

# National Strategic Planning: Prioritization for Impact

Training Materials from the Workshop on  
Design and Costing of HIV Programs in Asia,  
UNAIDS RST-ADB-UNDP-World Bank-ASAP,  
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# Outline

- ❖ The essential criteria for a National Strategic Plan
- ❖ The importance of prioritization
- ❖ Effective intervention
- ❖ The cost dimension
- ❖ Other vital elements
- ❖ Resources: Training agenda and manual, templates, toolbox, reference readings

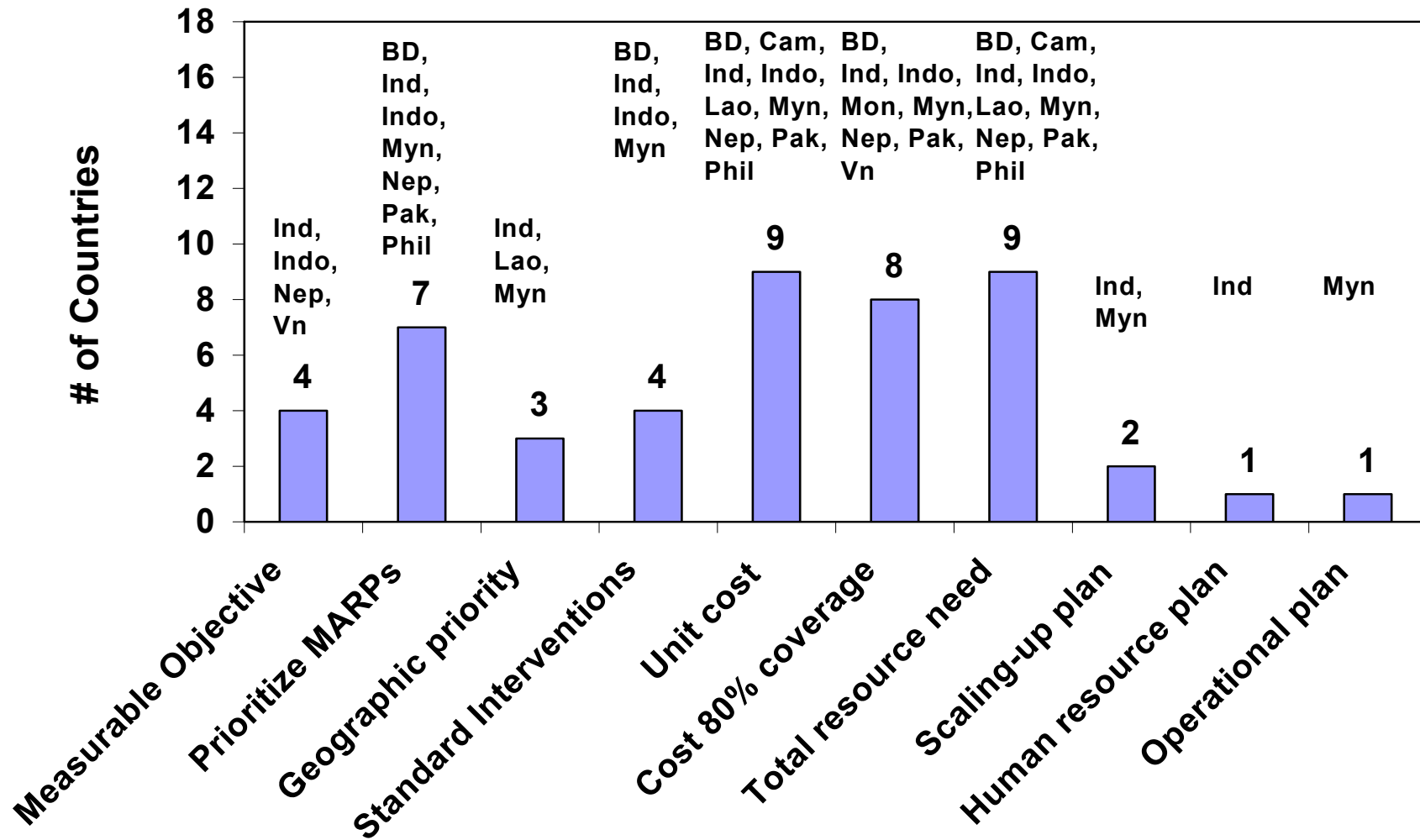
# National Strategic Plans should consider 10 essential criteria:

- Clear measurable objectives that reverse and/or halt HIV impact
- Prioritization by sub-populations at risk and geographic region
- Estimated number needing prevention, treatment, and mitigation services
- Recommended responses composed of standardized packages with best-practice elements
- Estimated unit costs of the intervention packages
- Estimated total resource needs allocated based on cost-effectiveness
- Operational plan for delivering interventions at scale
- Plan for human and infrastructure resource needs
- Built in management across sectors and sub-regions
- Mechanisms for monitoring and quality control of implementation

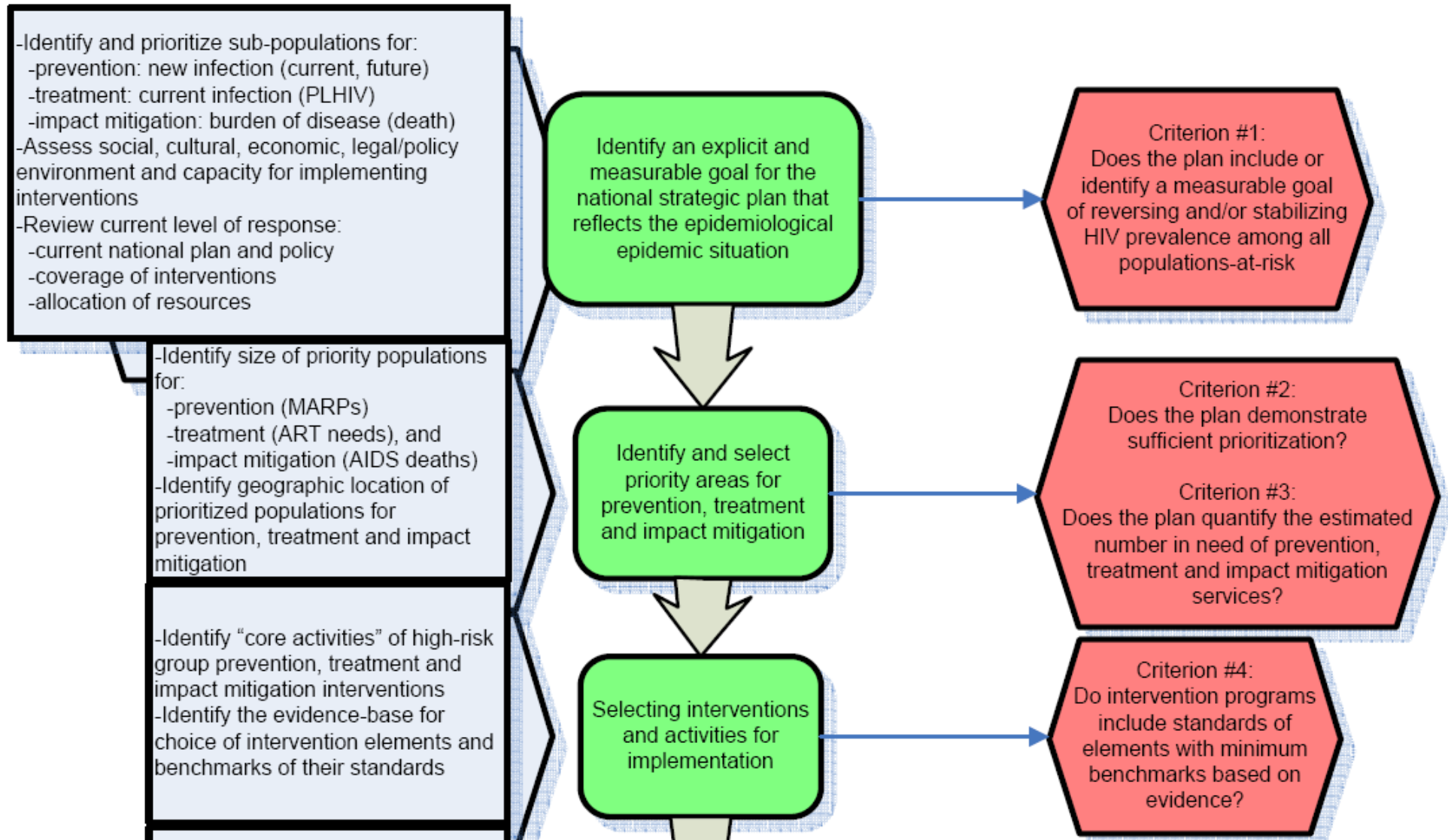
# But many country NSPs do not contain these elements



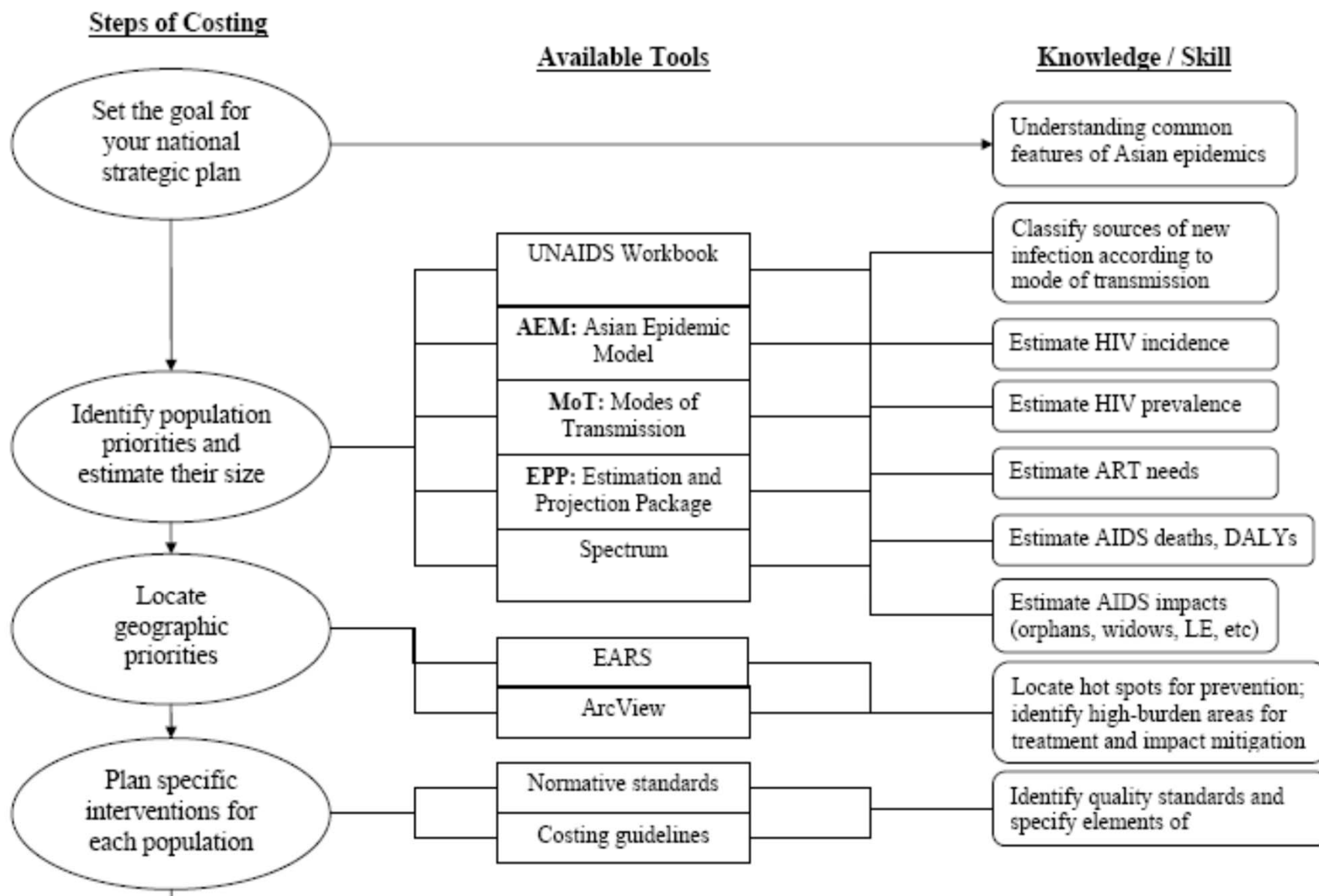
Analysis of NSPs in 18 countries, UNAIDS RST Dec. 2009



