DISCUSSION PAPER: WHAT IS THE INVESTMENT FRAMEWORK FOR HIV/AIDS AND WHAT DOES IT MEAN FOR THE ALLIANCE?

INTRODUCTION

What is the investment framework for HIV/AIDS?

This discussion paper provides a short introduction to an important new development in global HIV policy. A new model, an investment framework for HIV/AIDS,[1] was published in The Lancet in June 2011 to guide the global response to HIV. The Investment Framework for HIV/AIDS sets out a **model for HIV investment and HIV programming for the next decade**.

It is a framework that projects an increase in spending on HIV/AIDS leading up to 2015, followed by a decline in spending from 2015 to 2020.

For the first time, a model has been developed that can show a decline in the need for HIV programmes and services, as the effect of current and future targeted investments reach a tipping point. HIV investments, and HIV rates, decline.

Is this the prediction of the end of AIDS?

The framework has proven to be influential and topical already. It was developed by international experts from a range of agencies, including UNAIDS, the Global Fund, WHO and the US Government.[2]

This discussion paper describes some of most important features of the investment framework for the Alliance, along with some actions for us all in making it work for communities affected by HIV/AIDS.

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1. "Towards an improved investment approach for an effective response to HIV/AIDS" The Lancet Vol. 377 Issue 9782 pp 2031-2041, 11 June 2011

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Why does the investment framework matter for the Alliance?

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For four main reasons:

1. It sets out an investment plan that is not primarily aspirational, like the Universal Access by 2010 and 3 by 5 calls were. The difference here is that this plan refers to a specific and scientifically produced calculation of the investment required in order to create **a reduction in the trajectory of HIV – both spending, and in terms of HIV/AIDS epidemic dynamics**. It is a model, or a calculation, that says that if you invest in these specific ways, then the human and financial costs of AIDS will reduce dramatically by 2020. It provides a model for a highly targeted response.

2. It articulates an approach to the **implementation of HIV programmes** that reflects and supports our programming. The prioritisation of specific HIV programmes is accompanied by the concept of '**critical enablers**' that make these programmes work. It endorses working with key populations where they are most affected by HIV/AIDS, there is prominent support for community mobilisation, and for a range of other evidence based interventions that we are implementing, such as HIV testing and counselling, treatment adherence, behaviour change communication, needle and syringe programming, stigma reduction and advocacy.

3. It **positions human rights-based programming such as advocacy, stigma reduction and efforts towards supportive laws and practices as *critical*** to the model, not optional or additional but 'critical'. For example, advocacy to end the criminalisation of sex between men is critical to the implementation of behaviour change communication that reaches a sufficient number of men who have sex with men.

4. It responds to the increasing amounts of new evidence of t**he significant health improvement and HIV/TB prevention potential of ART**. Increases in ART provision are a cornerstone of this model. There are four important features of the way increases in ART provision is conceptualised in this model.

- Firstly, increased provision leads to improved health, reduced illness and death as more people living with HIV and tuberculosis receive ART.
- Secondly as reduced viral load prevents increased levels of onward HIV transmission.
- Thirdly, prevention of mother to child transmission (PMTCT) is a priority intervention.
- And finally, from a different perspective, increases in ART provision are conceptualised as producing cost reductions as ART programmes shift from high cost specialist provision to primary care and 'community-led approaches to delivery'.

The investment

The model calculates the increase in investment required – such as a $12.9 billion increase to $22 billion by 2015 followed by a decrease to $10.6 billion by 2020 – in order to avert 12.2 million new infections and to prevent 7.4 million deaths due to AIDS.

The decrease in investment after 2015 results from the impact of reaching optimal HIV programme coverage levels, along with cost efficiencies, and importantly, the declines in illness and death that are predicted because larger numbers of people are receiving ART.

So our calls for more investment in HIV (What's Preventing Prevention?) for the first time, can be accompanied by a scientific, modelled prediction of a decline in HIV/AIDS by the end of this decade.

