



A COMPARATIVE ANALYSIS OF SELECTED
NATIONAL AIDS INVESTMENT CASES
FROM THE ASIA-PACIFIC REGION

BANGLADESH • INDONESIA • MYANMAR • NEPAL • PHILIPPINES • THAILAND • VIET NAM

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Acknowledge

The “Comparative Analysis of Selected National AIDS Investment Cases from Asia-Pacific Region” aims to review and analyse existing national AIDS investment cases and document country experiences in developing and utilizing it to effectively address the AIDS epidemic beyond 2015. It will inform country preparations for the United Nations General Assembly High-Level Meeting on Ending AIDS (HLM) on 8-10 June 2016 in New York, USA and in subsequent actions at regional and country level towards ending the AIDS epidemic, promoting country ownership of a sustained AIDS response, and in achieving the Sustainable Development Goals (SDGs). It draws from a thorough desk review of 7 national investment cases on AIDS (Bangladesh, Indonesia, Myanmar, Nepal, Philippines, Thailand, Viet Nam) using an analytical framework that was designed to facilitate an understanding of how national investment cases can be effectively developed and positioned to inform transition plans and support national commitment to the sustainable financing and implementation of AIDS responses. The comparative analysis benefited from the review, inputs and suggestions from national-level experts from Governments, civil society and the United Nations system, as well as regional networks of civil society organizations, development partners and representatives of the UN Regional Interagency Team on AIDS at the “Regional Expert Consultation on Developing Evidence-Based National HIV Investment Cases and Sustainability Plans” held in Bangkok, Thailand on 9-10 December 2015. This consultation was jointly organized by UN ESCAP and UNAIDS in cooperation with UNDP. The participants’ contributions are sincerely acknowledged. Special thanks to Sally Wellesley, the author of the report. The development of the report was managed by Dr Maria Elena G Filio-Borrromeo, Regional Investment and Efficiency Adviser, UNAIDS Regional Support Team, Asia Pacific (UNAIDS RST-AP); Ms Nelle Fredrick, Policy Support, Sustainable AIDS Financing, UNAIDS RST-AP; Mr Tristram Price, Associate Social Affairs Officer, UN ESCAP; and Mr Srinivas Tata, Chief Social Policy and Population Section, UN ESCAP.

Abbreviations and Acronyms

AEM:	AIDS Epidemic Model
AIDS:	Acquired Immune-Deficiency Syndrome
ART:	Anti-Retroviral Therapy
ARV:	Anti-Retroviral
BSS:	Behaviour sentinel surveillance
CSO:	Community Service Organization
DALYs:	Disability Affected Life Years
FSW:	Female Sex Workers
GDP:	Gross Domestic Product
GFATM:	The Global Fund to fight AIDS, TB and Malaria
HCT:	HIV Counselling and Testing
HIV:	Human Immunodeficiency Virus
HSS:	HIV sentinel surveillance
IBBS:	Integrated Biological and Behavioural Survey
IEC:	Information, Education and Communication
Int.\$	International dollars
IPT:	Intimate partner transmission
KP:	Key population(s)
MCH:	Maternal and Child Health
MoH:	Ministry of Health
MSM:	Men who have Sex with Men
MSW:	Male Sex Worker
NAC:	National AIDS Commission
NASA:	National AIDS Spending Assessment
NFM:	(Global Fund) New Funding Model
NGO:	Nongovernment Organisation
NIC:	National Investment Case
NSP:	Needle and syringe (exchange) programme
OST:	Opioid substitution therapy
PICT:	Provider-initiated counselling and testing
PLHIV:	People Living with HIV
PMTCT:	Prevention of Transmission from Mother to Child
PWID:	People Who Inject Drugs
STI:	Sexually Transmitted Infection
TB:	Tuberculosis
TG:	Transgender
UHC:	Universal health coverage
UNAIDS:	Joint United Nations Programme on HIV and AIDS
UNAIDS RST-AP:	UNAIDS Regional Support Team for Asia and the Pacific
UNDP:	United Nations Development Programme
UNESCAP:	United Nations Economic and Social Commission for Asia and the Pacific
US\$:	US Dollars
WHO:	World Health Organization

EXECUTIVE SUMMARY

Although significant progress has been made towards responding effectively to HIV and AIDS in the Asia-Pacific region, there are signs that without a scaled up response, countries risk witnessing a resurgence of new HIV infections.¹ However, the funding landscape is increasingly uncertain. With diminishing inflows of external financing for HIV and AIDS to the region, countries, particularly those that are moving towards middle income status, are preparing to significantly increase the domestic share of investment in HIV and AIDS programmes.

In 2012, UNAIDS launched the HIV strategic investment framework to guide countries in allocating limited resources for maximum impact. Central to this framework is the development of an investment case—a country-led, people-centred package of investment priorities that is based on a robust analysis of the epidemiology, the current response and recent scientific evidence.

In January 2015, United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) member states adopted a Regional Framework for Action on HIV and AIDS beyond 2015 that includes the development of evidence-based national HIV investment cases and sustainability plans. This further reinforces country commitments to move towards ensuring sustainable funding and the effective implementation of their national AIDS responses.

In support of these ongoing country-owned initiatives and the continued strengthening of national commitments to HIV funding, UNESCAP and the UNAIDS Regional Support Team for Asia and the Pacific (RST-AP) are working jointly on an initiative to enable countries to share, analyse and document their experiences in developing and using investment cases and sustainability plans to effectively address the AIDS epidemic beyond 2015.

This report is the outcome of a comparative analysis of seven national investment cases from the region, and highlights key findings and recommendations for further action. The findings from this report and the Regional Expert Consultation on Developing Evidence-Based National HIV Investment Cases and Sustainability Plans held in December 2015 are expected to contribute to the knowledge base on how ESCAP Member States have developed national investment cases (NICs), and identify examples of best practice.

The analysis was based primarily on a desk review of the investment cases of Bangladesh, Indonesia, Myanmar, Nepal (Investment Plan), the Philippines, Thailand and Viet Nam, with additional input from in-country respondents and from the Regional Expert Consultation. The analysis covered:

i) The development of the investment cases, looking specifically at:

- Consultation processes, including the involvement of key stakeholders and government endorsement;
- Structure and application of UNAIDS guidance on NICs;
- Objectives and purpose;
- Analytical methodologies employed (including the use of epidemiological and cost models) including their usefulness to specific country context; and
- Key data inputs (e.g. definition and size estimates of key populations; costings related to interventions), including a discussion of how data are validated and how epidemiological modelling address missing or incomplete data.

ii) Content and implications for sustainable financing, by considering:

- Interventions included in the NICs (including whether the interventions are appropriate and effectively respond to the nature of the epidemic in the country);
- How funding across the different elements of the AIDS response (i.e. prevention; treatment, care & support; policy formulation; program management; others) is allocated vis-à-vis the needs of the country based on the epidemic profile;
- How interventions related to prevention and social enablers are treated in NICs;
- Links to national health/development agendas and processes (including the extent to which the NICs demonstrate the effectiveness of investment in HIV & AIDS in relation to broader health/development goals, and to what extent it becomes integral to national planning processes)
- Identification of opportunities for increased efficiency and cost savings to generate better value for money;
- Identification of sustainable domestic financing and how the NIC has used it or plans to use it (e.g. the integration of HIV & AIDS into universal health coverage); and
- The positioning of the NICs with regard to communication with key stakeholders and decision makers.

A number of promising practices were identified:

- Including an analysis of potential sources of sustainable financing for the enhanced response, as provided by the Indonesia, Viet Nam and Philippines investment cases.
- Including an advocacy plan (as in the Indonesia NIC) to help national programmes tailor their investment advocacy more strategically.
- Investment cases highlight the need to avoid wasteful investments and invest resources strategically; moreover, they clearly demonstrate to stakeholders that the cost of not doing so will be failing to meet the target of 'Ending AIDS'.

Further actions are recommended to strengthen the utility of investment cases:

- Ensure that the document is tailored to the intended audience (technical or non-technical).
- Emphasize the costs of inaction, while also demonstrating that investment works, by highlighting achievements in terms of lives saved and deaths and infections averted.
- Strengthen links to, or alignment with, broader national development plans or goals.
- Identify and assess effective mechanisms for financing civil society.²
- Strengthen data and evidence, including data on costs and expenditure.
- Research sustainable financing options that could be replicated across the region.
- Document and share examples of how investment cases have been used successfully to overcome resistance to domestic investment in politically unpopular programmes such as harm reduction.
- Use the investment case as an initial step in the development of a transition plan towards sustainable AIDS financing.
- Update NICs periodically to adjust to evolving funding/legal/epidemiological landscapes as well as advances in prevention and treatment, such as PrEP.
- Engage all relevant stakeholders throughout the investment case cycle to foster ownership, ensure buy-in to the investment proposals, increase access to data sources and build capacity for ongoing investment case analyses.

1 Introduction

1.1 Background

Although significant progress has been made towards responding effectively to HIV and AIDS in the Asia-Pacific region, significant challenges remain. In Indonesia and the Philippines, the epidemic continues to expand, and elsewhere in the region there are signs that without a scaled up response, countries risk witnessing a resurgence of new HIV infections.³

As several countries in the region move towards middle income status, they face an uncertain landscape. Inflows of external financing for HIV and AIDS to the region are diminishing as donor countries grapple with economic recession and shifting priorities. Under the Global Fund's New Funding Model, countries are being called upon to significantly increase the domestic share of investment in HIV and AIDS programmes in order to remain eligible for funding. At the same time, countries are increasingly looking to take ownership of their responses and reduce their dependence on external development partners. This was reflected in the adoption of the Addis Ababa Action Agenda at the Third Conference on Financing for Development which, inter alia, calls for strengthening the mobilization and effective use of domestic resources for sustainable development.

In 2012, UNAIDS launched the HIV strategic investment framework to guide countries in allocating limited resources for maximum impact. Central to this framework is the development of an investment case—a country-led, people-centred package of investment priorities that is based on a robust analysis of the epidemiology, the current response and recent scientific evidence. To assist countries in developing strong investment cases, UNAIDS produced an investment tool that guides users to identify cost-effective, high-impact interventions and programme enablers, and plan a prioritised scale-up that will put them on track to achieve global targets on AIDS, including the goal of Ending AIDS by 2030. Investment cases are also intended to help countries to recognise opportunities to leverage sustainable funding and reduce inefficiencies.

Since 2012, several countries in the Asia-Pacific region—among them Bangladesh, Indonesia, Myanmar, Nepal, the Philippines, Thailand and Viet Nam—have developed evidence-based investment cases or investment plans, some of which are already being used by governments to mobilize increased domestic resources to accelerate the national AIDS response and prepare for the transition away from donor support.

At the Asia Pacific Intergovernmental Meeting on HIV and AIDS convened by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), UNAIDS and UNDP in January 2015, member states adopted a Regional Framework for Action on HIV and AIDS beyond 2015 that includes the commitment to evidence-based national HIV investment cases and sustainability plans. This further reinforces country commitments to move towards ensuring sustainable funding and the effective implementation of their national AIDS responses.

(i) As of July 2015, the World Bank classified world economies as follows, based on gross national income (GNI) estimates for 2014: low-income: GNI per capita of 1,045 or less; lower middle-income: GNI per capita of more than \$1,045 but less than \$4,125; upper-middle-income: GNI per capita of \$4,125 or more but less than \$12,736; high-income: GNI per capita of \$12,736 or more. <http://data.worldbank.org/news/new-country-classifications-2015>

In support of these ongoing country-owned initiatives and the continued strengthening of national commitments to HIV funding, UNESCAP and the UNAIDS Regional Support Team for Asia and the Pacific (RST-AP) are working jointly on an initiative to enable countries to share, analyse and document their experiences in developing and using investment cases and sustainability plans to effectively address the AIDS epidemic beyond 2015. This includes holding a regional consultation on ensuring sustainable financing of the AIDS response among some Member States.