# Conceptual framework developed to assess information needs for essential NSP criteria



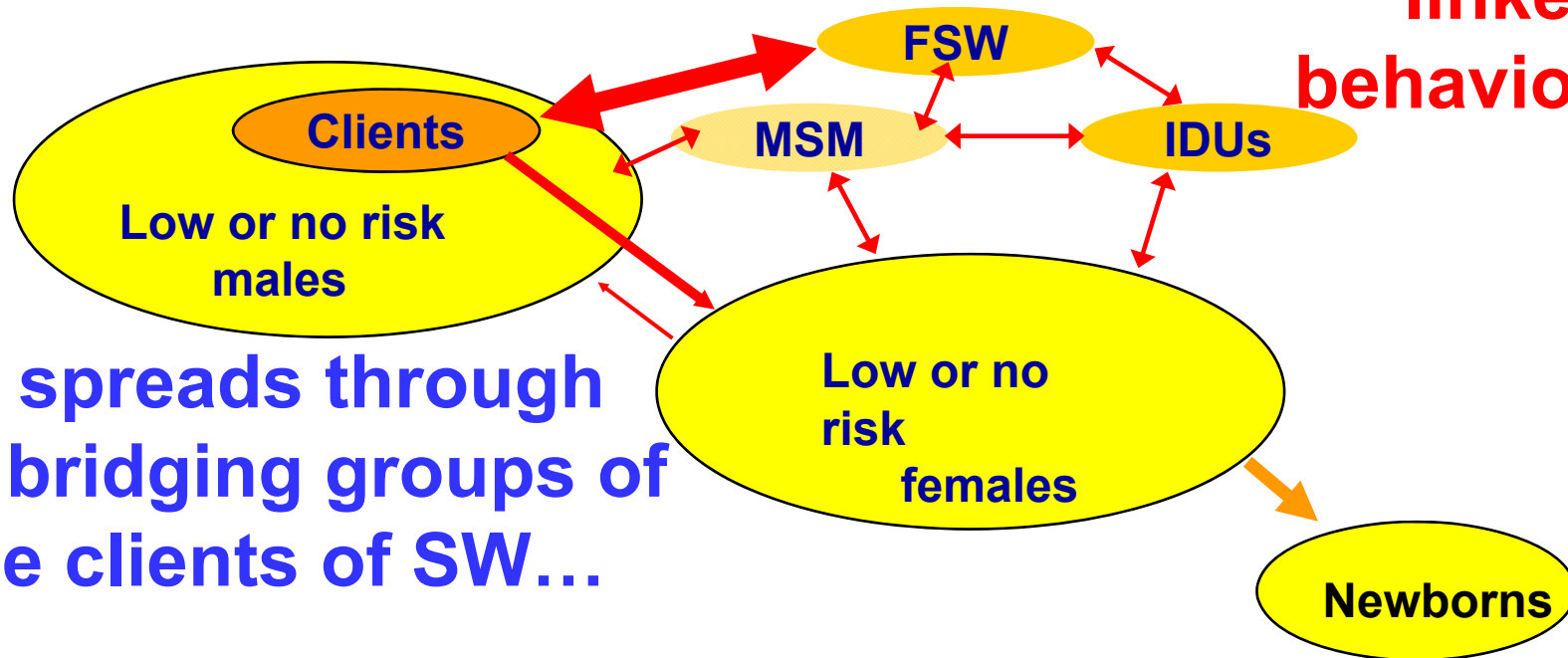
# For each information need there are recommended methods and tools



