come a long way since the onset of the global HIV epidemic, and today there is hope that new HIV infections, AIDS mortality, and HIV-related discrimination can all be ended. The backdrop for this hope, and key global beacons for national HIV strategies prospectively, are the complementary elements of a global framework—a long-term vision, a clear strategy, near-term agreed targets and a people-centred approach and methodology for making difficult decisions based on evidence:

**Getting to Zero** - In December 2010, the UNAIDS Programme Coordinating Board (PCB) adopted UNAIDS Strategy 2011–15 Getting to Zero, which is both a vision of an end-state of Zero new HIV infections, Zero AIDS-related deaths, and Zero discrimination and a global agenda and strategy for getting there. The Three Zeros are a fundamental reference point for framing the end-state goal for national HIV strategies.

**Global Commitments to Ten Targets** – Getting to Zero served as a central basis for the drafting of the 2011 UN General Assembly Political Declaration on HIV and AIDS: intensifying our efforts to eliminate HIV and AIDS. The Political Declaration reaffirmed global commitments to ten ambitious targets and elimination commitments to be met by UN member states. The Ten Targets are critical guideposts for national HIV strategies.

**Shared Responsibility and Global Solidarity** – In July 2012, African Union (AU) Heads of State adopted a Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa. Developed with the direct support of UNAIDS, the AU Roadmap offers a set of practical and African-owned solutions, which are structured around three strategic pillars—health governance, diversified financing and access to medicines—to enhance sustainable responses to AIDS, TB and malaria. In September 2012, on the margins of the UN General Assembly, world leaders and key global development partners embraced the AU Roadmap, voiced support for the principle of shared responsibility and highlighted the necessity for sustained global solidarity. Shared Responsibility and Global Solidarity are foundational principles to guide national HIV strategies.

**Millennium Development Goals and Post-2015 Development Agenda** – The Millennium Development Goals established two targets specifically addressing HIV: Target 6.A which called for having halted and begun to reverse the spread of HIV by 2015 and Target 6.B which called for achieving universal access to treatment for HIV for all those who need it by 2010. By 2013, new HIV infections were in decline in most regions and more people than ever

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25 World leaders embrace the African Union Roadmap on AIDS, TB and malaria: Establishing Shared Responsibility and Global Solidarity as a vision for global health in the Post-2015 development agenda.
were living with HIV due to fewer AIDS-related deaths. However, the pace of new HIV infections remains unacceptably high. While access to treatment for people living with HIV increased in all regions, the target of achieving universal access to treatment by 2010 remains a goal yet to be fulfilled.

The extraordinary progress made through the AIDS responses under the MDGs substantiates the case that ending the AIDS epidemic as a public health threat is possible in the post-2015 era. Building on approaches used for AIDS responses can reinforce other rights-based approaches that are necessary for bringing about wider health and development results.

The AIDS experience is also helping to inform the post-2015 development agenda. The post-2015 development framework will establish Sustainable Development Goals building on the successes of the MDGs. The principles and practices drawn from the global AIDS response can make valuable contributions towards new approaches to global health and development. UNAIDS has made the case for a post-2015 era where

- A commitment to ending the AIDS epidemic by 2030 is integral to the post-2015 agenda.
- Leaving no one behind is contingent upon rights—and gender-based action on the social, political and economic determinants of HIV.
- Inclusive accountability mechanisms should be strengthened to enable broad participation and ownership in implementing and monitoring the post-2015 agenda.
- Ending AIDS will benefit from and serve as a catalyst for achieving a shared vision of social, economic and environmental justice.

**A New Investment Approach** – The investment framework was initially developed in 2011 by an international group of experts, including from UNAIDS, the Global Fund, the Bill & Melinda Gates Foundation, civil society, PEPFAR, the World Bank, WHO, and UNICEF to optimize the impact of HIV funding and to assist countries in planning and prioritising different elements of an effective, efficient and sustainable AIDS response.

Following extensive consultations and invaluable feedback from countries and broader civil society, the framework was substantially refined as a new people-centred Investment Approach to AIDS intended to save lives, reduce costs and get the most out of the money invested—by investing effectively, investing efficiently, and investing to achieve scale. The Investment Approach aims to support countries in responding to HIV in a manner that is optimal to the national and local context and their unique epidemic patterns; enable countries to select interventions that will have the highest impact; and set priorities in resource allocation in accordance with national objectives to curb the HIV epidemic.

