Draft Working Paper

Assessing Costing and Prioritization in National AIDS Strategic Plans

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Executive Summary

This background paper examines costing practices, cost-effectiveness data and prioritization processes in national HIV/AIDS strategic plans. The first section is a literature review on costing and prioritization in the first generation of national strategic plans (NSPs). The second section uses the World Bank AIDS Strategy and Action Plan's Self-Assessment Tool Guidelines for costing and prioritization to provide a detailed assessment of 7 current-generation NSP documents (Botswana, Cameroon, Cote d'Ivoire, Malawi, Mozambique, Peru, and the Philippines). Through a simple scoring scale, patterns across these documents become evident. Botswana meets the most SAT criteria for the costing and prioritization categories (combined); Mozambique meets the fewest. With respect to prioritization guidelines, few countries mentioned cost-effectiveness as a key factor in selecting interventions to prioritize. With respect to costing/financing guidelines, few countries indicate that a transparent financial system is in place to track disaggregated spending for unit costs identification.

The third section examines global financing data availability and compares per capita and per infection costs based on 3 data sources. A minority of countries report any expenditure towards most-at-risk populations to UNAIDS. Section 4 presents a discussion of challenges to the strategic planning process as well as the need for systematic assessment tools. The paper closes with 7 key messages to improve national strategic plans:

1. Develop functional and transparent national financial systems

2. Track, report and share full cost and financing data

3. Conduct self-assessment and impact studies at the country level

4. Propose and deliver funding for most-at-risk populations

5. Develop more specific ASAP guidelines for NSPs

6. Create a refined, integrated system for assessment

7. Set and achieve rigorous targets for improved NSPs

Although there are startling shortcomings in the current generation of national strategic plans and financial tracking, it is critical that countries implement basic costing and prioritization policies in the short term in order to maximize impact in the long term.

Introduction

Global funding for HIV/AIDS has reached unprecedented levels, and the costs of care and treatment are expected to grow well into the future. This growing price tag, in combination with increased competition for international funding from other causes and the recent global financial crises, raises questions of transparency regarding national HIV/AIDS priority setting, expenditure tracking and strategic planning. This paper explores the content and the importance of the NSP as it guides and defines national responses to HIV/AIDS. The fundamental research question is: to what extent do evidence-based, cost-effective and rational processes define costing and prioritization in NSPs?

Systematic assessment of national strategic plans is difficult. Data in the public domain are limited, and data reported to UNAIDS/WHO often are incomplete. Tools for review and assessment of NSPs are lacking. This paper examines a set of primary NSP documents and related expenditure sources to understand data availability, costing processes and prioritization criteria. Box 1 on the following page sets forth brief definitions of 3 primary data sources for the current approach to national strategic planning: National AIDS Spending Assessment, National Strategic Plans, and Global Resource Needs Estimates.

This paper intends to inform the dialogue about the effectiveness of historical approaches to national strategic planning and financing. Section 1 of the paper reviews the literature on costing and priority setting in the first generation of NSPs. Section 2 presents a detailed assessment of costing and prioritization among 7 focus countries' documents from the current generation of NSPs. This assessment uses a simple score derived from a modified version of the AIDS Strategy and Action Plan group's Self-Assessment Tool. Section 3 compares selected financing indicators from the 7 focus countries and discusses potential misallocation with respect to funding for most-at-risk populations. Section 4 discusses the historical approach to national strategic planning and offers key messages for countries to improve their processes in the short term in order to more efficiently guide their responses over the coming decades.

BOX 1. DESCRIPTION OF PRIMARY DATA SOURCES

NATIONAL AIDS SPENDING ASSESSMENT (NASA)

The National AIDS Spending Assessment (NASA) resource tracking methodology is designed to describe the financial flows and expenditures using the same categories as the globally estimated resource needs. This alignment was conducted in order to provide necessary information on the financial gap between resources available and resources needed, and in order to promote the harmonization of different policy tools frequently used in the AIDS field. NASA provides indicators of the financial country response to AIDS and supports the monitoring of resource mobilization. Thus, NASA is a tool to install a continuous financial information system within the national monitoring and evaluation framework. NASA serves several purposes within different timeframes. In the short term, NASA might be useful to provide information on the UNGASS indicator for public expenditure; in the longer term, the full information provided by NASA may be used to:

- Monitor the implementation of the National Strategic Plan;
- Monitor advances towards completion of internationally or nationally adopted goals such as universal access to treatment or care;
- Provide evidence of compliance with the principle of additionality required by some international donors or agencies; and
- Fulfill other information needs.

NATIONAL STRATEGIC PLAN (NSP)

National strategic frameworks or plans provide a vision of the results that a country wants, and the approach for trying to achieve them (typically over a period of several years). NSPs are useful to the extent they:

- Set clear national priorities and align external support
- Respond to the heterogeneity of the epidemic
- Are translated into action
- Ensure an important role for civil society and communities and a multi-sectoral response
- Implement the "Three Ones" principle that provides the basis for coordinating the work of all partners
- Attract and sustain funding from national budgets and external donors

To meet these ends, all actors must help countries develop improved national strategic plans and annual action plans that are selective and carefully prioritized; evidence-driven; feasible, with clear implementation arrangements that draw on the diverse resources available, accountability and costing; and linked to functioning and sustainable systems for monitoring and evaluation. In the context of this paper, a costed NSP reflects what the country would like to spend.

GLOBAL RESOURCE NEEDS ESTIMATES (GRNE): UNIVERSAL ACCESS BY 2010

Estimating the global resources needed for HIV/AIDS is an ongoing activity that began in 2001. Each subsequent round of estimates has aimed to improve the methods and figures by incorporating new data and methodologies with each cycle. The updating process also presents an opportunity to provide coordination, communication and agreement that would support the technical working groups in conducting estimates of HIV and AIDS resource needs. In this most recent round (2007 GRNE), the methodology to estimate resources required for care and treatment has been revised. The new methodology contains six main categories of care and treatment interventions:

- Antiretroviral therapy
- Routine counseling and testing
- Treatment and care of opportunistic infections
- Essential illness prevention interventions for PLHIV
- Nutrition supplements for those on ART
- Incremental costs for ART patients with tuberculosis

The resources required for each category is the product of three variables: target population, unit cost, and coverage. The proposed definition for each of these variables is described for each category below. Coverage targets will be based on three scenarios. In the first scenario, Strategic Scale-up, coverage will grow by 1 million patients per year to reach 11 million on ART by 2015. In the second scenario, Current Scale-up, coverage will grow by 675,000 per year, reaching 8 million on ART by 2015. The Universal Access by 2010 scenario assumes that universal access to prevention, care and support is achieved in all countries by 2010. These numbers represent a maximal scenario, but are useful for illustrating the gaps among the 3 frameworks.