This report is the outcome of a comparative analysis of existing national investment cases from the region, and highlights key findings and recommendations for further action. It is envisaged that the report, together with the findings from a Regional Expert Consultation on Developing Evidence-Based National HIV Investment Cases and Sustainability Plans in December 2015, will contribute to the knowledge base on how ESCAP Member States have developed national investment cases (NICs) and identify examples of best practice.

The national investment cases analysed in this report are those of Bangladesh, Indonesia, Myanmar, Nepal (Investment Plan), the Philippines, Thailand and Viet Nam. Following a brief explanation of the report methodology below, Chapter 2 presents a brief overview of each NIC and the context in which it was developed. Chapter 3 discusses the findings, identifying key similarities and differences in the approaches to developing the NIC employed by each country, as well as challenges encountered. Chapter 4 highlights key issues from the analysis, either as examples of 'good practice' that can be applied in the development of future investment cases, or with suggestions for further action to address challenges or weaknesses in current practice.

1.2 Methodology

The report is based on a desk review of the designated NICs using an analytical framework that was designed to facilitate an understanding of how national investment cases can be effectively developed and positioned to inform transition plans and support the case for national commitment to the sustainable financing and implementation of AIDS responses.

The analysis covered the following:

i) Development/Process

- Consultation processes, including the involvement of key stakeholders and government endorsement.
- Structure and application of UNAIDS guidance on NICs.
- Objectives and purpose.
- Analytical methodologies employed (including the use of epidemiological and cost models) including their usefulness to specific country context.
- Key data inputs (e.g. definition and size estimates of key populations; costings related to interventions), including a discussion of how data are validated and how epidemiological modelling address missing or incomplete data.

ii) Content and implications for sustainable financing

- Interventions included in the NICs (including whether the interventions are appropriate and effectively respond to the nature of the epidemic in the country).
- How funding across the different elements of the AIDS response (i.e. prevention; treatment, care & support; policy formulation; program management; others) is allocated vis-à-vis the needs of the country based on the epidemic profile.

- How interventions related to prevention and social enablers are treated in NICs.
- Links to national health/development agendas and processes (including the extent to which the NICs demonstrate the effectiveness of investment in HIV & AIDS in relation to broader health/development goals, and to what extent it becomes integral to national planning processes)
- Identification of opportunities for increased efficiency and cost savings to generate better value for money.
- Identification of sustainable domestic financing and how the NIC has used it or plans to use it (e.g. the integration of HIV & AIDS into universal health coverage).
- Positioning of the NICs with regard to communication with key stakeholders and decision makers.

The analysis was primarily based on a desk review of the investment cases. Supplementary information was provided by in-country respondents who had been directly involved with the development of the investment case. Additional input was drawn from the Regional Expert Consultation on Developing Evidence-Based National HIV Investment Cases and Sustainability Plans, held in Bangkok on 9-10 December 2015.

2 Key Findings from the National Investment Cases

This section presents a brief overview of each NIC and the context in which it was developed. All socio-demographic and HIV data are sourced from the HIV and AIDS Data Hub for Asia Pacific⁴ unless otherwise indicated. Gross domestic product (GDP) amounts are stated in Purchasing Power Parity (PPP) US dollars. 'Testing coverage' or 'HCT coverage' refers to the percentage of key populations (KPs) who had taken an HIV test in the last 12 months and received the results. PMTCT (prevention of mother-to-child transmission) coverage refers to pregnant women living with HIV who are receiving antiretroviral therapy (ART).

It should be noted that the East-West Center of the University of Hawaii provided extensive technical assistance to all the countries that developed investment cases based on AEM analyses.



BANGLADESH

As of 2014, Bangladesh was classified as a lower-income country.⁵ With a total population of 158 million, it had a GDP per capita of US\$829 in 2013. Per capital total health expenditure in 2011 was Int. \$67.

The key populations affected by HIV and AIDS in Bangladesh are female sex workers (FSW), men who have sex with men (MSM), male sex workers (MSW), hijras (transgender people) and people who inject drugs (PWID). HIV prevalence was most recently measured at below 1% among all these key populations except for PWID. Nationally, HIV prevalence among PWID was 1.1% in 2011, although rates of up to 5.3% were recorded in Dhaka, the capital. Modelling indicates that more than half of HIV transmission is now related to sex work, while male-to-male transmission accounts for 9% of new infections and use of contaminated needles, 2%. Intimate partner transmission (from husband to wife) is thought to account for almost one-third of all new infections. Geographically, the epidemic is concentrated in Dhaka, and to a lesser extent in Sylhet and Chittagong. Recent data on risk behaviour among PWID and FSW are limited but surveys indicate that in 2013, 49% of MSM used a condom at the last sex.

A total of \$21.1 million was spent on Bangladesh's AIDS response in 2013, of which 16% came from domestic sources. Over half of this spending went to prevention, with less than 6% allocated for care and treatment. International sources accounted for 84% of prevention expenditure and 85% of spending on care and treatment.

Less than half of all KPs were reached by prevention programmes in 2014, with coverage ranging from above 45% for FSW and hijra to less than 40% for MSM, MSW and street-based FSW. While opioid substitution therapy (OST) coverage was below 4%, needle and syringe programme (NSP) coverage of males and females who inject drugs was 83% and 45%.⁶ Female sex workers and their clients accounted for the largest share of prevention spending (48%) in 2013, while 20% was allocated to PWID and 12% to MSM.

Less than half of all KPs received an HIV test and the results in 2013-14. Treatment is scaling up slowly but only 14% of the estimated 8,900 adult PLHIV were receiving ART in 2014 and 18% of pregnant women living with HIV were on treatment. It is estimated that there are fewer than 200 pregnant women living with HIV.

With frequent funding gaps and the global winding down of financial support for HIV programmes, as well as the country's vulnerability due to various socio-economic and cultural factors, including high rates of labour migration, the country faces a challenge to maintain low rates of HIV prevalence among key populations: the most recent AIDS Epidemic Modelling (AEM) exercise indicates that maintaining interventions at the current coverage and intensity will not be sufficient to end AIDS. An investment case has therefore been developed to demonstrate the need for increased domestic investment in the response and to present high-impact, cost-effective and sustainable investment options that will maximise the impact of the limited resources available.

At the time of writing, the country's investment case, 'Prioritizing Investment Options in HIV Response in Bangladesh to End AIDS by 2030', was still in draft form. The investment case, which is about 25 pages long before annexes, is based on the UNAIDS framework and is derived from an AEM exercise undertaken in 2015.

The investment case was used in the preparation of the Global Fund NFM application, which has already been approved. It is currently being used as input for the forthcoming health sector plan and will inform a revision of the national AIDS strategic plan that is planned for 2017. The NIC can also be accessed by interested agencies for the preparation of funding proposals, and as such will contribute to harmonisation of resources and programmes. The investment case will be updated with new evidence that will become available in 2016.

The key elements of the draft Bangladesh investment case are summarised below:

Coordinator and process:

- The process was led by the Ministry of Health and Family Welfare with collaboration from other sectors, development partners and civil society.
- A Steering Committee and a Working Group were established to ensure appropriate levels of technical participation and policy guidance. Several consultative meetings were held to review unit costs and to develop, validate and analyse the baseline model and scenarios.
- Findings were shared with the relevant stakeholders including government ministries, the National AIDS/STD Programme (NASP), the National TWG on M&E and Strategic Information in HIV and AIDS (whose membership includes KP

and PLHIV networks and CSOs) and development partners, as well as a wider group of key populations and PLHIV. The process is detailed in an annex.

Outcomes of modelling:

- Six investment options (including a baseline scenario) are compared.
- Impacts and costs are projected from 2015 until 2030 but the detailed cost-effectiveness analysis only covers the years 2015-2020.
- The most cost-effective option is a rapid scale-up of universal access for all PLHIV and a scale-up of prevention coverage for KPs as per the NSP in 23 priority districts, while halving prevention coverage and maintaining current treatment coverage (CD4<350) in the 41 remaining districts. Unit costs are to be reduced by 20% from the current costed implementation plan.

Key recommendations and extent to which they reflect the modelling and analysis:

- The highest priorities are: focus on KPs in high-burden areas; scale up HIV testing and treatment for KPs; ensure a sufficient supply of antiretroviral drugs; build on existing experiences to maximize efficiency; and use new technologies and test for triage (piloting of peer-led and community-based models; revision of testing algorithms and guidelines).
- In addition, community support for adherence should be enhanced by empowering and supporting communities, particularly PLHIV and KP networks and organizations.
- Other programmatic challenges that need to be addressed include: quality of services and delivery; the diversity of facility costs; getting returns on investment in a low prevalence country; social stigma and discrimination; gaps in the treatment cascade; addressing the epidemic in adolescents and children; setting up HTC and community-based and peer-led testing in a cost-efficient manner.
- In general, the investment options and interventions recommended seem to be consistent with the geographical concentration and projected trajectory of the epidemic in the country. However, there is little information on how intimate partner transmission (estimated to account for 31% of new infections in 2014) is to be addressed.

Efficiencies and options for sustainable financing identified:

- Efficiencies will be derived from better strategic planning (geographically targeted interventions that are optimized for key populations, and scaling up treatment to maximize returns on investment); and making better use of existing infrastructure through capacity building.
- No sustainable domestic financing opportunities are identified.

Other features:

- The document discusses lessons learned from the implementation of a range of interventions with young KPs, clients of sex workers, migrant workers, pregnant women and young people, and identifies possibilities for integrating the more effective strategies with the responses for KPs.



INDONESIA

Indonesia is by far the largest of all the countries included in the study in terms of both area and population, with over 252 million people in 2014. With a per capita GDP of US\$3475 in 2013, it is in the upper band of lower-middle-income countries. Per capita health expenditure in 2011 was Int. \$132.

In most of Indonesia, the HIV epidemic is concentrated among MSM, FSW, PWID and transgender people, but there is a low-level generalised epidemic in the provinces of Papua and West Papua. The most recent data suggest that the epidemic is beginning to stabilise among most key populations and among the general population in Papua and West Papua, but continues to expand among MSM. New infections are also on the rise among women in the general population. According to integrated bio-behavioural surveys in 2011, national HIV prevalence is highest among PWID, at 36.4%, followed by transgender people (21.9%), MSM (8.5%) and FSW (7%). There is considerable regional variation, however: for example, in Jakarta, HIV prevalence has been recorded at 56% among PWID and 30% among transgender people. Risky behaviours persist: in 2011 60% of MSM and FSW and 52% of PWID reported using a condom at the last sex but consistent condom use was below 50% for all KPs. On the other hand, almost 90% of PWID reported using sterile equipment at the last injection.

Of Indonesia's 502 cities and districts (which are administratively at the same level), 141 have been prioritized for HIV interventions. The response is currently focused around three strategic priorities: (i) the adoption of integrated continuum of care services, decentralized to the district/city level (known as *Layanan Komprehensif Berkelanjutan*, or LKB); (ii) expanding the strategic use of ARVs ('SUFA'),⁷ and (iii) the wider adoption of evidence-based good practices to increase the effectiveness of key interventions.

Indonesia's AIDS expenditure reached US\$87.5 million in 2012, of which 42% was sourced domestically. Around 27% was spent on prevention and 36% on care and treatment, increasing from 25% in 2011. Almost three-quarters of prevention spending (71%) were from international sources. Conversely, 75% of spending on care and treatment was domestically funded.

