

Smart Investments

**INVESTMENT CASES ACCELERATE
TRANSFORMATION**

**SMART INVESTMENTS RESPOND TO SPECIFIC
EPIDEMICS AND YIELD HIGH RETURNS**

**THE INVESTMENT APPROACH FOSTERS
INNOVATION**

**INVESTMENT CASES REFLECT AND PROMOTE
SHARED RESPONSIBILITY**

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INVESTMENT CASES ACCELERATE TRANSFORMATION

Investment cases promote the scaling up of optimally effective, rights-based responses that enhance equity and inclusiveness and overcome barriers for the populations most in need of services.

SMART INVESTMENTS RESPOND TO SPECIFIC EPIDEMICS AND YIELD HIGH RETURNS

Countries are focusing investments on high-burden regions and populations and optimizing the mix and coverage of interventions to maximize impact.

THE INVESTMENT APPROACH FOSTERS INNOVATION

Countries are leveraging the investment approach to reduce commodity costs, alter delivery systems, integrate services and decrease overhead expenses.

INVESTMENT CASES REFLECT AND PROMOTE SHARED RESPONSIBILITY

Countries are exploring new funding mechanisms, mobilizing additional resources and bolstering domestic contributions to ensure more sustainable funding and achieve shared responsibility.

MAKING THE CASE: SUSTAINABLE INVESTMENTS TO END AIDS

The HIV epidemic is a long-term challenge that requires a sustainable response. While in the past decade major gains have been made in reducing the number of new HIV infections and preventing deaths from AIDS-related causes, progress has not been evenly shared among those affected by HIV. With 2.3 million people newly infected by HIV and 1.6 million people dying from AIDS-related causes in 2012 alone, much work remains to lay the foundation to end the AIDS epidemic (1).

Recognising the need to rethink the approach to investments in HIV, UNAIDS joined with partners in 2011 to outline a new investment approach (2). UNAIDS subsequently developed guidance for countries to develop national HIV investment cases (3).

HIV investment cases provide an important vehicle for countries to deliver strategic, rights-based, sustainable responses to HIV. The process of developing investment cases provides countries with new opportunities to explore options for innovative funding and service delivery, to identify specific steps to enhance equity and inclusiveness for key populations, to use available evidence to understand better the health and economic benefits of timely, rights-based, smart HIV investments and to eliminate inefficiency in HIV programmes.

In addition to helping countries with resource allocation and financing decisions, investment cases can support countries in their dialogue with international partners. Reflecting the momentum of change initiated by the HIV investment cases, the New Funding Model of the Global Fund to Fight AIDS, Tuberculosis and Malaria requires that countries articulate the strategic investment thinking underpinning their funding requests. In removing the uncertainty around available funding, the New Funding Model is shifting countries' focus to ensuring that they are able to use the funding allocations optimally. The defining elements of the investment cases - linking investments with impact, and using empirical evidence and modelling to identify gaps - provide the platform for countries to develop a concept note and to support the dialogue process that is central to the New Funding Model (4). The cases can also serve as a starting point for developing partnership frameworks and sustainability plans for the United States President's Emergency Plan for AIDS Relief (PEPFAR) (5).

INVESTMENT CASES ACCELERATE TRANSFORMATION.

Investment cases promote the scale up of optimally effective, rights-based responses, enhance equity and inclusiveness and overcome barriers for populations most in need of services.

More than 30 countries plan to develop an investment case over the next two years. This report highlights examples from 14 countries that have begun to reshape their response in accordance with investment principles. It provides a snapshot of progress, lessons learned and challenges in implementing the investment approach. The data-based projections of health and economic gains from an investment approach it describes underscore the fundamental message of national investment cases – that countries can make important gains if they invest wisely.

What is an investment approach? What is an investment case?

An investment approach:

- Maximizes the returns of investment in the HIV response
- Allocates resources towards combinations of interventions that will achieve the greatest impact
- Enhances equity and impact by focusing efforts on key locations and populations with the greatest needs
- Improves the efficiency of HIV prevention, treatment, care and support programmes
- Uses empirical evidence and modelling to identify priorities and gaps
- Enables countries to secure sustainable funding for HIV programmes
- Provides the framework to align government domestic funding strategies for the medium and long term with donor-supported efforts

An investment case:

- Is an instrument for strategic decision-making around resource allocation, resource mobilization, service delivery and funding
- Can be articulated in a variety of forms, based on countries' specific contexts and needs
- Is a means of demonstrating national leadership in the response
- Unites diverse stakeholders including Ministries of Finance, Health, Development and Planning; Civil Society; people living with HIV; and international partners
- Articulates a common effort to identify programmatic gaps and bottlenecks and to create a roadmap for action
- Is sometimes different from a national strategic plan, which often includes an extensive and aspirational articulation of needs and is constrained by set time-frames

FIGURE 1

Making the case for HIV investments

Key steps in developing an investment case

➤ Understand

National responses need to be grounded in thorough understanding of the past and current epidemic and response. Countries comprehensively analyze epidemiological data, assess inclusiveness, equity and structural obstacles to the uptake of services, use evidence-informed methods to project how the epidemic is likely to change and assess current programmatic efforts, content, coverage and resource allocation. This review identifies key locations and populations with the greatest HIV burden and the greatest unmet needs for HIV services.

➤ Design

Building on a robust analysis to “know your epidemic, know your response”, countries select the combination of interventions that are likely to have the greatest effects on their epidemic. Modelling and other tools are used to estimate the effect of this combination on the number of people acquiring HIV infection and the number of people dying from AIDS-related causes, and agreement is reached on approaches that will be given higher and lower priority.

➤ Deliver

Investment cases use evidence-informed strategies to estimate both the future costs of the HIV response and the net efficiency to be generated. They identify and address bottlenecks to effectively implementing and scaling up programmes intended to achieve equity among those most affected by HIV, including stigma and discrimination. Comparing current commodity prices to international prices, countries develop strategies to minimize commodity procurement costs, maximize programme efficiency and revise delivery methods.

➤ Sustain

Based on estimates of the total optimized investment needed to accelerate the response towards the end of AIDS, the investment case provides a vehicle for identifying new sources of domestic funding and proposes plans to mobilize new resources.

Source: Investing for results. Results for people: a people-centred investment tool towards ending AIDS. Geneva: UNAIDS; 2012.

INVESTING RESOURCES STRATEGICALLY FOR GREATER IMPACT

A growing number of countries are using investment approaches to allocate resources in ways that enhance the impact of national responses – averting new HIV infections, saving more lives and avoiding significant treatment costs over time.

USING A GEOGRAPHICAL APPROACH TO SET PRIORITIES FOR INVESTMENTS

Increasing evidence shows that patterns of new HIV infections, HIV burden, and availability and access to services vary considerably within countries. In order to improve service coverage and return on investment, several countries have taken steps to focus services and resources in locations where most new HIV infections occur and where need is greatest.

- **Kenya.** The country's investment case responds to a comprehensive analysis of the epidemiological context and current resource allocation. One important feature of Kenya's investment case is its focus on programmatic choice and optimal resource allocation in the nine counties that account for 54% of new HIV infections (6).

FIGURE 2

Kenya proposes to focus HIV investments in the counties where need is greatest
Using a geographical approach to prioritize HIV investments in Kenya



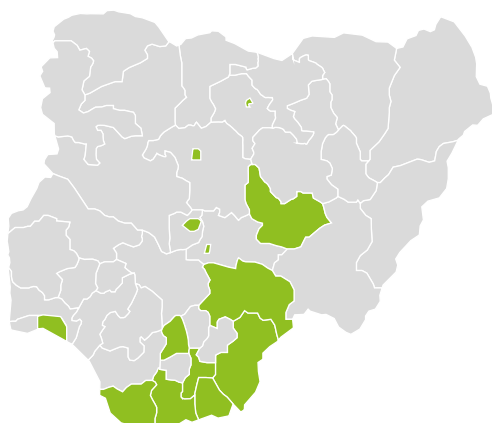
54%
of new HIV infections
in Kenya occur
in 9 counties

Source: Kenya HIV investment case summary. Nairobi: Government of Kenya; 2013.