# First ... we need to understand Asian epidemics

**Typically in Asia HIV risk is concentrated in certain behavioral or professional groups ...**

**strongly linked behaviorally**

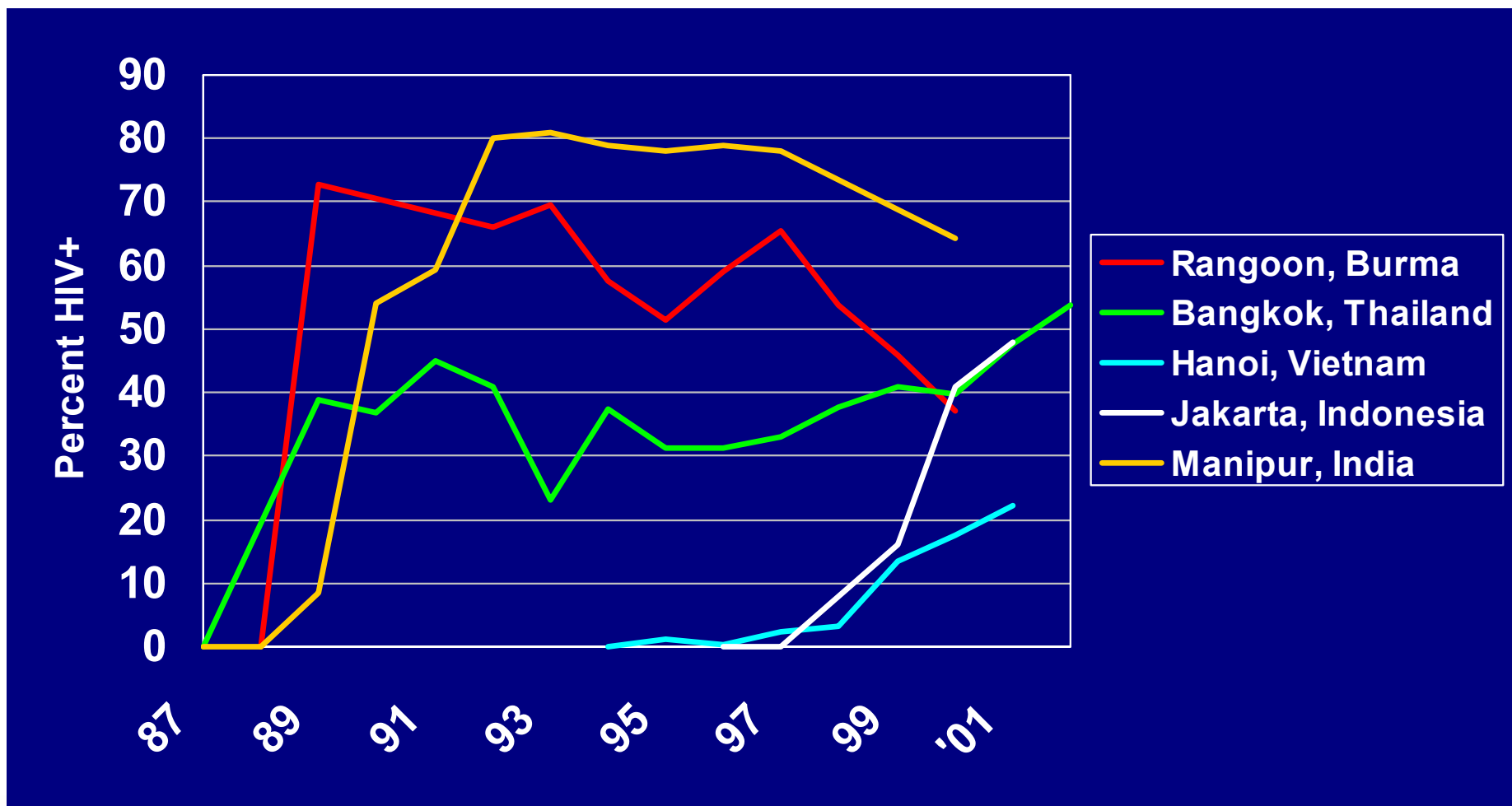


**HIV spreads through the bridging groups of male clients of SW...**

**... to low risk women & children**

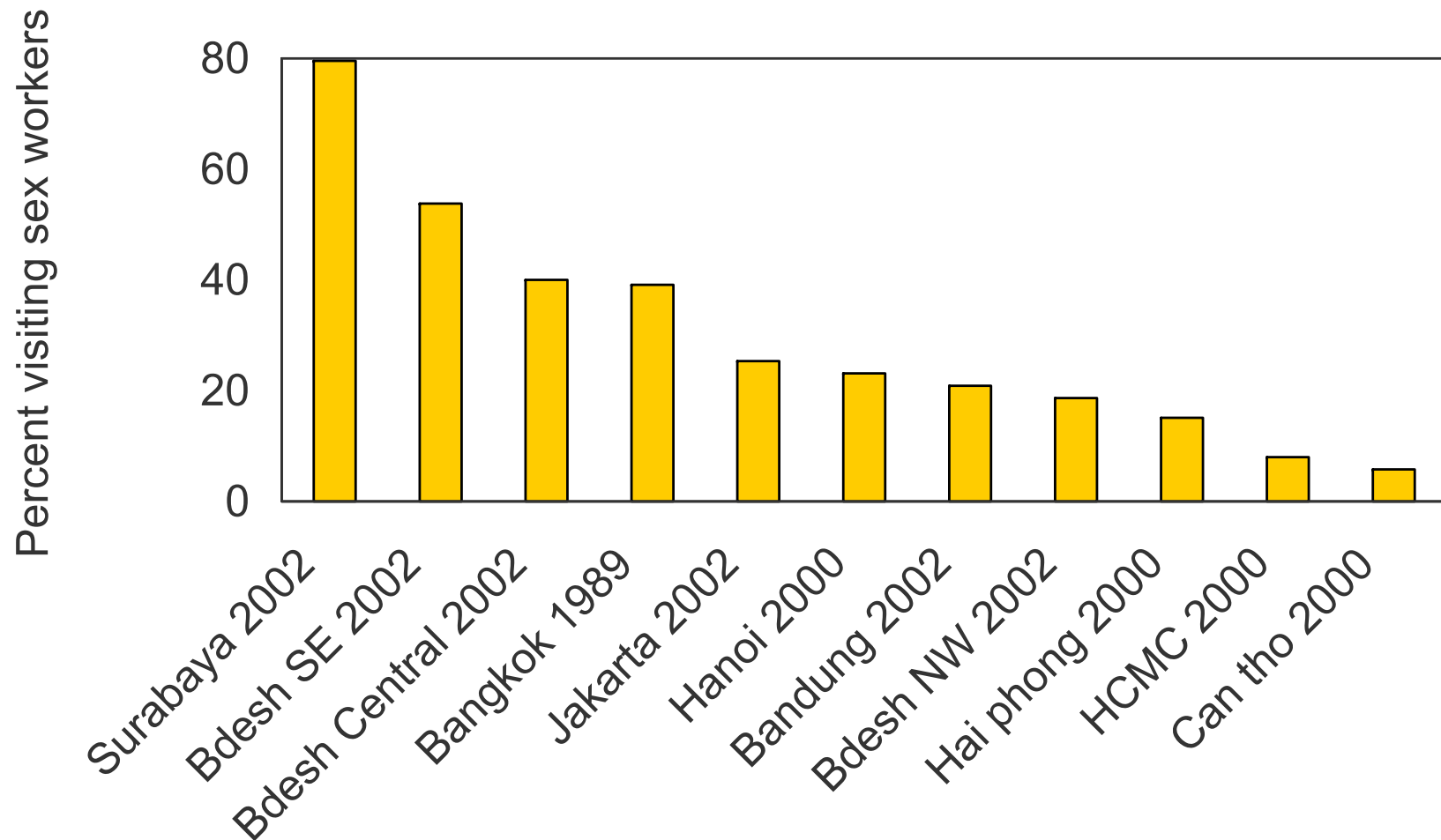


# HIV in IDUs takes off fast to hi levels...

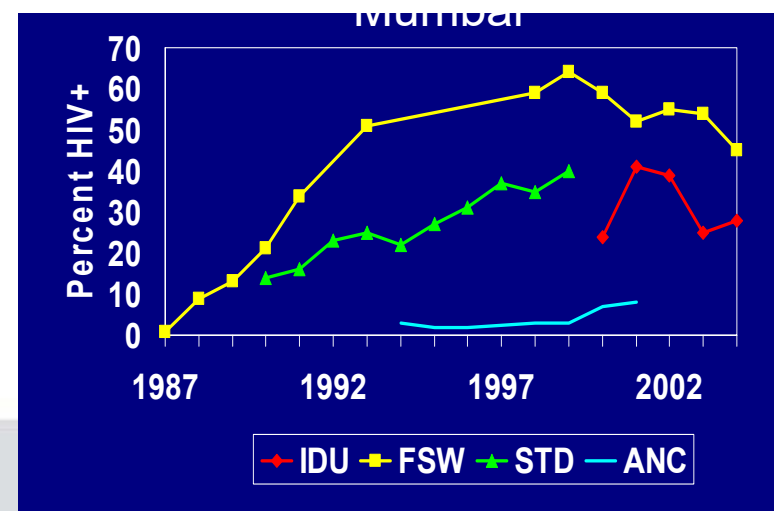
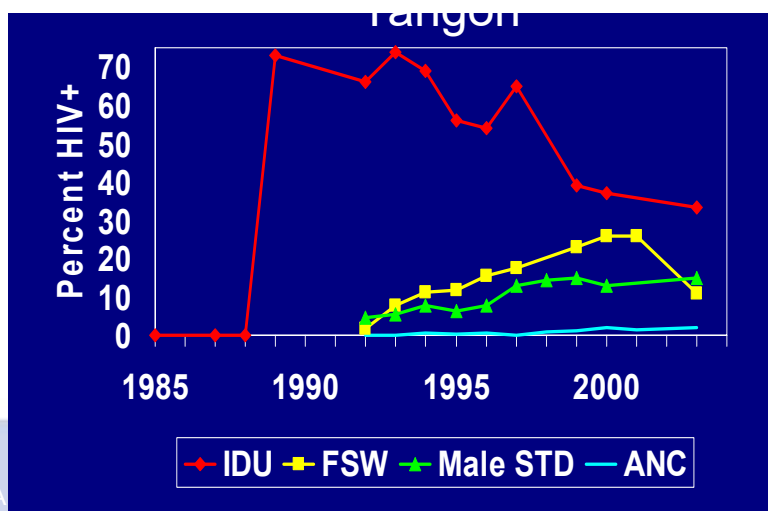
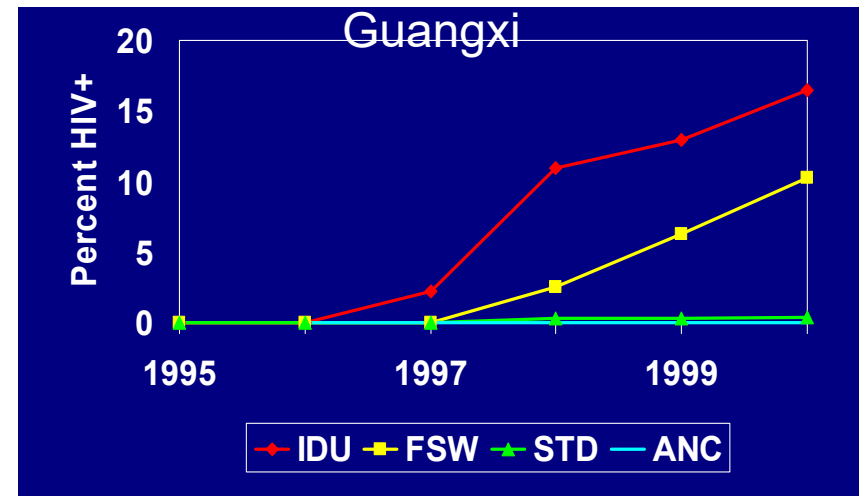
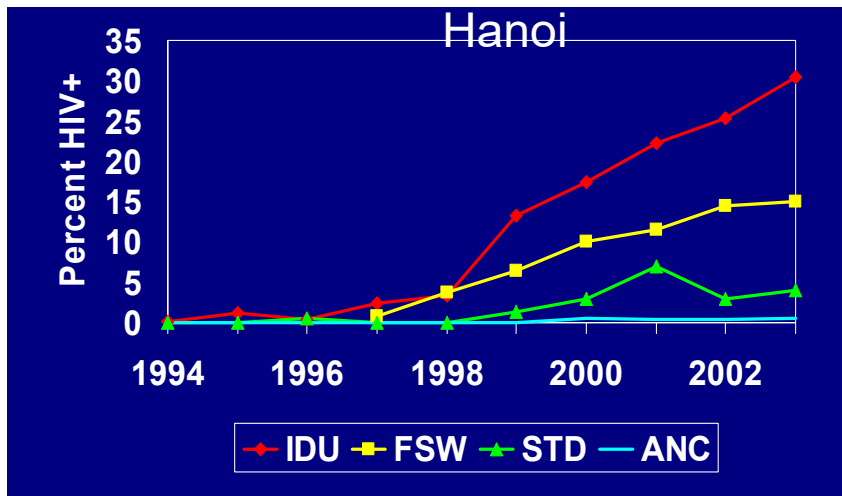


# ...and because IDUs often visit sex workers

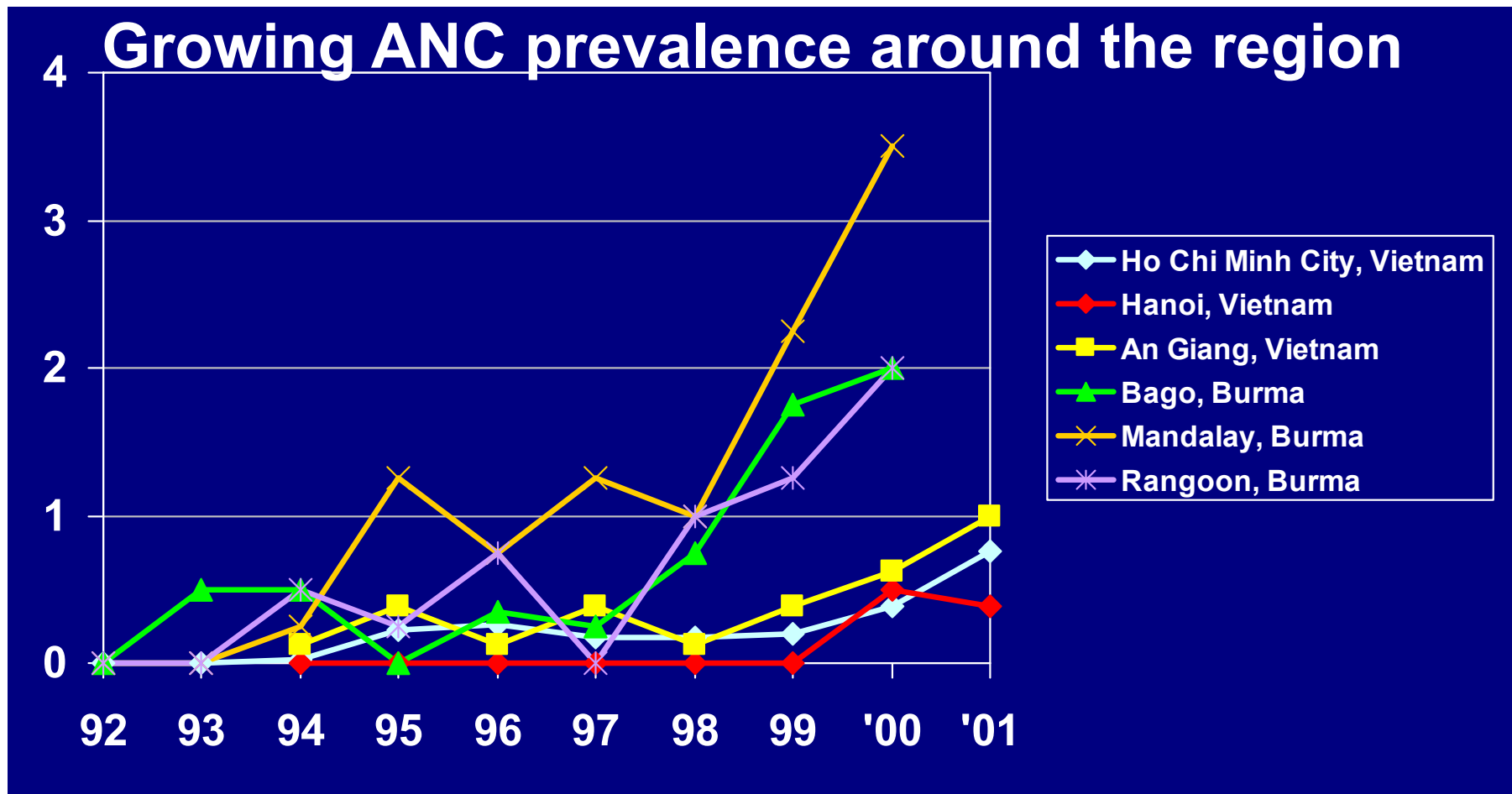
## Percent of IDUs visiting sex workers in last year