The Investment Approach is not a prescriptive menu of what countries should do, but a way of thinking, a conceptual approach that countries can use to improve the impact of HIV funding to

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26 Ending AIDS post-2015: A force for transformation that leaves no one behind, draft UNAIDS discussion paper, June 2014.
28 UNAIDS (2012): Investing for Results. Results for People. A people-centred investment tool towards ending AIDS.
accelerate progress towards the Ten Targets and beyond. It encourages decision-makers and stakeholders to think differently and more innovatively about how to plan and prioritise the various elements that make up an effective and efficient AIDS response. It is underpinned by meticulous analysis of the best available empirical, country-specific—or relevant—evidence of what works and what needs to be done to reduce HIV infection and increase access to treatment, care and support as well as a realistic appraisal of existing resources, and quantification of the returns of HIV investments. It shifts the focus from costs to investments that deliver returns.

The Investment Approach calls for investing in three areas essential to tackling the HIV response in any context: basic programme activities that have high impact, critical enablers, and development synergies.

Basic programme activities are high impact interventions that have a direct impact on HIV risk, transmission, morbidity and mortality, and work together with critical enablers and development synergies for maximum impact. High impact interventions are essential to an adequate HIV response and should be delivered at scale according to the size of the relevant population in need.

PEPFAR guidance to Coordinators includes the directive to support the Investment Approach at the country level. The Investment Approach has been endorsed by the Global Fund in the development of its New Funding Model, and is now being used to inform the Global Fund guidance to countries for the development of applications under the New Funding Model. Leading civil society networks are supportive of and engaged with the Investment Approach, which is viewed as “transformative.”

Box 2  The Global Fund’s New Funding Model

As of end of 2013, programmes supported by the Global Fund in more than 140 countries were providing antiretroviral therapy to 6.1 million people. The Global Fund has redesigned its funding model to bring the Global Fund Strategy of ‘Investing for Impact’ to life. Its New Funding Model (NFM) is intended to allow the Global Fund and the countries it supports to invest more strategically, to maximise available resources, to reward ambitious vision, and to make a bigger impact against the three diseases. Launched initially with a transition period in 2013, the full roll out of the NFM started in March 2014.

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29 The UNAIDS Programme Coordinating Board in 2012 called for the Secretariat and Co-sponsors to “apply investment thinking to nationally led and owned planning processes and implementation of programmes to strengthen prioritisation of resources”. See: Decision Point 5.2.

30 The Global Fund defines high impact interventions as evidence-based interventions that: (a) address emerging threats to the broader disease response; and/or (b) lift barriers to the broader disease response and/or create conditions for improved service delivery; and/or (c) enable roll-out of new technologies that represent global best practice; and (d) are not funded adequately at present.


32 http://www.aidsalliance.org/publicationsdetails.aspx?id=90547
The Global Fund “strongly encourages countries to base funding requests on quality national strategic plans and through national systems. For the purposes of developing a funding request to the Global Fund, national strategic plans should be developed using an inclusive multi-stakeholder process. Ideally, these plans will be jointly assessed through a credible, independent, multi-stakeholder process that uses internationally agreed frameworks. Where a country does not have a national strategic plan, or where one is no longer current, then an investment case\(^{34}\) may be presented in the concept note in support of the funding request.”\(^{35}\)

The NFM established incentive funding “…to incentivise high impact, well-performing programs and the submission of robust, ambitious requests based on national strategic plans or investment cases. The apportionment of funding to this stream will be substantial so as to ensure sufficient funds are available to motivate full expressions of quality demand.”\(^{36}\)

### Developing a national HIV strategy pillar by pillar

**Pre-planning for a national HIV strategy development process** requires development of an organisational note identifying the key actors and describing a roadmap for developing a context-specific response. National HIV strategies should be developed through an intensified national dialogue regarding investment choices and priority setting involving all key national partners, including civil society groups, at all stages. Appropriate forums for this dialogue include existing multi-stakeholder structures and processes such as national AIDS commissions and other governance bodies and partnership forums. The *Investment Approach* should facilitate an intensified dialogue between AIDS programmes and funding, planning and development authorities responsible for steering broad national development programmes. Opportunities for applying investment thinking and deriving new insights from this approach will arise in all stages of the planning and implementation cycle of national programmes. Processes during which investment thinking may be useful include development of investment cases for AIDS, sustainable funding discussions, reviewing and renewing national strategies and developing costing and implementation plans for national strategies.