- **Nigeria.** Seventy percent of new HIV infections in Nigeria occur in 12 of its 36 states and the Federal Capital Territory. Nigeria aims to accelerate the scale up of four key programmes in these locations including: combination HIV prevention among key populations and young people, HIV testing and counselling, preventing new infections in children, and HIV treatment (7).

FIGURE 3

Nigeria proposes to focus HIV investments in the states where need is greatest
Using a geographical approach to prioritize HIV investments in Nigeria



70%

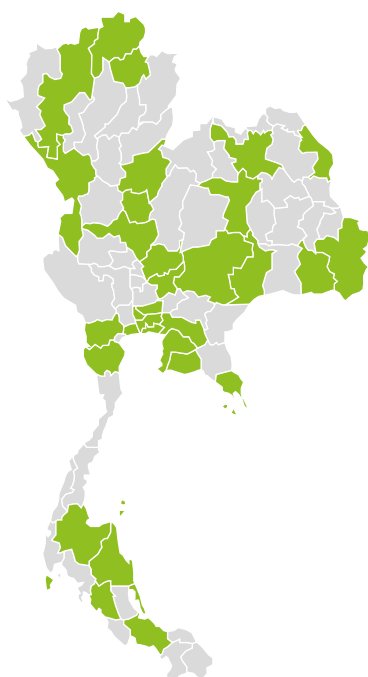
of new HIV infections in Nigeria occur in 12 states and the Federal Capital Territory

Source: President's Comprehensive Response Plan for HIV/AIDS in Nigeria 2013–2015. Lagos: National Agency for the Control of AIDS; 2013.

- **Thailand.** Aiming to be one of the first countries in Asia to end its AIDS epidemic, Thailand intends to scale up combination HIV prevention services for key populations. This includes the strategic use of antiretroviral medicines, with enhanced focus on the 33 of 76 provinces that account for 70% of new HIV infections (8).

FIGURE 4

Thailand proposes to focus HIV investments in the provinces where need is greatest
Using a geographical approach to prioritize HIV investments in Thailand



70%

of new HIV infections in Thailand occur in 33 provinces

Source: National AIDS Management Center. Ending AIDS in Thailand. Bangkok: Ministry of Public Health, Thailand; 2013.

Many countries are making progress in strengthening strategic information at subnational levels: the provincial or state level, district or county level and even subdistrict level. Efforts are also increasing to improve strategic information around key populations. Robust subnational data on epidemiological trends, service coverage, the nature of structural barriers to service uptake, cost of services and resources available are essential to using a geographical approach to set priorities for investments in the locations with the greatest need.

FOCUSED INVESTMENTS ON POPULATIONS WITH THE GREATEST NEED

In addition to geographical variation, the burden of HIV and availability and access to services also differs between populations. Female sex workers are estimated to be 13.5 times more likely to be living with HIV than other women of reproductive age in low and middle-income countries (9,11). The prevalence of HIV among men who have sex with men is 13-19 times higher than among the general population (10,11). The HIV prevalence among people who inject drugs is at least 22 times higher than in the population as a whole in 49 countries with available data (11).

Despite the need to give priority to services for key populations, efforts to address the HIV-related needs of key populations remain severely underfunded. Increasingly, however, countries are using an investment approach to strengthen evidence and rights-based programming for populations whose needs have not been effectively addressed. Focusing resources where they are most needed maximizes the returns on investment.

SMART INVESTMENTS RESPOND TO SPECIFIC EPIDEMICS AND YIELD HIGH RETURNS.

Countries are focusing investments on high-burden regions and populations and optimizing the mix and coverage of interventions to maximize impact.

- **Jamaica.** Although transmission among men who have sex with men and sex workers is a key factor in the country's HIV epidemic, the country allocated only 1.4% of HIV spending in 2010–2011 to programmes focused on these key populations. Using comparative cost-effectiveness to inform its planning for 2012 to 2016, Jamaica is increasing the proportion of HIV resources allocated to programming for men who have sex with men and sex workers to 6.4% (12).
- **Mauritius.** In 2013, an estimated 36% of new HIV infections were among men who have sex with men, 44% among people who inject drugs and 7% among clients of sex workers. Although the epidemic among people who inject drugs has stabilized, the prevalence of HIV among men who have sex with men rose from 8% in 2010 to 20% in 2012. While 56% of the resources for HIV prevention were allocated to harm reduction for people who inject drugs and 15% for the general population, only 2% of HIV prevention resources were spent on programmes for men who have sex with men and 2% on sex workers. Mauritius is now developing an investment case that focuses on increasing resource allocation to programmes for men who have sex with men and sex workers. It will also address the need to improve quality and scale of the harm reduction programmes for people who inject drugs and programmes to eliminate stigma and discrimination.

- **Nepal.** Based on an investment analysis, Nepal is reallocating resources to scale up services for key populations with the highest prevalence of HIV infection. Priority populations include female sex workers who inject drugs, street-based sex workers, transgender sex workers and male sex workers. Through strategic resource allocation, the Nepal HIV Investment Plan 2014–2016 (13) aims to achieve at least 80% service coverage for each of the priority populations. Between now and 2016, the plan calls for a tripling of funding for HIV prevention programmes for male sex workers, a doubling of investment on HIV prevention programmes for transgender sex workers, a 60% increase in funding for prevention programmes for female sex workers who inject drugs and sustaining current levels of funding for prevention programmes for street-based female sex workers and people who inject drugs (13).

An increasing number of countries have given higher priority to their HIV response to key populations. Political commitment and the presence of a legal and policy environment that focuses on reducing discrimination, increasing access to justice and changing harmful gender norms are essential to improving access to prevention, treatment, care and support services for the populations most affected by HIV. While data on the coverage of services for key populations and their costs is critical, participation of key populations in discussions around the use of epidemiological data and decisions to expand coverage is central to scaling up services effectively for the populations most severely affected by HIV.

Increasing funding for programmes for young women and girls

In sub-Saharan Africa, young women and girls are more than twice as likely to be living with HIV as young men and boys (1). In Congo, the Democratic Republic of the Congo, Kenya, Malawi, South Africa, Swaziland and Togo young women and girls are especially vulnerable to HIV. Cases are being made for increasing investments in services for these populations. Reducing discrimination, increasing access to justice, changing harmful gender norms and eliminating violence against women are essential to reducing the vulnerability of young women and girls to HIV infection and the impact of HIV.

In Kenya, for example, the prevalence of HIV among women 15–24 years old (3.6%) is twice that for men of the same age (1.8%) (1). The Kenyan investment case identifies a prevention response tailored to meet the needs of young women and girls as a game-changer (6). To strengthen the response for girls and young women, the new Prevention Revolution Roadmap in Kenya combines scaling up structural programmes on microfinance with gender-based violence reduction programmes and cash-transfer programmes which reduce girls' vulnerability, keep them in school and reduce the number of new HIV infections.

MAXIMIZING OUTCOMES AND OPTIMIZING RESOURCES

In working to remove inefficiency from programmes and services, costs may potentially be saved in three key areas: lowering commodity costs, including the costs of antiretroviral medicines; identifying alternative service delivery models, including community-based services; and eliminating parallel structures and integrating HIV services.

Value for money involves a balance that maximizes high-quality output while optimizing resources. At all times, efforts to save money should ensure that the quality of services is not compromised. Efforts to ensure value for money must be rights-based and gender-sensitive, ensuring that the HIV-related needs of the most severely affected populations are effectively addressed.