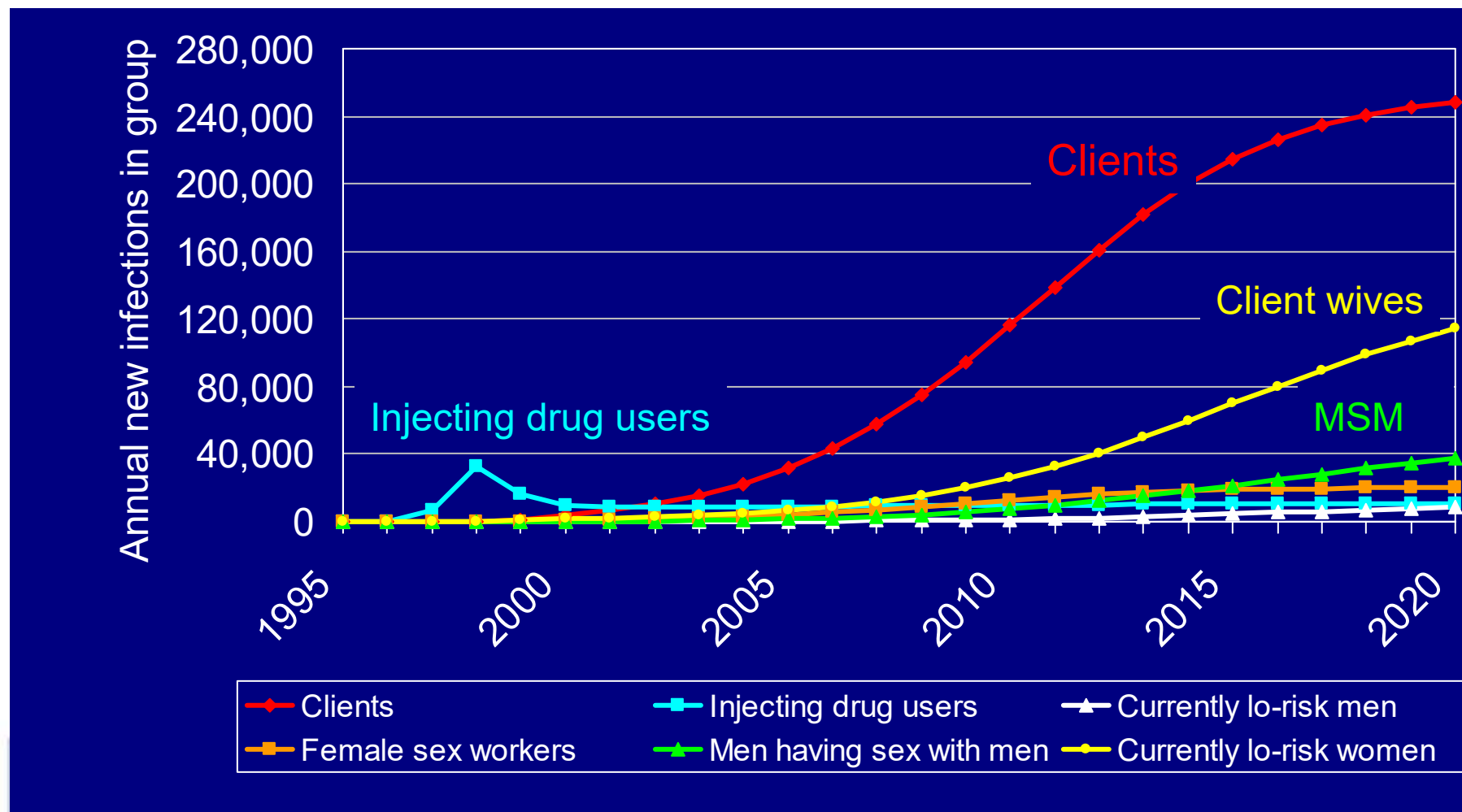
# Injecting drug use often seeds sex work components of epidemics



# ...ultimately HIV finds wives & children



# Injecting drug users kick start Asian epidemics, but Clients drive them



# Prioritization of populations is key

This comes out of good data generation,  
analysis, and synthesis

# What do we need to know to prioritize populations?

- HIV-related risk in populations
  - Sexual risk – levels and frequency of unprotected commercial sex, and anal sex between men who have sex with men
  - Injection risk - sharing of needles
- HIV prevalence of sub-populations
- Size of at-risk & vulnerable sub-populations
- Geographic location of risk populations

# Size estimation of populations at risk: HIV prevalence of at-risk populations matters...

Population group	HIV prevalence
Injecting drug users	37.5
Sex partners of injecting drug users	12.5
Female sex workers	2.8
Clients of female sex workers	0.28
Wives of clients of female sex workers	0.03
Men who have sex with men	1.3
Male sex workers	21.5
Wives and girlfriends of male sex workers	7.1



# HIV prevalence of at-risk populations matters... but knowing their size is vital for prioritization

Population group	HIV prevalence	Estimated population size
Injecting drug users	37.5	27 500
Sex partners of injecting drug users	12.5	20 900
Female sex workers	2.8	32 400
Clients of female sex workers	0.28	1 257 000
Wives of clients of female sex workers	0.03	808 700
Men who have sex with men	1.3	47 800
Male sex workers	21.5	5 500
Wives and girlfriends of male sex workers	7.1	2 600

# Methods for estimating size

- Census and enumeration
- Population surveys
- Multiplier methods
- Nomination methods - RDS
- Capture-Recapture
- *Data gap identified resulted in July 2009 regional size estimation training and draft manual*

# Geographic Prioritization

- Choose an administrative unit
- Assess prevalence and frequency of risky behaviors
- Assess HIV prevalence and disease burden
- Categorize your country units into 4 HIV-risk zones
- Respond with focused interventions

# EARS: Early Alert and Response System

To stay **AHEAD** of the epidemic.

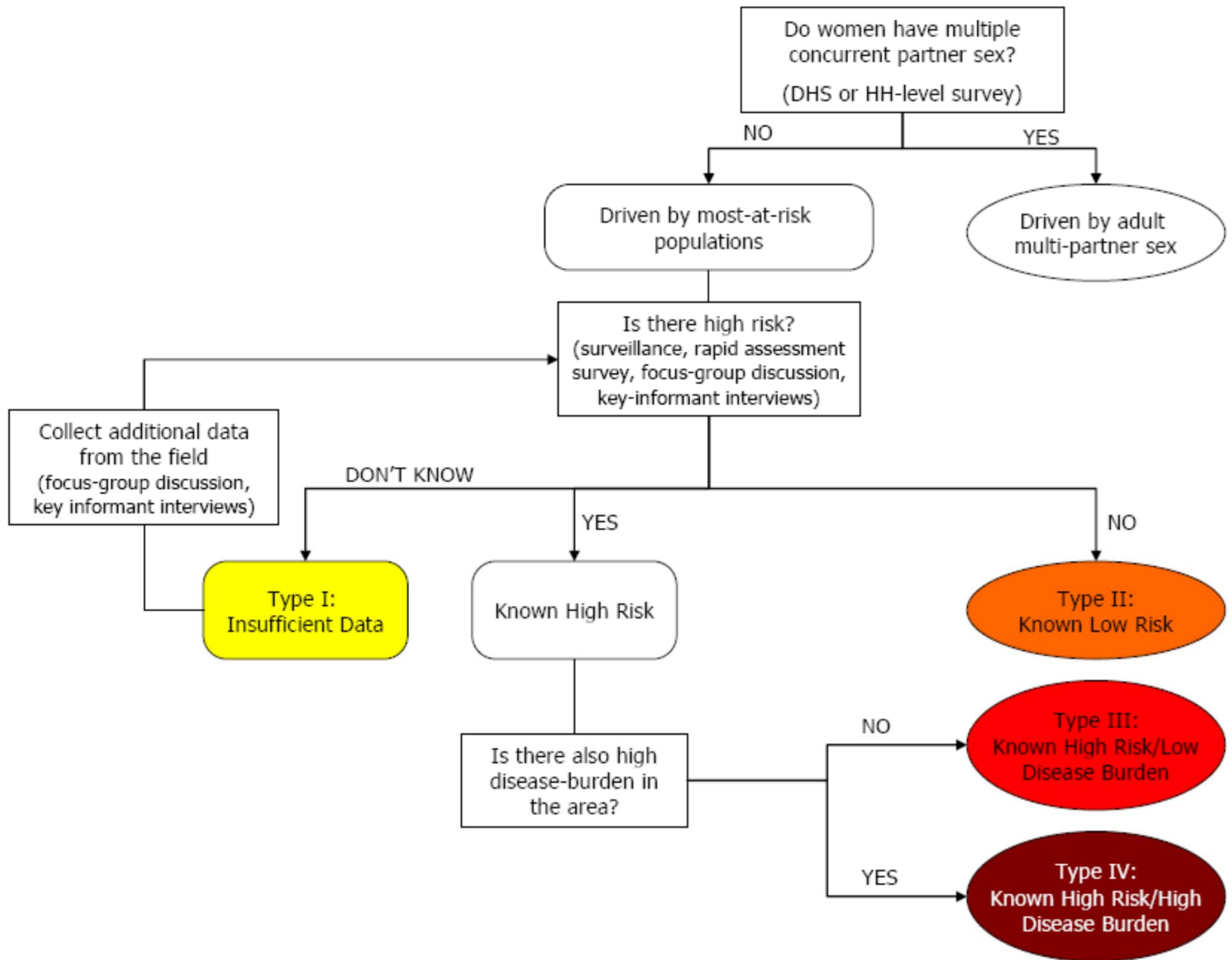
**A:** Identify *all* **AREAS** at risk for spread of HIV

**H:** Understand who the **HIGH RISK** populations are in those areas

**E:** Obtain good **ESTIMATES** of how large the at-risk populations are in those areas

**A:** **ASSESS** levels of risky behaviour among the identified risk populations in those areas

**D:** Assess levels of **DISEASE** (HIV and STIs) in identified risk populations in those areas



# Geographic prioritization of interventions: Mapping of IDU in Pakistan



## Prioritization and estimations of need narrow focus of NSP

- Estimate sizes of key populations at higher risk
- Categorize country units into HIV-risk zones
- Determine numbers in need of prevention, treatment, and care and support

# How many new infections are there? How many people do you need to treat?

- EPP- Spectrum
- Asian Epidemic Model (AEM)