Figure 1: Investment framework

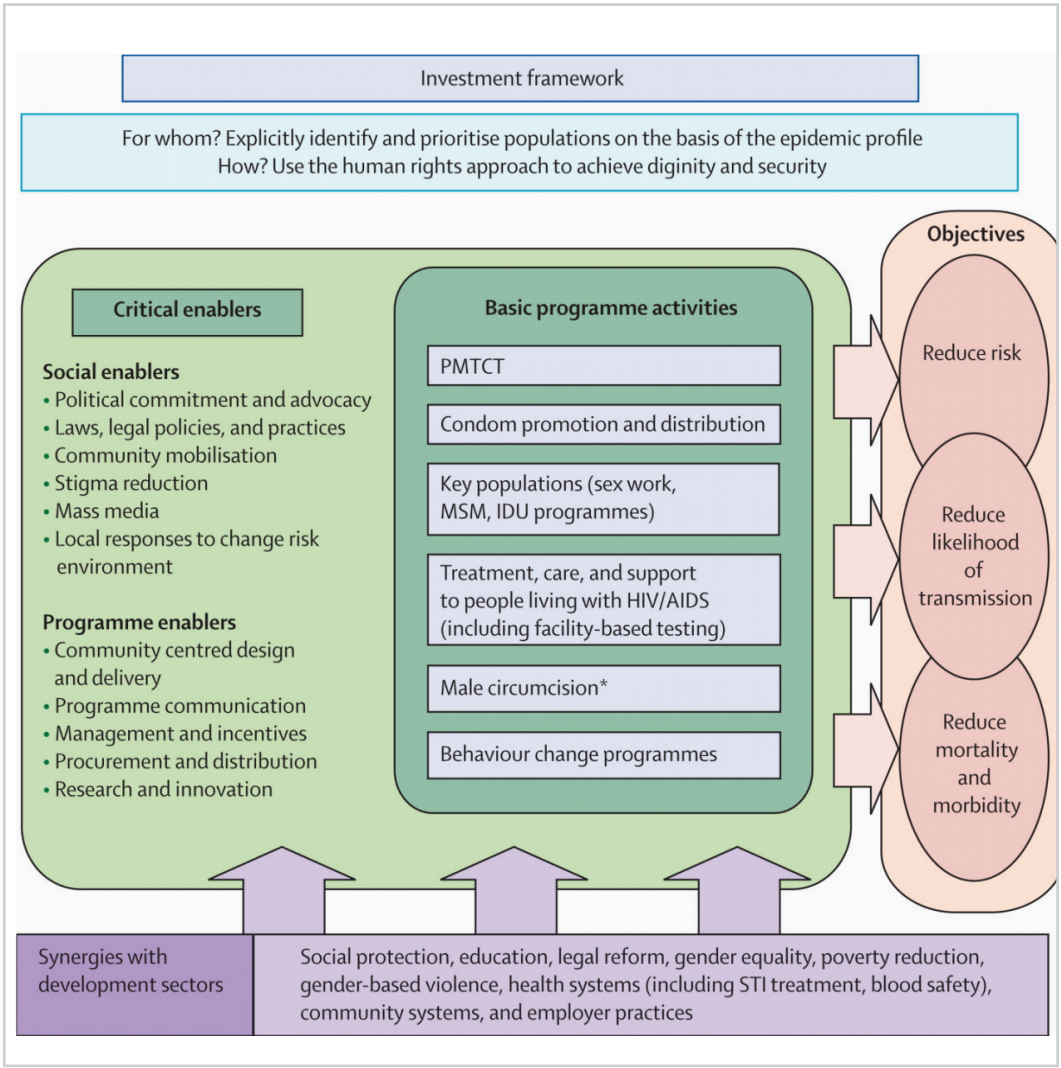

Figure 2: Resources required

	2011	2015	2020
Basic programmes (total)	$7·0	$12·9	$10·6
Prevention of mother-to-child transmission	$0·9	$1·5	$1·3
Condom promotion	$0·4	$0·5	$0·6
Sex work	$0·2	$0·2	$0·2
Men who have sex with men	$0·3	$0·7	$0·7
Injecting drug users	$0·5	$2·3	$1·5
Treatment, care, and support (including provision of provider-initiated counselling and testing)	$4·5	$6·7	$5·5
Male circumcision	$0·1	$0·2	$0·1
Behaviour change programmes	$0·2	$0·7	$0·7
Critical enablers	$5·9	$3·4	$3·7
Synergies with development sectors	$3·6	$5·8	$5·4
Total	$16·6	$22·0	$19·8

THE INVESTMENT FRAMEWORK IN MORE DETAIL

HIV programming priorities in the framework

What is new is that the framework provides an evidence based and costed case for doing more of what we do already in order to reach a critical point where the need for programmes and services will decline. It argues for, and calculates, **the value and potential impact of good quality HIV programming**. Developments in our understanding of the potential of ART feature here as well - t**he potential of ART to prevent HIV transmission, and to prevent tuberculosis amongst people living with HIV**.

The six programme areas that are emphasised are:

- PMTCT
- Condom promotion and distribution
- Key populations (sex work, MSM, IDU programmes)
- Treatment, care and support to people living with HIV/AIDS (including facility-based testing)
- Male circumcision
- Behaviour change programmes.