REDUCING THE COSTS OF ANTIRETROVIRAL MEDICINES AND OTHER ESSENTIAL HIV COMMODITIES

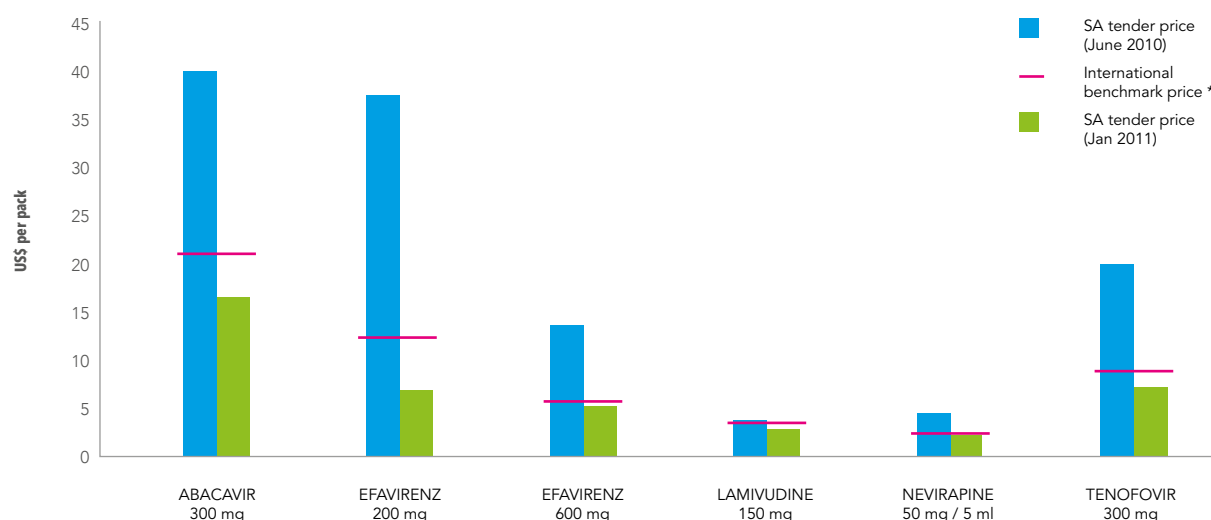
Antiretroviral medicines and other HIV commodities represent a substantial component of HIV expenditure. Minimizing the costs associated with purchasing essential HIV commodities may require action in various domains including: optimizing tenders and purchasing processes for antiretroviral medicines; diversifying potential suppliers, including local producers; joint procurement, forecasting and other ways of using volume to reduce prices; and policy change, such as using available flexibilities under the World Trade Organization Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) (14). A growing number of countries have shown that strategic action can ensure lower costs of commodities, and savings can then be reinvested in scaling up the HIV response.

- **South Africa.** South Africa has become the forerunner for approaches to lowering the costs of antiretroviral medicines. In 2011–2012, South Africa revised its tender and introduced a list of reference prices; awarded preference points for local manufactures; encouraged competitiveness throughout the entire contract period; and improved methods of estimating the antiretroviral medicines needed and the transparency of the process. These changes helped South Africa to reduce costs for antiretroviral medicines by 53%, generating estimated savings amounting to US\$ 640 million¹ over two years (15). The reduction in costs for both the fixed-dose combination (by 38% for a single dose of the triple combination of tenofovir, emtricitabine and efavirenz) and most traditional antiretroviral formulations will result in an estimated saving of US\$ 290 million² between 2013 and the end of 2014. Drawing on the success of revising the antiretroviral tender, the Government of South Africa has reformed other tenders, including for tuberculosis (TB) which resulted in a 36% reduction in the price of TB medicines.

^{1,2} At an exchange rate of 7.4 ZAR/US\$.

FIGURE 5

South Africa has significantly reduced the prices it pays for antiretroviral medicines
South African tender prices for key antiretroviral medicines, 2010-2011



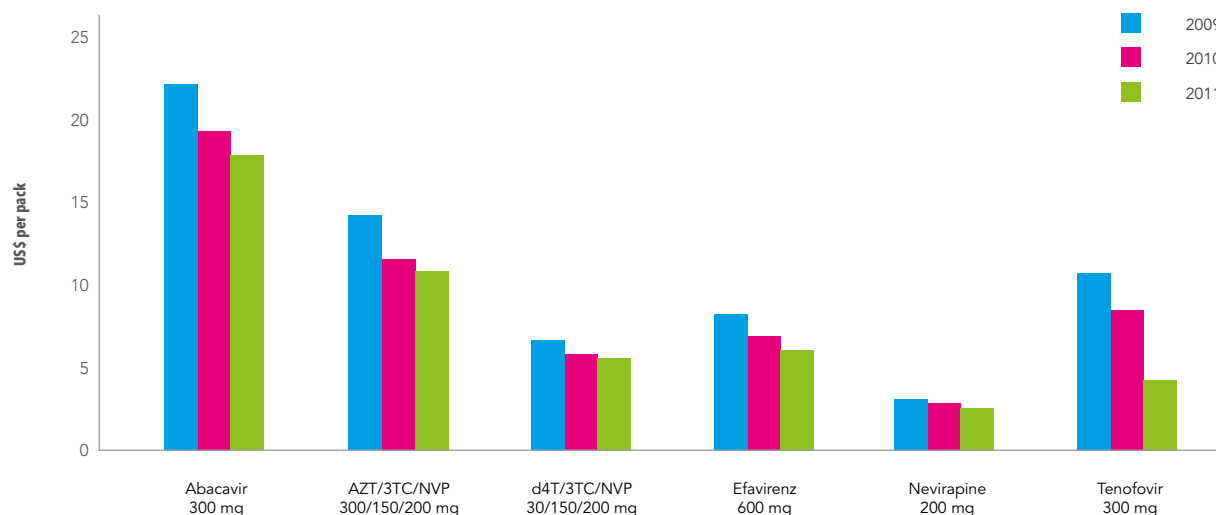
Source: Efficient and sustainable HIV responses: case studies on country progress. Geneva: UNAIDS; 2013.

Notes: *International benchmark prices are based on the most competitive pricing from the following sources: Supply Chain Management Systems, WHO Global Price Reporting Mechanism; and Clinton Health Access Initiative. Exchange rate ZAR/USD used: 1 USD = 8.02 ZAR (2011 exchange rate).

- **Swaziland.** Swaziland revised its antiretroviral medicines procurement tender process, saving US\$ 12 million between January 2010 and March 2012. In addition to benchmarking prices and improving forecasting, Swaziland incorporated historical information about supplier performance into the evaluation criteria. Swaziland secured prices below the benchmark for 93% of its antiretroviral medicines. This resulted in a significant (27%) price decrease between January 2010 and March 2011 compared with 2009 tender prices. In real terms, the reductions amounted to cost savings of US\$ 4.91 million, which is being invested in scaling up HIV treatment services (15).
- **Jamaica.** Confronted with a steadily increasing bill for antiretroviral medicines, Jamaica committed to reducing costs for first, second and third-line antiretroviral medicines. Jamaica determined that improved forecasting would reduce antiretroviral medicines costs by 10%, in part by averting expensive emergency orders and preventing expiry of medicines within inventory stock. The country has also expressed interest in exploring regional purchasing of antiretroviral medicines.

FIGURE 6

Swaziland has significantly reduced the prices it pays for antiretroviral medicines
Swaziland contract prices for key antiretroviral medicines, 2009-2011



Source: Efficient and sustainable HIV responses: case studies on country progress. Geneva: UNAIDS; 2013.