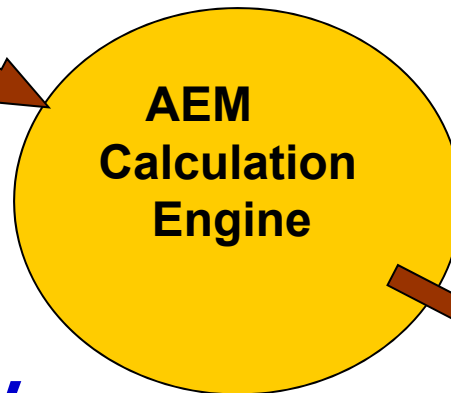


# AEM is a computer model that simulates HIV spread and makes future projections

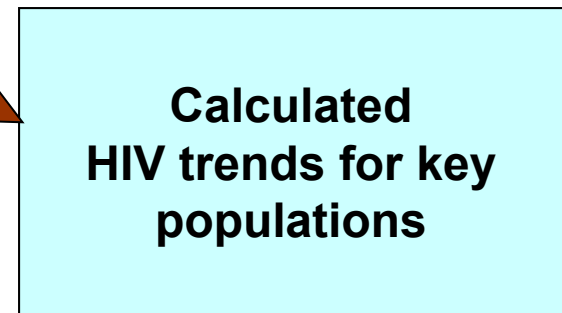


-Numbers of Men (Clients) & Women, Drug Injectors, Female & Male Sex Workers, Men who have sex with men  
-Behaviors  
-STI

**Populations & their behaviors are inputs**

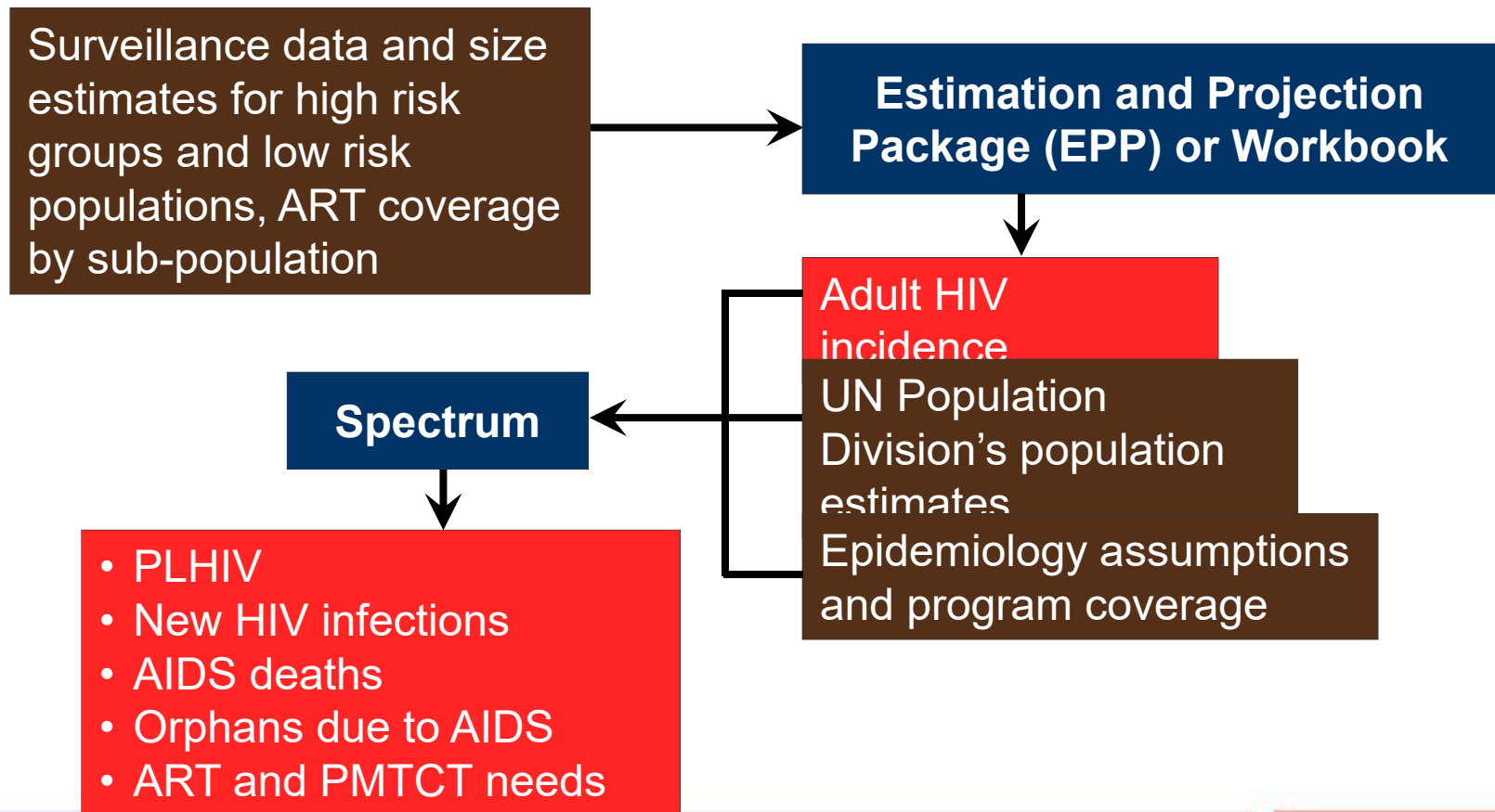


**Transmission is adjusted to fit country observations**



**and the outputs are HIV prevalence and incidence trends and deaths**

# EPP/Spectrum have less data needs than AEM and also make projections of numbers in need

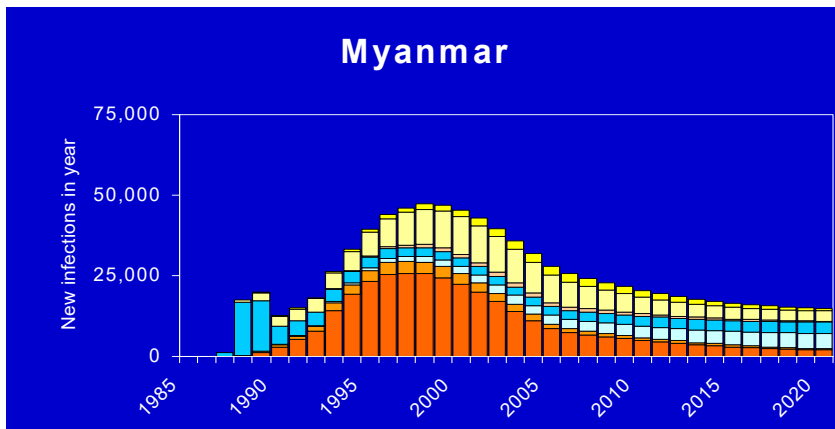
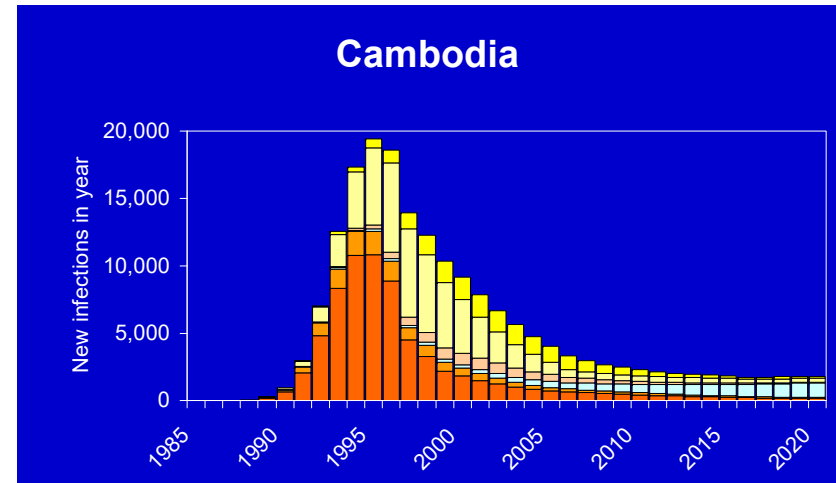
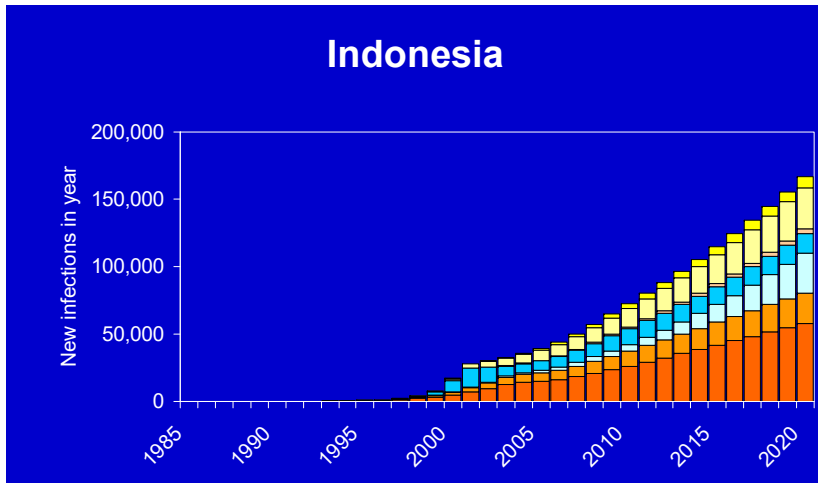


# Prioritizing Response: Elements of epidemic-driven, country- specific effective interventions



- Targeted at the strategic at-risk populations in strategic locations
- Based on the source of most new infections
- Effectiveness
  - Standardized packages incorporating best practice elements for each group available in Asia
    - BCC
    - Prevention commodities delivery
    - Prevention treatment
    - Monitoring and Evaluation
  - Peer outreach vs structural interventions
- High coverage