Resource allocation for prevention programming for KPs has averaged below 15% of all prevention expenditure between 2006 and 2012. While there have been notable successes, such as the reduced use of non-sterile injecting equipment by PWID, programme coverage and effectiveness among MSM, among whom HIV transmission is increasing, remains very limited.

In 2011, 39% of MSM, 57% of FSW and 63% of PWID had had an HIV test in the last 12 months and received their results. Both HIV counselling and testing (HCT) and ART (including efforts to increase retention) are currently being significantly scaled up, but in 2014 just 8% of the estimated 660,000 PLHIV in Indonesia were on treatment. There is also a large unmet need for PMTCT, as 10% of the estimated 14,000 pregnant women living with HIV were receiving ART in 2014.

Indonesia's investment case, entitled 'The Case for Increased and More Strategic Investment in HIV in Indonesia', was finalised in 2015, although the preface notes that it is a work in progress and will be updated once data from mapping and estimates exercises and IBBS undertaken in 2015 become available. Work began on the investment case analysis in 2013, in part to inform the development of both the new national AIDS strategy and action plan for 2015-2019 and Indonesia's NFM concept note for Global Fund support. The results of the analysis did indeed guide these two documents, even though the investment case had not been officially finalised/published at the time. The IC was also intended to inform a strategy for the transition to greater domestic investment post-2017, including coverage of HIV under the new universal health coverage scheme, which Indonesia began to roll out in 2014. An additional impetus for the development of the IC was to advocate to the new administration and legislature, following a general

election in 2014. The investment case is structured around the UNAIDS framework and has around 36 pages before annexes.

The key elements of Indonesia's investment case are summarised below:

Coordinator and process:

- The process was instigated by the UNAIDS Country Office, and coordinated by a national committee, chaired by the National AIDS Commission (NAC) and the Ministry of Health, with representation from key stakeholders in the response. Technical consultations were held with USAID, DFAT, the World Bank and WHO; PLHIV and CSOs were also consulted.
- Findings were shared with a broad group of relevant stakeholders through the NFM concept note development process.

Outcomes of modelling:

- Potential impacts of the main strategic priorities of the response (LKB, SUFA and wider adoption of evidence-based good practices) at different levels of coverage and implementation effectiveness are assessed. A total of nine scenarios are compared, but five are highlighted.
- Impacts and costs are projected from 2014 until 2030.
- Significant impact is projected for the current initiatives at a 'high' level of implementation performance. To reduce new HIV infections and AIDS-related deaths, the immediate priority should be to get more people tested and onto treatment. Sensitivity analyses confirm that strategic use of ARVs significantly enhances the impact of prevention programme efforts. Analyses also indicate that changing the ART initiation threshold from CD4<350 to CD4<500 for PLHIV other than KPs, TB patients, PLHIV with HIV-negative partners and pregnant women living with HIV would have little impact at the current low levels of coverage.

Key recommendations and extent to which they reflect the modelling and analysis:

- The recommended priorities are:
 - Decentralise and improve integration of HIV services within and between health facilities and in community settings.
 - Aggressive implementation of SUFA, with significant expansion of testing coverage and improvements in care and patient retention.
 - Increase intensity and quality of implementation to more closely approximate international good practices.
 - Increase program coverage among MSM, in line with the epidemic trajectory among this population; and clients of sex workers, to address the increasing infections among general population women through IPT.
 - Consider piloting the use of Truvada for PrEP.
- These priorities appear to be consistent with the modelling and epidemic analysis; however, the IC does not account for certain critical enablers such as reducing stigma and discrimination (although these are addressed in the national strategic plan) and legal/policy barriers to access.

Efficiencies and options for sustainable financing identified:

- Proposed efficiencies include a switch to cheaper drugs; the potential savings are calculated. Other efficiencies could be driven by improving the integration of HIV services at health facilities to reduce 'missed opportunities' to get KPs tested for HIV and STIs treated; and improved coordination between health facilities and CBOs.
- Possible sustainable funding sources are discussed at length, and include increased local government funding; increased private philanthropy; increased

coverage of HIV-related services by the national health insurance scheme; and increased private health sector participation in addressing HIV and AIDS via government subsidies.

Other features:

- An advocacy strategy for increasing financial support for HIV programming in Indonesia.
- Recommendations for undertaking provincial- and district-level investment case analyses.



MYANMAR

With a per capita GDP of US\$1,126 in 2012, Myanmar is a lower-middle-income country. Per capita health expenditure in 2011 was Int. \$23. The total population in 2014 was 53,719 million.

The epidemic is concentrated among men who have sex with men, female sex workers and people who inject drugs. The most recent surveillance data (2014) indicate HIV prevalence of 23.1% among PWID, 6.6% among MSM and 6.3% among FSW. The national data mask wide geographical variance, with rates recorded of up to 35.5% among PWID, 15% among MSM and 13% among FSW in certain areas. HIV prevalence has recently shown an increase among PWID, and according to AEM projections, the single largest source of new infections in 2015 will be the use of contaminated injecting equipment. Prevalence appears to be flattening or declining among the other key populations but projections indicate that MSM will account for an increasing number of new HIV infections in future. HIV prevalence is also on the rise among 'low-risk' women: one-third of new infections are estimated to occur among female partners of KPs.

Total spending on AIDS was US\$53.5 million in 2013, a significant increase from US\$39.4 million in 2012.⁸ Domestic financing accounted for 4% of the total. In 2011 roughly 45% of total spending was allocated to care and treatment and slightly less to prevention.

Assessing programmatic coverage when Myanmar's NIC was being developed was challenging, as the most recent behavioural surveillance surveys had been carried out in 2007-8 (PWID and FSW) and 2009 (MSM). At that time, 53% of PWID, 76% of FSW and 69% of MSM were being reached. Recent programme monitoring data suggest that coverage is scaling up. Distribution of sterile needles is increasing and the number of PWID receiving OST increased by one-third from 2012 to 2013. However, due to the remoteness of some areas and ongoing conflict in others, as well as other factors, gaps in the coverage of harm reduction services persist.

Uptake of HCT is increasing. In 2012, 13,986 FSW, 12,694 MSM and 4,540 PWID received an HIV test and post-test counselling. Treatment is scaling up in terms of sites and numbers of people on treatment (from 96 sites in 2011 to 147 in 2013; 40,000 on ART in 2011 to 67,643 in 2013). In 2014, 40% of the estimated 210,000 PLHIV in Myanmar were receiving ART. At 79% of an estimated 4600 pregnant women living with HIV, PMTCT coverage is relatively high for the region.

With uncertainty over the future of external funding for the AIDS response, Myanmar saw a need to reassess the evidence and optimise programmes to ensure greater impact and value for money, while leveraging greater domestic and international support, in order to achieve substantial reductions in HIV incidence and AIDS-related mortality by 2020.

'Investing for Impact'. From Resources to Results: Getting to Zero in Myanmar' was developed in 2013. It was designed to alert decision makers to the decline in global resources for HIV and AIDS and highlight the need for continued funding of the HIV response, with an increased domestic contribution, in order to influence the course of the epidemic. With about 25 pages of text and no annexes, the NIC is essentially based on the UNAIDS framework. The investment scenarios will be updated in December 2015, based on new targets, population size estimates and unit costs, and will be used in the new HIV National Strategic Plan 2016-2020.

The key elements of Myanmar's investment case are summarised below:

Coordinator and process:

- The process was led by the UNAIDS Country Office, with collaboration from the National AIDS Programme (Ministry of Health), the UN Joint Team on AIDS, donors and main NGO implementing partners such as PSI, MSF and MDM.
- The narrative report does not provide any information on the IC development process or those involved.

Outcomes of modelling:

- Four scale-up scenarios are compared using the AEM (impacts/resources).
- Impacts and costs are projected from 2013 until 2020.
- The 'optimal' scenario is a full scale-up of prevention interventions for KPs with the maximum feasible coverage of the most at risk sub-populations: 85% of FSW; 85% of MSM at high risk and 35% of MSM at lower risk; 60% of PWID reached with needle and syringe programmes and 10% of PWID covered by OST; and expanding ART to cover 85% of those in need.

Key recommendations and extent to which they reflect the modelling and analysis:

- Recommended strategies for the greatest impact are: maintaining the focus on interventions for KPs; scaling up harm reduction for PWID (this will avert more new infections than any other intervention); expanding programme coverage among MSM at high risk; scaling up ART, by increasing and decentralising treatment sites, to 85% of those in need.
- More intensive efforts are needed to reach younger FSW and MSM before they become infected.
- Decentralise HIV counselling and testing and switch to rapid HIV tests to support the treatment scale-up.
- Integrate HCT into antenatal care settings to support the ART scale-up and reach female partners of KPs, who currently account for one-third of new infections.
- The recommendations are consistent with the modelling and analysis.

Efficiencies and options for sustainable financing identified:

- Efficiency measures identified include using a single regimen for first-line ART, using rapid HIV testing, developing standardised packages for prevention services, better integration of HIV with general health services and using unit cost data and cost effectiveness analyses to identify where further savings can be made.
- No specific measures to increase sustainable domestic financing are proposed, although the IC does note the government's commitment to increasing budgetary allocations for the health sector, in part through social/health insurance. It also notes that the government has expanded PMTCT coverage and plans to further integrate HCT into ANC settings.

Other features:

- As mentioned above, a key challenge in developing Myanmar's investment case was the lack of, or gaps in, critical data on HIV prevalence, incidence and AIDS mortality; high burden areas and localities; population sizes; risk behaviours; and programme coverage. For the purposes of the AEM analysis, notional standardised, costed packages of services were agreed by the stakeholder group above. Nevertheless it was felt that this did not provide a sufficiently robust basis for a cost-effectiveness analysis.



NEPAL

Nepal is a lower-income country, with a per capita GDP of US\$694 in 2013. The total population in 2014 was 28,121 million. Per capita health expenditure in 2011 was Int. \$85. Nepal's HIV epidemic is concentrated among men who have sex with men, female sex workers, people who inject drugs, and male labour migrants. Nationally, prevalence was measured in 2011-12 at 1.7% among FSW, 6.3% among PWID and 3.8% among MSM; however, among certain sub-populations, such as male sex workers, transgender sex workers, street-based female sex workers and female sex workers who inject drugs, prevalence is higher. Recent estimates indicate that 'low-risk' women account for 30% of all HIV infections. Reported condom use at the last sex was 91% among MSM in 2012, 47% among PWID in 2011 and 83% among FSW in 2011. Significant progress has been made towards safer injecting, with around 5% of PWID reporting the use of shared equipment in the last week in 2011. Overall, the epidemic is on a downward trajectory, with new infections and AIDS-related mortality beginning to decline.

The most recent year for which AIDS spending data are available is 2009, when US\$19.9 million, almost entirely donor funding, was spent on the response.⁹ Around 55% of this went to prevention, and 6% was spent on care and treatment.

Just under two-thirds of MSM and FSW in Nepal were reached by prevention programmes in 2011-2012. There is a large unmet need for needle/syringe and OST services. Testing coverage remains low among all KPs: the most recent data indicate that in 2011-2012 55% of FSW, 21% of PWID and 42% of MSM in the Kathmandu Valley had received an HIV test and the results in the last 12 months. In 2014, 27% of the estimated 39,000 adults living with HIV were receiving ART and 33% of pregnant women living with HIV—estimated at less than 500—were covered by PMTCT.