PROMOTING EFFICIENCY THROUGH ALTERNATIVE SERVICE DELIVERY MODELS, INCLUDING COMMUNITY-BASED SERVICES

Countries have implemented pioneering methods of service delivery to facilitate rapid scale up and improve the effectiveness of programmes and services. In addition, efforts are being made to lower service costs and enhance the efficiency of programmes. Task shifting from physicians to nurses and community health workers has been shown to be effective and efficient (16). Task-sharing models in which health care teams expand partnerships with communities, faith-based organizations and the private sector have proven useful in extending health services beyond public clinics. These and other alternative partnerships require new modes of collaboration and lines of accountability to ensure their quality (17).

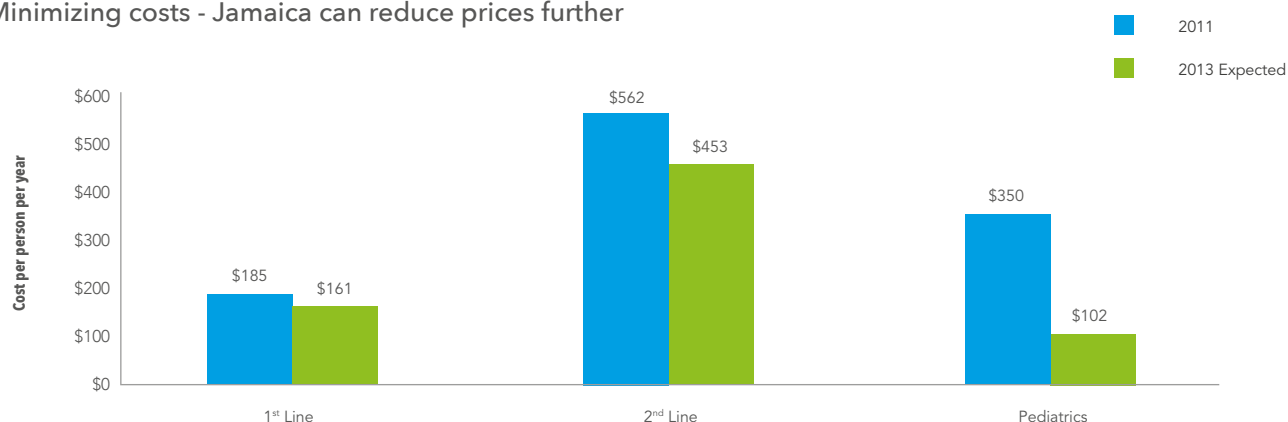
Other options are evolving. Decentralization brings services closer to the community and can be critical to scaling up services. Community-based service delivery can provide high-quality services at costs that are below those required for standard service delivery in more centralized systems. In addition, new diagnostic tools have either already emerged or are on the horizon that will enhance the efficiency of services (18).

- **Jamaica.** Expansion of availability of CD4 count machines is expected to reduce the turnaround time for HIV-related diagnostic tests from an average of 20 days to within 1 day, reducing costs and facilitating earlier initiation of HIV treatment.
- **Kenya.** Adoption of a new HIV counselling and testing algorithm which uses rapid test kits is projected to yield annual cost savings of US\$ 1.6 million. Kenya adopted this new algorithm based on the need to reduce the long turnaround time for enzyme-linked immunosorbent assay (ELISA) results, the long training time required for health care workers and the high costs associated with ELISA-based testing.

FIGURE 7

Jamaica could further reduce the prices of antiretroviral medicines through improved forecasting
Estimated price reduction of antiretroviral medicines in Jamaica

Minimizing costs - Jamaica can reduce prices further



Source: Clinton Health Access Initiative, Kingston, Jamaica.

- **Myanmar.** Myanmar has taken steps to strengthen its capacity to roll out key HIV services. In particular, Myanmar is decentralizing and integrating HIV testing and counselling into wider health services with the overall aim of facilitating early detection, increasing coverage of services for preventing new HIV infections among children and expanding treatment services. These efforts are underpinned by targeted, community-led awareness-raising campaigns. With support from the Joint UN Team on AIDS, the National AIDS Programme is providing HIV testing and counselling training at national and subnational levels to doctors, nurses and health assistants.
- **Zimbabwe.** Scaling up HIV services required task shifting, which resulted in improved efficiency and increased access to testing. The number of HIV tests conducted has risen from 1 653 000 in 2010 to 2 373 000 in 2012. The proportion of pregnant women living with HIV who accessed antiretroviral therapy increased from 58% in 2010 to 82% in 2012. Scale-up of treatment has also been accelerated by task shifting as nurses are now capacitated to initiate antiretroviral therapy (19).

Although there is often potential for innovative service delivery to optimize the return on HIV investment, countries developing investment cases have faced regulatory barriers to task shifting and sharing that make it difficult, and in some cases impossible, for communities to deliver HIV services. Community service delivery, decentralization and service integration, while saving costs in the long run, often require substantial start-up investment, new forms of quality assurance, some form of community support, remuneration and innovative strategies for data collection and performance monitoring.

Innovation in service delivery

Countries are taking innovative approaches to service delivery to provide high-quality services while reducing costs and improving the impact of health investment.

NEPAL. Nepal aims to improve the effectiveness of its HIV programmes by placing a high priority on HIV testing and counselling. Several approaches are planned, including community testing and counselling, professionalizing existing peer education and outreach programmes, increasing public-private partnerships and using potential transformative eHealth (electronic health) and mHealth (mobile health) interventions. Mobile telecommunication technologies will open new opportunities for innovation in health data collection, supply chain management and patient monitoring and treatment. eHealth will link patient records across service providers and minimize duplication of services, such as duplicate HIV testing.

THAILAND. Thailand has launched a “service delivery revolution” aiming to redesign service delivery to make full use of combination prevention and to overcome the prevention and treatment dichotomy. This includes community-based counselling and testing, adherence support and stronger partnerships with private service providers. Thailand is exploring a franchise model for private laboratories and pharmacies. Branding of private service providers and close collaboration with public facilities and civil society in defined geographic areas is expected to increase service options for people in greatest need through task sharing.

ELIMINATING PARALLEL STRUCTURES AND REDUCING PROGRAMME SUPPORT COSTS TO OPTIMIZE INVESTMENTS

Efficiency can be improved by integrating HIV with other health services. Eliminating parallel services not only saves valuable resources in terms of direct service delivery efficiencies, it also creates opportunities to increase the numbers of people accessing testing and counselling.

A 2012 review of available evidence on integrating HIV services with other health services (20) found broad support that integrating services reduces service costs. In particular, experience in India, Kenya and Uganda indicates that integrated HIV counselling and testing services are less costly than stand-alone HIV counselling and testing services by 31% to 79%.

1. Integrating HIV prevention in children into antenatal care and maternal and child health settings

- **Congo.** Congo is integrating services to prevent new HIV infections in children in antenatal and maternal and child health programmes. The integrated service models serve as an entry point for preventing new HIV infections in children and also for HIV prevention and treatment services for the broader population and for providing non-HIV-related health services.
- **Malawi.** Malawi has achieved considerable progress in scaling up services to prevent new HIV infections in children, recognizing that implementing WHO’s option B+ requires providing antiretroviral therapy services at all health facilities with maternal and child health services. Key achievements in 2013 include HIV testing rates of 77% of women attending antenatal care settings and 92% of women attending maternity settings (21). In developing the Malawi investment case, stakeholders are revisiting service delivery, in particular increasing community delivery models and further integrating services.

- **Nepal.** With 85% of pregnant women in Nepal attending antenatal care, the country is accelerating efforts to integrate HIV testing and a referral system in antenatal care settings. In addition to serving as a key entry point for preventing new HIV infections in children, antenatal care will also provide a portal for other HIV services for both men and women (13).
- **Swaziland.** Integrating services for preventing new HIV infections in children with maternal, neonatal and child health services facilitated programme scale-up and has led to increased access to services for preventing new HIV infections in children. One hundred and fifty of 171 maternal, neonatal and child health care facilities now provide such services. Currently, 83% of pregnant women living with HIV receive services for preventing new HIV infections in children. As part of its efforts to realize an estimated US\$ 31 million in efficiency gains through 2018, Swaziland is further integrating services for preventing new HIV infections in children into maternal and child health facilities.