Sources:
http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp
http://www-wds.worldbank.org/servlet/main?menuPK=64187510&pagePK=64193027&piPK=64187937
&theSitePK=523679&entityID=000333037_20080414042629.
http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1151090631807/BusinessPlan2008-2009Final.pdf
http://data.unaids.org/pub/Report/2007/20070925_annex_iii_treatment_care_methodology_en.pdf
http://www.futuresinstitute.org/download/Implications%20of%20New%20UNAIDS%20Estimates%20for%20Future%20Goals.pdf

First Generation NSPs

This section reviews the small body of literature on costing and prioritization details from NSPs written around or shortly after 2000: the "first generation" of NSPs. UNAIDS released the first guidelines for strategic planning in 1998, and many countries drew heavily upon this resource to develop their first national plans. Funding for HIV programs was extremely limited at this time, and priority setting was not a focal point of these guidelines. It was more important for countries to draft broad, comprehensive strategic plans in order to generate significant levels of resources. A 2005 World Bank review assessed the extent to which national plans represent a strategic approach to addressing the epidemic in its Multi-Country AIDS Program (MAP). Per MAP criteria, a strategic approach is evidenced by: clear goals; explicit priorities; systematic planning, targets, timeframes, and indicators; clear plans for monitoring and evaluation; specific implementing actors and responsibilities; and cost estimates and strategies for resource mobilization. Strategic approaches demonstrate efficiency, equity, relevance and feasibility. The review found 10 costed national strategies (and 2 health sector strategies).

Table 1. Selected data on countries participating in the MAP

						National strategy estimated cost			MAP project cost		
Country	Population 1999 (millions)	GNP per capita 1999 ($US)	Total annual health spending per capita 1997 (US$)	HIV prevalence (around 1998) (% adults)	Timeframe of national strategy	Estimated total cost (US$ millions)	Average annual cost (US$ millions)	Average annual cost per capita (US$)	Total cost (US$ millions)	Average annual cost ($US millions)	Average annual cost per capita (US$)
MAP I											
Benin	6	380	12	4.1	2000-2005	..	..	..	25.4	6.4	1.06
Burkina Faso	11	240	8	7.2	2001-2005	27.0	5.4	0.49	23.5	4.7	0.43
Cameroon	15	580	31	7.2	2000-2005	130.0	32.5	2.17	60.0	12.0	0.80
Central African Republic	4	290	8	12.9	2002-2005	..	..	..	18.0	3.6	0.90
Eritrea	4	200	6	2.4	2003-2007	..	..	..	50.0	10.0	2.50
Ethiopia	63	100	4	7.3	2001-2005	..	..	..	59.7	19.9	0.32
Gambia	1	340	12	..	..	..	..	..	16.2	3.2	3.24
Ghana	19	390	11	4.6	2001-2005	118.9	23.8	1.25	27.8	7.0	0.37
Kenya	29	360	17	13.0	2000-2005	200.0	40.0	1.38	50.0	12.5	0.43
Madagascar	15	250	5	0.9	2003-2006	101.0	25.3	1.68	21.0	4.2	0.28
Nigeria	124	310	30	5.9	2000-2003	182.0	60.7	0.49	96.3	19.3	0.16
Uganda	21	320	14	10.0	2001-2006	181.5	36.3	2.88	50.0	10.0	0.48
MAP II											
Burundi *	7	120	6	8.3	1999-2003	5.7	2.9	0.41	36.7	7.3	1.05
Cape Verde	0.4	1330	34	1.3	2002-2006	..	..	..	9.6	1.9	4.80
Guinea	7	510	19	4.1	2003-2007	..	..	..	22.3	4.5	0.64
Mauritania †	3	380	24	0.6	2003-2007	126.7	42.2	14.08	23.4	4.7	1.56
Mozambique	17	230	5	14.5	2000-2002	40.0	13.3	0.78	64.0	12.8	0.75
Niger	10	190	5	..	2002-2006	..	..	..	27.5	5.5	0.55
Rwanda	8	250	13	13.0	2002-2006	..	..	..	30.5	6.1	0.76
Senegal	9	510	23	1.4	2002-2006	..	..	..	32.2	6.4	0.72
Sierra Leone	5	130	11	7.0	..	..	..	..	15.3	3.1	0.61
Tanzania ‡	33	240	12	10.0	2003-2007	138.5	34.6	1.05	70.0	14.0	0.42
Zambia	10	320	27	20.0	2001-2003	559.9	186.6	18.66	46.0	9.2	0.92

* Estimated cost is for 2 years.
† Estimated cost is from sector strategies and is for 3 years.
‡ Estimated cost is from health sector strategy only.

Source: Mullen 2005.

The OED review specifically assessed the national strategies with respect to issues of economic efficiency and cost-effectiveness. None of the national strategies examined, however, mentioned the relative costs and effects of different interventions. An exception occurred in several strategies that noted the high cost of hospital care for PLWHA. In general, the low-prevalence countries in this study are devoting a higher percentage of total estimated costs toward prevention activities (Mullen 2005).

A 2004 joint World Bank and UNICEF review assessed national strategic HIV/AIDS plans and Poverty Reduction Strategy Papers (PRSPs) for the inclusion of HIV/AIDS targets with a specific focus on children and young people. The study included 19 African countries with full PRSPs, 18 of which had prepared a national strategic HIV/AIDS plan at the time of the study. A secondary finding of this study

was that only a minority of countries costed their NSPs. Fifty-six percent of NSPs provide aggregate cost figures for HIV/AIDS programs; 25% list costs by broad categories; and only 19% provide detailed costs in the plan (Bonnel et al 2004). At the NSP level, efforts to improve the costing of HIV/AIDS activities are urgently needed. The authors emphasized the interaction between the NSP and other national strategic documents. For the costing process to be useful, the calculations must be consistent with the procedures or frameworks used in the government budgeting process (Bonnel et al 2004).

An internal World Bank background note written in 2005 in preparation for the AIDS Strategic and Action Planning Workshop assessed 10 existing national strategic frameworks as to whether or not they are evidence-based, prioritized, costed and implementable. Its findings were consistent with those of the OED review discussed earlier: the first generation of national strategic plans contained a common set of strengths and limitations. Few plans were informed by either epidemiological data or empirical evidence on proven interventions. Furthermore, the plans rarely contained an explicit process for making strategic choices on relative priorities. Realistic and specific cost information was rarely present with respect to existing resources, resources required or requirements for implementation (ASAP 2005). There is a general focus on issues of process and implementation rather than on measured impact of programs on HIV transmission. Response analyses of national strategies as well as general MAP documentation confirm this problem (Mullen 2005).

These patterns are not surprising given the available tools for strategic planning at this time. The World Bank background note also reviewed international guidelines for strategic planning and implementation of HIV/AIDS programs. These documents set forth principles and frameworks for the strategic planning process (particularly for the first generation of national strategic plans), but they are weak in the areas of priority setting, costing frameworks, and implementation and monitoring plans. All countries in the review seem to have followed a nearly identical approach in drafting their national plans (ASAP 2005).

In sum, a literature review of first-generation NSP sources indicates only a minority of countries costed their first generation NSPs. Significant variety existed in content, structure, costing bases, resource allocation percentages, and targets from country to country. This variation and these shortcomings have received increased attention in subsequent years.