Male circumcision is specified as being applicable in generalised epidemics with a low prevalence of male circumcision. This is not a blueprint for male circumcision in every country.

How does this list match with HIV programme efforts in your country?

How is progress on each of these programmes in your country?

Does this list of priorities miss something important?

If funding follows this list, what does it mean for our current work?

Critical enablers

The framework articulates a very important concept for the Alliance, ***critical enablers***. In this framework, critical enablers are defined in two categories – social enablers such as community mobilisation, changing laws and stigma reduction. The second category of critical enablers are programme enablers, or efforts to make programmes work, such as community centred design and delivery, communication, management, procurement and research and innovation. These are important and familiar concepts in the Alliance.

The framework gives prominence to the concept of **community mobilisation** – a concept very close to the Alliance's heart. We understand how important the mobilisation of communities is to HIV programming, but this has rarely been described (and described as 'critical') in other models. It will be important to use this opportunity to intensify efforts at the community level.

Looking at the HIV programming priorities, and analysing them alongside the critical enablers, essential work at the community level is clear. For example, PMTCT is the first of the six HIV programme priorities outlined. What are the critical enablers for PMTCT? They might include some or all of the following:

- advocacy for political commitment to a national PMTCT programme
- change in practices such as discrimination by health care providers towards women living with HIV, in particular, in the area of family planning and provision of sexual reproductive health services
- community mobilisation for PMTCT so that local communities know about PMTCT and HIV testing, and can access PMTCT services
- local efforts to incentivise PMTCT programmes
- design of services so that they meet the needs of communities
- research on the best models of delivery.

These are examples of potential efforts we might highlight in order to make PMTCT more effective. Much of this effort lies outside the clinic and in communities. Using this framework, we can articulate the need for work at the community level, with community organisations, in order to make the investment in PMTCT clinics work optimally.

'Synergies with development sectors'

Another area of focus for the Investment Framework is broader development sectors and their links to HIV programmes and critical enablers. The sectors referenced include 'social protection, education, legal reform, gender equality, poverty reduction , gender-based violence, health systems, community systems, and employer practices.'

How does the list of development sector synergies match with HIV programme efforts in your country?

Is there clarity on what each of these synergies involves? (for example, what are the overlaps between HIV programmes and education?)

How is progress on each of these synergies in your country?

Does this list of priorities miss something important?

If funding follows this list, what does it mean for our current work?

Thinking through the meaning of each aspect of these three areas (programme activities, critical enablers and development sector synergies) at a country level is important work. This might lead to a re-programming of HIV efforts, and we will need to ensure that we can point to where our HIV/TB programming efforts, and our advocacy efforts, are supported in the framework. For many of us, we will need to advocate for changing the investments in HIV at the national or local level. We might be advocating for re-programming, or for the need to build capacity in different sectors to make this happen.

How can we use the framework?

In our advocacy and resource mobilisation. Instead of asking for more money for AIDS with an implied ever-increasing need, our advocacy for more resources for HIV has more precise goals – coverage goals that will need to be set nationally and locally – in order to reach a point where the need for this investment declines. Optimal coverage will be reached, efficiency gains will be realised and the decrease in new HIV infections will result in decreased need for services.

I**n our planning**. In order to understand the implications of this framework for HIV programming at a country level, we need to answer a set of critical programming questions:

What are the communities/populations that are most critical to the dynamics of HIV transmission in each country?

What are the critical enablers and how do they influence or affect the sexual and injecting practice or health seeking practice of the priority communities/populations?

What are the most critical HIV interventions for the priority communities/populations?

What are the optimal coverage levels for key HIV/TB interventions in each country?

What are the critical programmatic enablers? What are our programmes contributing to meeting coverage targets in each country? And what is their potential?

What is our work in civil society to address the critical enablers? What is the role of government?

What are the most important synergies for these populations, targets? Social protection? Human rights protections? Poverty reduction? Health systems? Community systems? Education?

Some of us will have the answers to these questions, some of us will need to work with others to seek or calculate the answers. The answers to these questions, and the assumptions contained in the framework, should increasingly form the basis of national HIV plans, including Global Fund proposals. These questions and their answers are critical for our strategic planning and fundraising efforts. We are contributing a lot to this national and global effort, but we need to be clearer in defining the HIV impact of this work, and in forecasting the potential of this work to achieve the point, in each country, where HIV is in decline.

Articulating the role we play in supporting the critical enablers will be important work for Alliance Linking Organisations – both the social enablers and programme enablers. What are our theories of change for each critical enabler? It is widely acknowledged that defining, planning and costing efforts to address the critical enablers is the weakest part of this model. We have to focus attention to this, and help shape this work. Defining, planning and costing the vital pieces of the model such as community mobilisation; changing laws, policies and practices; stigma reduction; changing risk environments; capacity building, management, procurement, research and innovation.