2. Integrating HIV and TB

- Belarus, Myanmar, South Africa, Swaziland and Ukraine are taking steps to further strengthen HIV and tuberculosis service integration and system collaboration. In Myanmar, stronger collaboration is envisaged between the national TB and AIDS programmes, ensuring that all people coinfected with TB and HIV receive antiretroviral therapy and that all people living with HIV are screened for TB by 2015. In Swaziland, TB and HIV service integration at national and health facility level has improved the uptake of antiretroviral therapy among people coinfected with TB and HIV from 32% to 68% between 2010 and 2012. As a result, mortality among this group has decreased from 18% in 2007 to 9% in 2012. Directly Observed Therapy Shortcourse (DOTS) coverage has improved treatment success from 62% in 2011 to 75% in 2012. South Africa has given priority to rolling out fixed-dose combination antiretroviral therapy for all people coinfected with TB and HIV. The decentralized management of multidrug-resistant TB is being scaled up using nurse-initiated and managed antiretroviral therapy.

3. HIV service integration in primary care

- **South Africa.** In South Africa, integration of HIV with TB services as well as with other services is increasing. At the policy and programme level, HIV and TB national programmes now undertake joint provincial review visits on a monthly basis in collaboration with maternal and child health services to ensure better coordination and delivery of integrated services in primary health care. Achieving a higher level of coordination and integration was also the principle behind carrying out the recent joint national review of the programmes for HIV, TB and preventing new HIV infections in children.

THE INVESTMENT APPROACH FOSTERS INNOVATION.

Countries are leveraging the investment approach to reduce commodity costs, adapt and improve service delivery systems, integrate services and reduce overhead expenses.

Effective programmes require resources that extend beyond service delivery, supporting vital functions including coordination, planning, management and monitoring and evaluation. These programme-support functions may be costly if implemented in parallel to other similar structures. Relatively few countries have taken steps to reduce costs in programme implementation above the facility level. Strategies could include merging departments within the health ministry, integrating HIV with existing joint structures or linking HIV with broader monitoring and evaluation systems.

- **Jamaica.** By merging the family planning and HIV units of the Ministry of Health, Jamaica has eliminated parallel structures, yielding savings of more than US\$ 700 000. The country is also exploring linking HIV to primary health care and noncommunicable disease programmes, which is projected to save US\$ 60 million over the next five years.
- **Nigeria.** The President's Comprehensive Response Plan for HIV/AIDS for 2013–2015 (7) plans to lower the proportion of programme costs among overall HIV spending to 23%.

Eliminating parallel procurement and distribution systems is critical to optimizing the return on investment but can often be challenging. Parallel procurement systems lead to uncoordinated drug purchase and a failure to match supply with demand. Similarly, vertical programmes organized around one specific intervention such as the prevention of new HIV infections in children, voluntary medical male circumcision or HIV treatment have arisen in many countries, with separate systems for management, monitoring, logistics, supply, transport and even physical stock and delivery facilities. Failure to address the duplication created through parallel systems is a missed opportunity from an efficiency perspective. However, these systems are often entrenched and eliminating them will take time and considerable commitment and effort from multiple stakeholders.

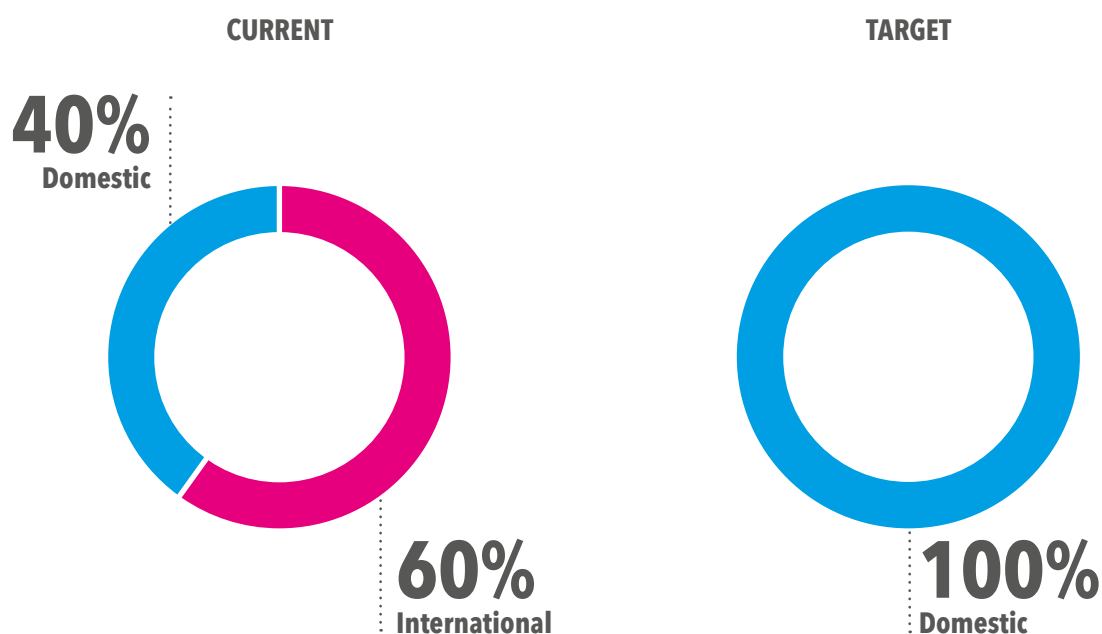
GENERATING SUSTAINABLE FUNDING FOR THE RESPONSE

Although international HIV investments have stagnated in recent years, domestic investments have steadily increased, with domestic sources accounting for 53% of all HIV-related investments in 2012 (1). Nevertheless, despite the leadership shown by low and middle-income countries, the US\$ 18.9 billion available for HIV programmes in 2012 was well below the target of US\$ 22-24 billion of annual investment required in 2015 set forth in the 2011 United Nations Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (22). New resources need to be found to meet the long-term HIV challenge.

Several countries have taken important steps to increase domestic investments in their HIV response to ensure more sustainable funding for the long term.

- **Belarus.** With international HIV funding likely to be withdrawn or severely reduced in the coming years, Belarus plans to assume 100% of the costs associated with antiretroviral therapy by the end of 2015 versus the present national share of 40% (23).

FIGURE 8
Belarus plans to fully fund the provision of HIV treatment by 2015*
Funding sources for HIV treatment in Belarus



Source: Project document on international technical cooperation 'Prevention and Treatment of HIV/AIDS in the Republic of Belarus-3'. Minsk: Ministry of Health, UNDP; 2013.