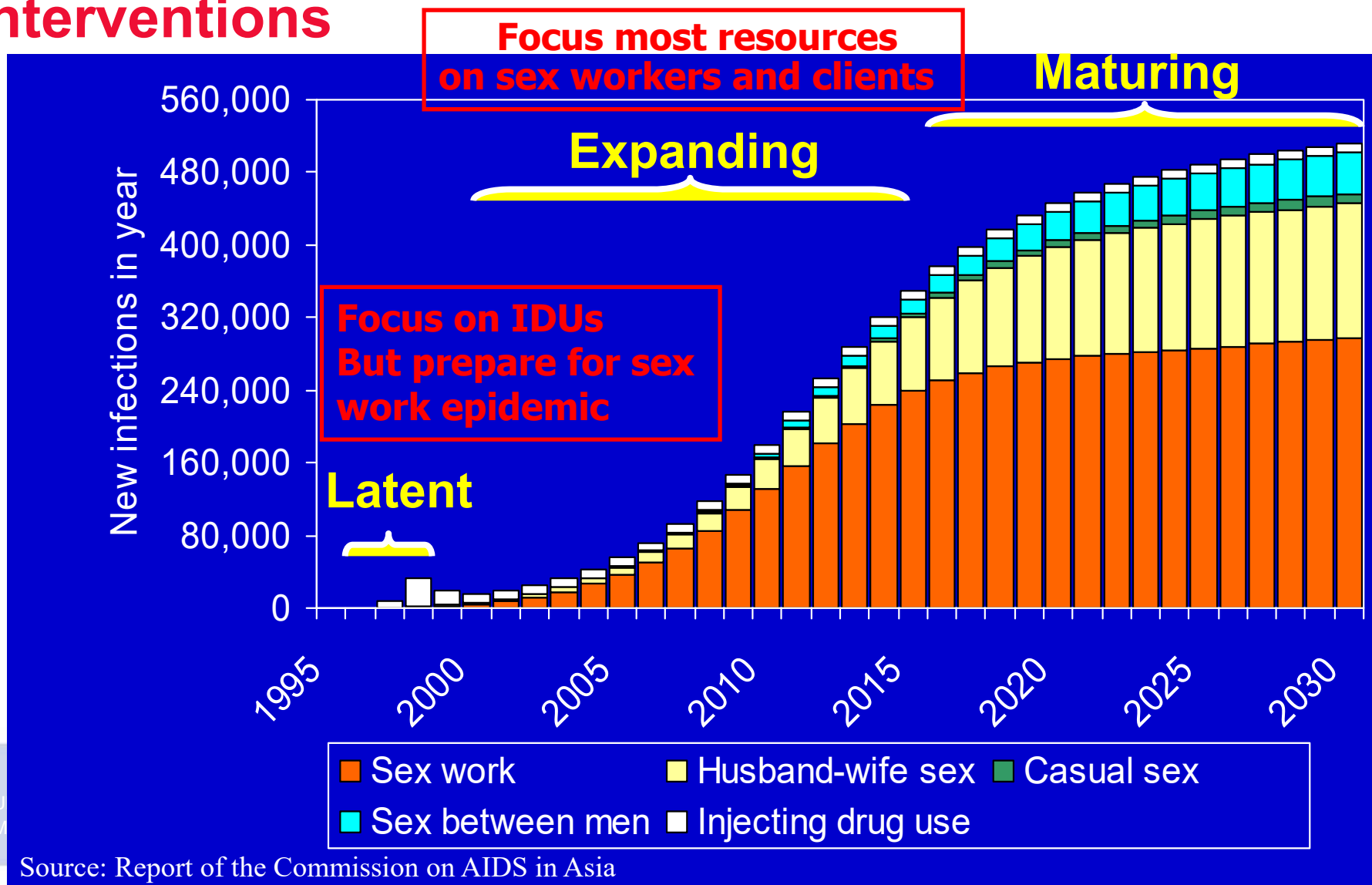
# The source of new infections varies in different countries across the region



...and effective prevention targets new infections

- Clients
- Sex workers
- MSM
- IDU
- Lo-risk male
- Lo-risk female
- Children

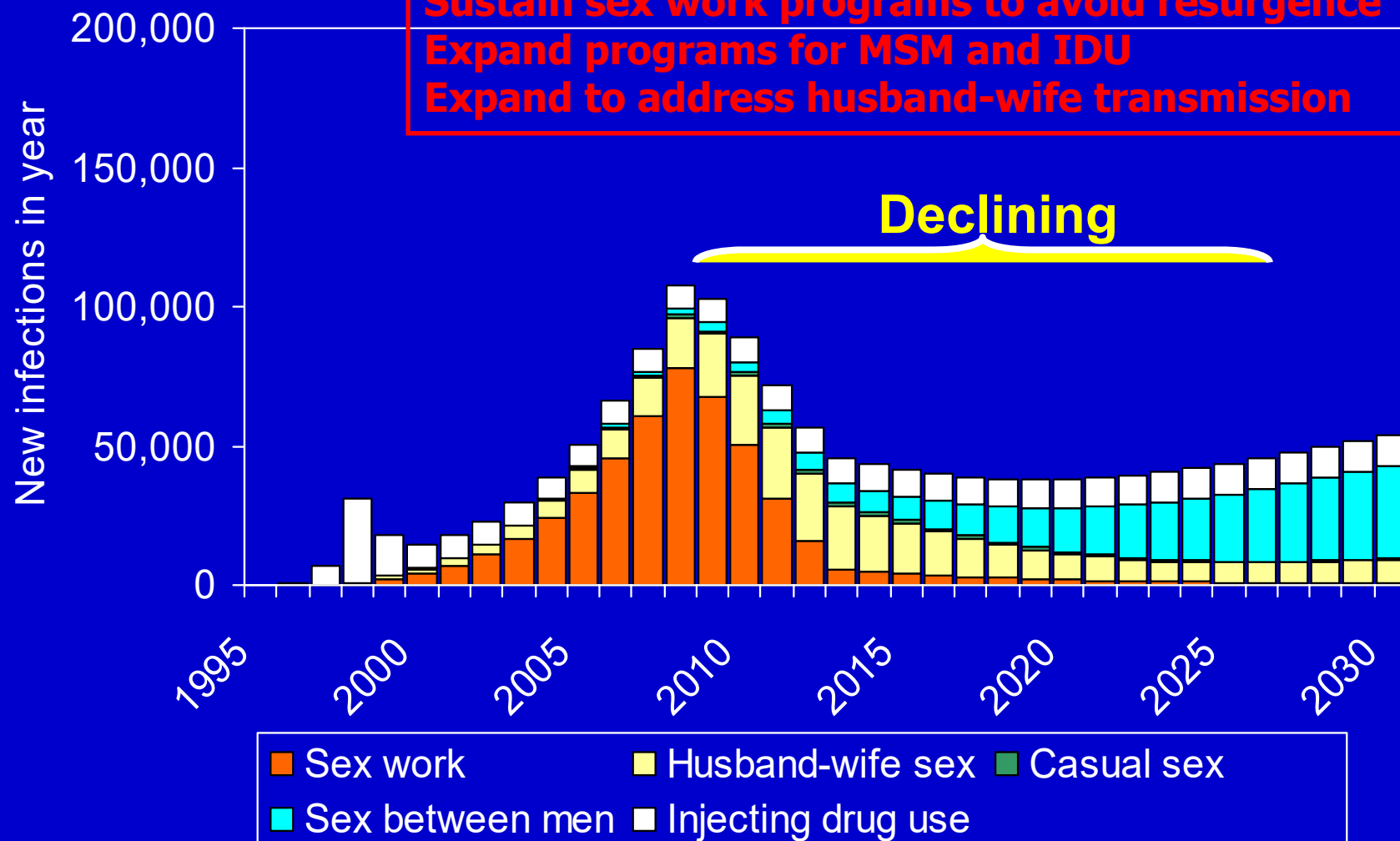
# The main source of new infections depends on the epidemic stage and experience has taught where to focus interventions



# When HIV in sex work is addressed ...

## other interventions become important

**Sustain sex work programs to avoid resurgence**  
**Expand programs for MSM and IDU**  
**Expand to address husband-wife transmission**

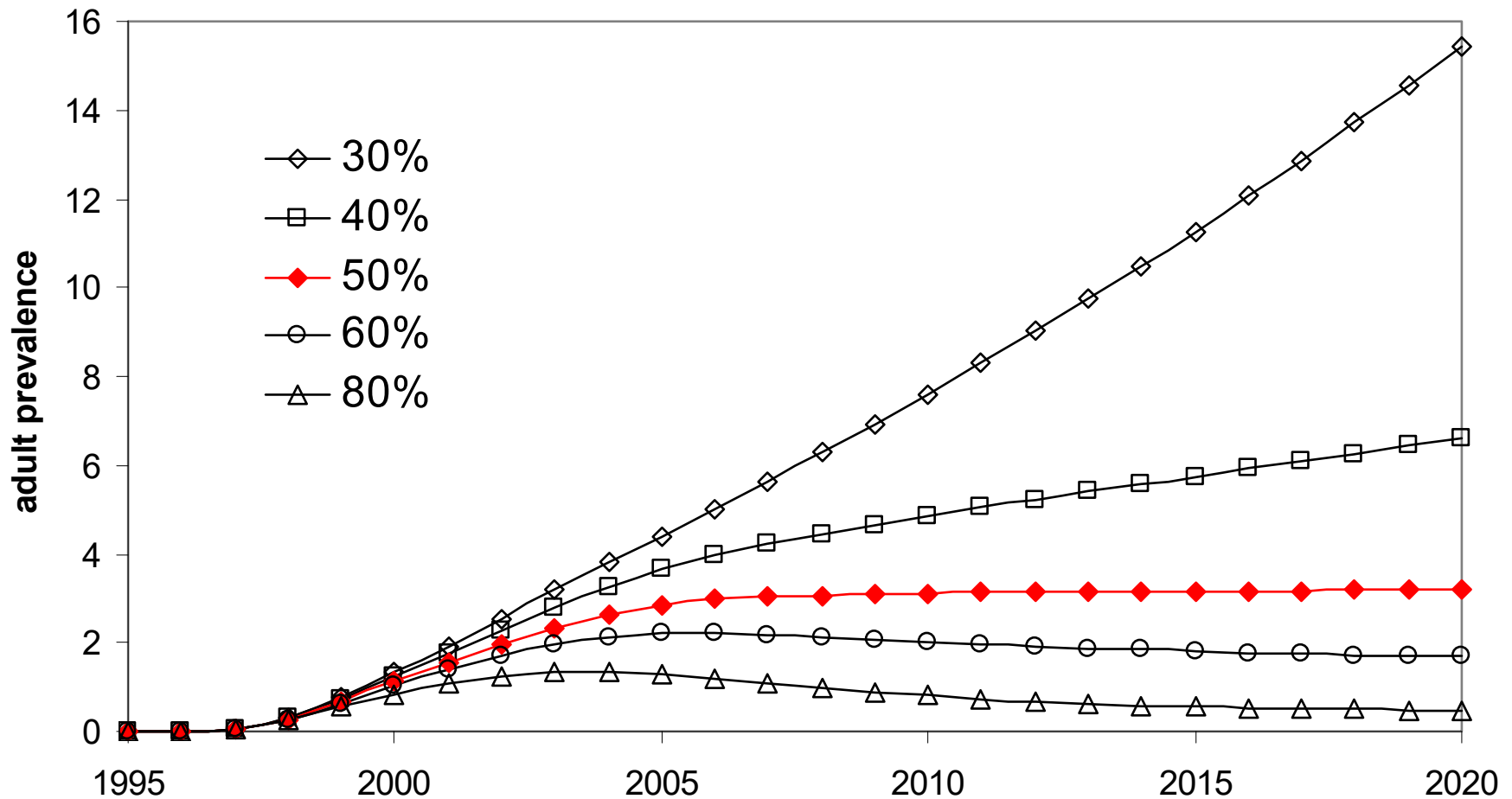


Source: Report of the Commission on AIDS in Asia

# SHARP: Standard Halt and Reverse Package

- So that funding not diverted to ineffective interventions
- So that effective HIV interventions not implemented at low coverage
- Difficult to scale-up interventions varying in elements, dosage, frequency of administration
- **Decide on the delivery unit of the intervention in order to cost and scale up**

