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Preparing National HIV/AIDS Strategies and Action Plans - Lessons of Experience

AIDS Strategy and Action Plan
...a service of UNAIDS

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Preface

This paper on HIV/AIDS strategy and action planning has been prepared as part of the AIDS Strategy and Action Plan (ASAP) service work program.

ASAP is a service of UNAIDS, hosted by the World Bank on behalf of UNAIDS, in association with its main partners within UNAIDS¹ as well as with other UN agencies and multilateral and bilateral providers of financial and technical support. ASAP was created in 2005 by the Global Task Team (GTT) on Improving AIDS Coordination Among Multilateral Institutions and International Donors, and began its operations in 2006 with funding from UNAIDS and other partners. ASAP's roll-out in 2006/07 has been closely aligned with the work of the Global Steering Committee on Scaling Up Towards Universal Access.

Information on ASAP's operations can be found on its website: www.worldbank.org/asap. ASAP's objective is to provide support to countries in: (i) enhancing AIDS strategies to make them more prioritized, evidence-based, costed and capable of being implemented; and (ii) preparing action plans to promote efficient, effective and inclusive implementation. As part of its knowledge sharing and capacity building program, ASAP has developed a strategy self-assessment spreadsheet tool and guidelines, a road map for preparing strategies, and case studies/practice notes (including this paper).

This study shares lessons on HIV/AIDS strategies and action planning. It was prepared by Jonathan Brown and Joy de Beyer (World Bank), Tim Lee (UNAIDS Technical Support Facility, Southern Africa) and Derek von Wissel (Director, Swaziland National Emergency Response Committee on HIV and AIDS - NERCHA) on the basis of reviewing HIV/AIDS strategies. The study benefited from a visit of the authors² to Swaziland which provided valuable contextual information. However, the study is about world-wide experience and not about the Swaziland strategy and action plan.

The authors are very grateful to the following reviewers for their constructive comments: Marie Laga (Institute of tropical Medicine, Antwerp), Tim Brown (East-West Center), Marian Schilperoord (UNHCR), Miriam Temin (UNICEF) and Bob Verbruggen (UNAIDS).

¹ ILO, UNDP, UNESCO, UNICEF, WHO and the UNAIDS Secretariat.

² More precisely, visits by the first three authors, hosted by the fourth.

Definitions

Strategies (also called National Strategic Frameworks/Plans) provide a vision of the results that the country wants, and the approach for trying to achieve them.

Annual Action Plans (also called Work Plans or Operational Plans) define the detailed activities that will contribute to strategy results, as well as who is responsible for undertaking them, the cost of each activity, and a timetable.

Indicators measure progress towards targets. For example, an indicator of condom use might be the percentage of men who reported using a condom at their last sex act.

Inputs are resources – money, people, equipment, supplies and know-how, which combine to produce outputs.

Outputs are the products and services needed to achieve outcomes. These are the first level of results in a results chain.

Outcomes – the second level of results in a results chain – refer to access to and use of services (e.g. number of people tested for HIV and counseled coverage of percent of pregnant women who access PMTCT services) and behavior changes (e.g. use of condoms).

Impact – the highest level in the results chain, this refers to longer term ultimate goals, such as reducing HIV incidence, improved survival and health of PLHIV.

Goals are statements of vision and direction describing what the strategy aims to achieve (e.g. reduced HIV incidence)

Results are representations of what success would look like (e.g. The percentage of people aged 15-19 reached with HIV prevention programs increases from 48% to 75% by 2010; use of testing services by pregnant women increases from 30% to 80% by 2012). Most HIV/AIDS strategies include broad goals, usually related to prevention, care and treatment, and specific results that would help achieve the goals, expressed in terms of coverage, utilization and behavioral change.

Drivers are the risk factors / behaviors which primarily account for the increase and maintenance of an HIV epidemic. (The terms used to be used to describe the structural and social factors, such as poverty, gender and human rights that increase people's vulnerability to HIV infection.)

Risk is the probability that a person may acquire HIV infection. Certain behaviors create, enhance and perpetuate risk. Examples include unprotected sex, multiple partners, injecting with contaminated needles.

Vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection.

Monitoring refers to data collection, compilation and review, so that it is possible to see what progress is being made, and make programmatic adjustments to improve progress.

Evaluation and analytical reviews provide strategic information that enables policymakers and program managers to steer policy formulation and strategy planning towards sustainable outcomes.

Preparing National HIV/AIDS Strategies and Action Plans - Some Lessons of Experience

1. National AIDS Strategies and Plans: Rationale, Areas for Improvement

Several factors provide a new opportunity to turn the tide against AIDS: stronger political commitment among donors and national leaders of developing countries, the drive by the development community for greater harmonization, coordination and alignment, the dramatic increase in funding for HIV in recent years, growing evidence on program efficiency and effectiveness, and more affordable treatment. The great challenge in the HIV response is to translate increased resources into results towards the goal of Universal Access.

An important starting place is to help countries develop improved national strategic plans (NSPs) and annual action plans (AAPs) that:

- make the case for high levels of funding;
- are selective, carefully prioritized and evidence-driven;
- are feasible, with clear and costed implementation arrangements that draw on the available implementation capacity, especially in civil society and the private sector;
- promote accountability; and
- are linked to functioning and sustainable systems for monitoring, evaluation and management for results.

This section identifies the rationale for having NSPs and AAPs, their common strengths and weaknesses, and key areas for improvement. Section 2 shares insights and suggestions based on experiences from different countries.

Why Have Strategies and Action Plans?

Strategies and action plans do not automatically enhance HIV prevention, care, treatment and mitigation. They have to prove themselves ... by their relevance in focusing activities towards the most important results, by their ability to assist stakeholders on the front lines of the fight, and especially by their ability to raise money. Otherwise, why make the effort, which is often substantial, to produce them?

Why Strategies?

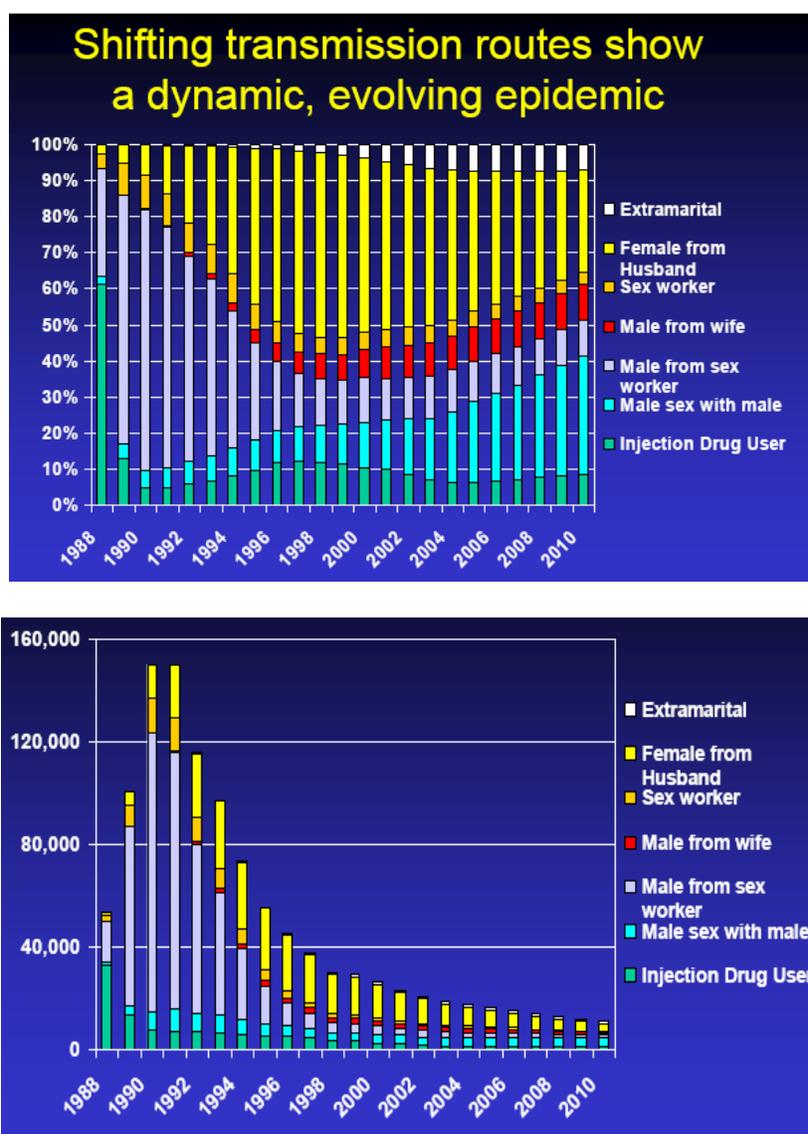
National Strategic Plans are useful to the extent they:

- *Set clear national priorities and align external support* to them. International donors are increasingly committed to ensuring that their funding fits within a national process of prioritization that is transparent, inclusive and rational.
- *Respond to the heterogeneity of the epidemic*. The drivers of the AIDS epidemic differ among countries, within countries, and within vulnerable groups, and change over time as box 1 on Thailand's HIV epidemic illustrates. NSPs can provide a process for analyzing and understanding HIV trends and the behaviors that drive them ("know your epidemic") and for developing an appropriate response in each country.