AIDS Strategy and Action Plan

In 2005, the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (GTT) recommended the establishment of a group to assist countries with the improvement of their HIV/AIDS strategies. The initial goals were: (i) assisting 15 countries over a two year period to enhance their HIV/AIDS strategies and 28 countries over two years to establish improved annual action plans; and (ii) developing a set of internationally recognized standards and criteria for annual priority AIDS action plans and a scorecard-style tool that countries can use for self-assessment of the plans. Early 2006 saw the organization of the AIDS Strategy and Action Plan (ASAP) group hosted at the World Bank. Designed to be a one-stop shop for countries requesting assistance, ASAP works to provide advice and support to: (i) enhance strategies by making them more evidence-informed, prioritized, costed and capable of being implemented more efficiently and effectively; (ii) establish action programs to move from strategy to implementation; (iii) build capacity; and (iv) develop tools, share knowledge and promote coordination and harmonization in strategic planning (ASAP 2008).

ASAP provides four main services based on country demand: peer reviews of draft strategies, comprehensive technical support to clients, capacity building and the development of tools and guidelines. Guidelines from ASAP encourage national planners to meet certain criteria in ten programmatic areas:

- Synthesis of epidemiologic data and the current response
- Evidence-based, results focused planning
- Prioritization
- Results-based monitoring and evaluation
- Participatory process
- Financing/resources/budgets and costing
- Capacity and constraints
- Management and coordination
- Policy environment
- Action plans

ASAP's experiences and its portfolio of available resources are central to the analysis and recommendations contained herein. The next section applies one tool to actual NSP documents for an in-depth understanding of costing and prioritization in these plans.

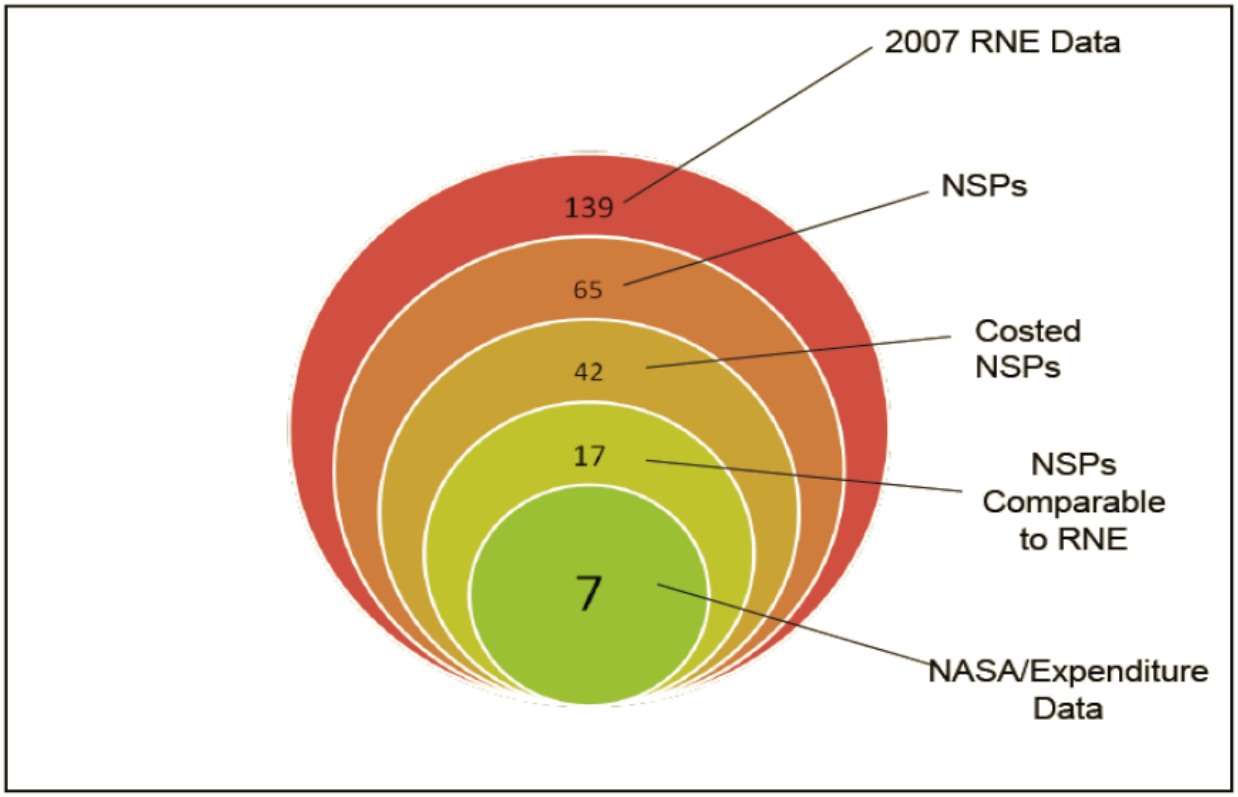
Current Generation NSPs: Selection of Focus Countries

Subsequent analysis focuses on 7 countries selected based on availability of three data sources:

- 2007 Resource Needs Estimates
- A costed NSP comparable to the country's RNE
- NASA data/expenditures reported to UNAIDS

A 2007 internal UNAIDS report examined national strategic plans and Resource Needs Estimate figures for potential comparison on a line-by-line basis. As shown in Figure 1 below, Resource Needs Estimates (RNE) data currently cover 139 countries. Of these 139 GRNE countries, 65 have national strategic plans. Of the 65 with national strategic plans, 42 of them include annual spending requirements. Seventeen of the 42 plans with annual spending requirements are presented in sufficient detail to allow comparison between the country RNE and its national strategic plan (Izazola et al 2007). Of the 17 plans with NSPs comparable to RNE, 7 report expenditures for one or more years of the NSP period. These 7 countries (Botswana, Cameroon, Cote d'Ivoire, Malawi, Mozambique, Peru and Philippines) comprise the focus group for detailed assessment of costed NSPs and related financing details.

Figure 1. Selection of 7 focus countries



Source: Izazola et al 2007; UNAIDS.

Costing in NSPs

ASAP published guidelines for financial details of national strategic plans which stipulate that a strong plan is one that:

- Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.
- Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.
- Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended.
- Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups (ASAP SAT Guidelines).

To assess the quality and breadth of costing details in current-generation NSPs, it is insightful to apply the ASAP SAT Guidelines to the 7 focus countries. With regards to the costing criteria above, applying

a simple 0 to 4 scale for each criterion allows us to score each country's NSP out of a possible 16 points:

Botswana:	9
Cameroon:	3
Cote d'Ivoire:	3
Malawi:	2
Mozambique:	2
Peru:	3
Philippines:	3

Botswana's NSP document is the strongest among these selected focus countries. Malawi and Mozambique score the lowest.[1]

In the costing/financing category, the criteria with the lowest score across the 7 NSPs was: indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended. The criterion with the highest score across the 7 NSPs was: has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups. This is to be expected, as one of the requirements for selection into this focus group of 7 countries was a costed NSP.

Prioritization in NSPs

ASAP resources and publications provide a clear understanding of the ideal elements a national strategic plan should feature. With respect to prioritization, the guidelines give the highest score to a strategic plan meeting the following criteria:

- Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).
- Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.
- Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.
- Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.

[1] For more details on the scoring of these documents, please see Appendix A. For more details on the detailed assessment of these documents, please see Appendix B.

- Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.

- Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.

- Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).