Nepal's investment case document, 'The Nepal HIV Investment Plan', was published in October 2013. The development process took place in parallel with the drafting of Nepal's Phase 2 Renewal Request for its Global Fund Single Stream Funding HIV grant. The Investment Plan was endorsed by the Health Secretary, who acknowledged the intended role of the Plan in driving the implementation of the final three years of the National HIV Strategy 2011-2016. The Plan substantially informed Nepal's NFM concept note, which was submitted to the Global Fund the following year.

The Investment Plan has 23 pages before annexes, and is based on the principles of the UNAIDS framework. The Plan was designed to identify specific strategies that would have the greatest impact achieving the 'Getting to Zero' goal, and to estimate the resources required over the three-year period.

Unlike the other ICs in the study, the cost-effectiveness analysis is not derived from an AEM exercise but is instead based on a triangulation of the country's epidemic data with evidence from various cost-effectiveness studies among KPs in Asia. The results were used as the basis for selecting priority interventions. Accordingly, there is no calculation

of projected impact or cost savings. Nepal has since carried out an AEM exercise and updated its investment priorities and unit costs; these will be incorporated in the country's National Strategic HIV Plan 2016-2021, which will be drafted in early 2016. The key elements of Nepal's investment plan are summarised below:

Coordinator and process:

- The process was instigated by the UNAIDS Country Office, and directed by a Steering Committee comprising representatives from the Ministry of Health and Population, the National Centre for AIDS and STD Control (NCASC), the Ministries of Finance, Home Affairs, and Women, Children and Social Welfare government, PLHIV, KPs, development partners and NGOs.
- The Working Group comprised NCASC, WHO, UNAIDS, KPs, programme implementers and consultants. The group consulted extensively with stakeholders throughout the process.
- The Plan was endorsed by the Health Secretary.

Outcomes of modelling:

- The cost-effectiveness analysis is derived not from an AEM exercise but is instead based on a triangulation of the country's epidemic data with evidence from various cost-effectiveness studies among KPs in Asia. The results were used as the basis for selecting priority interventions. Accordingly, there is no calculation of projected impact or cost savings.
- The investment plan covers the period 2014 to 2016.

Key recommendations and extent to which they reflect the modelling and analysis:

- First priorities are a scale up of basic programme activities and critical enablers to achieve 80% coverage of the most affected key sub-populations: female sex workers who inject drugs, street-based sex workers, transgender sex workers, male sex workers); 60% coverage of other transgender people, MSM and PWID; a rapid scale-up of testing, including community-based testing; immediate treatment ('Test, Treat and Retain') for KPs; an effective elimination of vertical transmission (eVT) programme, particularly for KPs.
- Second priorities are mobile populations and their families; women who are at higher risk of exposure to HIV, such as the female partners of males who inject drugs and of MSM; and HIV sero-discordant couples.
- The recommendations are largely consistent epidemiological and cost-effectiveness analyses.

Efficiencies and options for sustainable financing identified:

- Proposed opportunities to increase programmatic efficiency and impact include improving cooperation among NGOs to reduce duplication and fragmentation of services; and cooperation between government, private, NGO and community service providers.
- The resource gap is analysed but options for mobilising sustainable domestic financing are not discussed.

Other features:

- The document includes a detailed operational plan and budget for the 3-year plan.
- One of the innovative features of Nepal's Investment Plan is that for the first time in the country, KPs are disaggregated into sub-populations based on epidemiology, infection dynamics and current levels of coverage, to ensure more targeted interventions and greater coverage of hard-to-reach populations.



PHILIPPINES

With a per capita GDP of US\$2765 in 2013, the Philippines is in the upper band of lower-middle-income countries. Per capita health expenditure in 2011 was Int. \$182. The total population stood at just over 100 million in 2014.

Having maintained relatively low HIV prevalence for the last two decades, the Philippines is one of the few countries in the region that is now seeing a rapid expansion of the epidemic among key populations. In 2013, prevalence was 3.3% among MSM, 0.4% among FSW, 3.7% among transgender sex workers¹⁰ and 1.1% among male sex workers. Among PWID, prevalence escalated from 13.6% in 2011 to 44.9% in 2013.¹¹ This appears to be driven by an increase in the use of non-sterile injecting equipment: the proportion of PWID reporting the use of clean needles and syringes fell from 85% in 2009 to 33% in 2013. While 73% of FSW and 55% of transgender sex workers reported using a condom at the last sex in 2013, the figure fell well below 50% for MSM, MSW and PWID. Unprotected male-to-male sex now accounts for the largest share of HIV transmission in the Philippines. The Department of Health (DoH) has prioritised 70 sites in the country for HIV interventions; 22 of these, including all the cities within Metro Manila, are categorized as very high priority.

In 2013 the Philippines invested US\$10.3 million in the AIDS response; 43.9% of this was sourced domestically. Domestic sources accounted for 48% of prevention spending and 31% of care and treatment spending in 2013. Just under 50% of total expenditure went to prevention in 2013, while 23% was spent on treatment. Less than 30% of prevention programme spending targeted KPs.

This lack of focus on priority populations is reflected in the generally low prevention programme coverage of KPs: 54% of MSW, 32% of TG sex workers and 23% of MSM were reached in 2013. This in turn contributes to low testing coverage, with 16% of FSW, 9% of MSM and 6% of PWID receiving an HIV test and their results in 2013. ART is scaling up slowly but in 2014, 24% of the estimated 36,000 adults living with HIV were on ART. Of less than 500 pregnant women estimated to be living with HIV in 2013, 10% were receiving ART.

Beginning in 2012, the country undertook an inter-agency AEM exercise, led by the DoH's National Epidemiology Center (NEC) and the Philippines National AIDS Council (PNAC), to validate the cost estimates in the AMTP5 Investment Plan (developed in 2011-2012 by PNAC and the National Economic and Development Authority - NEDA) and to model the outcomes and impact of the investment scenarios. Several national stakeholder meetings were held to validate the results and costings. With the country facing a potential explosion of the epidemic at a time when international support is beginning to recede, it was decided that selected investment options from the AEM should be highlighted in an advocacy document to demonstrate how the scarce resources available could be targeted for maximum impact, and to present a compelling case for a substantial and sustainable increase in domestic funding over the next decade.

'Investment Options for Ending AIDS in the Philippines by 2022' was published by the UNAIDS Country Office in January 2015. The 30-page document is based on the UNAIDS framework. The AEM report and the investment options document have informed the 2015-onwards Health Sector Plan on AIDS, the Global Fund NFM funding application; the 2016 National Budget hearings in Congress, and PNAC's annual budget planning for 2016 onwards.

The key elements of the Philippines' investment case are summarised below:

Coordinator and process:

- The AEM exercise was led by the DoH's National Epidemiology Center (NEC) and the Philippines National AIDS Council (PNAC) with representatives from the National AIDS/STD Prevention and Control Program (NASPCP), UNAIDS, NEDA, NGOs and others. Several national stakeholder consultation and validation meetings were conducted to validate the results and assumptions. The AEM report was endorsed by the government.
- The investment case process was led by the UNAIDS Country Office in collaboration with the NEC and PNAC.

Outcomes of modelling:

- Three investment scale-up scenarios are compared.
- Impacts and costs are projected from 2015 until 2030.
- Modelling indicates that the highest impact will be delivered by scaling up treatment coverage to 90% of all PLHIV by 2017; reaching 90% of MSM and PWID with prevention programs; and sustaining prevention coverage for FSW at current levels. Together, these interventions would end AIDS as a public health threat by 2022.

Key recommendations and extent to which they reflect the modelling and analysis:

- The recommended priorities are: scaling up evidence-based interventions for MSM and PWID; scaling up HIV testing and treatment for KPs; ensuring a sufficient supply of ARVs; enhancing care and support to improve adherence; focusing on KPs in high-burden areas; integrating and decentralizing HIV service delivery systems; increasing enrolment in the national health insurance scheme (PhilHealth); and leveraging sustainable financing.
- The recommendations are largely consistent with the modelling and epidemiological analysis, but there is little indication of investment in addressing the growing number of general population women who are exposed to HIV by long-term partners who are KPs or clients of FSW.

Efficiencies and options for sustainable financing identified:

- The investment options document discusses a number of opportunities for savings and efficiencies such as strengthening supply chain management, and maximising synergies between public, private and community health care systems.
- Potential sustainable financing options include increasing enrolment of PLHIV in the national health insurance scheme and increasing its coverage of HIV services; mobilising local government and multisectoral budgets; tax revenues ('sin tax' on tobacco and alcohol); and partnerships with the private sector.

Other features:

- The complete analysis and assumptions are documented in the full AEM report, a separate document.



THAILAND

With GDP per capita of US\$13,586 (2012), Thailand is the only upper-middle-income country included in this study. The total population stood at 70,243 million in 2013. Total per capita health expenditure in 2009 was Int. \$327.

Thailand's HIV epidemic is concentrated among men who have sex with men, female sex workers and people who inject drugs. Following a sustained and effective response,

numbers of PLHIV, new infections and AIDS-related deaths are now in decline, and vertical transmission from mothers to children has been virtually eliminated. However, HIV prevalence remains high among key populations: in 2012 it was measured nationally at 25.2% among PWID, 2.2% among FSW and 7.1% among MSM, although prevalence of up to 24.4 was found in Bangkok. HIV transmission is now being driven by unprotected male-to-male sex. Intimate partner transmission from KPs to their female partners is a growing concern, and currently accounts for 31% of new infections. The epidemic is also geographically concentrated in certain districts and provinces.

Thailand spent a total of US\$314.4 million on the response in 2011, of which 85% was from domestic sources. Care and treatment absorbed 75% of this expenditure, with 11% going to prevention. Over half of all prevention spending (56%) in 2011 was supported by international funding, while care and treatment is almost entirely funded by the government. Key populations accounted for 23% of prevention spending in 2011.

HIV prevention programmes reached 54% of FSW and 53% of MSM in 2012. In that year, 94% of FSW, 86% of MSM and 49% of PWID reported condom use at the last sex. NSP coverage is low, but in 2012, 80% of PWID reported using sterile equipment the last time they injected. Prevention interventions are also focused on migrants, young people and the private sector.

Uptake of HCT is still limited: testing coverage was reported at 56% for FSW, 44% for PWID and 26% for MSM in 2012. In 2014, 61% of the estimated 450,000 adults living with HIV were receiving treatment, and PMTCT coverage (of an estimated 4800 pregnant women living with HIV) was 95%.

Despite the successes of the response, Thailand recognised that without a refocused response that included more strategic utilisation of the preventive effects of treatment, it may not succeed in reducing new infections to the targeted levels.

'Ending AIDS in Thailand' is, at two pages and no annexes, the shortest of all the investment cases studied. Produced in 2013, it summarises the epidemic situation and current response in Thailand, before outlining the strategies needed to optimise the response and end AIDS as a public health threat. It has been endorsed by the National AIDS Committee (NAC), which is chaired by the Deputy Prime Minister and comprises the Ministry of Public Health (MOPH), the Finance Ministry, the Planning & Development Ministry, and networks/CSOs/representatives of key populations and PLHIV.

The analysis presented in the investment case informed the development of Thailand's National Operational Plan 2015-2019 and the Global Fund NFM funding application for 2015-2016.

The key elements of Thailand's investment case are summarised below:

Coordinator and process:

- The investment case was instigated by the National AIDS Management Center (NAMc)/MOPH, the Secretariat of the NAC and UNAIDS, and the process was led by the NAMc. Input was provided by several technical partners, including the Bureau of AIDS and STI, estimation and projection experts from the Bureau of Epidemiology/MOPH, USCDC, the National Health Security Office (NHSO) on Universal Health Coverage, national health economists (IHPP, HITAP), the Thai Red Cross, UNAIDS and WHO, and academics. A national consensus was organized for a wider stakeholder group, including program managers and

civil society (including representatives of PLHIV and key populations) to review the preliminary results. This information was provided by country respondents: the document itself does not include any information on the process.