Box 1: Thailand's changing epidemic and response

Thailand is an example of an evolving HIV epidemic. Following the implementation of a sustained and resolute prevention program that gave priority to preventing new infections in sex workers and their clients, new HIV infections among these groups fell dramatically. By contrast, while there was some attention early on to men having sex with men (MSM), it was largely confined to small programs in Bangkok. This group accounts for an increasing proportion of all new infections. A recent study in Bangkok found that HIV prevalence among MSM grew from 17% in 2003 to 28% in 2005, and almost one quarter had also had sex with women in the previous six months. New studies also suggest that young people are more likely to be sexually active before marriage than in earlier years, increasing the risk of infection among this group. Thailand's challenge is to revitalize and adapt its prevention strategies to match shifts and new trends in the epidemic.

New HIV infections in Thailand in each year, showing proportions of all new infections (top) and absolute numbers of new infections (bottom)



Source: Analysis and Advocacy (A²) Thailand Team, Pattaya presentation to ASAP meeting, January 2006.

- *Are translated into action.* Even an excellent strategy will have no impact unless it is translated into action and actually implemented. The time and resources invested in developing a strategy are wasted, unless the strategy is implemented, and used to guide decisions and activities that make up the national response.
- *Ensure an important role for civil society and communities and a multisectoral response.* Most programs in education, energy, health, infrastructure, etc involve well-defined stakeholders groups and often a limited number of them. HIV is different – its impact is multisectoral, and the response needs to reach from communities to the national level, and requires important contributions from civil society and the private sector, especially for prevention and care, as well as from the public sector.
- Implement the “*Three Ones*”³ principle of one agreed HIV/AIDS Action Framework that provides the *basis for coordinating* the work of all partners
- *Attract and sustain funding* from national budgets and external donors (box 2). AIDS is one of many programs that countries may or may not choose to fund from domestic financing and external sources. NSPs are a key instrument for competing for limited resources.

Why Action Plans?

Strategies provide the guiding vision, but to have impact, they have to be complemented by action plans that:

- Ensure that “strategic priorities” become *operational realities*.
- *Improve the efficiency, effectiveness and transparency of program implementation* by focusing on the real challenges of implementing agents.
- *Clearly identify, coordinate and facilitate the actions of implementing agents* from the community to the national level, across sectors, in the public and private sectors and in civil society, and hold all stakeholders accountable for the things they commit to doing.
- Make it possible to monitor progress and performance, and identify and resolve bottlenecks for faster progress towards the country’s Universal Access targets.
- Ensure that changes in vulnerable groups and epidemic “hot spots” and *lessons about what works and doesn’t work are recognized* and become the basis for program redesign, because the epidemic is dynamic and the response must match.
- *Encourage donors to move from “project” to “program” financing.* The fact that some donors provide funding in the form of program support for AIDS and other purposes has encouraged many AIDS stakeholders to suggest that this should become the norm. Donors who provide program funding do so normally on the basis of detailed action plans encompassing all key stakeholders within a common fiduciary framework.

³ The Three Ones, adopted by UNAIDS and many donors in 2004 are: One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; One national HIV/AIDS coordinating authority, with a broad-based multisectoral mandate; and One agreed country level monitoring and evaluation system.

Box 2: How Strategies Affect Decision-Making in the Public Sector

AIDS prevention, care and treatment and mitigation programs compete for resources in the public sector in an environment of scarce resources. Each level of decision-making has its own interests and authority. In deciding on priorities and allocating scarce resources, decision-makers may be influenced by many factors, including:

- How resources provided in the past were used; with what efficiency, effectiveness, equity, transparency and impact (Is the “impact” demonstrated in a way that policy makers appreciate?)
- Based on past implementation rates, whether current program requests are reasonable and relevant?
- How good the supporting documentation and data are, and whether the case for resources is presented in a persuasive way.
- Whether program proposals are formulated in a way that decision makers can understand, with policy options clearly indicated.
- Can the interventions be sustained over the long term?
- Is the capacity available for implementation?

In many public sectors there are four levels of decision makers:

1. **Program Management** - The essential role of this level is to formulate proposals and policy options and prepare appropriate documentation and data in a way that is persuasive for the other decision-making levels and makes the case for allocating resources within a competitive environment.
2. **Line Ministries** - Informed by the documentation and proposals from program management, this is the first level of decision-making. This level has technical and programmatic knowledge, and is likely to have to decide among many laudable proposals, particularly when it comes to the impact on operating costs and staffing levels. This level is often tempted to recommend more than strictly warranted.
3. **“Corporate” Ministries** (e.g Finance, Planning, Office of the President) - This second level of decision-making has the challenging task of deciding among many competing sectors, while staying within overall budget ceilings. The quality of documentation, the impact of previous funding, and proven implementation capacity are often important criteria.
4. **Cabinet** - The final decision-making level in which the political process is important in a representative government, so the “persuasive” nature of the documentation is key.

Decision taken at the three highest levels can be greatly influenced by the quality of documentation, how persuasive proposals are within the overall public context, and the extent to which decision-making procedures are fulfilled. Sound strategies and good Action Plans can attract national and external financing.

Source: Adapted from a presentation by Carl Browne, PANCAP, ASAP Workshop, St Lucia, December 2006.

Strengths and Weaknesses of HIV/AIDS Strategies Developed before 2006

Strategic planning is an important part of country responses to HIV. Three reviews⁴ of NSPs have collectively assessed 34 strategies from 31 countries and concluded:

- **Sound overall approach, but a need to adapt to the new global AIDS environment.** Most NSPs follow the UNAIDS 1998 guidelines and share many characteristics of a sound strategy: (i) broad stakeholder involvement; (ii) grassroots and community mobilization; (iii) decentralization; (iv) multisectoral response; (v) capacity building; (vi) empowerment; (vii) gender sensitivity; and (viii) a general results orientation. There is now a need to place strategies within the challenging objectives of moving to Universal Access and the framework of the Three Ones and managing for results.
- **Broad scope, but weak linkage with other strategies.** Most NSPs are comprehensive and encompass prevention, care and treatment, mitigation, stigma reduction and the creation of an enabling environment. However, there is little attention to integrating AIDS with broad development processes such as Poverty Reduction Strategies and Medium Term Expenditure Frameworks which are important for sustaining funding, from both domestic and external sources, over the medium and long term. There is also little attention to integration with other disease programs (reproductive health, TB, chronic disease care, etc), to other sectoral planning, and to ensuring the AIDS program is designed so that it strengthens (and does not weaken) the health system.
- **Weak analytic underpinning.** Most strategies contain some analysis of the drivers of the epidemic, which varies in rigor and seldom informs decision-making, in part because of the very recent availability of population-based HIV surveys. So the link between epidemiological evidence and strategic decisions has been weak in countries with both generalized and concentrated epidemics. (See box 3: Looking for the “Strategic” in Strategic Planning.). It is important for a country to know where the last 1,000 HIV infections occurred, to know how to design efforts to prevent new infections.
- **Lack of explicit, evidence-based prioritizing.** Most strategies lack clearly defined and explicit priorities, based on the reality of the epidemic, funding and implementation capacity. Some NSPs have been essentially long “wish lists” of hundreds of activities. While this may satisfy many stakeholders, it does not make a concerted attack on the key drivers of the epidemic or focus on interventions most likely to be effective. Sometimes stigma, taboos, denial, illegality, and social marginalization of important target groups (men who have sex with men, sex workers, injecting drug users) make decision makers uncomfortable about targeting the sub-populations where most infections occur. This makes strategies less likely to prevent new infections.

⁴ 1. Nguyen-Van Houte et al. 2006.

2. Mullen, 2005.

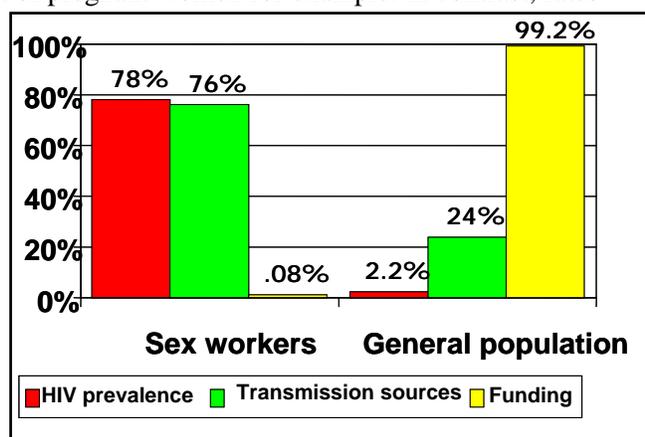
3. Bonnel et al. 2004.

Box 3: Looking for the “Strategic” in Strategic Planning

Many countries have developed national plans, often through extensive consultation with stakeholders. These plans have helped to boost national commitment, foster engagement and promote social openness about HIV/AIDS. But they often have not been truly strategic; that is, they have not identified and targeted the primary ways HIV is transmitted in a that country.

One country in Africa prepared a consultative strategic plan presupposing a highly generalized epidemic and emphasizing wide engagement of society and a broad range of interventions. HIV prevalence in the country’s general adult population is 1.8 percent and antenatal data indicate that the epidemic has been stable for approximately a decade. The data also suggest that the peak age of HIV infection is relatively high, between 35-39 years, for men and women. In contrast to relatively low rates in the general adult population and among youth, HIV prevalence among sex workers is exceptionally high—78 percent and 82 percent in the two largest cities. The great difference between rates among sex workers and the general adult population suggests that a significant proportion of infections in this country arise from commercial sex. A recent study estimated that 76 percent of infections among sexually active men in the capital were acquired from sex workers. Yet only 0.8 percent of this country’s HIV/AIDS investments were for sex work interventions.