It is important to note whether or not the NSP reflects a prioritization process to explain the setting of these targets and the allocation of resources. Assessing each NSP based on the ASAP prioritization criteria set forth above, the following scores are obtained:

Botswana:	19
Cameroon:	13
Cote d'Ivoire:	9
Malawi:	9
Mozambique:	8
Peru:	14
Philippines:	13

Again, Botswana scores the highest, and Malawi, Mozambique and Cote d'Ivoire score the lowest.[2]

In the prioritization category, the criteria with the lowest score across the 7 NSPs was: demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective. None (0%) of the 7 NSPs scored 3 points. Two countries (29%), Botswana and Peru, received 2 points. Two countries (29%) received 1 point. Three countries (43%) received 0 points. To reiterate, the presence and use of cost-effectiveness within NSPs was the central research question for this study. Accordingly it bears mention that the minority of the focus countries demonstrated a robust reliance on cost-effectiveness in their strategic planning process.

Comparisons of Financing Details

Reviewing expenditure data allows an understanding of the connection between proposed spending and actual disbursement of funds. In the 2008 UNAIDS report on the epidemic, 147 countries report on progress made under the Declaration of Commitment, but only 106 of these countries provide data under UNGASS Indicator 1: Country Reports of Domestic and International AIDS Spending by service categories and financing sources. Very few of these countries report full data by share of source or across service/program area to UNAIDS as part of UNGASS indicator reporting—the majority provide a total annual figure. Only 7 countries have available data permitting a comparison of costed NSPs, RNE and NASA. (Cameroon has a total NASA figure available, but it is not disaggregated across program areas.) The 6 countries with full data available across these 3 sources are Botswana, Cote d'Ivoire, Malawi, Mozambique, Peru and the Philippines. Years of available data varied from country to country,

[2] For more details on the scoring of these documents, please see Appendix A. For more details on the detailed assessment of these documents, please see Appendix B.

but most NSPs were written for the years 2006-2010. Table 3 sets forth per capita cost/expenditure and per infection cost/expenditure for these three data sources.

Table 3. Comparison of per capita and per infection data for select countries

Country	NSP Years	NSP annual per capita* $US	NSP annual per PLWHA $US	2007 RNE per capita $US	2007 RNE per infection $US	2005 Total expenditure per capita $US	2005 Total expenditure per infection $US
Botswana	2003-2009	193.59	1,225.62	127.91	809.79	112.71	713.58
Cameroon	2006-2010	1.12	37.04	9.84	324.34	2.43	79.95
Cote d'Ivoire	2006-2010	6.21	221.92	8.99	321.28	0.85	30.24
Malawi	2005-2009	9.36	137.56	14.95	219.63	4.27	62.77
Mozambique	2004-2008	4.87	76.92	13.10	206.93	2.84	44.80
Peru	2007-2011	1.42	554.29	1.58	617.39	0.80	312.50
Philippines	2005-2010	0.03	404.76	0.62	7,476.14	0.08	977.43

Sources: Izazola et al; UNAIDS 2008; Authors' calculations.

Botswana	APC:	NSP > RNE > NASA
	API:	NSP > RNE > NASA
Cameroon	APC:	RNE > NASA > NSP
	API:	RNE > NASA > NSP
Cote d'Ivoire	APC:	RNE > NSP > NASA
	API:	RNE > NSP > NASA
Malawi	APC:	RNE > NSP > NASA
	API:	RNE > NSP > NASA
Mozambique	APC:	RNE > NSP > NASA
	API:	RNE > NSP > NASA
Peru	APC:	RNE > NSP > NASA
	API:	RNE > NSP > NASA
Philippines	APC:	RNE > NASA > NSP
	API:	RNE > NASA > NSP

It is interesting to note that 4 countries (of the 7 with full data) follow a similar pattern for per capita cost and per infection cost: RNE > NSP > NASA. This pattern suggests that funding gaps (or national underspending) are common, and that progress towards universal access targets (or realization of MDGs, etc) will most likely continue to be hampered by financial constraints. Among these 7 countries, only Botswana's NSP proposed a budget greater than (on a per capita and per infection basis) the RNE for the country.

Funding for Most-At-Risk Populations (MARPs)

147 countries provided reports on the implementation of the UNGASS Declaration of Commitment on HIV/AIDS. Only 106 countries provided any expenditure data (Indicator 1) in the 2008 UNAIDS Report on the Global AIDS Epidemic. 51 of the countries submitting expenditure data report any expenditure towards most-at-risk populations (UNAIDS 2008). The UNGASS Indicator 1: Country Reports of Domestic and International AIDS Spending by service categories and financing sources tracks amounts spent towards a country's programs. The fact that only 48% of countries reported expenditures in these areas may simply be due to a lack of reported or collected data; it may, however, reflect strong political reluctance to acknowledge or support these groups, particularly with public funds. Unfortunately the data refer to <u>any</u> spending towards SW, MSM or IDU programs; these numbers are not disaggregated to allow an understanding of which combination(s) of MARPs received funding.

Returning to the ASAP SAT categories under prioritization, one category relates directly to the potential misallocation between drivers of the epidemic and actual expenditures. Of the 7 focus countries in this project, no country failed outright to "include a careful analysis of the epidemic and subpopulations where most new infections are occurring." All scored higher than 0 in the detailed assessment. Table 5 sets forth each country's score in this category as well as available expenditure data towards MARPs in recent years.

Table 5. Indicators related to support for MARPs in 7 focus countries

	Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	2005 Total MARP expenditure (Million US dollars)	2005 MARP expend. (as % of total expenditure)	2006 Total MARP expenditure (Million US dollars)	2006 MARP expend. (as % of total expenditure)	2007 Total MARP expenditure (Million US dollars)	2007 MARP expend. (as % of total expenditure)
Botswana 2003-2009	2	NA/NR	*NA*	NA/NR	*NA*	*	*
Cameroon 2006-2010	3	NA/NR	*NA*	NA/NR	*NA*	NA/NR	*NA*
Cote d'Ivoire 2006-2010	2	$0.005	0.03	$0.004	0.01	*	*
Malawi 2005-2009	2	NA/NR	*NA*	*	*	*	*
Mozambique 2004-2008	1	$0.305	0.52	$0.140	0.15	*	*
Peru 2007-2011	2	$1.128	5.16	$0.798	2.46	$1.935	6.91
Philippines 2005-2010	3	$1.331	19.45	$1.531	19.92	*	*

***** Indicates the country reported no expenditure data to UNAIDS for the given year

Source: UNAIDS 2008; Authors' calculations.

The Philippines is the only country to both score high in this category and to report any expenditure toward MARPs. Cameroon, the only other country to score a 3 in this category, reports no expenditure toward MARPs for any of the 3 most recent years. It seems reasonable to expect the countries with concentrated epidemics (Cote d'Ivoire, Peru, and the Philippines) to spend a substantial share of available funds towards one or more MARPs, and yet the Philippines is the only country to do so. Cote d'Ivoire spends less than 1% towards these populations. This is an alarming indication that money is not being spent where it should be in order to halt or reverse the epidemic in certain settings. This misallocation is illustrated by the disconnect among: a) the reality of these concentrated epidemics; b) the priorities set forth in NSP documents; and c) reported expenditures towards MARPs. Without alignment of these 3 elements, it is simply impossible to expect substantial progress in these settings.