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\(^{34}\) Investment case: a document that makes the case for optimized HIV investments. At its core is a description of returns on investment in a country’s optimized HIV response over the long-term (typically 10+ years). It summarizes the state of the epidemic and the response, describes the prioritised interventions, populations, and geographic areas to be implemented to achieve the greatest impact over the long term and the resources required. It also outlines the main access, delivery, quality and efficiency issues to be addressed to improve HIV services and describes what will be done to address these issues. It includes an analysis of, and plan for, realistic and more sustainable financing of the HIV response, including increases in domestic financing where relevant. While there is significant overlap between robust NSPs and investment cases in the sense that investment cases are also evidence-based documents providing essential information on the epidemiological context, the current response, and other key areas, a sound investment case quantifies the returns on HIV investments. Investment cases have a longer-term perspective (typically 10+ years) as returns of investments often occur beyond the 5-year horizon of a NSP.


\(^{36}\) GF/B28/DP4, Paragraph 5.
A national HIV strategy and implementation plan cycle involves four pillars as shown in figure 1 below.

**Figure 1  The national HIV strategy and implementation plan cycle**

![Diagram showing the national HIV strategy and implementation plan cycle]

Source: Adapted from “Joint Program competencies and the Bank’s AIDS strategy”, The World Bank

**Understand – Be situation and context specific:** Strategies and implementation plans deal with real situations documented by objective assessments of a country or region and considering the sociocultural, economic, religious and other specificities of the populations affected by HIV. Being “situation specific” requires knowing your epidemic and knowing your response, and prioritising the results to be achieved on the basis of this understanding.

“**Knowing your epidemic**” requires rigorous epidemiological, social and economic analysis to identify key populations at higher risk or geographical hotspots, and helps to define the types of behaviours and activities (and their relationships to underlying norms, laws and policies) that are most likely to increase risk or vulnerability to HIV infection.\(^{37}\) This is critical information for knowing the modes of transmission and how to break the chain of transmission and reduce the rate of new HIV infections. It also means analysing the impact of the HIV epidemic on women, families and communities in the medium to long term.\(^{38}\)

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“Knowing your response” means that sufficient information is available and taken into account regarding how well previous and current HIV programmes have performed in terms of preventing new HIV infections,· increasing the health, longevity and quality of life for people living with HIV, and mitigating the impact of HIV infection on individuals, families and communities. This analysis should consider what the strong points of implementation have been, as well as the obstacles that impeded success. It is also important to learn from elsewhere: strategic planners want to draw from the vast pool of experience accumulated during the last few of years of their national response, to avoid “reinventing the wheel”. Taking examples from neighbouring countries’ experiences or from known best practices and adapting them to the country’s particular situations and context will save time and increase the chances of success.

National priorities then need to be defined on the basis of understanding the key drivers and critical enablers of the HIV epidemic, and what works within countries. This prioritisation will often significantly differ between countries with HIV epidemics that are concentrated in particular populations compared with countries that have generalized epidemics. The complexities of HIV have sometimes led governments and international organisations to attempt planning for all eventualities. Moreover, donors and other external agencies sometimes add their own agendas and priorities to already unwieldy plans that cover many areas, resulting in generally low implementation rates, poor performance, failure to achieve the agreed-upon results, and overburdening of scarce national staff. A more strategic approach concentrates on planning for results and focusing on priority areas, through identifying the epidemic’s most important determinants.

**Design – Determine and prioritise the results to be achieved:** 39 Based on the analysis of the situation and the response, and subsequent prioritisation, it is then important to establish the results that national stakeholders wish to achieve within the time frame of the national AIDS strategy. Results need to be measurable, with clear, time-bound targets developed. In line with international targets, national stakeholders should consider how far they can go towards achieving vision of the Three Zeros 40 and the 10 global HIV targets highlighted in the Political Declaration on HIV and AIDS: intensifying our efforts to eliminate HIV and AIDS. 41 In prioritising interventions drawing upon scarce resources and their related expected outcomes, strategies should be guided by the Investment Approach.