Outcomes of modelling:

- The impacts new infections, costs and benefits of three different treatment scale-up options are described briefly.
- Impacts and costs are projected from 2014 until 2022.
- The cost-benefit analysis suggests that investing US\$100 million over the next decade in HIV testing, early treatment (regardless of CD4 count), and adherence support can yield more than US\$300 million in saved hospitalization and treatment costs and productivity gains.

Key recommendations and extent to which they reflect the modelling and analysis:

- The NIC recommends a geographically targeted, scaled up response that focuses on combination prevention. This includes innovative service delivery models to increase testing and generate demand among KPs for services along the prevention-treatment-care continuum; strategic use of ARV; early treatment; and community adherence support. This is to be supported by strengthened data management and reporting information.
- This very brief document does not reflect the full investment strategy. As it stands, the IC focuses on scaling up the strategic use of ART but does not address other interventions that may be indicated by the epidemiological analysis, such as harm reduction and measures to address IPT (which accounts for an estimated 31% of new infections), or the enablers required to maximise returns on the investment.

Efficiencies and options for sustainable financing identified:

- The IC notes that savings could be made by focusing financial and human resources on high impact interventions.
- Sustainable financing is not discussed.



VIET NAM

Viet Nam had a total population of 92,548 million in 2014. It is a lower-middle-income country, generating a per capita GDP of US\$1911 in 2013. Per capita health expenditure in 2011 was Int. \$ 227.

Viet Nam's HIV epidemic is concentrated among people who inject drugs, men who have sex with men and female sex workers. Nationally, HIV prevalence among PWID, MSM and FSW was 10.3%, 3.7% and 2.6%, respectively, in 2013, but much higher rates have been recorded in certain cities. HIV prevalence appears to be increasing among MSM. Overall, the number of new infections has stabilised, but numbers are rising in certain areas. A significant proportion of new infections are now being found among the long-term female partners of KPs and clients. In 2013, 92% of FSW, 66% of MSM and 41% of PWID reported using a condom at the last sex; reported use of sterile injecting equipment by PWID has been consistently above 90% since 2009. AIDS-related mortality has begun to stabilise.

Vietnam's expenditure on the response reached US\$95.4 in 2012. Of this total, 75% came from external sources. Care and treatment accounted for 43% of spending whilst 31% was spent on prevention. In 2010, donor funding supported 91% of treatment spending and 82% of prevention spending. In the same year, less than 30% of prevention expenditure was spent on KPs.

This is reflected in the generally low coverage of prevention programmes: in 2013 51% of FSW and 42% of MSM were covered; NSP and OST services reached 29% and 15%, respectively, of PWID.

In 2013, 35% of FSW, 29% of MSM and 24% of PWID had received an HIV test and their results in the last 12 months. Treatment coverage is scaling up steadily, reaching 37% of the estimated 250,000 adults living with HIV in 2014, while 54% of the estimated 3000 pregnant women living with HIV were accessing PMTCT.

Viet Nam's investment case, entitled 'Optimizing Viet Nam's HIV Response: An Investment Case', was published by the Ministry of Health in October 2014. The IC has 29 pages before annexes. Like most of the other NICs studied, it was developed in the context of diminishing donor funding and the need to secure sustainable domestic sources of financing for the response; and the need to optimise that response in order to consolidate the gains already made and eliminate AIDS within the next 15 years.

The key elements of Viet Nam's investment case are summarised below:

Coordinator and process:

- The process was led by the Ministry of Health's Viet Nam Administration for HIV/AIDS Control (VAAC) in consultation with development partners and other stakeholders. A technical working group was established and inputs were sought from civil society representatives from across the country (including networks of PLHIV and KPs). The consultative process included a meeting to share the draft NIC with government ministries, international partners and civil society. The final decision on priorities was made by the Steering Committee based on recommendations from the technical working group and civil society.

Outcomes of modelling:

- Impacts and costs of five investment scenarios are analysed.
- Impacts and costs are projected from 2014 until 2030.
- The most cost-effective approach is to scale up PWID programme coverage to at least 65% for NSP and at least 35% for MMT; scale up ART coverage to at least 80% of PLHIV with a CD4 count of ≤ 1000 ; positive prevention (80% coverage of long-term sexual partners of PLHIV) for sero-discordant couples; in addition to meeting the national strategy targets by bringing prevention interventions to scale.

Key recommendations and extent to which they reflect the modelling and analysis:

- The recommended priorities are: bringing evidence-based harm reduction to scale, including NSP, MMT and condom programmes (which will focus not only on KPs but also their female partners); scale up testing and treatment, with immediate treatment for KPs living with HIV; focusing interventions on KPs in high burden areas; sustainable financing; integration and decentralisation of HIV service delivery systems; ensuring sufficient supplies of ARV drugs, methadone, reagents and other commodities for the HIV response.
- These priorities appear to be consistent with the modelling and analysis.

Efficiencies and options for sustainable financing identified:

- Proposed efficiencies include: more comprehensive coverage of HIV services through national health insurance, integrating and decentralising HIV service delivery systems, increasing coordination with TB and MCH programmes; increasing domestic production of methadone, strengthening supply chain management and negotiating lower prices for ARVs.

- The IC references the Project on Sustainable Financing, which proposes various approaches to increase domestic investment in the response, including increasing national and sub-national budget allocations, greater engagement of the private sector, and demonstrating more effective use of resources. Expanding the delivery of HIV services through the national health insurance system is proposed.

Other features:

- The development process, data sources, the modelling exercise and assumptions are detailed in annexes.

At-a-glance comparisons of the seven countries by income, AIDS spending and key epidemic indicators can be found in Annexes 1 and 2. Table 1 below shows a quick comparison of key features of the national investment cases (also as Annex 3).

Table 1. Checklist of Key Features in the National Investment Cases

Country	NIC publication date	Items addressed or included in the document						
		Consultation process	Key data inputs	Social enablers	Links to national health & development objectives (other than AIDS)	Efficiencies and cost savings	Sustainable financing	Full analysis and assumptions
Bangladesh	draft as of Sep 2015	✓	✓	✓		✓		✓
Indonesia	2012-15	✓	✓		✓	✓	✓	✓
Myanmar	2013		✓	✓	✓	✓		
Nepal	end 2013	✓	✓	✓		✓		
Philippines	2014-15	✓	✓	✓	✓	✓	✓	
Thailand	2013			✓		✓		
Viet Nam	Oct 2014	✓	✓	✓		✓	✓	✓

3 Discussion

3.1 The Investment Case Process

This section draws out the key similarities and differences in the approaches to developing the NIC employed by each country, highlighting actual and potential challenges and identifying, where applicable, best practices.

• Consultation process

'National investment packages should be developed through an intensified national dialogue around investment choices and priority setting involving all key national partners, including civil society groups at all stages.' UNAIDS: Investing for Results, 2013.

The Bangladesh, Philippines, Nepal and Vietnam NICs all explicitly refer to broad consultation throughout the process as well as high-level support from the health departments. It seems clear that, from the perspective of policy makers and decision makers, a process led by figures at senior levels of government, with extensive consultation of stakeholders, would lend credibility to the investment case. High-level endorsement of the NIC findings from within Ministries or Departments of Health is likely a prerequisite if they are to be used to lobby effectively for increased resources allocations.

In the Philippines this 'buy-in' to the investment case has very recently led to the Health Secretary petitioning Parliament for a doubling of support for the response and calling on other sectors and CBOs to be effective partners in the response. The Health Department is backing up their case with explicit reference to the investment analysis findings.

Neither Thailand's nor Indonesia's investment cases offer details about the development or consultation processes, but there has clearly been high-level buy-in at the national program level, as their analyses have informed the development of their respective Global Fund NFM concept notes as well as Thailand's draft National Operational Plan for 2015-2019 and Indonesia's National Strategy and Action Plan (NASAP) for the HIV and AIDS Response 2015-2019.

Getting other key sectors, such as Finance and Planning, involved in the process has been more problematic, as observed by Indonesia and Bangladesh, among others, at the Regional Expert Consultation. This may have implications for securing regular budget allocations for the response as countries transition to full domestic funding.

It is less clear what impact a lack of consultation with and support from civil society, and particularly key populations would have. It would almost certainly have implications for the successful implementation of the proposed interventions, particularly as in most countries community engagement is pivotal to leveraging recruitment and retention into the continuum at the scale needed to reach goals.

Although the key populations and PLHIV were involved or consulted at various stages of the process in all seven countries, more effort may be needed to ensure that they are engaged in all aspects of the investment case development so that they can contribute fully to providing data, developing scenarios, shaping and delivering advocacy messages, and monitoring and evaluating the implementation of the investment case.

• **Structure and application of UNAIDS guidance on investment cases**

The UNAIDS investment case tool¹² was designed to assist countries in applying the investment approach, which essentially consists of designing a response that is optimised for effectiveness and efficiency; estimating or projecting the impact of the response; mapping the resource requirements; and preparing for financial sustainability.

The tool sets out a four-step process to guide decision-makers in determining an optimal investment package. The resulting investment cases are typically built around these four steps, which form the main sections of the document:

Understand the problem: countries must recognise not only what is driving the epidemic but also the economic, social and legal context and challenges for the current response. Each of the NICs studied provides a concise analysis of these elements, describing the status of the epidemic, an assessment of the response and critical challenges.

Design the investment portfolio to solve the problem: here, countries identify priorities for investment. All the NICs include this section, describing a range of investment scenarios or options that could address the needs analysed in the previous section, and assessing their potential impact on the epidemic. Unlike the AEM-based analyses, which are generated from country data, the impact assessment in the Nepal investment plan is based on an analysis of evidence-informed interventions in the region, triangulated with Nepal's epidemiological data.

Deliver: apply the investment portfolio at scale and generate efficiency: in this section countries discuss the scale and resources required for the desired impact, and assess returns on investment and cost-effectiveness. Again, most of the NICs address these issues: the Myanmar case does not project financial returns on investment.

Sustain for impact and ending AIDS: countries are asked to assess resource gaps, identify opportunities for greater efficiency and effectiveness, such as increasing community engagement and integrating HIV services in health and community systems; and explore opportunities to reduce dependence on external funding. Only the Indonesia, Philippines and Myanmar cases include a discussion of sustainable financing options.

The NICs of Bangladesh, Indonesia, Nepal, Philippines and Viet Nam also include, in the preface, introduction or an annex, a section on the methodology and process followed in developing the investment case.

• **Objectives and purpose**

The NICs all share the common objective of the investment approach: to make the case for an immediate and substantial increase in sustainable domestic spending and more efficient use of existing resources, by demonstrating, in economic terms, the benefits of leveraging strategically targeted investment in AIDS, to achieve the target of ending AIDS as a public health threat by 2030. Moreover, they describe the optimal allocation of funds for maximum impact, the resources needed and their expected impact.

There are, however, some differences in the purpose and positioning of the NICs within the national HIV and AIDS as well as broader health and development planning contexts. For example, whereas most NICs set out to provide a range of investment options for scaling up over a 5- to 15-year time period, Nepal's investment plan, which did not have the benefit of the longer term projections generated by an AEM analysis, provides a costed plan of priority interventions for the next three years. In addition, it was developed

in parallel with a Global Fund grant renewal request (and later NFM concept note), with the intention, at least in part, of bringing a more rigorous, evidence-based approach to the reprogramming of the remaining Global Fund grant as well as other resources in order to maximise impact on KPs.