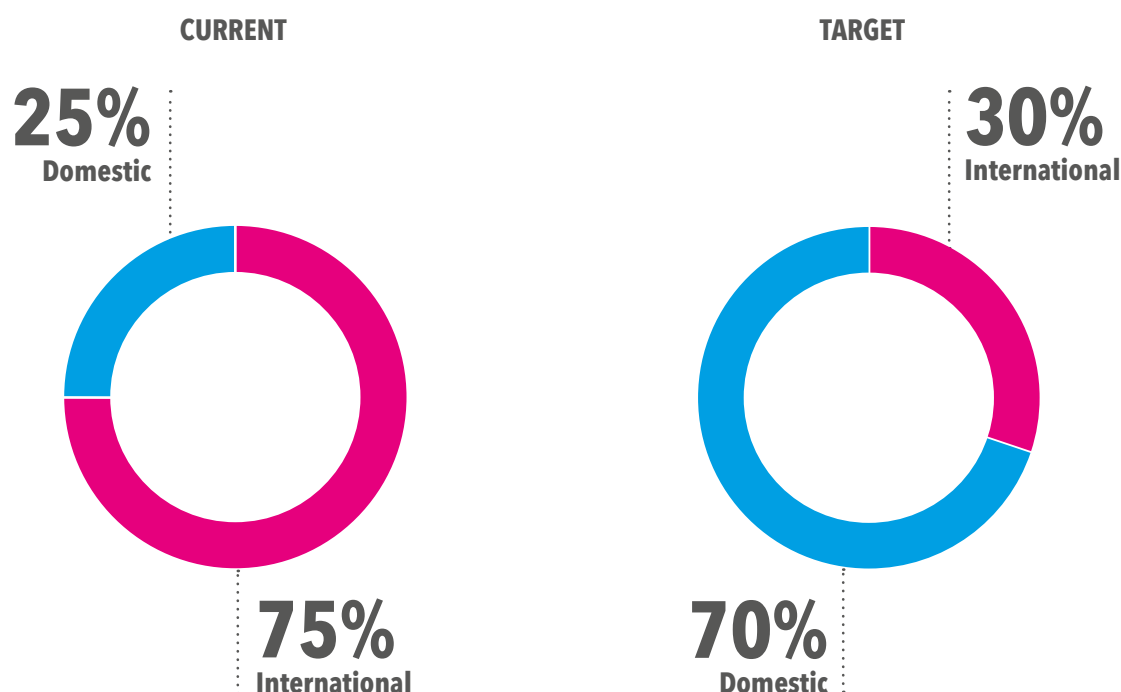
* Eligibility for HIV treatment based on 2010 WHO HIV treatment guidelines.

- **Jamaica.** The country has established a private foundation to mobilize domestic resources for the response, created an HIV donor coordination group to harmonize resource mobilization efforts and authorized a study on sustainable funding, with the results presented to the Cabinet and Parliament (12). The New Funding Model of the Global Fund will require that Jamaica assumes at least half of all HIV-related costs, amounting to about 0.2% of gross domestic product. Having concluded that such costs are manageable and fiscally sustainable, the government is now developing a long-term sustainability plan that will include financing options and strategies to increase programmatic efficiency.
- **Kenya.** In December 2012, the Cabinet authorized a trust fund for HIV and priority noncommunicable diseases, with the goal of ensuring that at least 70% of the cost of the HIV response is covered by domestic funds. Various mechanisms to fund the trust fund are being explored, including earmarking an amount equal to at least 1% of all ordinary revenue collected by the government, an airline levy, a percentage of the interest earned on all unclaimed financial assets, voluntary private sector contributions, grants and donations.

FIGURE 9

Kenya plans to fund 70% of the HIV response through a trust fund for HIV and priority noncommunicable diseases

Current and target funding sources for the HIV response in Kenya

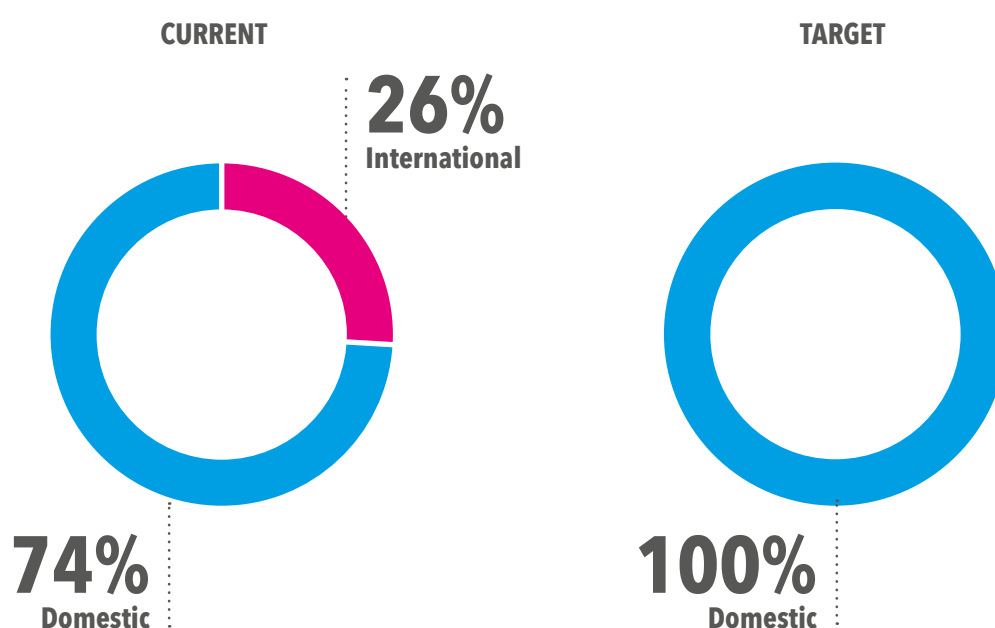


Source: Kenya HIV investment case summary. Nairobi: Government of Kenya; 2013.

- **South Africa.** South Africa increased its annual HIV expenditure leading up to and beyond 2011. During a three-year period, public funding for HIV and TB increased by 27% on average, reaching US\$ 1.2 billion in 2009–2010.³ In 2009–2010, public sources contributed 75% of total HIV investments (24). According to the National Department of Health Annual Planning Tool, funding for HIV from the National Department of Health rose by 8% between 2010–2011 and 2012–2013 (25). Multisectoral government investments in HIV increased by 21% over the same period.
- **Thailand.** With current annual HIV investments of US\$ 300 million and the government funding 90% of the response, Thailand has committed to increasing its domestic expenditure to cover the additional US\$ 75 million of HIV funding needed between 2015 and 2017. A total of US\$ 100 million is required between now and 2022.
- **Ukraine.** In 2010, domestic spending accounted for 53% of total HIV spending and 74% of funding for HIV treatment. To meet the resource needs estimated at US\$ 778 million for 2014–2018, Ukraine will need to increase significantly its domestic HIV investments. The government plans to fund 81% of the total HIV resources needed through national and local budgets. It is also foreseen that state funding of HIV treatment will be increased to cover 100% of the costs, with coverage of HIV treatment increasing by 41 % in 2013 to 83% in 2018 (26). The Cabinet of Ministers approved the National AIDS Programme 2014–2018, and the programme budget is currently being reviewed.

FIGURE 10

Ukraine plans to fully fund the provision of HIV treatment by 2018*
Funding sources for HIV treatment in Ukraine



Source: National AIDS Programme 2014–2018. Kyiv: Government of Ukraine; 2013.

* Eligibility for HIV treatment based on 2010 WHO HIV treatment guidelines.

³ 1 US\$ = ZAR 8.02 (2009–2010 exchange rate).

- **Zimbabwe.** Increased domestic funding through Zimbabwe's AIDS trust fund, a taxation-based levy introduced in 2000, has leveraged significant increases in international resources. HIV investments in Zimbabwe grew from US\$ 150 million in 2011 to US\$ 260 million in 2013, with total HIV funding projected to average US\$ 293 million annually in 2014–2016 (27).

Increasingly, countries are developing more diversified, balanced and sustainable funding approaches to their HIV responses. Doing so requires analyzing current HIV expenditure, resource requirements for an effective and efficient response and the fiscal space to increase domestic investments in HIV. Analyzing the capacity to increase domestic HIV investments necessitates assessing projections for economic growth and total government expenditure, examining health expenditure and assessing how disease allocations in overall health budgets relate to the burden of disease. Reviews of the ability of low and middle-income countries to pay for HIV programmes conclude that most countries are able to contribute more than current levels (28). This is especially true for middle-income countries but also applies to low-income countries. Nevertheless, even if all countries increase their domestic investments to the full extent of their capability, the international community will need to continue to maintain and increase its investments and commitment to the AIDS response.