# Reaching 80% MARPs coverage can turn around Asian epidemics





**Where information is lacking - rely  
on nominative standards...  
*until you get better data***

## Injecting Drug Users: Peer-education based

	Specific type	Provider	Periodicity	Specification
Education	Peer education NGO outreach NGO education	CBO NGO Mix (specify)	once per week once in a fortnight once per month once in 3 months once in 6 months	
Needle Syringe Program	Distribution Exchange thru Pharmacy	NGO CBO Government Mix (Specify)	Twice/day once a day bi-weekly weekly	20% – 80% of needles required
Drug Substitution	Buprenorphine Methadone	NGO Government Mix (Specify)		20% - 100 % of population (Dosage: )
Enabling Environment	Self-organization Provider/ beneficiary immunity Local advocacy Legal provision Involvement of police Strong political commitment			
Project-level Management	Training of staff Supervision of implementation	CBO NGO Government		Guided by the community
Project-level Monitoring	Output monitoring (condoms/needles distributed, STI or drug substitution treatment provided) Outcome monitoring (STI reduction, needle sharing, condom use)	Peer educators Implementing NGO Managing NGO Govt staff	Weekly Quarterly Annually Every three years	Data used for mid course correction by the community

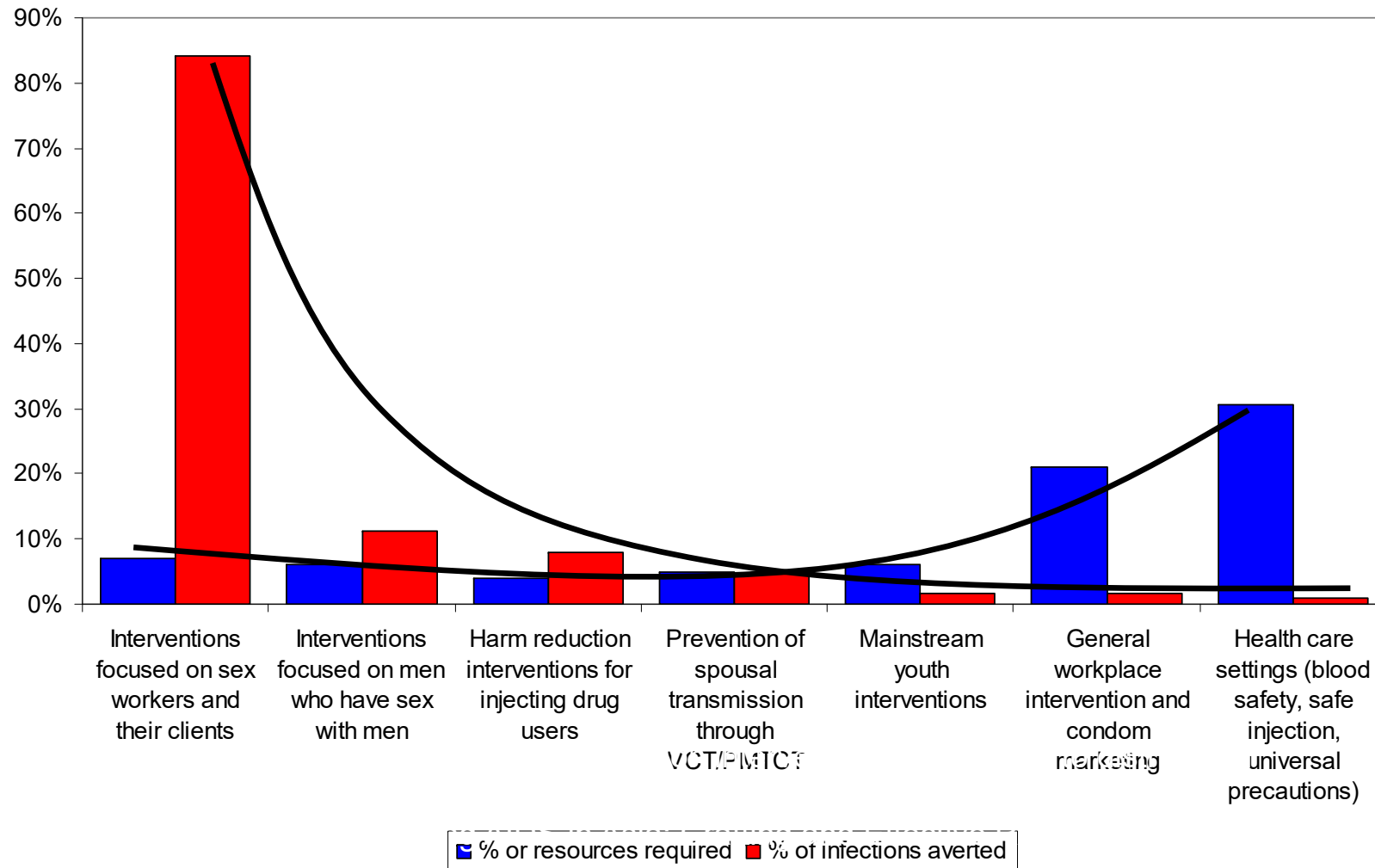
# Monitoring and Evaluation: Up front in planning process, not as an afterthought

- What should be contained in the M&E plan?
  - **Section 1 of M&E plan:** General information.
  - Background and context: Epidemic Situation and Response Analysis
  - Mandate
- Process to develop it
  - **Section 2 of the M&E plan:** What will be measured?
  - Results /goals / objectives from NSP
  - 12 component M&E System Strengthening Tool
- Indicators
  - **Section 3 of the M&E plan:** How/when/where will measurements take place?
  - Plan and cost each of the 12 M&E system components

# The defining element: Cost

- Needed to prioritize interventions
- Assess feasibility for scale-up
- Advocacy tool for prevention intervention strategies
- Balance of prevention versus treatment
- Operational plan must accompany NSP
- Essential for operational planning and scaling up

# Prevention focused on at-risk populations has more impact and is more cost-effective



# Prioritization of resources to avert the most new infections

	Cost of Interventions	
Effect (averting new infections)	<b>Low-cost, High-impact</b> (prevention among most-at-risk populations)	<b>High-cost, High-impact</b> (antiretroviral treatment and prevention of mother-to-child transmission)
	<b>Low-cost, Low-impact</b> (general awareness programmes through mass media and other channels)	<b>High-cost, Low-impact</b> (health systems strengthening through universal precautions and injection safety)

# Cost of a Priority Response

Interventions	Total Cost (millions USD)	% of total
High-impact prevention	\$1,338	43%
Treatment by ART	\$761	24%
Impact mitigation	\$321	10%
Programme Management	\$363	12%
Creation of an Enabling Environment	\$359	11%
<b>Total</b>	<b>\$3,143</b>	<b>100%</b>

**Average total cost per capita ranges from \$0.50 to \$1.70, depending on the stage of the epidemic.**

## Costing Tools: Many options, many purposes

- What do you need to know?
  - Unit costs, total resource needs, commodity costing, cost effectiveness ...
- Use the right model for the purpose
  - INPUT
  - ASAP ABC Costing Tool
  - Resource Needs Model
  - Asia Costing Model
  - AEM Cost Effectiveness Tool
  - Global Fund proposal
- Costing by intervention package for service delivery versus costing per target group
- If no data use nominative standards based on regional averages
- **Country demand for clear guidance and a harmonized tool**



# Scaling up

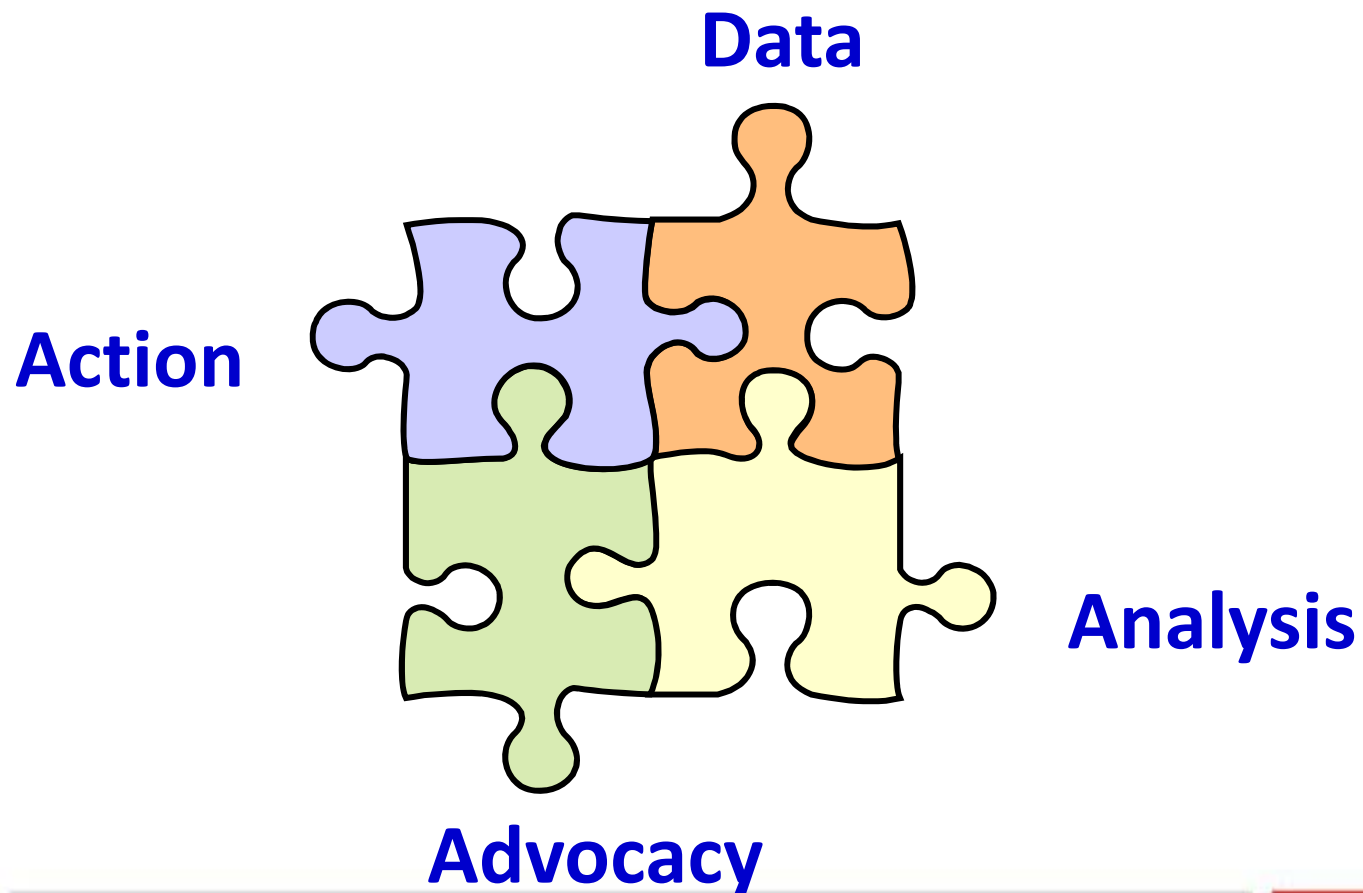
- Human resource needs
- Management plan
- Linking analysis to advocacy
- Country examples
  - India – NACO and Avahan
  - China – MMT clinics
  - Others ...