Discussion

Two standards became clear through this analysis. First, full data availability (RNE, costed NSP comparable to RNE, and NASA/expenditure data) is startlingly rare. There are dozens of very important countries (important either in terms of HIV/AIDS prevalence and/or levels of international donor funding) that are not reporting full data. Myriad reasons for this lack of data exist: difficulties orchestrating multisectoral responses, limited human resources and physical capacity to implement and track these programs, and the failure of parallel donor systems to strengthen public systems and data collection processes, etc. Nevertheless, it is troubling to realize that after 25 years of the epidemic, the global community lacks a sufficiently accurate understanding of how these funds are spent or where they should be spent for maximum impact.

The second standard pertains to the detailed assessment of the NSP documents among the 7 focus countries. Scoring well within each category when SAT is applied is just as important as data availability across the 3 data sources. Yet there are numerous categories in which all 7 countries score zero. Why aren't the guidelines to shape these NSPs more rigid? Are the existing tools and techniques to draft and assess NSPs sufficient? This paper uses a modified adaptation of the ASAP SAT, and although the SAT guidelines explicitly state that it is not intended for cross-country scored comparisons, there are simply no other tools available to provide systematic assessment of these plans. This line of inquiry raises important questions about the NSP process and its adaptability to current global demands. Should there be a more uniform or strategic scoring of NSPs? Are we past the point where simply creating this document is sufficient? How are we able to tell whether or not the resources have been allocated well? Should an outside organization conduct independent assessment? How can we envision a more stringent scoring system?

There are several limitations to a study such as this. To begin, certain countries' (such as Malawi) expenditure data are noted to be preliminary by UNAIDS. These numbers may not include information on all of the major global donors. Additionally, as countries revise and release new strategic documents, the denominators of this analysis may change, potentially affecting even the small focus group of 7 countries. UNAIDS provided most strategic documents upon which this analysis focuses; an assumption is implicit on the exhaustive nature of this dataset. As mentioned above, the SAT is not intended for cross-country comparison. Furthermore, the detailed nature of the guidelines/criteria in the SAT makes it difficult to assign an exact value in this type of assessment. Situations in which a document meets one of many elements set forth by a category's criterion present complications in teasing out the best value for the document's score. There is a clear need for more refined assessment tools specifically for NSP review across multiple countries.

Looking ahead: Improving NSPs in the long term

Prerequisites for costed and prioritized plans

The ideal source data for costed NSPs is robust, local unit costs. An active, stable, and comprehensive financial system that is integrated with development partners is necessary to monitor spending. Tracked expenditures and complete NASA data serve to inform progress under a national response across the years. Achieving costed and prioritized NSPs will be made possible by support to overall strategic planning in the following ways: requests for and incorporation of ASAP technical assistance with NSP process; periodic midterm review of NSP; supplementary country-level impact studies to inform all programmatic areas of NSP process; and adequate and prior funding for robust M&E to inform these areas. Governments and donors should support the improvement of country-specific unit cost/cost-effectiveness data as well as continued development of tools and resources to facilitate costing and resource allocation scenario exercises.

With respect to prioritization among interventions in NSPs, explicit and substantiated prioritization processes are critical for such an important document as the NSP. Accurate, recent epidemiological data about the sources of the last 1000 infections in a country will illustrate the key drivers of each country's epidemic. This information must be incorporated into the prioritization of interventions. Modeling of and attention toward various funding scenarios and resource allocation scenarios (such as the Goals model can provide) will only strengthen the decisions made as part of the strategic planning process. Improved accessibility and uptake of technical support and tools for this type of modeling will help all countries.

Donor requirements

The global health funding landscape has undergone a recent shift from an emphasis on individual projects to a focus on broader program funding (ASAP 2005). New Global Fund application guidelines require costed national strategic plans, offering considerable motivation for countries to conduct costing exercises in the near future. Appeal panel reports from the Global Fund indicate shortcomings related to costing and prioritization among numerous applications. Technical review and assistance often accompanies the appeal process for denied or delayed funding, helping countries improve these areas of strategic planning. There is reason to believe that the presence or absence of costing in national plans will be less of an issue moving forward. The quality of the costing methodologies informing national plans as well as the patterns of resource allocation for interventions to be funded may become two salient issues for national strategic documents in the long term. Under the reauthorization of PEPFAR, country compact agreements will be implemented beginning in FY08 and FY09. While the country compact agreements will not legally bind any parties, they are meant to coordinate major actors and facilitate collaboration, improve efficiency, and avoid duplicate data collection or service provision.

Disincentives for costed plans

As the OED review discusses, the problem is "that priorities are not discussed clearly and up-front, but left to the budgeting and implementation stages. Perhaps this ambiguity is necessary for political reasons, leaving tradeoffs between the desires of different stakeholders to the future or to negotiations over budget allocations. The participatory NSP process in most countries runs the risk of resulting in a plan that proposes to support "everything and the kitchen sink." However, this lack of transparency in prioritization undermines the main point of doing strategic planning at all, and is the major weakness of most of these national plans. The practical effect is likely that prioritizing is left to more detailed sectoral plans, and perhaps eventually to the budgeting and implementation of projects such as those in the Africa MAP (Mullen 2005). The Africa MAP documents, however, show that prioritization between areas of intervention is not explicitly discussed, but only reflected in budget allocation (Mullen 2005). Similarly, the ASAP background note indicates that most countries score poorly when assessed for prioritization in their national strategic plans (ASAP 2005). Swaziland 2006-2008 NSP is among the poorest scored in their review because it presents no evidence of prioritization of objectives or strategies. It lacks a strong understanding of the drivers of the epidemic, and it does not prioritize or sequence actions to be taken (ASAP 2005).

Lack of costing in NSPs can be exacerbated by data limitations with respect to unit costs and cost-effectiveness figures. Use of a range of unit costs based on various "best estimates" (as opposed to actual data or validated information) is less preferable than using international best estimates or country-specific unit cost data. A lack of assessment of current HIV/AIDS spending is also problematic, whether it pertains to spending in the country overall or spending by donors. The absence of a strong financial management system for HIV funding or failure to track HIV expenditures is less than ideal. Expenditure tracking should be transparent and efficient so as not to delay program implementation. Finally, a costed national strategic plan should include sufficient resources for the management and coordination of the plan. A sufficient budget for hiring, retention and staffing of all actors at all levels

of the national responses should be included (ASAP SAT Guidelines). Arbitrary resource allocation decisions, unsupported by evidence or empirical process, will also leave a country's NSP open to criticism. Particularly in concentrated epidemics, insufficient data about or funding towards MARPs is unacceptable. Knowledge of the recent drivers of the epidemic will be critical in terms of narrowing a list of all possible interventions from a comprehensive response into a tailored response comprised of prioritized strategies.

Key Messages

We note a common set of shortcomings among the plans that score lowest in this analysis: poor data/surveillance systems (both epidemiological and cost-related); vague language and objectives in national strategic plans; lack of technical assistance or capacity with strategic planning process; funding gaps creating such a wide range of costs/expenditures per capita and per infection; unsupportive policy environment towards MARPs; insufficient allocation towards MARPs or drivers of the epidemic; lack of analysis of results of the national response to date (no circular flow of information from NSP cycle to cycle); adherence to global indicators or indicators for another type of epidemic; and lack of expenditure tracking.