This is not an isolated phenomenon. In one Asian country, HIV infection in the general population remains low, at under 0.3 percent of pregnant women for example. In contrast, rates among injecting drug users approach 80 percent in the largest city, and rates of 30 percent have been reported among sex workers in selected sites. This country is clearly experiencing a concentrated epidemic, with exceptional vulnerability among marginalized populations. Epidemiological analyses for the country indicate that injecting drug use contributes perhaps three-quarters of all HIV infections, and injecting drug use and sex work together account for more than 90 percent. Despite these data, interventions to protect these two vulnerable groups are just one of this country’s nine major strategic priorities.

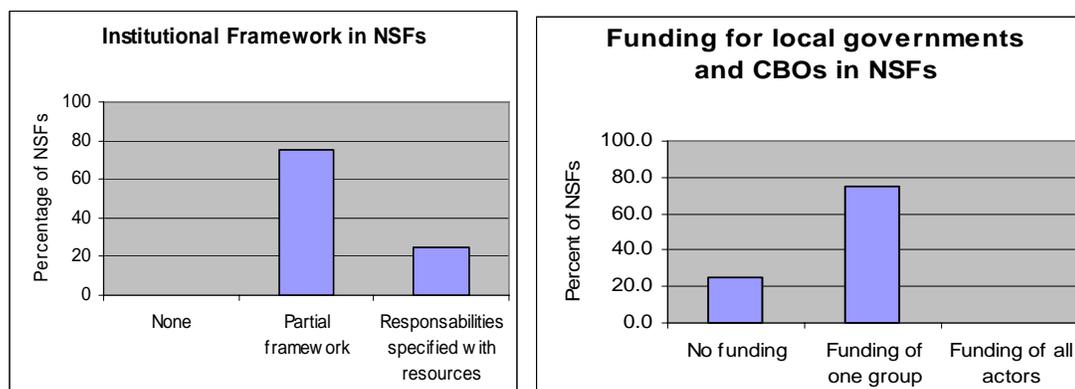


In one Latin American country, the epidemic is largely concentrated among men who have sex with men. A study of over 7,500 such men between 1991 and 1997 found that more than 15 percent were HIV-positive, against an overall adult prevalence of 0.3 percent. Given the likelihood that bisexual men are one route by which AIDS enters the heterosexual community, low condom use among this population is worrisome. In the same survey, 85 percent of bisexual men in this country never used condoms during anal sex with their female partners, and 69 percent never used them during vaginal intercourse. Yet the majority of HIV prevention funds in the country are directed towards the "general population" and less than 10 percent are targeted towards men who have sex with men. (Source: World Bank 2005)

- **Inadequate targeting, coverage and reach.** Although some NSPs mention targeting specific groups or geographic areas, few provide an adequate rationale or sufficient budget to support the targeting decisions. Many NSPs would benefit from more explicit plans to achieve high coverage of priority interventions for sub-populations most at risk, or to reach rural, vulnerable or marginalized groups.
- **Static documents rather than dynamic frameworks.** Strategies tend to be seen as a document, instead of a dynamic framework focusing on key results, with flexibility to react to new developments; such as new information on the epidemic pattern or its drivers, changes in evidence, technology and treatment or the donor environment.
- **Too little detail on costs and resource mobilization.** Few NSPs present detailed costs and budgets, implications for government Ministry budgets, or adequate provision for scaling up programs implemented by civil society and private sector stakeholders. In addition, there is insufficient attention to:
 - how resources will be mobilized from domestic and external partners;
 - how to phase programs in the event that full funding is not available at the start.
- **Participation is improving,** especially for ensuring an important role for PLWH.
- **Processes for implementation, coordination and allocation of responsibilities are not specified.** Most NSPs advocate multisectoral action, but few strategies adequately describe a clear and realistic allocation of responsibilities for implementing the strategy. Nor do they outline a process for establishing institutions and/or supporting them with human and financial resources (the “institutional framework” for implementing the strategy shown in Figure 1). Few provide adequate funding for the many actors needed to implement a multisectoral strategy, as Figure 2 illustrates. The activities and results expected from ministries and sectors beyond health often are not clearly indicated. Some of the difficulty is because the coordination role is not well understood or defined, and there can be tension between the multisectoral Coordinating Authority and the unit in the Ministry of Health responsible for leading and implementing the health response to HIV.

Figure 1: Institutional Framework for HIV/AIDS Interventions in NSF (left hand figure)

Figure 2: Funding for Local Governments and Community-Based Organizations (CBOs) in NSF (right hand figure)



Source: Bonnel et al. 2004

- **Implementation planning tends to be weak.** Few strategies provide a clear process for moving quickly and directly to action planning and implementation, particularly with regard to the roles, responsibilities and funding of implementers. Ensuring the institutional and human resources needed for implementation is essential for moving from vision to reality. An important aspect of implementation is for strategies to provide a road map and timetable for donors to align their activities with country systems, especially with regard to: (i) joint country-led annual reviews; (ii) common fiduciary assessments; (iii) common or closely coordinated implementation processes; and (iv) an overall national procurement plan.
- **Much stronger focus on results, and clearer Results Frameworks are needed.** While all NSPs contain targets and indicators, few NSPs are truly “results focused”, i.e. specify clear objectives or goals, which are supported by measurable indicators⁵ and targets that can be tracked over time to assess how well policies and programs are being implemented, and the progress towards the results for which they aim. Few NSPs present concrete, funded plans for monitoring and evaluation that will produce data:
 - when needed;
 - that are used for decisions and program redesign to improve the response; and
 - that enable the country to meet its reporting commitments to donors and the global community.

Building on these assessments of early strategies, the rest of this paper shares what we are learning from ASAP’s work with countries reviewing draft strategies and from recent country experiences in striving to develop strategies that:

- are based on an analysis of the trends and behaviors driving the epidemic in each country;
- focus on key results;
- are translated into clear annual work plans with associated costs, budgets and implementation arrangements;
- include a system for monitoring progress, identifying and resolving bottlenecks and improving performance, and evaluating whether results are achieved, what worked and didn’t work and why.

This paper can be read as a complementary commentary to the checklist/Roadmap of key steps in developing a results-focused strategy and work plan.⁶

⁵ Often indicators are designed to track activities to be implemented rather than the results to be achieved.

⁶ “Key Steps in Preparing a National Strategic Plan”, AIDS Strategy and Action Plan (ASAP) service, 2006 (discussion draft). See also the “Self Assessment Tool” and “Guidelines for Using the Self Assessment Tool (ASAP, 2006), which cover the following topics: Synthesis/analysis of epidemiological data (trends and drivers of the epidemic) and the national response, Evidence-based, results-focused planning, Prioritization, Participatory process, Results-based monitoring and evaluation, Financing/resources/budgets and costing, Capacity and constraints, Management and coordination, Policy environment, and Action plans.
On line at: www.worldbank.org/asap

**KEY STEPS IN DEVELOPING A NATIONAL STRATEGY and WORKPLAN /
OPERATIONAL PLAN**

Plan the process

- Step 1** Clarify the **purpose** of the strategy and workplans and **how they will be used**
- Step 2** Decide on the methodology/**process** to be used in developing the National Strategy and Workplan (NS&WP). Determine **who** will be involved and **how**. Establish **links** with other strategies and planning processes.
- Step 3** Draw up a **road map with timetable** (including plans for validation of key steps)

Analysis and Synthesis

- Step 4** **Analyze the HIV and AIDS situation**
- Step 5** **Analyze the HIV and AIDS response. Do Institutional Assessment.**
- Step 6** Strengthen **capacity** for results-based planning as needed

Develop the Results-based Strategy and Workplan

- Step 7** Identify **key results** (impacts and outcomes) the strategy will aim to achieve, based on the analysis of the situation and response.
- Step 8** Select **strategic programs** for attaining the desired results. Select measurable indicators, baselines and targets. **Estimate costs**, trim programs to be within the likely budget and other resource constraints.
- Step 9** **Specify an Action plan/work plan/operational plan** with activities and cost estimates, and **that identifies who is responsible for** implementation (Operational Plan/Workplan/Action Plan)

**Plan for Collecting, Analyzing and Using Data to Monitor, Manage and Evaluate Results –
Revise (or draft) the national M&E Plan**

- Step 10** Identify **data sources and data collection** procedures for each indicator
- Step 11** Indicate how the M&E data and results will **be used** for managing the AIDS response, improving performance, and revising the strategy and plan in future
- Step 12** Develop a detailed evaluation plan: specify planned epidemiological & behavioral surveys, operations research, impact evaluations, independent evaluations

Finalize and Use the National Strategy and Workplan

- Step 13** Validate and finalize the National Strategy and Action Plan
- Step 14** Disseminate widely the National Strategy, Action Plan and M&E Plan
- Step 15** Use the National Strategy and Workplan, Monitor Results

2. Lessons from Recent Experience in Developing Strategies and Plans

Many countries are grappling with similar challenges in developing or revising national AIDS strategies and action plans. While each particular situation is unique, sharing what is learned from experience can prove useful. Developing good strategies that help achieve strong results is difficult. But most countries have already developed at least one HIV strategy, so have experience to draw and improve on. The paper draws on detailed discussions of Swaziland's experience, and recent reviews of 15 new draft strategies. The principles and lessons are broadly relevant -- for high and low prevalence countries, for countries with generalized, concentrated and mixed epidemics, and across all continents.