The Global Fund now strongly encourages countries to base their applications on an investment case, particularly where an existing national strategic plan is not sufficiently robust, and indeed in all seven countries, the investment case process took place at around the same time as applications to the Global Fund were being developed.

The investment cases of Indonesia and Thailand were produced ahead of the development of the National Strategic Plan and National Operational Plan, respectively.

The NICs of Bangladesh, the Philippines and Viet Nam are explicitly aligned with UNAIDS' Fast Track approach¹³ (launched in 2014). Modelling indicates that the Fast Track target of Ending AIDS by 2030 is, with adequate scale-up, achievable in those countries. The Myanmar and Nepal NICs, both published in 2013, cite the 'Getting to Zero' goal. Indonesia's NIC acknowledges that it will not be possible to achieve zero new HIV infections by 2030 even with the highest investment scenario.

• **Analytical methodologies**

All but one of the NICs studied were based in analyses derived from AIDS Epidemic Modelling (AEM). Where sufficient input data are available, AEM allows countries to generate comprehensive projections of the impacts, costs and benefits of various investment scenarios by adjusting interventions and levels of programme coverage. The impact indicators considered include annual numbers of new and current HIV infections, HIV infections averted, AIDS-related deaths, deaths averted and disability-adjusted life years (DALYs) saved.

The AEM-based investment cases describe between three and nine investment scenarios, which can essentially be grouped into 'baseline' (current level of investment in response, projected forward), 'full funding' or 'Ending AIDS' (i.e. a level of funding at which national strategy targets will be achieved), and some intermediate levels of funding.

As Nepal had not begun using the AEM when the Investment Plan was developed, an alternative methodology was employed. Data on HIV and STI prevalence, population size, behavioural and service coverage and effectiveness for each of Nepal's key populations were triangulated with evidence from various regional cost-effectiveness studies among KPs both in Nepal and elsewhere in Asia to determine priority interventions. Although this approach did not allow for a comprehensive analysis of costs versus benefits for each intervention, including the number of HIV infections averted, it did enable Nepal to make a compelling case for reassessing the priorities in the National Strategic Plan based on the cost-effectiveness analysis as well as new scientific evidence on high impact interventions.

• **Data inputs and limitations**

In the case of the AEM-based investment cases, the key data inputs were HIV estimates and projections; key population size estimates; results from the behaviour sentinel surveillance (BSS), HIV sentinel surveillance (HSS) and HIV integrated bio-behavioural surveillance (IBBS); routine programme monitoring data; unit cost data for prevention and treatment interventions and other critical enablers. National AIDS spending assessments (NASA) were used where available. Where relevant, surveys, evaluations and other

studies conducted in the country were included in the inputs. It should be borne in mind that the reliability of the AEM modelling outputs is dependent on the quality of the inputs: both the Myanmar and Viet Nam NICs acknowledge that there are significant gaps and weaknesses in the data.

Nepal used similar data sets but, as noted above, triangulated them with evidence from various cost-effectiveness studies among KPs to determine priority interventions. The Investment Plan acknowledges that a local, up-to-date cost-effectiveness study would have been preferable, but Nepal had not started using AEM when the Investment Plan was being developed. Thailand's investment case is the only one that does not specify the data inputs.

Vietnam, Indonesia, the Philippines and Myanmar mention that cost data were validated by representative working groups or through consultation with stakeholders. This is particularly important where costs are not standardised among implementers (as in Viet Nam and Myanmar, for example).

Certain technical assumptions are included as annexes in the NICs of Nepal, Bangladesh, Indonesia and Viet Nam, but not in those of the Philippines, Myanmar or Thailand. Even though these three documents appear to be targeting a broader, less technical audience than the others, it would nevertheless be helpful to include references so that interested readers could access the assumptions if needed. Getting consensus on these assumptions is another critical part of the process, as noted during the Expert Consultation, as the quality of programme data can be variable due to the lack of standardised definitions for programme coverage used by various donors.

Myanmar's investment case specifically mentions critical strategic information gaps and notes that some of these would be addressed through the 5-year country strategy to expand surveillance and population size estimates. In the absence of standardised unit costs across the country, national standard costed service packages were agreed for the purposes of the AEM exercise but a full cost-effectiveness analysis was deferred until costs were fully standardised by the country.

A common theme emerging from the investment cases is the need to differentiate program coverage and intensity for subpopulations with different levels of risk. In all the countries, however, not all data are disaggregated into such subpopulations. IBBS data or population estimates often do not differentiate between transgender people who do and do not engage in sex work, for example. In the Philippines, Nepal and Viet Nam, HIV prevalence is thought to be increasing among women who inject drugs, but the populations are very small and may overlap with FSW populations. The lack of data on these and other 'hidden' populations who do not access services makes it difficult to build—or cost—appropriately targeted interventions. Clearly, concerted efforts to improve strategic information in all the countries would allow for better targeting of interventions to maximising the impact of the investments.

Two other challenges that were identified at the Regional Consultation were, firstly, demonstrating the cost effectiveness or efficacy of certain interventions, such as harm reduction or innovative approaches to reach certain subpopulations; and secondly, costing interventions to address social, structural and legal barriers.

3.2 Content and Implications for Sustainable Financing

• *Interventions included in the NICs*

While recognizing that each country requires a unique portfolio of interventions that reflect its specific epidemiological, demographic and socio-economic context, UNAIDS has identified six high priority activities that need to be at the core of an effective response. The extent to which these are addressed in the NICs studied, and their relevance to the country context, is discussed below.

- Focusing outreach on people at higher risk: all the investment cases identify this as a high priority. Bangladesh, Nepal, Indonesia and Myanmar include a further disaggregation of key sub-populations based on epidemiology and infection dynamics to ensure that interventions can be targeted even more effectively and with greater reach. All the NICs call for geographical prioritisation of investment in high-burden areas.

- Providing ART for people living with HIV and treating opportunistic infections: again, all the NICs recognise the need to close the treatment gap and ensure that PLHIV have access not only to ART but to the full continuum of care, including community-based adherence support, if the goal of Ending AIDS is to be achieved. The NICs highlight various related critical enablers, including scaling up testing (all countries), ensuring an adequate, undisrupted supply of ART by optimising supply chain mechanisms (Bangladesh, Myanmar, Nepal, Philippines, Viet Nam) and seeking more advantageous pricing (Indonesia, Viet Nam).

- Treatment for prevention: all the investment cases are predicated on leveraging the prevention benefits of ART to reduce new infections. The Indonesian NIC includes a detailed analysis of the effectiveness of ART in preventing onward HIV transmission at different levels of coverage and treatment initiation, showing that the impact of treatment as prevention multiplies as ART coverage increases. Viet Nam, the Philippines, Bangladesh, and Thailand recommend early treatment of PLHIV while Indonesia, Nepal and Viet Nam also call for positive prevention for sero-discordant couples. The Nepal Investment Plan is the only NIC to include pre-exposure prophylaxis (PrEP) as an investment priority.

- Providing HIV prevention services for women and girls who are pregnant: with intimate partner transmission (IPT) accounting for significant numbers of new infections in some countries (Bangladesh, Indonesia, Myanmar, Viet Nam, Nepal, the Philippines) and low PMTCT coverage in others (Indonesia, Nepal, Bangladesh, the Philippines), action is clearly needed. Bangladesh, Indonesia, Myanmar and Nepal all call for investment in PMTCT, particularly in high burden areas, and greater integration of HIV services through antenatal, maternal and child health and sexual and reproductive health service delivery mechanisms. Elimination of vertical transmission (eVT) is one of the highest priorities in Nepal's Investment Plan. The Viet Nam NIC addresses IPT by recommending engaging wives/regular partners through outreach to male PWID, to generate demand for and ensure access to prevention and treatment services, while Indonesia calls for increased programme coverage of clients of sex workers to address IPT. As noted above, Indonesia, Nepal and Viet Nam recommend positive prevention for sero-discordant couples.

- Behaviour change including condom promotion: all the investment cases recommend scaling up behaviour change interventions for key populations. All the NICs highlight the need to optimise such activities by tailoring strategies to specific sub-populations, focusing on evidence-informed, high-impact interventions and employing innovative approaches.

- Male circumcision is recommended for countries with high HIV prevalence and low rates of circumcision. The countries included in this study, with epidemics that are concentrated among specific populations at higher risk, do not fit this profile, and accordingly, do not include this activity in their intervention packages. One possible exception is Indonesia, where there is a low-level generalised epidemic in the provinces

of Papua and West Papua. Unlike the rest of predominantly Muslim Indonesia, males in the largely Christian and/or animist indigenous population are typically uncircumcised. Exploratory steps are being taken to assess the acceptability and effectiveness of medical male circumcision in these two provinces, but it is not yet being recommended as a priority intervention.

• **Allocation of funding across the different elements of the AIDS response**

The results of the AEM analyses—in terms of where/how investment should be focused to achieve maximum impact—are broadly similar across the countries studied. As highlighted under the next item, all the NICs recognise the importance of scaling up investment in prevention, and of prioritisation, both geographically and population-wise, with different levels of coverage and implementation intensity proposed for higher and lower priority areas and populations.

Consistent with the epidemic situational analyses provided in the 'understand' sections, each NIC disaggregates some KPs into specific subpopulations whose members are either harder to reach, or are at significantly higher risk of exposure to HIV, or both, and require specifically targeted interventions. These communities, who typically include street-based FSW, women who inject drugs, male and transgender sex workers, are identified as priority communities who are in need of the highest levels of coverage. Similarly, the growing numbers of low-risk women who are being infected through IPT are given special attention in the Nepal and Viet Nam NICs, where specific interventions are recommended for female partners of PWID and MSM, and in the Indonesia and Myanmar cases, which propose scaling up PICT in health care settings in priority regions (also recommended in the Viet Nam case).

Another universal priority is the strategic use of ART: a rapid scale-up of HCT and ART for KPs at high coverage rates, consistent with current scientific evidence, which indicates that increasing the number of PLHIV on treatment will have the biggest impact on new infections and AIDS-related mortality.

The AEM-based NICs analyse multiple investment scenarios (each focusing on different combinations of prevention and treatment interventions at various coverage levels), highlighting the strategy that represents the optimal combination of impacts (on new and current infections, AIDS-related mortality, new infections averted and deaths averted), returns (DALYs, treatment cost savings) and investment. The selection may also take into account the feasibility of the scenarios with regard to financing and acceptability in the local context. None of them, however, show a specific allocation of resources beyond the broad categories of 'prevention' and 'treatment'. Nepal, with its 'costed priorities' format, is a notable exception; however, it covers a 3-year timeframe whereas the other NICs project costs forward to 2030.

In general, the investment options and interventions recommended seem to be consistent with the epidemiological analysis, geographical concentration of HIV and the projected trajectory of the epidemic in each country. However, the investment cases of Bangladesh and the Philippines pay scant attention to addressing intimate partner transmission, which is estimated to account for a significant share of new infections in those countries. The Indonesian investment case analysis does not prioritise critical enablers such as reducing stigma and discrimination and legal/policy barriers to effective service delivery, some of which are still in place, particularly for PWID. However, these enablers are addressed in the national strategic plan.

Thailand's investment case is more difficult to assess in this regard; the 2-page document is restricted to advocating for increased investment in scaling up the strategic use of ART to end AIDS and does not address other interventions that the epidemiological analysis suggests might also be investment priorities, such as harm reduction, measures to address IPT (which accounts for an estimated 31% of new infections), and the critical enablers required to support effective service delivery. However, these may well be addressed in the operational plan.