Testing the assumptions inherent in the model will be important in each country. For example, the model depends heavily on increases in ART provision. Is that assumption realistic and feasible from the perspective of very marginalised people? And if not, what are the changes, what are the critical enablers, in order to reach and increase the uptake of ART amongst marginalised people? Improved drug procurement and distribution systems? Reduced discrimination towards key populations in health care settings? ART more accessible in a wider range of settings? Improved access to opiate substitution treatment for injecting drug users? Changes in policy so that people without identity cards, or people in prison or detention, can access ART? More intensive community mobilisation so that more people know about ART and can see the benefit of it for themselves and their families? Increased support for community health workers and caregivers to deliver ART and support adherence?

Left solely to public health planners, some of these types of questions may not be asked. Increasing ART provision is a goal for all of us, but getting the right actions in place in order to achieve this is more complex. Community activists and community based programmers must be part of this analysis to ensure that plans go well beyond the provision of more clinical services. And when the goal is to shift more aspects of ART service provision to communities and their organisations, that this effort is costed and funded properly, not undermined by 'doing it cheaply', dependent on volunteer labour, unpaid care and the under-funding of community organisations and their staff.

Limitations of the framework

As described above, the 'critical enablers' described in the framework are poorly defined, costed and tested. They are not universally agreed either, and rest uneasily on an unstable body of evidence. Further work is required to understand the barriers and enablers to effective HIV responses in every context, and to define and demonstrate the value for money of key interventions that are enabling.

The daily struggles to ensure access to HIV services to and to protect the human rights of very marginalised and poor people are well understood by community organisations. Sometimes a list of clinical and health promotion interventions fails to 'get at' the range of needs, struggles and problems shaping the lives of people who are detained, denied services, who are subject to violence, breaches of privacy, hate crime, discrimination and other violations, who live far from health services, who have uncertain immigration status or who are poor, young, old or socially isolated. Social and behavioural research, political science and operations research can define HIV and other

needs more deeply. They can help to build a bridge between our understanding of the complexity and extent of social and personal needs, and a set of health programmes that can stop HIV. The science that we bring to the model needs more social science, and more implementation science.

The critical programmatic enablers need to address corruption, capacity building, building social capital, strengthening community systems and strengthening health systems so that health systems better serve all people with HIV needs, including those who are criminalised and marginalised.

Acting on the investment framework

We need to act on this investment framework to more directly promote effective and community driven responses to HIV in each country where the Alliance operates. There is some critical thinking to be done. We can use this framework to intensify and improve national planning for HIV. Informed by the investment framework, some immediate tasks arise:

Ensure the framework is on the national agenda.

Do your national planning institutions (NACs, CCMs) know about it? Get this framework onto the agenda of these committees. Foster debate about the model. Brief government, civil society and relevant professional agencies about it. With UNAIDS and WHO colleagues, form a working group made up of relevant specialists to examine the meaning of the framework in your country: national HIV government/public health planners, HIV civil society organisations – both key population representatives and HIV programme implementers, HIV/TB clinicians and social/care providers, HIV technical agencies, clinical researchers, HIV/TB/SRH epidemiologists, HIV social scientists, HIV social care experts, HIV human rights specialists.

Identify the key populations, programmes and coverage levels in your country, and analyse assumptions.

Work with other experts to identify the most important populations, programmes and investments. Analyse how these programmes and critical enablers are synergising with other development sectors. Identify the most important critical enablers to ensure the programmes are of high quality and are reaching sufficient numbers of people from specifically targeted populations. Seek endorsement for your analysis, including from government. Analyse the assumptions in the model for your country. What interventions will make increases in ART most feasible? How do behaviour change communication and condom promotion interventions change as a result of increased evidence for treatment as prevention, and male circumcision? What will be the effects on sexual and injecting practice, and how will behaviour change communication respond? What are the community mobilisation efforts for the six programme areas?

Advocate for a more high impact, precisely targeted and costed national HIV programme.

Use this framework to advocate for more precision in targeting and for a more expanded and nuanced role for communities and their organisations. It will help to analyse current investments in HIV to ensure that our best efforts focus on high impact – the potential to prevent 12.2 million new HIV infections and prevent 7.4 million deaths due to AIDS by 2020.

ABOUT THE ALLIANCE

Established in 1993, the International HIV/AIDS Alliance is a global partnership of nationally-based linking organisations working in over 40 countries, to support community action on AIDS in developing countries.

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