The authors of this paper would be pleased to incorporate additional suggestions and comments that countries think would help others.⁷

2.1 Planning and Managing the Process

Making and sharing a “Roadmap” and timetable

In planning for a new or updated strategy, a useful early task is to summarize the detailed planning for the process in a “roadmap” listing all the activities and dates, who is primarily responsible for each activity, and who else is involved. If this is disseminated widely and well in advance, it will help stakeholders to organize and plan to provide their input. It will be easier to keep to a **timetable that is realistic** and allows enough time between key stages for stakeholders to consult with their members, review and prepare for the next stage.

Start with a realistic, detailed plan of the process for developing the strategy. Share it with all stakeholders.

It is extremely important to **assign responsibility for each task**, including costing the strategy, preparing an Annual Action Plan (also called an Operational Plan, or work plan) and developing an M&E Plan or reviewing and revising an existing M&E Plan. This is also the stage to identify what technical assistance may be needed, and identify sources of financing. Drafting TOR and identifying consultants early in the planning stage will help make it possible to hire appropriate consultants in a timely way, since many consultants may not be available at very short notice.

Thought also needs to be given as to how to **ensure that the content and format of different related tasks and outputs are aligned and consistent**. For example, Swaziland developed a new National HIV and AIDS Policy at the same time as the new National Strategic Plan was developed. Combining the processes for the new Policy and new Strategy was efficient, and ensured that they were fully consistent, and that policy issues that might affect implementation of the strategy could be discussed and resolved.

It is most important that the roadmap **include plans for using the Strategy and Action Plan**, since there is little point in putting considerable effort and expense into developing strategies and plans that are not actually used. So, for example, the date for a donor fund-pledging conference could be agreed well in advance with potential donors and included

⁷ Please send feedback and comments to jdebeyer@worldbank.org

in the roadmap,⁸ as well as the timetable for transferring funds to implementers (if relevant) and for reviewing implementers' progress against work plan targets.

On the topic of funding, developing a national strategy and action plan can be time consuming and costly, especially if done in a highly participatory way, and with considerable input from international consultants. A realistic budget and adequate funding are needed.

Line up funding for the strategy development process.

The time and resources it takes to develop a strategy argue for a five year strategy rather than a three year strategy. Action plans, being more detailed, are difficult to do for more than a year or two, and need to be revisited annually in the light of changing needs, resources and other circumstances.

Getting donors on board

Many countries would much prefer donors to provide *program* financing in which they contribute towards the cost of a good national strategy and action plan, instead of funding donor-specific projects. This is the implication and an important part of the rationale of the "Three Ones", to which donors have all agreed in principle, but have not yet fully adopted in practice.

A good NSP will encourage donors to help fund the national program

Some actions that could help donors move towards program financing are:

- talking with donors and getting early "buy in" to the idea of helping fund the national strategy;
- agreeing a timetable for funding decisions (which will need to take account of donors' own institutional funding timetables);
- ensuring appropriate participation/representation of international development partners in developing the strategy;⁹ and
- making sure that the AIDS strategy is integrated into broader development planning (such as a PRSP or Medium Term Expenditure Framework), which is increasingly important as donors move away from project support to budget support.

The more confidence that donors have in the strategy and the work plans for implementing it, the more willing they will be to help fund it, instead of funding their own project. The stronger the strategy and plans, the more confidence donors will have in it.

Donors are also more likely to agree to help fund the national strategy if they have a shared understanding of the trends and drivers of the national epidemic, and that these are

⁸ In one country the process of moving from a strategy to an action plan was interrupted by the country's need to prepare a major submission to a donor. It would have been ideal if the strategy and action plan themselves could have been submitted with a request to fund specific parts.

⁹ To fully achieve "one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners", donors will need to adjust their policies and procedures so that strategies and action plans are the basis for donor funding decisions rather than the current system where each donor insists on its own format for receiving country proposals for projects that may not fit within the national strategy.

reflected in the strategic priorities. This can avoid a situation where donors develop their own priorities that are not firmly grounded in the epidemiology of the country. A presentation by experts of the epidemiological and behavioral data and a discussion of the picture that emerges from the data of the epidemic trends and drivers, and the implications for the strategic focus needed to respond effectively to the epidemic, would be a very useful starting place. (See Section 2.2 on understanding the epidemic.)

Key Roles

National coordinating bodies typically do not do all the activities associated with strategy development themselves. Moreover, they may consider it important not to play a dominant role, to ensure wide national ownership of the strategy, and avoid the perception that it is the NAC's strategy rather than a shared national strategy. However, it is essential that they lead, coordinate and carefully monitor the progress of NSP development.

Most countries use **consultants** to help develop and write strategies and plans, relying on their expertise and ability to work full time for a specified time period without competing claims on their time and attention. Continuity of consultant input is advisable wherever possible. Different consultants see and do things in different ways, and these variations can cause confusion, delays and frustration (box 4). If different consultants are brought in at different stages, careful briefing and leadership by the NAC can help keep everyone “on the same page” and avoid duplication and wasted effort.

Plan ahead for technical assistance. Manage consultants to ensure effective contributions.

Box 4: Consultant Chaos

In one country, three different providers of technical support provided costing experts at different times, each applying their own, and different, methodology. The inefficiency of this approach is matched only by the frustration it causes for national stakeholders. While some countries have the ability to “manage” consultants, others find it difficult, and the providers of technical support could be much more helpful if they cooperate and coordinate better.

Technical working groups (TWGs) that tackle key issues can play a very useful role in formulating a national strategy (box 5). Their mandate is to ensure the *technical* relevance of the strategy. So it is essential that all members have strong skills and experience in the relevant areas. The way to ensure this is to ask members of the TWGs to serve in an individual capacity based on their expertise or knowledge, and NOT as institutional representatives. Involving relevant stakeholders in technical working groups can help create strong ownership in the process and the plan. Although representation of different sectors and stakeholders is important, the working groups should be wary of including members purely for the purpose of representation.

The optimum size of a TWG will be depend on how its role is defined, and must balance including a wide range of stakeholders and expertise, against keeping the group small

enough to function well. Inevitably, if there are many members drawn from different institutions, attendance at TWG meetings will vary, which undermines continuity and efficiency -- points that are fully discussed in one meeting may be raised again in a later meeting by someone who missed the earlier discussion. As far as possible, TWG members should be asked at the outset to commit to a predictable, regular schedule of meetings. Two ways to maintain inclusiveness and draw on wide expertise, while still keep a small enough group to work efficiently, is (i) to form smaller technical core teams within a large TWG, or (2) to have a small "core" of TWG members, and then supplement them by asking other experts or community members to come to particular meeting/s to contribute to specific topics. This makes it possible to select a small core TWG of very committed people (usually mid-level people with the time and commitment to come to all the meetings. This helps eliminate the problem of people missing meetings and ensures solid continuity of the TWG work. The flexibility to bring others in as needed allows full consultation and engagement of relevant stakeholders.

2.2 Analyzing the Epidemic and Reviewing Results of the Previous Strategy

Epidemic Situation Analysis

Every effective strategy is based on the best available data and a good understanding of the epidemic. It is especially important to identify the population sub-groups where most new infections are occurring, and the behaviors that appear to be driving the epidemic. For example, if most infections are among injecting drug users (IDUs), then unless interventions reach IDUs and their sexual partners and have high coverage of this group, there is little hope of preventing most new infections.

First “Know your epidemic”

This step requires surveillance data on HIV and on relevant behaviors, and expert analysis of the data. Access to the latest research literature or main new findings are very helpful – for example, there is growing understanding of how people who have multiple concurrent sexual partners can cause a dramatic, rapid increase in the number of new infections. Adequate epidemiological and analytic expertise may not be available in the country. Even if in-country capacity exists, there is always benefit to asking external experts to look at the data and analytic conclusions. It is easy to be blinkered by prior beliefs, or to be just too close to the data to step back and see the bigger picture.

There is no single answer as to where to turn for expert help. Countries’ national AIDS programs and UNAIDS offices will often know of national and international institutions that could help analyze and synthesize data to identify major drivers and sources of transmission, and the Global HIV/AIDS Program at the World Bank will also be happy to offer suggestions. But existing global expertise is limited, disbursed and overstretched. There are modeling and analytic tools, which are being simplified to make them easier for countries to use. Even with improved tools, the need for a steady stream of external support will remain. UNAIDS, the World Bank, the US Government, Asian Development Bank and other international agencies are working to nurture additional capacity, including national epidemiological and analytic capacity.