SMART INVESTMENTS

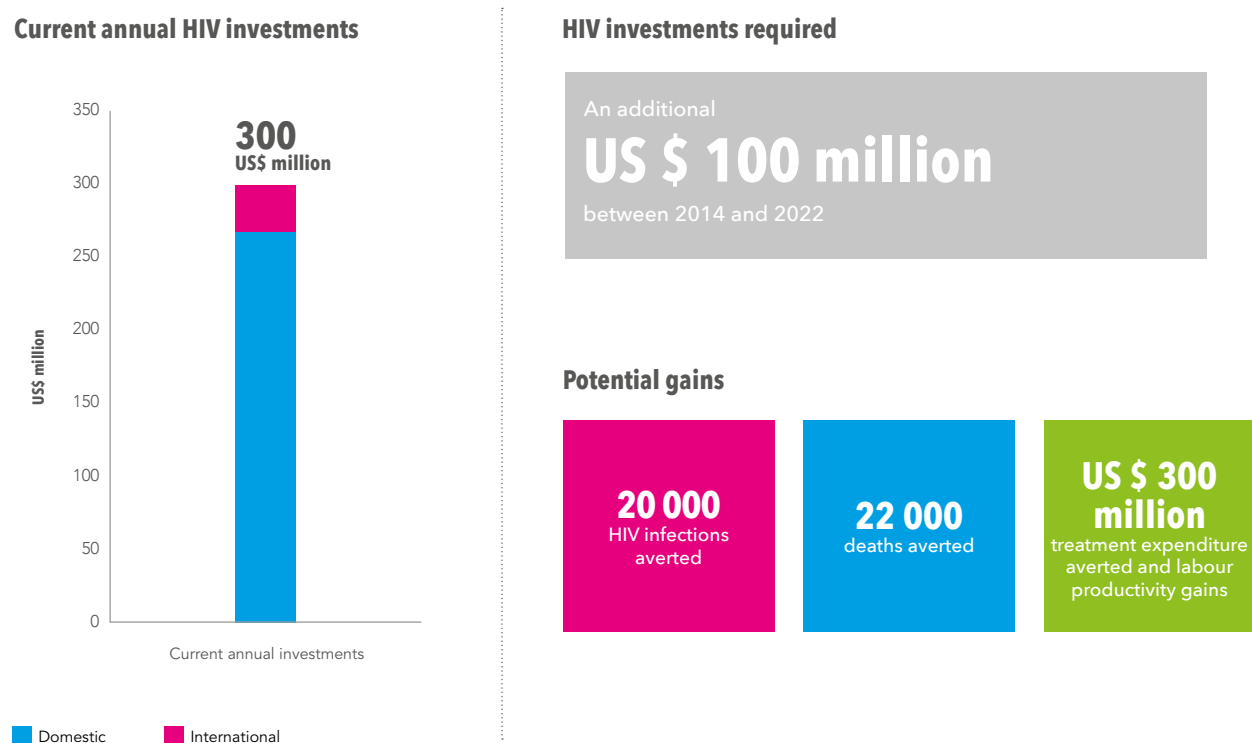
YIELD RETURNS

Investing in the response to HIV is a sound investment in preventing illness and saving lives. In addition to the large health gains generated, the benefits of investing in HIV treatment in low and middle-income countries are estimated to largely offset and likely exceed programme costs through labour productivity gains, averted orphan care and deferred health care costs (29).

Countries have undertaken evidence-informed modelling exercises to estimate the value of their HIV investment as a part of their investment cases development process.

- **Thailand.** An additional US\$ 100 million invested in high impact interventions focusing on key populations in the next decade will prevent an estimated 20 000 people from acquiring HIV infection, avert 22 000 deaths and provide economic benefits of US\$ 300 million through treatment costs averted and labour productivity gains (8). Every additional dollar invested in HIV now will return three dollars in the future.

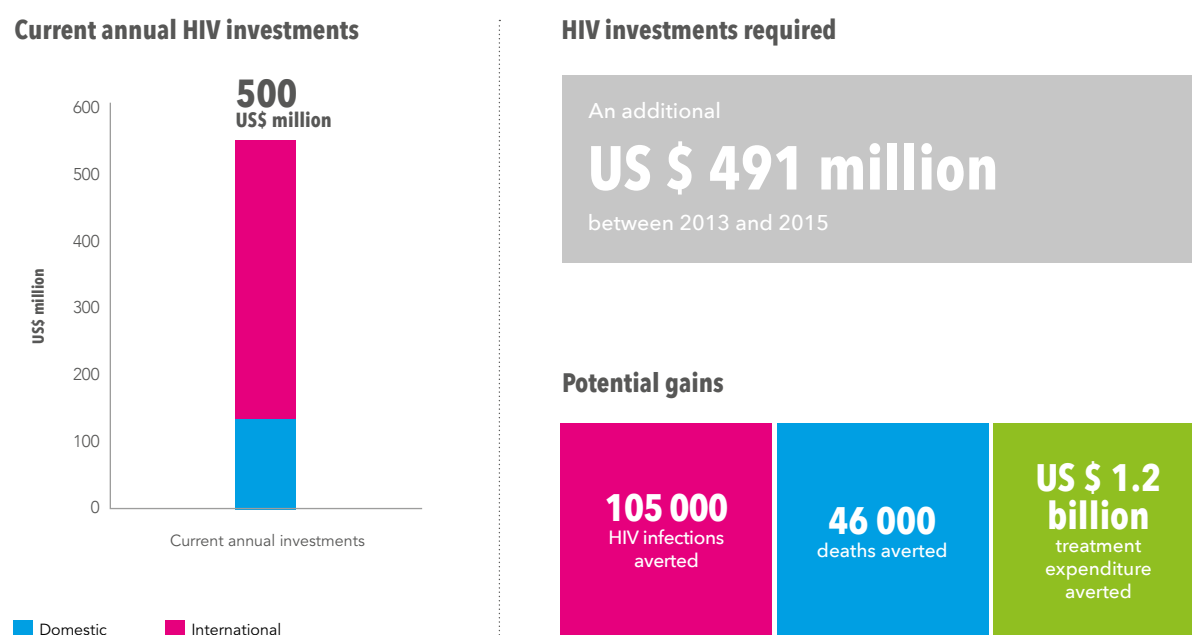
FIGURE 11
Smart HIV investments will yield returns in Thailand, 2014–2022



Source: National AIDS Management Center. Ending AIDS in Thailand. Bangkok: Ministry of Public Health, Thailand; 2013.

- **Nigeria.** By focusing on the geographical areas with the highest HIV burden and scaling up key programmes over the next two years, Nigeria's response is projected to prevent 105 000 people from becoming newly infected with HIV (a 24% reduction in two years) and to prevent 46 000 deaths, including 13 000 among children. In addition, fully implementing the planned programmes would result in savings of US\$ 1.2 billion from averted future HIV treatment costs (7).