# Commission prevention recommendations:



- Prioritize the most effective interventions
  - Prevention coverage must reach 80% to reverse the trend of the epidemic
- Focus on high impact interventions to reverse the epidemic and lessen impacts
  - High-impact prevention should receive at least 40% funding - \$ 0.30 per capita
- Leverage other resources to address other drivers and impediments
- Increase local investments in responses
  - Return on investment is high
- Remove road blocks to service access (enabling environment) – integrate additional 10% of funding into prevention

# The processes for building an effective National Strategic Plan



## Workshop Resource People and Facilitators:

Thanks to the following workshop contributors:

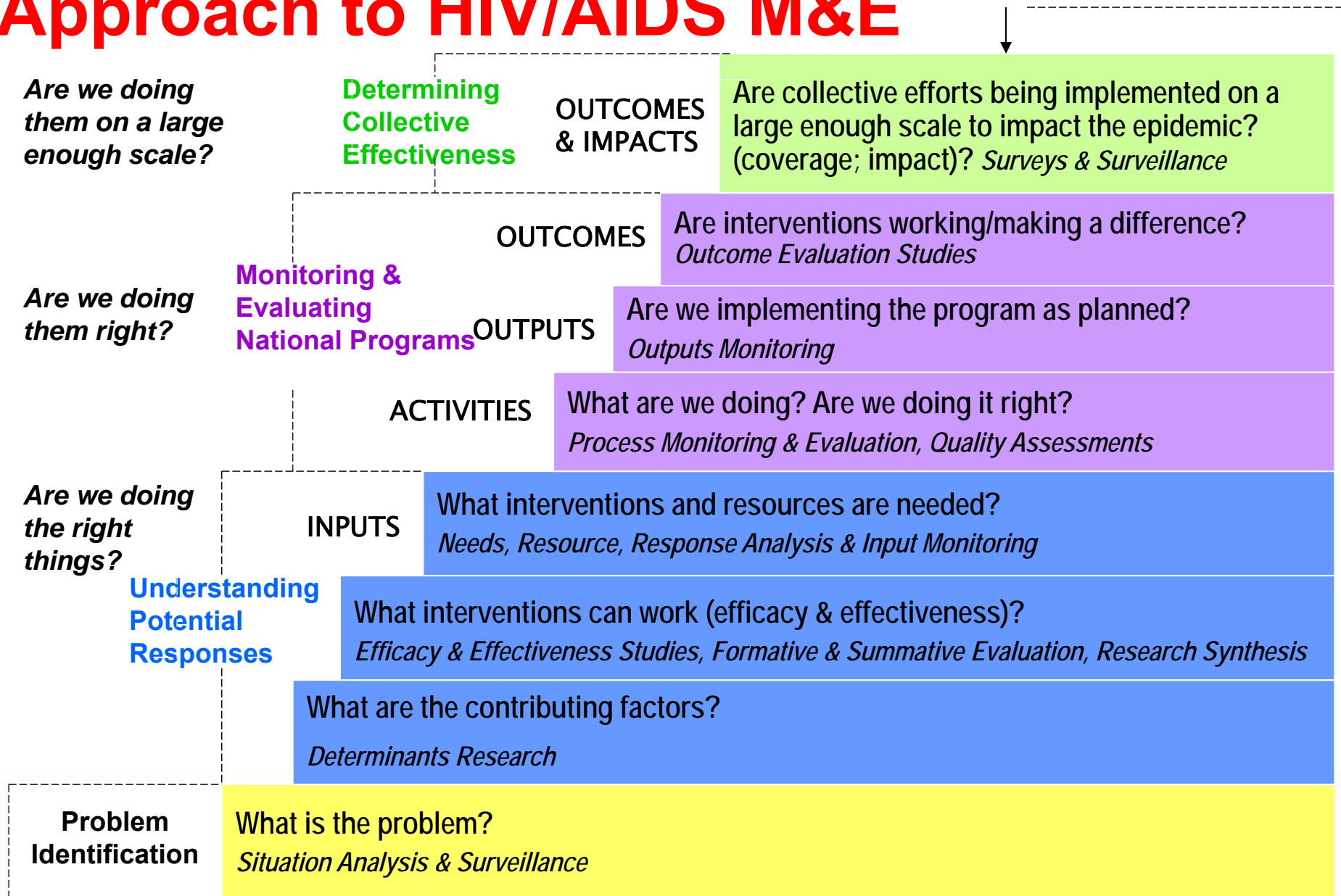
Anita Alban, Carlos Avila, Tim Brown, Robert Greener, Michael Hahn, Jacques Jeugmans, Prabhat Jha, Sukhum Jiamton, Chuleeporn Jiraphongsa, Naretrit Khadthasrima, Riaz Khan, Sukhontha Kongsin, Tony Lisle, Geoff Manthey, Ibu Nafsiah Mboi, Ross Stewart Mcleod, Wiwat Peerapatanapokin, Wiput Phoolchareon, Abu S. Abdul-Quader, Aparajita Ramakrishnan, Amala Reddy, JVR Prasada Rao, Sujatha Rao, Jim Rock, Kriengsak Rojnkureesatien, Swarup Sarkar, Tobi Saidel, Nalyn Siripong, Oussama Tawil, Kazuyuki Uji, Caitlin Wiesen-Autin, Brian Williams, David Wilson.

Several slides are adapted from their lectures

***Thank you!***

# Extras:

# A Public Health Questions Approach to HIV/AIDS M&E



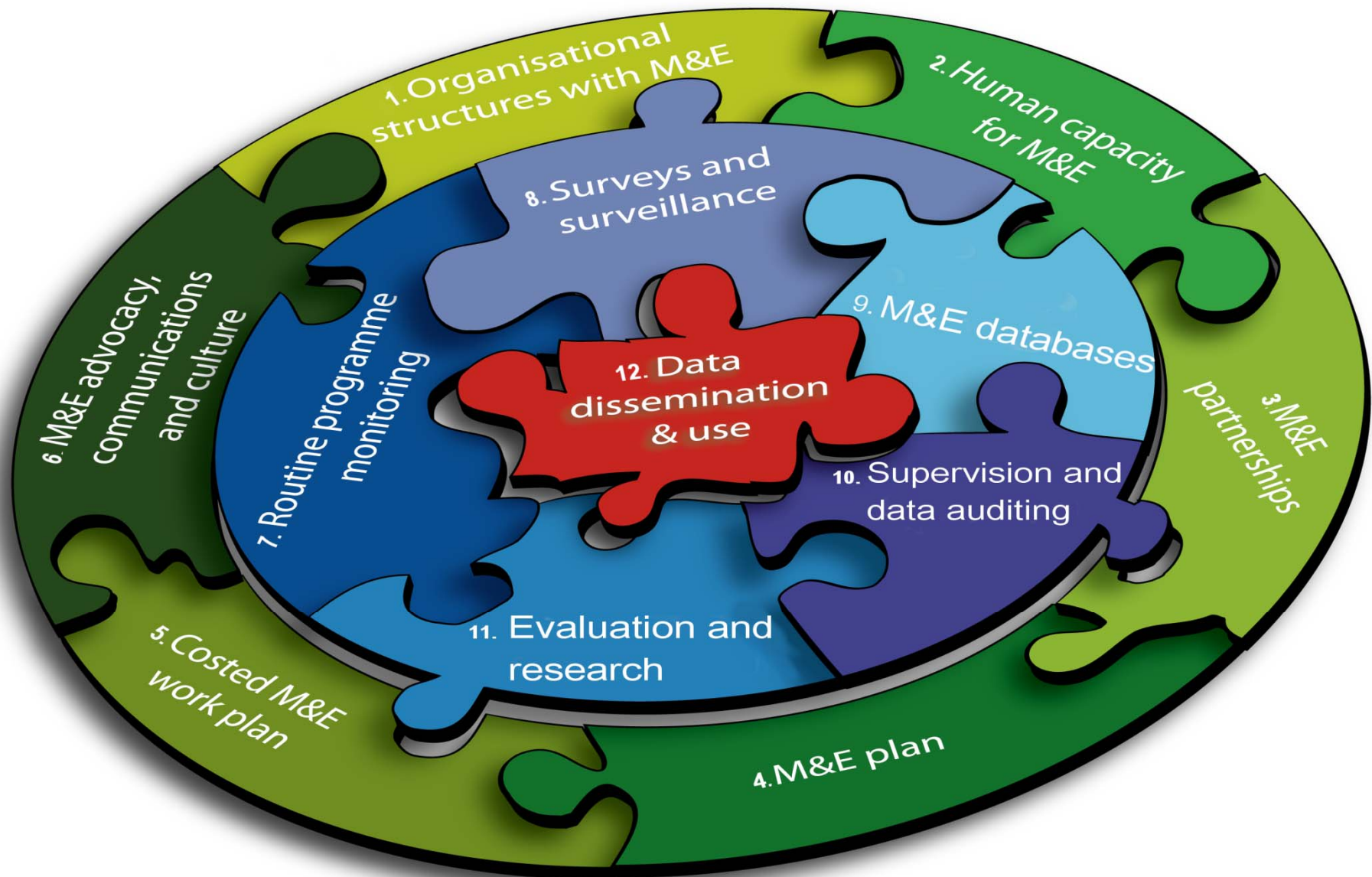
# Key Messages



1. Approaching information needs for HIV from a public health perspective provides a clear understanding of the comprehensive data needed and how they will be used in program management to ensure an effective HIV response
2. The questions (steps) follow a logical order. In reality, information needs can not always be addressed in this order and may also work iteratively
3. It is essential to develop a plan for what is needed and regularly identify and address data gaps



# Organizing Framework for a Functional National HIV M&E System



# Key Messages

1. Key components need to be in place and working to an acceptable standard to achieve a fully functional national HIV M&E system; performance (goals, objectives, results) should be defined and regularly assessed
2. Countries may need to focus on a few components at the outset, building the system up over time
3. The 12 components are not intended to be implemented sequentially (i.e., they are not 12 implementation steps); not all components need to be implemented at all levels (i.e., national, sub-national, service delivery)
4. Data use for decision-making is the ultimate purpose of any M&E system