Box 5: How Swaziland Managed the Strategy Development Process

Developing a national strategy and work plan in a highly participatory way is a complex task. Swaziland's National Emergency Response Council on HIV and AIDS (NERCHA) set up a Steering Committee and Core Team to oversee and manage the process, hired a consultant team of local and external experts and worked with five strong technical working groups (TWG) of local experts, practitioners and stakeholders. A small administrative team provided support and handled logistics. The composition and roles and responsibilities were as follows:

A fairly large **Steering Committee** (23 people) was set up to oversee the process, provide strategic management and coordinate implementation of the entire exercise. The Committee included representatives of the NERCHA Management Committee and other stakeholders to ensure multisectoral representation: members of the UN Expanded Theme Group on HIV/AIDS, the country's Coordinating Assembly of NGOs, representatives from the Prime Minister's Office, key Government Ministries, the National Coordinating Body for People Living with HIV/AIDS, Coordinating Body for Faith Based Organizations and the Business Coalition on HIV/AIDS. The Steering Committee was active, and gave good input to the Core Team.

A **Core Team** of 8 people, drawn from the Steering Committee, was responsible for the day to day decisions and administration of the whole process. It met every week or so with the consultant team to provide feedback and guidance.

Five Technical Working Groups (TWGs) already existed to play an advisory role to NERCHA. These Technical Working Groups were strengthened and expanded to provide technical input in developing Swaziland's new national HIV/AIDS policy and strategy. The TWG areas of expertise/mandates were: (1) prevention; (2) care, support and treatment; (3) impact mitigation; (4) management of the national response; and (5) monitoring and evaluation. They varied in size from 12 people to 47 people. This meant that the TWGs included broad representation of stakeholders and a wealth and depth of expertise to draw on, but the downside of having large groups was the difficulty of convening full meetings.

A full time **Process Administrator and Assistant** were responsible for logistics, day to day management, administration and implementation of the strategy and policy development process. This was a huge task, especially during the extensive community consultations. A program of this magnitude requires adequate administrative capacity to efficiently manage all the different processes, activities, committees and working teams involved. The need for an adequately staffed secretariat or administrative team cannot be over emphasized.

Technical Consultants were hired (eleven people, for varying lengths of time ranging from 2 weeks to several months), drawing on expertise in Swaziland and the region. Some of the consultants had specialist technical expertise, for example in costing, in supporting a planning and budgeting processes, and in AIDS policies. Development of a National Monitoring and Evaluation Operational Framework was already underway by NERCHA, working with an M&E expert from the Global AIDS Monitoring and Evaluation Team (GAMET), so there was no need to hire an M&E consultant. The strategy consulting team worked with the NERCHA M&E Coordinator and GAMET expert to develop the M&E component of the National Strategy, and align it with the national AIDS M&E system, known as SHAPMoS (Swaziland HIV and AIDS Program Monitoring System)

Analysis needs to focus on both the national and sub-national levels. National data may help to determine broad strategy, but local circumstances in ‘hot spots’ and heavily affected areas and among specific population groups often require specific attention. Careful analysis is required to identify and quantify the key populations driving the epidemic dynamics. This analysis must be the bedrock on which the strategy is built.

The analysis of the available data on the epidemic provides an opportunity to begin to review data generation, collation and dissemination procedures.

Early questions to ask about the Monitoring and Evaluation System

- Does the existing M&E system include behavioral and epidemiological data?
- Does the M&E system collect data on the response – e.g. the services delivered, numbers of people reached, etc, – so that coverage can be estimated, and the effectiveness of the response monitored and improved?
- Are estimates up to date concerning key target groups, especially high risk groups?
- Are the latest data widely published and easily available, so they can be used to guide program decisions?

In countries with limited data on the drivers of the epidemic, preparing an “interim” strategy that includes a major focus on researching the drivers of the epidemic may be appropriate. An alternative is a two-phase strategy, with intensive data collection and analysis in the first year, as a basis for setting priorities and defining the program for the following years (see Section 2.4).

Detailed review of achievements and shortcomings of previous National Strategic Plan/Programs

Review of the existing and past national response as guided by the previous national strategy is also a key step. This can identify successes and failures, and assess the impact programs are having, and the appropriateness of previous initiatives in the light of changing epidemic trends, needs, opportunities, technologies and conditions.

Assess the national response to be able to improve it

Prior to beginning to develop a new national strategy, under the leadership of NERCHA, Swaziland undertook a review of the response that had been guided by the Multisectoral National HIV and AIDS Strategic Plan for 2000-2005. This joint effort among the partners in the HIV response covered six thematic areas: (i) Prevention; (ii) Care and Support; (iii) Impact Mitigation; (iv) Funding and Resource Mobilization, Utilization and Tracking Mechanisms; (v) Management, Coordination and Institutional Arrangement and Communications; and (vi) Monitoring, Evaluation and Research. The Joint Review identified gaps in the previous Strategic Plan, the lack of a nationally agreed Action Plan, and the need for a new National HIV and AIDS policy, among many other insights.

“The reviews of the national response and health sector response were very revealing. There were many surprising findings. For example, the IEC materials

had not reached some people; some people did not know about ART while some who had started treatment were told by others that the drugs were poisonous. Some people didn't know about home-based care, and we heard misconceptions about condoms.” (Ministry of Health representative)

One participant noted that criticism needs to be grounded in facts – although people don't like criticism, unless a review is frank and clear about shortcomings and problems, it is not possible to address and remedy them, to achieve better impact.

Reviewing the results of the national response should also help answer questions about the adequacy of the national M&E system:

- **Does it generate information that is used to guide and improve the national response?** The most important function that M&E can play is to provide feedback to implementers, managers and decision-makers, so they can identify and fix problems and improve the response.
- Does it generate the data needed for measuring the various indicators of the HIV/AIDS strategy?
- Does the unit responsible for managing the M&E system have sufficient staff and budget?
- Do all stakeholders use the same M&E system?

The answers will help inform the development of the M&E Plan.

2.3 Consultation and Participatory process

Consultation and participation help improve quality and relevance, and ensure broad ownership of national strategies and plans. However, it can take considerable time and resources, and raise expectations; for example, people may expect to see all their ideas and contributions in the final document. Well thought through and well managed consultation and participation can be worth the cost and effort. One of the clear benefits of the full and active participation of key stakeholders in developing Swaziland's new national strategy was that many stakeholders then reviewed their own existing plans and strategies and aligned them to the priorities in the national strategy.

Considerable thought and careful planning is needed to ensure meaningful participation of diverse stakeholder groups. For example, translators and local facilitators fluent in local languages, Braille translations, multiple channels and media to consult with different groups; etc. may be needed.

Community Consultation

Community level consultations can provide valuable input, and encourage wide ownership of the national response to HIV. However, they are expensive, time consuming, and logistically onerous. There is a danger that they may raise expectations that will not be met. Information gathered in community consultations needs to be carefully filtered and distilled to identify the key issues.

It is important to clarify whether community consultations are for information-gathering or for awareness-raising or both. The pure ‘information-gathering’ approach encourages involvement and input from community members, but can have damaging results if it gives “air time” or credibility to misinformation and stigmatizing comments. On the other hand, it can help identify misconceptions and issues that subsequent public information efforts can address. Awareness-raising where negative or inaccurate comments are immediately discussed and countered provides an opportunity for community education, but may change the dynamic and make people less open about expressing their views.

“Consultation is good, but it is not an end in itself. To make the most of it, first be clear about the purpose, and what you want to get out of a consultative process. Then structure it to yield that result.” (Local consultants to Swaziland’s National AIDS Strategy development)

If communities are consulted, it is a good idea to provide feedback later on to the communities, disseminate the National Strategy once it is developed, and explain how the consultations influenced it. Time and budget constraints may mean relying heavily on mass media for this, or integrating it into other activities.

Appendix 1 describes the extensive consultations held in Swaziland to discuss the main factors driving the epidemic; solicit ideas to inform the new national strategy; and gather information about the impact of HIV and coverage of interventions at community level.

“The beauty of it is that people don’t see [the Strategy] as a Government or NERCHA document, since they were consulted and contributed.”

Swaziland’s consultative process reached all levels of society – the Queen Mother, the Prime Minister and Members of Parliament, business leaders, chiefs, international partners, technical agencies, civil society and communities across the entire country. A Ministry of Health representative noted that a valuable consequence of the consultations, media information, and discussion around the strategy preparation had been to increase knowledge about and demand for existing HIV services. The consultations became part of the overall IEC program.

Full, active participation of **groups with special needs** may involve additional resources or preparation: for example, Braille translation of documents, sign language translation, and choosing venues that are accessible to people in wheelchairs (box 6). Participation and addressing the needs of refugees and internally displaced persons is also a particular challenge; the office of the United Nations High Commissioner for Refugees (UNHCR) can be very helpful in this.

Box 6: Including People with Disabilities

The Federation of People with Disabilities in Swaziland (FODSWA) was fully involved in developing Swaziland's National Action Plan for HIV and AIDS. They were provided with support (funding and technical assistance) to work with member groups to articulate their needs and how they could best contribute to the national priority objectives on HIV.

“After several years of advocating for inclusion of disabled people in HIV, we are very glad that we were fully involved and represented ... this was a big step forward from NERCHA” (FODSWA Representative)

There were challenges: many disabled people have had poor access to education, and find budgeting and costing difficult. Working with disabled people often involves higher costs (for translation, transportation, assistants etc) but this is not always appreciated when budgets are reviewed. Many countries have scant statistics on disability, which makes it hard to set coverage targets or estimate needs. The needs of people with different types of disabilities vary, so it may not be easy to produce a single consolidated plan.