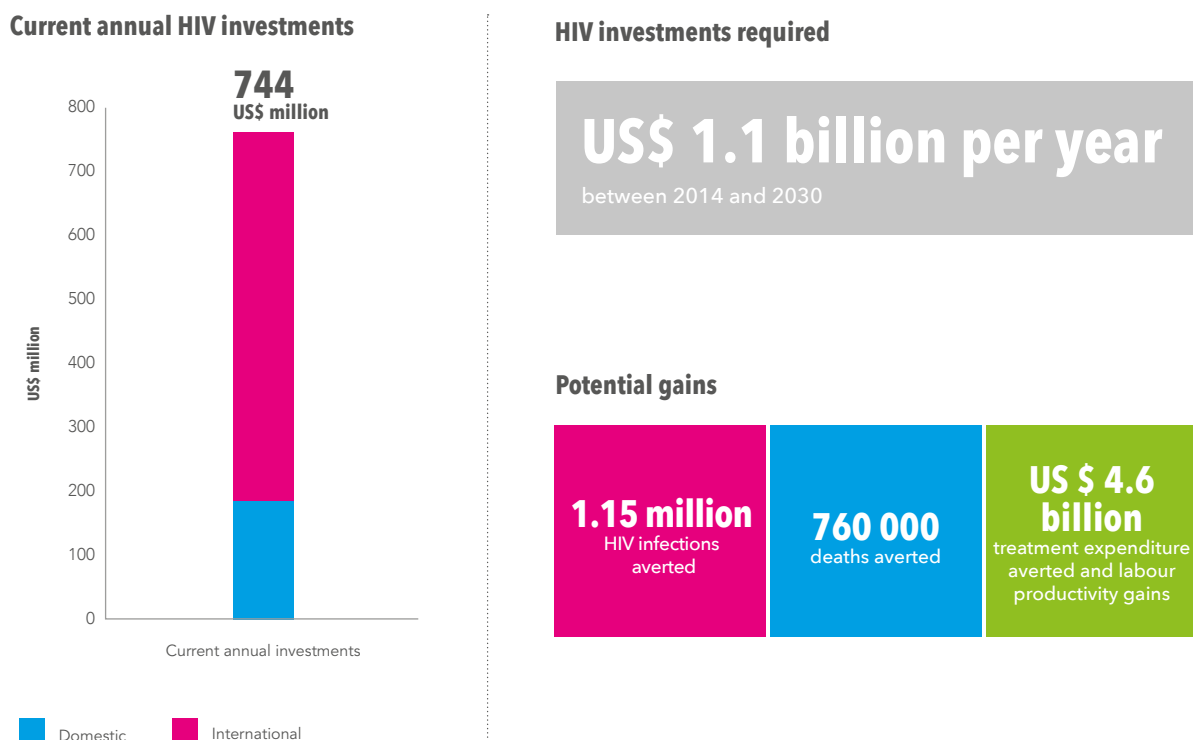
FIGURE 12
Smart HIV investments will yield returns in Nigeria, 2013–2015



Source: President's Comprehensive Response Plan for HIV/AIDS in Nigeria 2013–2015. Lagos: National Agency for the Control of AIDS; 2013.

- **Kenya.** Kenya projects that investing an estimated US\$ 1.1 billion per year between now and 2030 in a refocused response with clear priorities will prevent a total of 1.15 million people from acquiring HIV infection and prevent 760 000 people from dying from AIDS-related causes (6). More than half of this investment would be offset by savings in treatment costs and labour productivity gains.

FIGURE 13
Smart HIV investments will yield returns in Kenya, 2014–2030



Source: Kenya HIV investment case summary. Nairobi: Government of Kenya; 2013.

Estimating the returns on an effective and efficient response is an indispensable component of making a case for investing in HIV. This is the heart of the investment case – providing analysis to better understand and compare the health and economic benefits of various realistic portfolios of HIV investments. Building capacity for modelling, estimation, projections and economic analysis in the countries developing investment cases is essential.

CHALLENGES, EMERGING LESSONS AND RECOMMENDATIONS FOR MOVING FORWARD

More and more countries are applying investment thinking to set priorities among high-impact programmes and strategies, basing their decisions on existing evidence, investment principles and modelling. These exercises are also underpinning the development of roadmaps for mobilizing more sustainable resources.

Developing an investment case is an important step in optimizing resources and raising the priority of HIV in the context of competing demands. Ultimately, investment cases need to be operationalized and implemented to meaningfully affect national aspirations to reduce health burdens, reduce inequities, increase value for money, generate overall cost savings and realize the right of everyone to enjoy the highest attainable standard of physical and mental health.

Implementing an investment approach implies new ways of doing business and can entail some challenges.

- Developing an investment case is an inherently political process that requires difficult decisions by diverse stakeholders, including Ministries of Finance, Health, Development and Planning; Civil Society; people living with HIV; and international partners.
- Many countries continue to struggle to match investments to their respective epidemics. Sometimes political considerations undermine programme evidence which highlights the need for geographical prioritization or an increased focusing on key populations. The failure to respond to the evidence results in suboptimal resource allocation. Stakeholders with vested interests may resist efforts to rethink resource allocation or to expose allocation decisions to rigorous examination.
- Many countries developing investment cases face key structural constraints. Existing regulatory and legal frameworks impede the adoption of task shifting and task sharing, for example. In several countries, only certified health professionals may initiate HIV counselling and testing and/or antiretroviral therapy. To be effective, task shifting and task sharing requires initial investment in the capacity of potential service providers that the country may not be in a position to make. Many countries are faced with existing parallel procurement and supply systems supported by international partners that will be a challenge to consolidate.
- The overall legal environment remains an issue in a number of countries. Many countries continue to have punitive laws and law enforcement against key populations that act as major obstacles to accessing HIV services. In addition, some countries do not have legal or policy provisions for enabling service delivery by civil society organizations even though civil society partners are indispensable partners in expanding the coverage of services – especially to key populations.
- Empirical data on the costs of HIV services are a major gap in available evidence in many countries. In many cases, countries have difficulty in generating data on costs and obtaining cost data from international partners or from international programme implementers. Although financial data may often be sensitive, the availability of such information is absolutely essential if countries are to develop sound, robust investment cases.

INVESTMENT CASES REFLECT AND PROMOTE SHARED RESPONSIBILITY.

Countries are exploring new funding mechanisms, mobilizing additional resources and bolstering domestic contributions to ensure more sustainable funding and achieve shared responsibility.

- Although some countries have limited fiscal space to substantially increase their investment in the AIDS response, all countries can do more. Developing an investment case, including quantifying the anticipated return on various investment options, provides a useful framework for developing new national funding mechanisms, including budgetary commitments and exploring innovative funding tools.

MOVING FORWARD

Early adopters of the investment approach have demonstrated not only its feasibility but also how the approach can foster efficiency-promoting measures, innovative service delivery models and initiate steps towards more sustainable financing and shared responsibility. These aspects are critical to achieving the targets for 2015 set forth in the 2011 United Nations Political Declaration on HIV and AIDS (22) and will support laying a firm foundation to end the AIDS epidemic in the longer term.

UNAIDS, together with partners, is supporting countries to apply investment thinking, develop investment cases, translate them into operational plans and ensure their implementation. This includes technical support and capacity development, emphasizing investment cases as catalysts for rapid HIV service scale-up, intensifying quality throughout the process and taking advantage of the transformative potential towards more rights-based, gender-sensitive HIV responses and community empowerment.

In the coming months, UNAIDS will intensify its activities to support country-level investment cases as a matter of urgency and priority. The major strategic areas are as follows:

- **UNAIDS will institute a quality assurance process to ensure that all investment cases are of the highest quality.** UNAIDS will establish a quality assurance mechanism that reacts rapidly to the needs of countries developing investment cases. An ad-hoc advisory body comprising of country representatives and international experts from various disciplines will be established to ensure the development of high-quality products.
- **UNAIDS will use the momentum created by investment cases to convene dialogues on sustainable HIV investments.** Investment cases take a long-term perspective and in so doing provide an opportunity to make significant headway in the shared responsibility and global solidarity agenda and in envisioning the HIV response post-2015. At the global and regional levels, UNAIDS will convene consultations on sustainable HIV funding.
- **UNAIDS will facilitate dialogue with the Global Fund, PEPFAR and other key partners to maximize the impact of investment cases.** Investment cases are the beginning of an ongoing country-owned and led dialogue on investment thinking and value for money in the HIV response. They will inform and provide the platform for the development of concept notes for the Global Fund's New Funding Model, and provide a starting point for developing partnership frameworks and country sustainability plans with PEPFAR. UNAIDS will further intensify collaboration with the Global Fund, PEPFAR, the World Bank and other strategic partners to ensure that investment cases are used to their fullest potential and respond – to the extent possible – to the many institutional needs and expectations.

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