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40 UNAIDS 2011-2015 Strategy – Getting to Zero

41 UNAIDS Ten targets: targets and elimination commitments. Geneva, UNAIDS
Box 3  Joint Assessment of National Health Strategies

Joint Assessment of National Health Strategies\textsuperscript{42}, or JANS, is a shared approach to assessing the strengths and weaknesses of a national strategy or plan. Countries are using JANS to enhance the quality and relevance of the national plan, increase confidence in the strategy, and help inform decisions about funding, ensuring that funding is closely aligned to the national health strategy. The JANS tool can help assure the quality of a national HIV strategy by examining its soundness and feasibility in five areas:

1. **Situation analysis and programming**: clarity and relevance of priorities and strategies selected based on a sound situation analysis

2. **Process**: soundness and inclusiveness of development and endorsement processes for the national strategy

3. **Costs and budgetary framework for the strategy**: soundness and feasibility of the financial framework

4. **Implementation and management**: soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy

5. **Monitoring, evaluation and review**: soundness of review and evaluation mechanisms and how their results are used.

**Deliver – To deliver desired results, plan implementation realistically**: Results indicators and targets need to make fine judgments that balance ambition and realism. Particularly for this reason, the strategy development process should be inclusive of all key stakeholders.

Implementing the planned interventions in priority areas requires will, people, competencies, materials and money. Strategies need realistic and viable initiatives that stimulate and apply the resources and strengths of communities affected by the epidemic and that draw on the support of political, religious and other community leaders, the private business sector, and international partners. These groups need to be part not only of developing the national HIV strategy but also of planning how the strategy will be put into action, including deciding in what areas they will take responsibility and how all parties will be held to account for commitments to deliver these areas of the strategy. Similarly, it is important that national HIV strategies be linked to sectoral strategies where implementation is done by those sectors.\textsuperscript{43}

Delivering desired results requires intensive and dynamic coordination of the efforts of all partners, including the provision of essential technical support, based on a shared implementation plan. Excellence in the operational execution of implementation plans is built on a well-established foundation of situational awareness and intelligence from field visits, monitoring, and intensive networking coupled with bottle neck analysis and decisive trouble

\textsuperscript{42} Joint Assessment of National Strategies \url{http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/}

\textsuperscript{43} For example, UNODC resource: HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings. A Framework for an Effective National Response \url{http://www.unodc.org/documents/hiv-aids/HIV-AIDS_prisons_Oct06.pdf}
shooting. Strong operational leadership with concomitant authority and accountability are the sine qua non of effective delivery.

**Sustain – Maximise performance and ensure long-term sustainability:** National HIV strategies should address the challenges related to a sustainable AIDS response, e.g., by synergizing health investments with investments in other development sectors that can have a positive effect on HIV programmes and outcomes, integrating key services, and avoiding duplications. The *Investment Approach* emphasizes the need for more sustainable financing of the HIV response through identifying new sources of domestic and external funding. Increased domestic funding is essential for achieving larger scale-up and sustainability.

Ensuring that the AIDS response in a country fits within efforts to promote health and development more broadly will require partnerships for cooperation, coordination and consultation between private and public sectors and civil society, in order to leverage resources and maximise impact.

Sustainability, and making the case for continued AIDS investment, cannot be achieved without appropriate measures to monitor programme progress, evaluate what works and how, analyse returns on investments and document impact at a population level. Mobilising and leveraging resources in resource-constrained environments requires demonstrating impact and good use of resources—human, financial and material. It also demands agreement with development partners regarding how each player will share responsibility for achieving results and ensuring there are sufficient resources and appropriate monitoring mechanisms and indicators in place.

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44 For example, investments in prisoner health, education and social protection.
A final note

The chart below provides a single visual reference for how the new instruments and tools and the updated framework for developing, assessing and implementing national HIV strategies described above fit together (also available in table form in appendix 1).

Figure 2  New instruments, tools and updated framework

Effectively implementing the strategy and achieving priority results are the raison’d’etre for developing national HIV strategies. Accordingly, particular attention needs to be given to identifying the mechanisms or structures which are accountable for the overall delivery of the strategic and implementation plans, and how executing these plans will be managed, indicating responsibilities to guarantee that activities materialize, and establishing partnerships to monitor them.