2.4 Selecting the Most Important Results to Aim for – Setting Priorities¹⁰

For a strategy to be truly strategic and likely to make a real impact, it is essential to select a small number of high priority results to aim to achieve. Prioritized results might focus on a small number of areas in each of the three major program areas (prevention, treatment and care, support and mitigation). It makes sense to combine/fully align strategy targets and results with setting Universal Access targets.

In prevention, the most important basis for deciding on the priority results is the analysis of the epidemic, in particular, the groups and behaviors that are “driving” the epidemic, that is, that are responsible for most new infections. For example, if a country has a concentrated epidemic in which injecting drug use and sex work (and especially sex workers who inject drugs) are responsible for most new infections, then the strategy needs to give top priority to achieving high coverage of these groups with proven interventions (including consistent and correct condom use, clean needles, etc). In generalized epidemics, prioritized results might be to discourage multiple concurrent sexual partnerships (which recent research indicates are often a major driving factor); or to bring down high infection rates among teenage girls and young women that may be driven by sexual partnerships with older men.

Prioritization is an essential part of developing national strategic and action plans. However, the terms ‘priority’ and ‘non-priority’ are commonly misunderstood. In practice, ‘prioritization’ involves two related but distinct elements. The first is the realization that ‘we cannot do everything’; i.e. a basic division between the achievable and the non-achievable. The second is about identifying those things that require urgent

¹⁰ For more information on making strategies Results-focused, please see Rodriguez-Garcia and Kusek 2007.

or special attention – most importantly because they will have most impact on the epidemic (or perhaps because they have been ignored or given insufficient attention in the past, or because of a new development requiring greater attention). It is not the case that ‘priorities are important’ and ‘non-priorities are unimportant’. Many essential parts of a national response may be categorized ‘non-priority’, simply because they are already on track, to scale, operating effectively, and so on (i.e. they do not require urgent additional attention).

However, difficult decisions may need to be taken about things that will not be done – because they are not proving effective, or are unaffordable, or because there are more important things that are likely to have a greater impact in preventing infections and providing needed care.

It is important that stakeholders understand the process of deciding priorities in national strategic plans, which can be done in various ways (box 7). The most important principles are that **difficult choices often must be made**, and that **priorities must be informed by a sound understanding of the pattern of the epidemic in the country**. The epidemiological and behavioral data need to be analyzed to understand what behaviors and which sub-populations are driving the epidemic (see Section 2.2). Changing those behaviors and reaching high-risk populations must be the priorities, in order to prevent new HIV infections. Treatment and care, and support and mitigation priorities also need to be based on data on the numbers and needs of infected and affected people.

There are countries that do not have enough solid epidemiological and behavioral data to be able to “know their epidemic”. Clearly, their first strategic priority is immediate action to collect enough basic data to know how best and most effectively to target prevention efforts, and treatment and care services. While data are being collected, the interventions that are clearly needed and important would go ahead. Then, as soon as the data have been collected and analyzed for a better understanding of the epidemic, the priority actions can be revisited, to be aligned with the emerging understanding of the epidemic.

Planning always involves **sequencing activities** – e.g. training providers before rolling out a new service; evaluating a pilot program before deciding whether and how to scale it up, etc. A strategy can lay out the framework for progressing towards the countries Universal Access targets, and then the annual Action Plans define the detailed activities each year for making progress towards the targets. As new information, new capacity, new drugs, etc emerge, new steps can be defined in the next Action Plan.

There should be strong involvement of the national AIDS coordinating body in the priorities that a national strategic plan and national action plan will adopt; these are tasks that cannot be delegated to consultants. Although participation and consensus are highly desirable, when difficult choices have to be made, it may be necessary to do this independently from stakeholders, because all stakeholders will make compelling cases as to why their interest areas are a priority.

Box 7: Three Different ways of selecting priorities in Swaziland

A. “Informed judgment” (implicit criteria)

A preliminary prioritization had identified 215 actions among the full list of 910 as the “Urgent and Priority Agenda” on the basis of informed judgments of the team developing the strategy, after consulting with a wide range of stakeholders.

B. Explicit criteria, with rating and weighting

The consultant costing team used a simple scoring system to rank activities and identify priorities in an explicit way. They used three criteria, with different weights assigned to reflect relative importance:

- **Capacity** (given a weight of 3)—the degree to which capacity was available to conduct the necessary preparatory activities and carry out the specific action effectively
- **Immediate Benefit** (given a weight of 2)—the degree to which the action would provide immediate benefit to those at risk, orphans and vulnerable children (OVC), others who are vulnerable because of the effects of HIV or persons living with HIV
- **Long-term impact** (given a weight of 1)—the degree to which the action had the potential for long-term improvements in quality of life for PLWH or their families, or for reducing HIV infection rates.

For each of the three criteria, activities were scored on a scale set at 1 for low, 2 for medium, and 3 for high. Thus the maximum any activity could score was 18 (3x3 for activities for which there was good capacity + 2x3 for high immediate benefit + 1x3 for high long-term impact). Capacity received the most weight because no activity can achieve its potential impact unless there is capacity to carry it out. The severity of the HIV epidemic was the reason for giving greater weight to immediate benefits than to long-term impact.

C. Explicit Criteria (impact and feasibility) - Yes or No decisions

In the process of finalizing the strategy, a small team in the National AIDS Coordinating Authority carefully reviewed all the proposed activities, and used three explicit criteria to identify high priority activities that would be feasible to implement. Priority activities had to satisfy all three criteria.

- Is this an evidence-based activity likely to have an immediate impact on the epidemic?
- Does the country have the capacity to implement the activity?
Is it fundable (does the country have or could it get the resources)?

The criteria used in Swaziland raise an important point – what if the country does not have the capacity to act on the most important priorities for preventing new infections? For example, sex work and injecting drug use are overwhelmingly the main epidemic drivers in much of Asia. What if the country does not have laws, policies, systems, expertise and service delivery capacity that would enable these groups to be reached with effective prevention services? Then the urgent strategic need would be capacity building, and perhaps operations research as a basis for developing effective programs. Sex work and drug use would still be top priorities, based on the epidemiology. The lack of capacity to address them would not be a reason to de-prioritize them, but would drive urgent action to build the needed capacity.

Budget envelopes are required for effective prioritization to take place, even if the budget amounts are rough estimates compiled by the national AIDS coordinating body. Prioritization necessitates the discipline of realistic (but ambitious) planning, within the limits of what can be afforded and for which implementation capacity exists or can be developed. The earlier in the process that indicative budgets are agreed the better (see section 2.5).

2.5 Budgets and Resources

Setting budget envelopes

Without budget envelopes, planning easily becomes an exercise in ‘wish-listing’. This can waste time and scarce technical and human resources. Relations with stakeholders can be damaged when wish lists are eventually and predictably cut back (either by the national AIDS coordinating body or by asking stakeholders to do it). It is frustrating and disempowering to be asked to develop and cost plans, only to see them removed, ignored or deep cuts made at a later stage.

On the other hand, if budget figures are released prior to action planning, people may restrict their plans to the available funds, without taking into consideration their ability to mobilize additional resources. However, planning without indicative budgets has worse potential negative consequences. And in fact, even when asked to plan within a budget limit, people often present plans that exceed the budget. Ideally, action plans need to be developed with knowledge of likely budgets (available funds, plus reasonable fundraising expectations).

Funding scenarios: One option is to ask people to develop plans that show what they would do within the envelope of funds likely to be available, as well as the additional activities they could undertake if there were (a specified level) of additional funds. If plans are presented that exceed the likely budget, it can be helpful to ask stakeholders to rank activities into 2 or 3 categories, corresponding to pessimistic, medium and optimistic funding scenarios: (1) most important, give top priority for available funding (under pessimistic funding scenario), (2) next most important for funding (medium funding scenario); (3) cut these if inadequate funding forces something to be omitted, carry out under optimistic funding scenario.

Costing

A companion note discusses different approaches to costing a strategy and action plan (see box 8 and “*Costing a National AIDS Strategy: Exploring Two Different Approaches, some lessons of experience*”, ASAP, 2008). Wide participation in costing may help to make budgets more realistic and owned by the implementers. However, costing requires knowledge of costs, and skills in using spreadsheets to do it efficiently. It is unhelpful to ask people to cost activities and develop budgets if they are unaware of the likely costs of activities. Participants in costing exercises should be carefully chosen and given strong support by consultants and the staff of national coordinating bodies.

There are costing tools and models that offer cost information based on data from a range of countries, which can be used as a first approximation, if local cost data are not available. But it is very important to collect and compile local costing information so that realistic estimates can be made of the costs of activities, and alternatives can be compared to choose those which give the best value for money. Relative costs are clearly important to consider when deciding on priorities and making difficult choices.

Tracking and Mobilizing Resources

Resource tracking is an integral part of the planning, prioritization and costing process. Without knowing the contributions to be expected from government and development partners, it is impossible to know the realistic limit for an aggregated budget, or how many actions can be prioritized and achieved within any given timeframe. Unfortunately, an effective system for resource tracking is missing in many countries at this time.

National coordinating bodies need to be aware of and respond to funding flows into the country from different sources, and constantly able to facilitate links between resource providers and the priority needs of implementers.

Ideally, resource providers should engage in the strategy and operational planning processes at an early stage, to assist implementing bodies and coordinating agencies to develop realistic and fundable proposals and plans.