- **Interventions related to prevention and social enablers**

All the NICs studied emphasize the need for sustaining or scaling up (depending on existing coverage of the target population and infection dynamics) and optimising prevention interventions for KPs, and include these in the costed analysis. Even though the design and/or implementation of prevention interventions has not been fully effective in several countries (as indicated by coverage levels and uptake of HCT), it is recognised as the entry point to the treatment and care continuum for the majority of KPs, without which treatment cannot be scaled up effectively, and the preventive effects of ART will not be realised. In addition, the cost of preventing an infection is substantially less than the cost of treating one; projections show that without adequate investments in prevention, treatment costs will spiral out of reach. Nevertheless, there is a need to review and optimise prevention programmes, using evidence-informed, 'best practice' service delivery models where possible, as noted in the Viet Nam, Nepal and Indonesia NICs, to ensure that the impact of the investment is maximised.

The NICs show more variation in the coverage of social enablers. The UNAIDS framework recommends that every HIV response includes not only basic programmes but also critical enablers that support access to these programmes. Essentially, enablers—social and programme¹⁴—are interventions to eliminate bottlenecks or improve the efficiency of service delivery, or to address constraints on access to services; anything that could impact, for better or worse, the effectiveness of response. UNAIDS defines social enablers as programmes or initiatives that 'create environments conducive to rational HIV responses',¹⁵ such as outreach for HIV testing, activities to reduce stigma, advocating for human rights, addressing the criminalisation of people who are disproportionately affected by HIV, and mobilising communities.

UNAIDS recommends that social enablers are costed and included as essential activities in national strategic plans and operational plans.¹⁶ However, the UNAIDS investment tool notes that social enablers are often 'context specific' and 'difficult to measure.'¹⁷ This is reflected in approaches to costing such activities—to what extent is an enabler an integral part of a standard package of services, or a stand-alone intervention? In concentrated epidemic settings, outreach for testing is typically done through prevention programmes for KPs and may or may not be costed as part of that. For example, the basic prevention programme unit cost in Indonesia includes outreach, peer education and testing; the unit costs for prevention interventions used in the Myanmar investment case included a cost for 'creating an enabling environment.' The basic programme activities categorized as 'first priorities' in Nepal's Investment Plan include an innovative peer-led approach aimed at increasing uptake of HCT and strengthening government-community partnerships throughout the continuum of care. Costed social enablers include human rights and gender-related initiatives.¹⁸ Nepal's detailed costing was also envisaged as a route towards cost-sharing on enabling initiatives with other sectors, such as social welfare and justice.

The Bangladesh NIC takes a slightly different approach: the resource needs analysis does not include the cost of some critical enablers such as awareness raising and advocacy, but does indicate the approximate additional amount that they would add to the annual investment.¹⁹ Thailand's NIC does not specify social enablers or whether they are costed, but notes that more effective delivery models for HCT and adherence support are critical to secure returns on investment. The Philippines' NIC identified a number of social enablers including decentralising testing to the community level and empowering communities to provide peer support and care. These are not costed, however. Myanmar cites law reform and reducing stigma and discrimination as critical enablers, but these are not costed. Vietnam's NIC does not address social enablers directly but initiatives to increase access for underserved populations are included in the priorities.

Almost all the NICs underline the fact that social enablers are critical to programme effectiveness (Indonesia's NIC is the exception, but critical enablers are addressed in the national strategic plan). Investing in social enablers, particularly creating a more enabling legal and policy environment, will be crucial in the transition to domestic funding. To ensure that these essential activities are funded, NICs need to be more explicit about what they cost. If these costs cannot for some reason be included in the model, they could be specified as an approximate add-on cost as in the Bangladesh NIC.

- **Links to national health/development agendas and processes**

All the NICs underline their alignment with the strategic priorities and targets of their respective national AIDS strategic plans, and, in most cases, with global AIDS goals such as the UN High Level Meeting targets for 2015, the 90-90-90 by 2020 treatment target and Ending AIDS by 2013. There is minimal reference, however, to national health plans and strategies. The Philippines NIC states that the AEM analysis has been used extensively in the development of the Health Sector Strategic Plan for 2015-2017, while the Myanmar case observes that AIDS is one of the priority diseases in the National Health Plan, but does not provide any further explanation of the National Health Plan targets and how the prioritised investments could help to achieve them. This omission is somewhat surprising given that in nearly all cases, countries identify greater integration of HIV and AIDS into the general health system as one of the priorities for increasing access to services and reducing inefficiencies.

Despite the lack of overt linkages to health sector plans, some of the investment cases (Bangladesh, Indonesia, the Philippines, and Thailand) have already provided input to such processes, or will do so in the next planning cycle.

None of the NICs make any specific reference to broader national development agendas beyond health, such as poverty eradication, gender equality, human rights and social justice, protection of children, etc. even some of the priorities proposed have clear relevance to those. Only Indonesia's Advocacy Plan, which is packaged with the NIC, recommends that advocacy to the National Planning Agency should be synchronised with the updating of the country's Medium-term Development Plan.

Moreover, all the AEM-based investment plans quantify some of the socio-economic benefits of scaling up in terms of health outcomes, financial savings, DALYs saved and productivity. Demonstrating these gains in the context of wider development goals could help to make the investment cases more compelling for policymakers and decision makers beyond the sphere of HIV and AIDS. Is this a missed opportunity?

There is an interesting contrast with the AIDS investment cases from the Eastern and Southern Africa region discussed in Markus Haacker's report.²⁰ All four countries in the study have generalised epidemics, which naturally gives AIDS greater prominence on the national agenda than in countries with concentrated epidemics, where AIDS is not a leading cause of death. The Kenya and Uganda NICs link the impacts of AIDS and the outcomes of the response to general national policy objectives, including GDP growth, and in Uganda's case, poverty.

However, the report does note the challenges of analysing the economic impacts of AIDS: firstly, they are secondary to the health impacts; in addition, the empirical evidence for economic impacts is much weaker than for health outcomes. Haacker concludes that AIDS is such a critical health issue in these countries that whether increase in AIDS-related mortality affects poverty rates or GDP by a few percentage points would not necessarily make an investment case more persuasive.

If it is difficult to conclusively link AIDS outcomes to GDP in a region where the epidemic is generalised, it will undoubtedly be even more of a challenge to make such inferences in a region where concentrated epidemics predominate, and where the impact of AIDS on the population as a whole is not as great. On the other hand, AIDS is not such a critical issue in the Asia-Pacific region, and national HIV and AIDS programmes struggle to compete against numerous other priorities. In this context, investment cases that emphasise the health impacts, financial and social returns that can be derived from cost-effective, prioritised investments, and can link the same to national policy agendas, could help to position HIV and AIDS programmes more favourably with regard to resource allocation.

- **Identification of potential cost savings/efficiencies**

The AEM projections demonstrate that the core priorities of the investment cases—including a strategic population and geographical focus, optimised prevention interventions for key populations and scaling up treatment coverage—will deliver increasing returns on investment as they are taken to scale in the form of savings on treatment and care costs.

Nepal and the Philippines identify opportunities to leverage the effectiveness and efficiency of prevention interventions by strengthening accountability systems; diverting resources away from underperforming interventions or programmes; eliminating duplication between different service providers; improving financial and program management; standardizing unit costs and strengthening referral networks. Viet Nam notes that a total market approach to condom programming yields efficiencies while ensuring increased coverage.

Further efficiencies can be gained from adopting innovative service delivery models for HCT, such as using rapid tests (including saliva testing), decentralising to the community level and increasing community and peer engagement in testing to increase uptake and reach. These approaches, proposed in the Myanmar, Bangladesh, Thailand, Nepal and Viet Nam NICs, may require the revision of testing algorithms and guidelines.

A priority identified in all the full-length NICs is the integration of HIV with existing health service delivery mechanisms. Potential efficiencies include reduced unit costs of interventions, avoidance of parallel systems; and task sharing. Integration will, however, increase the burden on already-stretched public health systems, at least initially, and the Viet Nam NIC warns that shortages of health workers trained on HIV and AIDS could challenge service delivery. The transition away from donor funding will need to be

carefully planned to ensure that project staff can be absorbed by the public sector. Maximising synergies between the public, private and community health sectors could also alleviate some of the burden.

Several NICs suggest efficiencies around ART. Viet Nam and Bangladesh propose optimising procurement systems and negotiating more favourable pricing. Indonesia details the savings that could be gained by increasing the use of a cheaper first-line drug, while Myanmar anticipates reducing costs by shifting to a single regimen for first-line ART.

Local sourcing of drugs could yield cost savings. To reduce costs and secure supplies, Viet Nam is moving to increase domestic production of methadone (conversely, it found that locally procured ART would be more costly).

Nepal and Bangladesh propose the use of new technologies, particularly information and communication technology (ICT) to deliver efficiencies in a range of activities, from monitoring to diagnostic applications, training and outreach.

Other than Indonesia's analysis of the savings to be made by changing the ART regimen, there is no calculation in any other NICs of the economic value of the efficiency measures proposed.

- **Identification of sustainable domestic financing**

In most of the NICs studied, with the exception of Thailand and Bangladesh, the projected costs of the proposed investments are significantly above current levels of expenditure. Moreover, a large proportion of existing financial resources for the responses in the region—particularly for prevention—are provided through the Global Fund, which has yet to clarify its funding model, if there is to be one, post 2017. Despite this, only three of the cases studied explicitly discuss strategies or options for transitioning to increased domestic financing for the response.

The investment cases of Bangladesh, Nepal and Myanmar acknowledge the need for sustainable funding but do not propose specific solutions, although Myanmar's NIC does note that taxation and universal health coverage are being considered by the government as it moves to increase health financing. The investment case proved to be timely, as the country is now setting up its national UHC programme with support from the World Bank. Thailand is a special case, as its AIDS response is already almost entirely supported by domestic funding.

The Philippines, Indonesia and Viet Nam NICs address the funding gap by proposing approaches to increase the fiscal space for domestic financing of the AIDS response and manage the transition away from external funding. These are discussed below.

- Increasing coverage of HIV by the national health insurance system. In the Philippines, PhilHealth (Philippine Health Insurance Corporation) already covers ART and routine monitoring for people on treatment. However, the scheme could assume a greater share of AIDS financing by increasing enrolment among PLHIV and KPs and by expanding the scope of the HIV-related services that are covered. Similarly, in Indonesia, which launched its universal health coverage (UHC) mechanism in 2014, some HIV-related services are covered, but in the context of planning an exit strategy from the Global Fund and other donor funding, the country will need to seek opportunities to increase coverage of HIV. The Viet Nam NIC refers to a proposal to include more HIV services under the national health insurance scheme. In Myanmar, HIV treatment, testing, PMTCT and

prevention commodities have been included in the initial draft of the Essential Package of Health Services for the forthcoming UHC scheme. HIV treatment has also been costed under the National Social Protection Strategy adopted in early 2015.

As one of the Sustainable Development Goals, universal health coverage will play central role in the health component of the post-2015 development agenda.²¹ This is an opportune time for countries to advocate for greater integration of HIV and AIDS into UHC; however, they must also address potential service quality issues, and particularly the stigmatization and harassment that KPs still encounter²² when accessing services from public health settings.