The AIDS response is unique: in the movement that drives it; in the unprecedented resources it has mobilised; in the partnerships between science, activists, communities, and the public and private sector; and, most importantly, in the impact it has had on delivering health, welfare and human dignity to millions of people. Today we are at the dawn of a new era where there is realistic hope that new HIV infections, AIDS mortality, and HIV-related discrimination can all be ended.
National HIV strategies are the glue that binds people together to achieve this hope—people advancing together are both the Means of success and the End which is what it is all about.
## Appendix 1

### Table A.1 Developing national HIV strategies for impact: summary of key steps and relevant elements/components

<table>
<thead>
<tr>
<th>No.</th>
<th>Steps</th>
<th>Actions/Outcomes/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Recognize the big shifts</td>
<td>- A shift in vision, from managing AIDS to ending the AIDS epidemic&lt;br&gt; - A shift away from the AIDS ‘exceptionalism’ and stand-alone architecture&lt;br&gt; - A shift in favour of an investment approach&lt;br&gt; - A shift in the content and package of interventions—focusing on evidence-based programme activities and critical enablers, while maintaining a rights-based and gender equality approach&lt;br&gt; - A shift in population-targeting with a focus on affected and vulnerable population groups and geographical areas&lt;br&gt; - A shift towards increasing the use of domestic resources&lt;br&gt; - A shift of focus from planning to implementation and delivering results</td>
</tr>
<tr>
<td>2.</td>
<td>Recognize core principles and best practice</td>
<td>- Ensuring country ownership including non-government actors and constituencies&lt;br&gt; - Recognizing the role of government as the ultimate duty bearer&lt;br&gt; - Ensuring responses are evidence-informed&lt;br&gt; - Reaffirming GIPA principle and enabling full engagement of affected communities&lt;br&gt; - Achieving/moving towards universal access to HIV services and eliminating HIV-related marginalization&lt;br&gt; - Advancing human rights and gender equality, including eliminating HIV-related stigma and discrimination&lt;br&gt; - Recognizing the role that ‘critical enablers’, both social and programmatic ones</td>
</tr>
<tr>
<td>3.</td>
<td>Pre-planning/roadmap</td>
<td>- Identification of key processes, stakeholder involvement, partnerships and special political considerations&lt;br&gt; - Clarification of the coordination and decision-making mechanism&lt;br&gt; - Identification of key strategic information and foundation documents to drive strategy development&lt;br&gt; - Identification of technical support needs for the process</td>
</tr>
</tbody>
</table>
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</table>
| 4.  | Situation analysis  | - Analytical report on what is known (or not known) about the epidemic and the responses to it  
    |                     |   - Understanding the context (i.e., programmatic, political, cultural, social and institutional)  
    |                     |   - Financial and material resource gap analysis                                          |
| 5.  | Prioritisation      | - Vision setting and articulating mid-term goals and results                            |
|     |                     | - Linkages with the broader health sector and development instruments and with international commitments |
|     |                     | - Framework for investing scarce financial resources                                    |
| 6.  | Programming         | - Key principles and approaches to be emphasized                                        |
|     |                     | - Packages of interventions to be pursued                                               |
|     |                     | - Integration (linkages with health programmes)                                         |
|     |                     | - Management arrangements and related systems                                           |
|     |                     | - Costing and budgeting                                                                 |
| 7.  | Validation          | - National review including with key international partners                              |
|     |                     | - Authoritative national endorsement of strategy                                        |
|     |                     | - Launch and dissemination of strategy                                                |
| 8.  | Implementation      | - Operational/ implementation plan development (where deemed necessary)                  |
|     |                     | - Pursuit of economies of scale and efficiency gains                                    |
|     |                     | - Coordination of technical support provision                                          |
|     |                     | - Ongoing monitoring of implementation and coordination of multiple actors and players  |
| 9.  | Assessment and resourcing | - Governance, accountability and reporting structures                               |
|     |                     | - Programmatic and financial risk assessment                                            |
|     |                     | - Monitoring and evaluating impact and return on investments                             |
|     |                     | - National budget, other domestic sources of funding and external financing             |