Resource mobilization should be an active ongoing process. National coordinating bodies and implementing agencies should continually scan the donor environment and formulate resource mobilization strategies (outlining what money is required, for what, and from whom). This approach can greatly assist not only the national response, but also the resource providers by helping them target their funds on priority actions and develop a sense of shared ownership of the implementation of the national strategy.

A related issue is tracking spending on HIV interventions. National AIDS Spending Assessments (NASA) offer a consistent methodology for doing this. It is important to keep track of spending, to make it possible to monitor costs, ensure that resources are used well, and assess and compare the “value for money” or cost effectiveness of different approaches and interventions.¹¹

¹¹ See UNAIDS 2005 for details on NASA.

Box 8: Costing strategies - Lessons distilled from experience

- Different approaches to costing have advantages and disadvantages. A small technical team can do the work quite quickly using standardized costs, accounting formulas and linked spreadsheets. Participatory, “bottom up” costing by implementers who prepare individualized estimates that are then aggregated takes longer, but can build capacity and ownership among many stakeholders.
- If implementers are to be meaningfully involved in planning and costing, their **capacity development needs** should be adequately addressed. This is true for senior staff and more widely across organizations. Over the long term, involvement of more staff and stakeholders (including beneficiaries and volunteers) should improve the relevance and accuracy of planning and costing, and reduce the burden on senior implementing agency staff.
- However costing is approached, sooner or later the process requires staff/consultants with strong skills in using spreadsheets. ASAP is developing “user friendly” costing software, which will make the task quicker and easier.
- The greater the degree of **participation, the more time is needed** for planning and costing. The process needs to be mapped out in detail and relevant information and timetables disseminated well in advance, so that people can schedule time to devote to the exercise. Leaving time in between key steps allows consultation, reflection, and improvement.
- Describing in detail each activity in a plan, and how it is to be implemented allows costs to be checked and assumptions to be revisited and changed later if necessary, enables closer monitoring of implementation, and is an ‘institutional memory’ in case of staff turnover.
- There is a strong case for **including senior managers, program managers, and financial and procurement staff** in the costing process. Senior managers can ensure that distortions in the scope of activities and/or priorities are kept to a minimum; program managers can provide essential technical input; finance and procurement staff can ensure that the unit costs and the overall approach are fiscally sound.
- Standardization of costs greatly simplifies the process and can promote fairness. But unavoidable variations in costs need to be accommodated. For example, providing services in rural or remote areas or serving people with special needs tends to cost more.
- Effective prioritization and optimal planning require **budget targets or constraints**, even if these are rough estimates compiled by the national coordinating body. Without budget targets, costing and planning tends to result in ‘wish-lists’ that have to be pruned later, which can be demoralizing and waste time, and technical and human resources.
- **Resource tracking** is an integral part of the planning, prioritization and costing process. Without knowing the contributions expected from government and development partners, it is impossible to decide on a realistic overall budget and hence how many actions can be prioritized and achieved within any given timeframe. Unfortunately, an effective system for resource tracking is missing in many countries at this time.

Source: Adapted from Haazen, Lee & Brown (2008), ASAP

2.6 Annual Action Plan / Operational Plan / Work plan

A strategy provides a vision of the results that the country wants, and the approach for trying to achieve them. An Annual Action Plan (also called a Work Plan or Operational Plan) defines the detailed activities that will contribute to those results, as well as who is responsible for undertaking them, the cost of each activity, and a timetable.

One person in Swaziland described the difference between a Strategy and an Action Plan as follows:

“A Strategy you can read and then put aside, but an Action Plan is very different – you need to look at it often, to see what you have done, and what you still need to do.”

It became clear from many conversations with stakeholders who had been involved in developing the national strategy and action plan that there needs to be a systematic process or requirement to make sure that progress against the Action Plan is in fact monitored, so that action plans are used and regularly consulted.

“Top down” work planning is not a good idea; Action Plans need to be developed through a “bottom up” approach. Thus Action Plans cannot be developed without the input and collaboration of implementing partners, nor finalized without consulting with them. Asking stakeholders and implementers “What can you do to help achieve the national objectives (results being aimed for) in the National Strategy?” can be very constructive, and help ensure that actions are focused well.

Thailand is taking an interesting approach to Action Planning. Smaller groups have been asked to develop action plans for specific affected sub-populations -- MSM, sex workers, IDUs, youth, etc. This allows for strong participation of affected groups and people with expertise in specific areas – relevant implementers and community members, backed up by scientific experts who can explain the data and evidence on what works and make sure the planning process pays close attention to the relevant data. Then a higher level group is putting these plans together to make a national action plan that closely reflects the data, scientific knowledge, needs of the communities and capacity on the ground. This approach seems especially suited to countries with concentrated epidemics where the groups at highest risk and with greatest needs may be easier to identify.

One of the major challenges is to **develop the Action Plan fairly quickly**, so that the planning process does not use up too much of the valuable time needed to implement the plan. There are many examples of the planning process stretching over many months, and the Annual Plan being finished and budgets transferred as late as nine or ten months into the year in which they are supposed to be implemented. Providing simple, clear, standardized formats for plans can help, as well as early help, so that all stakeholders understand clearly what they need to do, and have access to support and help for the planning. In various discussions, many countries and other partners have asked for practical help for developing good Action Plans in an efficient, streamlined way. ASAP has commissioned a “good practice note” on Action Plans, the draft of which is under discussion with countries.

Benefits of bringing different groups together to develop a national Action Plan – from the perspective of stakeholders

“It was helpful to see that there are many different implementers, all doing different things to help those affected by AIDS. It helped our group to decide that we did not have to try and cover all the needs, we could leave some things to other groups and focus more on the things we could do best.”

“Some groups came together for the first time. It was good to realize that are others in the HIV response, doing similar activities.”

Strengthening capacity for results-based planning that links results, programs and targets

Capacity for developing detailed plans is a concern in many countries. Weak or emerging capacity among implementing agencies may slow down the process and leave a question mark over the quality of plans and budgets. If implementers are to be meaningfully involved in planning and costing activities, their capacity development needs should be adequately addressed. This is true at senior staff member level, but also more widely across the organizations and institutions concerned. Over the long term, the greater involvement of staff and a wider group of stakeholders (such as service beneficiaries or volunteers) should improve the relevance and accuracy of planning and costing, and reduce the burden on senior implementing agency staff.

Specific training workshops can help clarify requirements and responsibilities, and build capacity among stakeholders. Participatory approaches take longer but can build capacity in a wide set of stakeholders. Alongside this, it is important to ensure that the financial (and other) personnel of national AIDS coordinating bodies have the skills they need.

Capacity-building is not just a one-off event; it is an ongoing process, which is often challenging and time-consuming. The time and resources for capacity building need to be factored into the planning process.

Different stakeholder groups/sectors require different amounts of time to contribute to strategic planning or to carry out action planning. Relevant factors include the education and capacity of the group, the complexity of their activities and contributions, whether they have strong “umbrella” organizations that the various groups are used to working through or whether the groups usually work independently, and how familiar they are with planning and costing processes.

Templates and easy to use tools can harmonize and streamline planning and costing processes (wherever possible, provide “hard copies” on paper, as well as electronic files). Training in how to use these tools should be offered at an early stage, and ongoing technical support and guidance made available. It is helpful if the same tools and templates are used each year. This allows sectors and implementers to build confidence and competence in using the tools.

Define activities within each strategic program with specific targets

A useful plan describes each activity in detail, specifying what is to be done, who will carry out each activity, and when it will be done. (What roles do central and local government agencies play? What roles can the private sector and civil society play?) This documentation process allows costs to be estimated and checked, and means that any assumptions can be revisited and changed later if necessary.

Detailed plans can be very helpful in keeping implementers focused, if they frequently refer to their plans, noting what needs to be achieved each month or each quarter. They also serve as an ‘institutional memory’ in case of staff turnover.

Regular reviewing and updating of plans keeps them current and relevant

National coordinating bodies might consider reviewing progress against Action Plans every quarter or every six months. As the Principle Recipient for Swaziland’s Global Fund grant, NERCHA reviews each implementer’s progress against their plans and targets each quarter, and releases funding for the next quarter based on performance.

Developing a new annual plan should become easier each time. A careful review of the previous year’s work plan is a good starting place for the coming year’s work plan. If detailed plans cover more than one year, it is a good idea to re-verify multi-year or rolling plans annually.

2.7 Monitoring and Evaluation

The Monitoring and Evaluation Technical Working Group (M&E TWG) or expert group has an important role in helping ensure that appropriate indicators are selected and defined for measuring progress towards the key result and strategic program goals/targets. For each indicator, data source/s and data collection procedures must be identified, and plans included for any additional data collection and research that may be necessary.

The national M&E plan may need to be revised (or developed if one does not exist) to ensure that the national M&E system will meet the needs of the national Strategy (box 9). M&E activities need to be adequately costed, and included in the National Action Plan. There is little use in collecting data that are not useful and used, which requires explicit plans for regular and widespread dissemination of data to all potential users. One of the most important roles of the NAC can be to review progress against plan targets and then discuss with implementers ways to resolve bottlenecks and improve performance.