In order to meet the ASAP guidelines with respect to costing and prioritization, we recommend that all countries:

1. DEVELOP FUNCTIONAL AND TRANSPARENT NATIONAL FINANCIAL SYSTEMS: Delivery and monitoring of funds is critical for program success; integration among all national actors is crucial.

2. TRACK, REPORT AND SHARE FULL COST AND FINANCING DATA: Data must be available to UNAIDS, country planners, and the general public in order to ensure transparency and accountability. Country-level unit costs, cost-effectiveness studies and related information must be calculated and must inform the costing of national strategic plans.

3. CONDUCT SELF-ASSESSMENT AND IMPACT STUDIES AT THE COUNTRY LEVEL: At least one self-assessment per strategic planning cycle would be ideal, and countries should strive to score higher than 0 in each category of the ASAP SAT; complementary economic and/or demographic impact studies of various interventions and scenarios will strengthen the NSP process as well as overall implementation.

This paper also aims to encourage a long-term and innovative perspective on current challenges in HIV/AIDS costs and financing. Beyond the basic level of progress toward ASAP guidelines, we also propose that countries and donors:

4. PROPOSE AND DELIVER FUNDING FOR MOST-AT-RISK POPULATIONS: In concentrated epidemics, this will involved CSW, MSM and IDU; in other epidemics, the known, recent drivers of the epidemic must receive adequate funding in order to expect a downward trend in incidence. Mention of epidemiological data in the NSP is inadequate; expenditures must also be reported towards these groups.

5. DEVELOP MORE SPECIFIC ASAP GUIDELINES: ASAP is leading the way in terms of technical assistance to national strategic planners, but their guidelines should be expanded to emphasize cost-effectiveness throughout the strategic planning process. ASAP materials and consultations should give clear guidance on concrete ways countries can relate spending to outcomes.

6. CREATE A REFINED, INTEGRATED SYSTEM FOR ASSESSING NSPS AND EXPENDITURES: An international assessment system to link strategic plans with expenditure data and outcomes. All countries should have NSPs and expenditures assessed by a reliable, accountable independent body.

7. SET AND ACHIEVE RIGOROUS TARGETS FOR IMPROVED NSP PROCESSES: To accelerate progress with respect to strategic planning, the top 15 countries in terms of national prevalence and the top 15 countries ranked by Resource Needs Estimate should work to meet every ASAP guideline for NSP within the next generation/iteration of strategic planning. Donors, UNAIDS, and country planners should support these targets before 2015.

Conclusion

Numerous resources exist to improve national strategic planning processes, and the challenge will be for each country to incorporate these resources quickly and effectively. The World Bank ASAP group lists 22 available tools in its first business plan document (ASAP 2005). Of these tools, several contain content specific to prioritization and/or costing. UNAIDS is organizing a shared database called CoATS to track international technical support and indicators for national responses. International donors could play an important role in continuing to set forth incentives to increase country demand for strategic planning assistance. Perhaps a reward structure or additional financing could be offered to countries that commit to consistent self-assessment or demonstrate high-quality national analyses of their strategic planning and resource allocation processes.

Among costed current generation NSPs, use of modeling and cost-effectiveness data is only present in a minority of national plans. It is clear, however, that this type of evidence base strengthens the NSP document and hopefully, by extension, the overall coordination and implementation of the national response. Donors should support projects involving technical assistance and/or capacity building, country-specific (or regional) cost-effectiveness studies/data collection, and cost modeling exercises. If countries adopt the measures and recommendations herein, it is completely feasible for NSPs to be consistent with ASAP guidelines within the next 5-7 years.

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Appendix A: NSP Scoring Based on ASAP SAT Guidelines by Country

Key: 0 = No/Not at all/Does not exist/Not applicable

1 = To some limited extent

2 = Reasonable, but could still be improved

3 = Yes, sufficient

Costing Section							
	Botswana 2003-2009	**Cameroon 2006-2010**	**Cote d'Ivoire 2006-2010**	**Malawi 2005-2009**	**Mozambique 2004-2008**	**Peru 2007-2011**	**Philippines 2005-2010**
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	3	0	0	0	0	0	1
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	2	1	0	0	0	1	0
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	1	0	1	0	0	0	0
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	3	2	2	2	2	2	2
COSTING SUBTOTAL:	**9**	**3**	**3**	**2**	**2**	**3**	**3**

Appendix A: NSP Scoring Based on ASAP SAT Guidelines by Country

Prioritization Section							
	Botswana 2003-2009	**Cameroon 2006-2010**	**Cote d'Ivoire 2006-2010**	**Malawi 2005-2009**	**Mozambique 2004-2008**	**Peru 2007-2011**	**Philippines 2005-2010**
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	2	3	2	2	1	2	3
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.	2	0	0	0	1	2	1
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	3	1	1	1	2	3	2
Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	3	1	0	0	1	2	2
Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	3	3	2	2	1	2	3

Prioritization Section							
	Botswana 2003-2009	**Cameroon 2006-2010**	**Cote d'Ivoire 2006-2010**	**Malawi 2005-2009**	**Mozambique 2004-2008**	**Peru 2007-2011**	**Philippines 2005-2010**
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	3	3	2	2	1	2	1
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	3	2	2	2	1	1	1
PRIORITIZATION SUBTOTAL	**19**	**13**	**9**	**9**	**8**	**14**	**13**
TOTAL (out of 33):	**28**	**16**	**12**	**11**	**10**	**17**	**16**

Appendix B: Summary of NSP Assessments by Country

BOTSWANA 2003-2009

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	Yes: Cost data obtained from ongoing programs in-country; where data unavailable, unit costs from interventions from other countries were used (94).
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	Present costs do not reflect the necessary programs or resource allocation to meet the goals of the national response, so Goals modeling was conducted to estimate the costs needed to meet national goals in the areas of prevention, treatment, support and mitigation and management (94). (Goals Model Version 2.0 in December 2001 by Futures Group) [Note: A 2006 NASA exists but was not incorporated into the NSP]
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No: Plan acknowledges the limited capacity of the present financial management system to ensure effective resource allocation and fund disbursement to all levels of the national response (95). Variation occurs across all levels with respect to funding proposals from different organizations or institutions (95). Separate proposal submission, review, approval and funding channels exist based on applicant type, amount of funding requested, and type of funder (95-96). Domestic variation is exacerbated by separate systems used by development partners for allocating, disbursing and reporting (95).
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes: Section 12: Resource Requirements (91-96) has costing information for entire plan. Resource envelopes correspond to each objective of the plan. Figures distinguish between proposed government spending and development partner spending. Annex (97-101) has detailed costs for each goal of the national response. Costs include management (including M&E, capacity building, coordination and policy) in all areas of the national response (94). Roles and responsibilities of NGOs are described in Section 8, but no costs are given (68).
OTHER COSTING NOTES	This NSF is the first time a costing exercise of this magnitude has been conducted in Botswana (91).
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	Yes, to a moderate extent: Prevalence details and key determinants of risk for HIV infection are presented (15). The plan prioritizes 6 vague subpopulations (youth, women, orphans, poor, mobile populations, PLWHA) but also calls for a phased approach based on relative priority. Each of the groups will undergo a detailed segmentation allowing for better prioritization and precisely targeted interventions. This will permit a prioritization of implementers based on comparative advantage addressing each segmented group (17).
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most	Cost-effectiveness underlies the shift from an emphasis on care and treatment to an emphasis on prevention as the key goal (94-95). Modeling exercises involved application of Goals model to assess the impact and costs of different intervention scenarios (94).