Box 9: The challenge of ensuring continuity and consistency

Several different teams of consultants helped at different stages of one country's strategy and work plan development. The team that helped to finalize the strategy decided to rewrite some of the objectives and indicators "to improve their focus or clarity or make them more realistic" (in their view). However, the indicators had been discussed at length by the M&E and thematic technical working groups, and an indicator corresponding to each objective in the strategic plan had been agreed. At the same time as the strategy was being developed, an M&E plan was developed, that was designed to operationalise an M&E system to collect the data needed to monitor progress towards the strategy's objectives. This provided complete consistency between the M&E plan and system, and draft national strategy. However, while the strategy was being finalised, the post of M&E coordinator at the NAC was vacant for several months because of staff turnover. The result was that the M&E technical working group was not consulted when the indicators were revised and the new set of indicators were not fully consistent with the M&E system, and had to be revisited again later.

The M&E TWG had also developed and approved a national HIV M&E Road Map -- a national and integrated plan for implementing the M&E system that defined all the activities necessary to achieve the M&E objectives in the national strategy. For each activity, the Roadmap included a cost estimate, the funding source, and who was responsible for implementing it. The National HIV M&E Road Map should have been included in its entirety in the national action plan, so that it was a national, integrated and costed plan for a comprehensive HIV response in the country

National coordinating bodies have a vital role to play in building the confidence and skills of implementing agencies to carry out M&E and reporting. National systems requiring implementer input should be simple and straightforward, designed with the weakest not the strongest agencies in mind.

2.8 Finalizing, disseminating and using the National Strategy and Action Plan

Finalizing the National Strategy and Action Plan

The process of finally pulling together a national strategy, operational plan or M&E plan requires someone with strong skills in word-processing and spreadsheet programs so as to ensure accurate use of time-saving formulae, avoid errors of transcription and inconsistencies of formatting, etc. This stage often takes much more time than anticipated, so the person responsible needs to be able to dedicate uninterrupted time. Printing (including proof-reading) may also take several weeks.

Using the plan

Finalizing and disseminating the National Strategy and Action Plan documents is a great accomplishment, but only the first steps towards realizing their purpose of achieving results in the response to HIV. The process of developing the strategy and plan should

move seamlessly into funding, implementation, fundraising, support and monitoring. A donor conference should be scheduled in coordination with the completion of the Action Plan to encourage donor buy-in to the nation's priority plans.

National coordinating bodies can 'lead by example'. Having organized or commissioned strategy development and action planning processes, it is crucial to follow through and use the resulting strategies and plans, and be seen to use them to ensure good performance and progress. A good monitoring system enables the country to recognize signs of changes in the epidemic, and identify implementation problems and successes early on, which may signal the need to correct or change course. This helps enhance the consistency, focus and impact of the national response.

Appendix 1: Swaziland's National Community Consultations

Community consultations in rural areas

Swaziland held community consultations in all 360 chiefdoms across the country, to engage community members and leaders in a discussion about the main factors driving the epidemic in Swaziland; solicit ideas to inform the new national strategy; and to gather information about the impact of HIV and coverage of interventions at community level. (The initial plan to hold the consultations in 10 of the country's 55 constituencies was revised at the behest of a senior decision-maker, and additional generous financial and technical support secured from various partners for this enormous undertaking.)

An early step was to approach the Deputy Prime Minister's Office with a proposal for their administrative leadership and involvement in regional meetings, and mobilizing Chiefdoms, Tinkhundla (an administrative level that includes a group of Chiefdoms) and Regions to participate in the exercise. Next, meetings were held with the country's Regional Administrative Secretaries, who then helped mobilize chiefs across all four regions of the country. These meetings presented an opportunity for the Core Team to sensitize the country's chiefs and their councils, and solicit their support and assistance in mobilizing their constituencies for the consultative meetings.

Approximately 100 facilitators from each of the four regions of the country were engaged and trained to conduct the grassroots level consultative meetings. Many facilitators were university graduates (with a background in social work, social sciences or research methods), but chiefs were also encouraged to identify eligible candidates from within their communities to increase community ownership and engagement. Facilitators from within the chiefdom were preferred by some chiefs who were reluctant to have "outsiders" – especially rather young ones – perform this role. Although the facilitators received some training and orientation, in retrospect, more training and greater clarity about what was expected from them would have been good. To provide technical and operational oversight to the facilitators, 20 supervisors were engaged, who also helped distill the messages from the consultations, and reported up to the Tinkhundla and Regional levels.

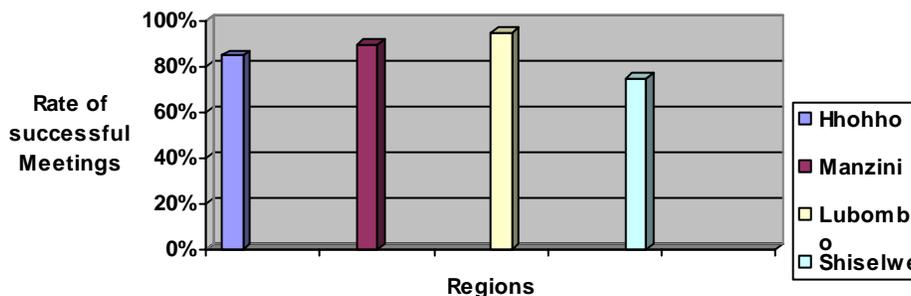
At an Induction Workshop, the consultants helping with the process developed an Operational Framework as well as Tools for Data Collection in both English and SiSwati. These were used by the trained facilitators to solicit comments from community members.

In each Chiefdom, women, men, youth and young married women (*Bomakoti* or Daughters in Law) talked in separate groups, so that people would feel more comfortable speaking out. This also encouraged contributions by keeping the groups smaller. The separation of young married women was seen as strategic, in the sense that in traditional Swazi society some of the experiences and challenges they face result from their social identity as *Bomakoti*.

The chiefs had asked that a meal be provided, as most people had to walk long distances to the meetings. So a fleet of vehicles had to be hired and borrowed, to deliver meat and mealie-meal to 360 points across the country before the meetings, and to transport the facilitators and supervisors on the meeting days. Even though Swaziland is a very small country, this was a formidable logistic challenge.

Extensive mobilization and preparations by the Process Administrators at NERCHA and the Regional Administration Secretaries helped ensure a high success rate for the community meetings (with some variation across regions, figure 3) and generally good participation. In the cases where meetings were not held, reasons ranged from disputes among neighboring chiefdoms with regard to jurisdiction; community ceremonies, and poor mobilization of community members by leaders. Where possible, the research teams were encouraged to reschedule the meetings.

Figure 3: Percent of planned meetings successfully held, by region



Participation of youth in the community meetings was very low. Because the views of this critical social group were regarded as important for the strategy and policy, young people were invited and encouraged to call a Toll Free Line based at the Ministry of Education. The response from young people throughout the country was a great improvement over the community meetings, and indicative of the vibrancy with which young Swazi people engage in dialogue when there is an appropriate avenue.

The comments made during the meetings were consolidated into chiefdom reports, which were presented to all the chiefs within that particular *Inkhundla*, representatives from the Chief's Council (*Tindvuna Temcuba, Bucopho*), Headmen (*Indvuna Yenkhundla*) and the Member of Parliament representing that *Inkhundla*. This gave community leaders the opportunity to learn what issues had been raised in their constituencies and add their own comments. These sessions took place over two to three weeks. Next the *Tinkhundla* reports were consolidated into regional reports that summarized the strategic and policy issues raised by each region. These were then presented to all the chiefs, their councils, MPs, and Regional Administrators. This process of giving feedback to community leaders at every level of reporting aimed to increase ownership and familiarity with the issues.

Community consultations in urban areas

A similar consultative process was carried out at the same time in urban areas by the Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL). This activity followed the approach already used by AMICAALL of holding "Community Conversations in Towns" to discuss various issues. Mobilization was done by City and Town Councilors, and the meetings were facilitated by a team already affiliated to AMICAALL. These facilitators had received some training from UNDP and so only needed briefing on the meeting goals and data collection instruments. Reports were compiled and presented to the Town Councilors, who added their own contributions.

Additional national consultations

Extensive consultative meetings and in-depth interviews were held by the team of consultants with a broad spectrum of key informants and stakeholders from different sectors and agencies, development partners and donors. Live call-in talk shows on national TV and radio proved to be a very effective tool for sensitizing and engaging the public. Stakeholders and partners were also invited and encouraged through the national media to participate in national stakeholder meetings to review the draft Policy and Strategy. During these meetings, Priority Areas for Action were identified to inform the National Action Plan.

Consultative meetings were also held with Cabinet Ministers and members of the Parliament Portfolio Committee on HIV/AIDS. The purpose of these meetings was to sensitize and familiarize Ministers, Senators and MPs with the process and documents. It also was an opportunity to solicit their commitment in adopting and implementing the National Policy and Strategy.

Costs and benefits

The consultative, participatory processes were time-consuming, resource intensive and a massive logistic undertaking. The consultations generated a wealth of information, that was difficult to fully digest and do full justice to. Some people wonder whether the money and effort that went into the consultations might have been used better in implementing interventions. However, many people in Swaziland are of the opinion that the consultations were important and worthwhile, and helped create an enabling environment for implementing the National Strategic Plan and Policy, because these documents are based on the actual concerns, priorities and interventions identified by the Swazi people. The process ensured that the new National Strategy was not dictated by a small group of people in Mbabane, but is a truly national, broadly owned strategy.

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