cost-effective.	
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	Yes, clearly.
Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	Yes, use of Goals model to inform planning process is systematic (94).
Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	Costs are based on and align with the 5 goals of the national response (98-101).
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	Yes, and the plan is clear about the missing data, inaccurate data, or best estimates, particularly for certain programs still in the proposal development stages (91) such as prevention programs and those dealing with the legal and ethical environment.
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	Yes, to a moderate extent: states a goal of no new infections by 2009 as ambitious but possible through revised resource allocation (91).

Appendix B: Summary of NSP Assessments by Country

CAMEROON 2006-2010

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	No: it is unclear how cost estimates were derived.
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	No: different funding sources for the health sector overall are mentioned, but the amounts or shares are not given (6).
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No expenditure tracking is mentioned. Global Fund's presence and activity are mentioned, but no accounting details are presented.
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes, the plan is costed for each year of the plan and for each strategy (Annex). It is unclear how or if the staff costs and NGO activities are built into the line items of the budget/cost estimates.
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	Yes, to a moderate extent: the plan presents epidemiologic surveillance data describing the feminization of the epidemic, the increasing rates among young age groups, trends in behavior, attitudes, knowledge (12) and the country's high-risk groups (12-16).
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.	No.
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	Yes, although the process is implicit and could use further explanation.
Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	Yes, to a moderate extent.

Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	Yes, the costed plan matches the strategic priorities (Annex).
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	Yes.
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	Yes, to a moderate extent: The responsible parties for implementation are not clearly set forth for all of the strategies (Annex).

Appendix B: Summary of NSP Assessments by Country

COTE D'IVOIRE 2006-2010

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	No: there is no mention of country-specific or international unit costs.
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	No: there is no evidence of a recent spending analysis. Expenditure tracking is listed as an objective (Annex) for the financing component of the NSP, as is a balancing of expenditures with planned expenses.
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No: issues of fragmentation in the financial system are described. The plan states it shall be a priority to align and harmonize all actors and financing systems as well as to promote data sharing among all actors.
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes, the plan has been costed, but the staff costs and NGO activities are unclear.
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	Yes, to a moderate extent: the plan has detailed sero-surveillance information and mentions national tracking (18-25); 4 high-risk groups are listed (25). However, the long list of 10 DAP (Priority Action Areas) may reflect a lack of prioritization (31-34). 15 subpopulations are listed as priority targets for intervention.
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.	It is not clear whether or not cost-effectiveness informed the prioritization. 58 references were consulted/used in the drafting of the NSP, but the connection to cost-effectiveness was not made explicit in the document (134).
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	Yes, to a moderate extent.
Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	No, the resource allocation is not described in this way.

Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	Yes, to a limited extent: the strategies contained in the plan do not align directly with the actual costing breakdown (79).
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	Yes, to a moderate extent: costs are presented, but the likely sources of funding are not. The amounts of necessary funding are listed, and the funding gap is described as a percentage of the total cost of the plan. No scenarios for full or partial funding are given, nor is a plan to close the funding gap.
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	Yes, to a moderate extent: the plan sets forth a long list of activities (DAP details), but the responsible agencies are listed (page 36 on).

Appendix B: Summary of NSP Assessments by Country

MALAWI 2005-2009

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	It is not clear if country-specific unit costs were incorporated in this plan. The previous NSP mentions a need to clarify true costs for country-specific interventions (15).
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	There is limited information on historical spending analysis. This very objective is set forth (in Annexes) for future years of the NSP.
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No: shortcomings are described regarding resource mobilization and utilization (39). The FMA system reports indicate partial or limited tracking of fund disbursement across all types of actors (Page 10 of Annex 2). The use of the financial system by development partners and the harmonization of actors are not described in detail.
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes, the plan has been costed, but the details do not not include NGO implementation activities. Cost summary is in the main document (39); Annexes 2, 3 and 4 provide annual proposed costs and current financing.
OTHER COSTING NOTES	The main text of the plan indicates that Annex A and Annex B are costed in detail, but these documents are not available/were not included in the documents supplied by UNAIDS for this paper.
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	Yes, to a moderate extent: a breakdown of the modes of transmission is given (4) along with geographic and sociodemographic indicators on the epidemic (4). However, the list of eight priority program areas unfolds into even-longer lists of strategies and vague targets (16-56).
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.	No.
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	The plan has a very long list of priority areas, strategies and objectives; these objectives are vague and unspecific (Sections 4-10).

Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	It is not clear that resources were allocated according to this criteria.
Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	Yes, to a moderate extent (Annex 2/page 13).
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	Yes: a summary of costs (39) is given. Annexes 2, 3 and 4 set forth additional costs and financing information for the period of time covered by this NSP.
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	Yes, lead government agencies for implementation are identified in the Annexes.

Appendix B: Summary of NSP Assessments by Country

MOZAMBIQUE 2004-2008

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	No, to a limited extent only: Few country-specific unit cost data exist given the situation in the country (88). Estimates of costs per year are given, but do not link to the operational plan/actual budget (88).
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	No, to a limited extent only: Health sector expenditures in 2002 and the effect of implementing the NSP are discussed briefly (23). [Note: a NASA available for Mozambique was published in January 2008. This NASA covers the period 2004-2006, after this NSP written]
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No: improvements to the financial management system are described as objectives throughout the plan in anticipation of increased amounts of funding entering the country (31). A need for harmonization among all actors is stated (71).
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes, to some extent (88), although specific costs for NGOs are not given in the document.
OTHER COSTING NOTES	Document says Annex 10 sets forth methodology of costing, but it is not attached to the file. The bottom of page 88 has other per capita costs and guidelines referenced.
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	To a limited extent: the plan has a lengthy list of objectives and strategies throughout. The data includes a geographic/provincial breakdown of potential demand and projected infections over the course of the NSP (20-21).
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.	Yes, to a moderate extent: cost-efficiency criteria are mentioned (6) in selection of interventions (11). A review of cost-efficiency is mentioned (11) briefly, but the details of this prioritization process could be more explicit in the document.
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	To a limited extent: The plan gives consideration to the geographic spread of potential future demand for HIV/AIDS services combined with potential supply from health sector (20-22). Future intentions to use equity criteria for prioritization are mentioned.

Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	Yes, to a moderate extent: the effects of selected interventions in combination are mentioned to be greater than those if interventions are implemented individually (6). Costing and allocation were not done at the earliest stage of planning process, however, and will need to be integrated with the broader health sector objectives (62).
Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	To a limited extent: There are both links and inconsistencies between the plan's strategies, each strategy's sub-objectives, and the line items in the total costed NSP (88; Section V).
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	The plan is costed (88) according to 18 interventions. The plan anticipates a funding gap and how this would change the combination of interventions selected, but does not go into further detail about the specifics of various scenarios (89).
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	To a limited extent: Details of implementation and the responsible actors are not spelled out (88).
OTHER PRIORITIZATION NOTES	The NSP mentions a document drafted later (the Operational Plan) which contains more detail about quantifiable targets, etc.

Appendix B: Summary of NSP Assessments by Country

PERU 2007-2011

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	No.
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	No, to a limited extent only: the plan includes general national details on insurance coverage, public health expenditures, financing gaps, etc (18-19). 25% of health financing is covered by the state, 33.5% covered by employers, and 36.9% out of pocket by households (PAHO numbers) (19). No detailed HIV spending data is available for any years after 2000 (44).
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No: the plan states that the Global Fund and other partners contribute to fragmentation of the national response across different sectors (15). No explicit mention is made of the financial system, aside from repeated references to the Global Fund country coordinating mechanism. HIV expenditures are not tracked.
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes, the plan has been costed to a moderate extent: Section 5.4 has proposed estimated costs for 2007-2011 for each of the 9 strategic objectives (67). For the year 2007, each strategic objective is disaggregated into detailed line items (69-73). The plan says the responsibilities of various actors are yet to be delineated clearly (52). It is unclear if staff costs are built in throughout the plan, but it appears that some of the strategic objectives include human resources (Annex).
OTHER COSTING NOTES	The 2001-2004 NSP was never approved, so funding for its implementation was never approved (15). Global Fund is implementing/financing programs in the country now (15).
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	Plan identifies a concentrated epidemic (14), high-risk populations and geographic areas (19-20). Sentinel surveillance studies have taken place for years among MSM (23), CSW (24) and their clients (24-25), and pregnant women (25). The plan does not explicitly prioritize subpopulations, but it does list the riskiest ones.
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most	Yes, to a moderate extent, but it could be clearer in its links between cost-effectiveness and the decisions behind the prioritized interventions. Cost effectiveness and evidence in the literature are mentioned with respect to VCT (47), interventions

cost-effective.	with CSWs (48), treatment of STIs (48), etc (49-50).
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	Yes, the concentrated epidemic and its implocations are discussed throughout. The plan includes discussion of balancing cost-effectiveness with human/social concerns of provision of ART for PMTCT (48-49).
Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	Yes, resources are allocated across objective strategies and by year, although the process by which this was done could be discussed more explicitly (Annexes).
Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	Yes, the prioritized interventions and the costing of plan link clearly to the 9 objective strategies.
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	Funding gaps are described/anticipated throughout; Sources and amounts (76) presented for 2007 only; Funding gaps presented for 2007, disaggregated by strategic objective (77). Certain line items within the strategic objectives mention lack of identified funding (60, example).
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	Yes, to a moderate extent: the list of activities seems manageable and ambitious, but the parties responsible for implementation are not discussed (Annexes).
OTHER PRIORITIZATION NOTES	Details on NGOs are mostly retrospective (41-44).

Appendix B: Summary of NSP Assessments by Country

PHILIPPINES 2005-2010

COSTING	
Uses actual country-specific unit cost data, or, if such data were not available, international estimates were used and validated based on discussions with implementers.	The plan does not clearly describe how cost estimates were derived in the Part 3 Indicative Resource Requirements (37).
Reflects a recent, comprehensive analysis of HIV spending in the country, which includes spending by national organizations, local organizations and out-of-pocket spending by individuals or households.	No. The plan mentions briefly that care and treatment financing is primarily reliant on donations and out of pocket payments by PLWHAs (12).
Indicates a fully transparent financial system is in place that can track and report HIV spending, and enables spending to be disaggregated so as to monitor unit costs of various services or HIV/AIDS programs; the financial system is used by development partners and enables money to be spent without delays and ensures that it is spent in the ways and for the purposes intended	No.
Has been costed and includes staff costs appropriately, as well as costs for activities to be implemented by non-governmental groups	Yes, to a limited extent: PNAC has limited staffing and inadequate financial resources to coordinate the national response (14). Part 3 of the plan, Indicative Resource Requirements, has costs for each of the 5 key strategies across the 6 years of the plan with line items for the KRAs (Key Resource Activities) (37).
OTHER COSTING NOTES	Document also includes a Resource Requirement Plan and a 1-year Operational Plan for the first time in the country's NSP history.
PRIORITIZATION	
Includes a careful analysis of the epidemic and subpopulations where most new infections are occurring as well as a final list of prioritized groups that is manageable (e.g., does not present more than 5 target subpopulations).	Yes: the epidemiologic details include demographics of recent infections, key subpopulations, and high-risk groups (7-8). 3 high-risk priority groups are set forth (18); 4 objectives for the national response and 5 key strategies for achieving these goals are described (18-19).
Demonstrates cost-effectiveness was a key factor in selecting the interventions to prioritize and that the planning committee reviewed the literature and/or conducted a modeling exercise to determine which interventions would be most cost-effective.	No, to a limited extent only. The plan mentions that procurement of drugs must be organized in a cost-effective and efficient manner, meaning centrally through the DOH (33). The plan mentions that IECs have room for improvement in terms of their cost-effectiveness, but does not provide numbers (10).
Results from a process that used issues of equity and vulnerability as key factors in choosing priorities, targets and interventions.	Yes, to a moderate extent: the plan has criteria for ranking certain areas of the country according to degree of risk for HIV (41). It has quantifiable and measurable (although somewhat vague) targets linked to each of the 5 key strategies of the national response (51-53).

Allocates resources in the costing of the plan at an early stage of the planning process and in a systematic way; HIV prevalence, treatment, care and mitigation needs, other program needs, costs of interventions, synergies across different strategic components were all considered before an appropriate allocation of resources was finalized.	Yes, to a moderate extent, but the details of this resource allocation could be more explicit within the plan. Key strategy #4 has no costs associated with it, as it will be addressed by the money allocated to the other 4 strategies (37).
Addresses inconsistencies between strategic priorities and the costed strategic plan such that the resource allocation matches the identified priorities.	Yes: priority activities are those strategies which directly link to the 5 key strategies, which in turn support the objectives of the national response (37; 30).
Presents costs, likely sources and amounts of funding, and various scenarios for full or partial funding; a clear plan is included for identification of additional funding to close a funding gap.	No: only the costs (semi-detailed) are presented. No funding sources or scenarios are discussed under resource mobilization.
Has a list of activities that is manageable and sufficiently ambitious, with clear indication of the parties responsible for implementation (ASAP SAT Guidelines).	Yes, to a moderate extent.
OTHER PRIORITIZATION NOTES	"The current response has been adequate in programmatic scope, but inadequate in terms of coverage. This is especially true with IEC. A national communication plan exists but this has not been utilized such that there remain many missed opportunities in improving their overall cost effectiveness. A number of IEC initiatives have been undertaken but evaluating the effectiveness of these initiatives to help in further sharpening key messages and identifying the most cost-effective media mix has not been consistently pursued" (10).
NOTES	The plan covers many important points for the national response, but it is very vague on the process by which these priorities were set.

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