- **Local government.** For several years, Indonesia's National AIDS Commission has pursued a strategy of mobilising increased funding at the province and district levels. The investment case notes that there is scope for further contributions, but more effective advocacy is needed. The investment case proposes that city/district-level investment cases can play an important role in resource mobilisation, and provides an assessment (in Annex 18) of what local governments and AIDS Commissions need to do to carry out such analyses. The Philippines' NIC observes that as central government largely shoulders treatment costs (including through PhilHealth), local governments can be mobilised to cover a greater share of prevention, monitoring and advocacy expenditure. This is already happening in Quezon City, where a city-level investment case had effectively informed a successful advocacy effort to leverage various local resources for the response. Other cities in the country are also demonstrating that there is the political will to allocate resources to prevention programmes implemented by local government units and/or CSOs. The ASEAN 'Cities Getting to Zero' initiative could serve as a forum for information exchange and shared learnings across the region on this issue. At the national level, however, there is as yet no policy in place to channel central government funds to CSOs, nor any accountability mechanisms for the same. Indonesia faces similar constraints. This will need to be addressed if community organisations are to continue providing support.

- **Taxation.** The Philippines NIC suggests that more funds for the response could be raised from levies on alcohol, tobacco, mobile phone services, air travel, and so on. The country has already instituted such a 'Sin Tax' on alcohol and tobacco, revenues from which help to underwrite the UHC system. While this has been successful in the Philippines, such levies can be unpopular with both consumers and the industries concerned, and leaders may be unwilling to risk losing political support by imposing them. More analysis will be needed to determine acceptable tax rates and assess potential revenues.

- **The Philippines and Indonesia NICs** propose intensifying resource mobilisation from corporate and private donations. A number of corporations in the region are already channelling funds to the HIV and AIDS response through their corporate social responsibility (CSR) programmes, targeting not only their own employees through various workplace initiatives but also the wider community through their community outreach missions. The potential of private domestic philanthropy was recently demonstrated by a substantial donation, matched by the Gates Foundation, to HIV and other priority programmes in Indonesia.²³

- **Indonesia** has identified an opportunity for the private health sector to play a greater role. Many KPs (including gay men and highly paid FSW in some areas) are part of Indonesia's rapidly growing middle class, and have shown an appetite for accessing STI and HIV services through private clinics. If such services are effectively reaching communities that are unwilling to use public clinics, subsidising HIV and STI test kits and drugs delivered through these outlets might prove to be a cost-effective and sustainable means of increasing coverage. The role of the private sector is also highlighted in Nepal's Investment Plan, which identifies (and costs) the establishment of relevant and effective

public-private partnerships throughout the continuum of care as a critical enabler. In countries like Indonesia and Nepal, where a substantial portion of health care is delivered through the private sector, engaging private health providers will be critical to the sustainability of the AIDS response.

As noted in Indonesia's NIC, none of the potential revenue sources or efficiency gains identified would be sufficient on their own to close the resource gap; thus countries would need to pursue a range of different approaches.

FINANCING OPTIONS IN EASTERN AND SOUTHERN AFRICA

Interestingly, the investment cases in the Eastern and Southern Africa study propose similar options to the Asia-Pacific countries. All of them analyse the scale of the financing challenge. Kenya and Uganda are setting up national health insurance schemes that could cover HIV/AIDS services. However, Haacker notes that 'the costs of services to people already living with HIV in both countries would be very high relative to the revenues of an insurance scheme.' Botswana and Uganda propose tax-based approaches. Like the Philippines, Uganda proposes taxes on specific goods and services (phones and internet services, beer, soft drinks and cigarettes), while the Botswana IC estimates that one additional percentage point in VAT or income tax rates would be sufficient to finance the additional HIV/AIDS costs.

Two other approaches are discussed that are not identified in the Asia-Pacific cases. Kenya proposes an HIV/AIDS trust fund. This would not create additional revenues but could promote efficiency gains by serving as a central vehicle for procurement, consolidating funding from different sources and raising additional funds, as well as funding costs of people already living with HIV/AIDS role in the transition to a national health insurance scheme. Borrowing is also suggested as a means of managing and spreading the costs of the response and avoiding the need to divert resource allocations from other areas initially, when resource needs are high, but would lead to higher costs in later years as debt repayments and interest are added to the cost of the response.

¹Haacker, M. 2015: HIV/AIDS Investment Approach Application in the Eastern and Southern Africa Region

In Viet Nam, steps were taken at the highest level to address the issue, when in 2013, the Prime Minister endorsed the 'Project on Sustainable Financing for HIV/AIDS Prevention and Control Activities 2013-2020'. The objective was to increase the domestic share of AIDS spending to 50% by 2015 and 75% by 2020 by increasing central budget allocations, mobilizing provincial and private sector investment, utilizing existing health mechanisms such as insurance, and integrating HIV into broader development activities. The future of the Project now looks uncertain as funding for the national HIV program was cut by the National Assembly. However, the Project set a useful precedent, and a detailed analysis, with quantitative projections, of the available options for leveraging sustainable financing should arguably be an integral part of the national investment case.

The omission of sustainable financing opportunities in the Bangladesh, Nepal and Myanmar investment cases perhaps reflects the fact these three countries are at the lower end of the income scale, and the scope for mobilising large-scale domestic financing is still limited. In contrast, Indonesia and the Philippines are both at the upper end of the lower-middle-income segment and are presently contributing more than 40% of total AIDS spending. Thailand, as the only upper-middle-income country, contributes almost 100% of funding for its response.

The reality is that HIV and AIDS are competing for attention and resources against numerous other priorities, particularly in this region, where AIDS is not a leading cause of death. Moreover, stigmatization and discrimination against key populations is still prevalent in most of the countries in the region, and generally social conservative governments can find allocating public funds to benefit such populations, including to prevention programmes targeting KPs, a struggle.²⁴

The analyses and modelling undertaken in the Asia-Pacific countries included in this study demonstrate clearly that, where epidemics are concentrated among key populations, a sound investment approach entails focusing resources on interventions that benefit and, increasingly, are implemented or led by, those populations. In all the countries studied, a substantial proportion of these programmes is currently internationally funded and is therefore at risk during the transition to domestic funding. The experience of a number of countries in Eastern Europe and Central Asia that are no longer eligible for Global Fund grants indicate that harm reduction programmes are particularly vulnerable to defunding if a transition strategy is not in place.^{25, 26} Investment cases can therefore be a vitally important advocacy tool by highlighting the rights perspective and presenting evidence-based arguments for the social and economic benefits of ending AIDS to society as a whole, as well as catalysing the discussion on sustainable financing. This discussion will also need to address the issue, noted earlier, of establishing mechanisms to channel government funding to community organisations to ensure predictable, sustained budgets for vital prevention and support services.

- **Positioning of the NICs**

Each of the investment cases included in the study appears to have been designed for one or more specific purposes, which may or may not be made clear in the introduction or preamble. The intended audience is generally less easy to discern.

The Global Fund's requirement for funding applications under the New Funding Model (NFM) to be built around a costed, prioritised national strategic plan or an investment case was a likely catalyst for the development of at least some of the NICs studied: a quick analysis of timelines shows that all of them were produced just ahead of, or concurrently with, the preparation of the countries' applications. For the concept note, the investment case exercise not only provides the rigorous analysis of available evidence necessary for a strong concept note but is also helpful in proposing the 'full expression of demand' above the country's budget allocation, for potential funding through the unfunded quality demand mechanism.

In Thailand, the key impetus was the national leadership's aspiration to be self-reliant once Global Fund support ends in 2017, and to end AIDS by 2030. The Nepal Investment Plan was also designed to lay the groundwork for an exit strategy (through the integration of HIV services into the general health system); Indonesia's investment case is performing a similar function.

In all the countries, there were additional factors motivating the investment case. The NICs of Indonesia, Myanmar, Nepal, Bangladesh, Viet Nam and Thailand were also designed to feed into the national strategic planning cycle, but at quite different stages. Nepal's investment document is a costed, prioritised plan for the final three years of the existing National HIV Strategy for 2011-2016, aimed at focusing spending and implementation where it is most needed and most likely to have an impact. In contrast, the Indonesia, Myanmar and Thailand NICs were all prepared ahead of new strategy documents. In Indonesia's case, the NIC is a technical document containing detailed analysis and assumptions that was intended to guide the planning and resource needs for the Strategic Use of ARV (SUFA) programme, and to serve as a reference for the preparation of the National Strategic Plan for 2015-2019. The Myanmar investment case analysis was developed ahead of a one-year extension to the national strategic plan, while in Thailand's case the analysis was undertaken to guide the development of the Operational Plan 2015-2019. The published NIC documents from Thailand and Myanmar are clearly designed as advocacy briefs, giving a very brief, non-technical summary of

the analysis and recommended investment priorities. Though not referred to in the investment cases themselves, the analyses and assumptions are documented separately.

The Philippines' investment case, like those of Myanmar and Thailand, is a non-technical advocacy document aimed at decision and policymakers beyond the health department. The report containing the full results and assumptions of the AEM analysis is referred to briefly in the preface.

The Viet Nam, Bangladesh and Indonesia NICs, in contrast, are clearly positioned for a different audience; relatively technical, and incorporating the higher level analysis and assumptions, they might not be readily accessible to non-specialist stakeholders.

The essence of an investment case is the analysis of the evidence and the identification of priority interventions and the most cost-effective investment options. We can assume that these core elements will need to be packaged differently for different audiences and different purposes at different times. The investment case needs to be sufficiently versatile to accommodate these needs. One option would be to capture the core elements in a document of around 30 pages at a sufficient level of technical detail that it could be used as the basis for a planning document such as a national strategic plan or funding application. Higher level analysis and technical assumptions can be included in annexes, as in the Indonesia and Viet Nam cases, or in a separate report (similar to the AEM report of the Philippines).

Various other products can then be derived, with minimal modifications, from this core investment case, targeting a range of audiences, as needed: detailed investment options for senior officials within the health, planning and finance ministries; PowerPoint presentations; 2-page advocacy briefs for parliamentarians or congress members; investment brochures for potential philanthropic donors; and so on. Indeed this has already been done, to some extent, in the Philippines, Indonesia and Myanmar. Annex 4 provides some country examples of how the investment cases have strengthened advocacy for their HIV and AIDS responses.

4 Recommendations

Given the diversity observed in the investment cases in this study, identifying examples of best practice is a challenge. Each case reflects the purpose for which it was designed, the availability of data inputs, and the national context in which it was developed. However, there are some lessons that could be more widely applied.

Promising practices

- An analysis of potential sources of sustainable financing for the enhanced response—as provided by the Indonesia and Philippines investment cases—is helpful.
- The inclusion of an advocacy plan (Indonesia NIC) is another valuable supplement to the investment case package, and can guide national programmes in tailoring their investment advocacy more strategically.
- This is less a best practice than an observation: one of the key strengths of the investment cases reviewed here is that they highlight the need to avoid wasteful investments, and to focus resources firmly where they are needed. Analyses of AIDS spending in the region reveal that scarce resources were not being used strategically in several countries in the region

(including Indonesia, Nepal, the Philippines, Thailand and Viet Nam). Coverage of KPs, even subpopulations where the epidemic is known to be expanding, has often been too low to achieve any impact. Investment cases provide an opportunity to update strategies with new evidence, refocus key interventions on KPs to ensure a more targeted, optimised and cost-effective response, and highlight potential efficiencies in service delivery. Moreover, they clearly demonstrate to stakeholders that the cost of not doing so will be failing to meet the target of 'Ending AIDS'.

Suggestions for further action to strengthen investment case utility

- Ensure that there is clarity about who the document is addressing. Keep it non-technical for a non-specialist audience but to ensure credibility, provide annexes or references to technical documents where the assumptions can be found. Alternatively, a core document can be developed that is pitched at the level of senior health officials, and can, with minor modifications, be targeted at a range of specified audiences.

- The financial commitment needed to end AIDS can appear daunting; however, ICs should also emphasize the costs—human as well as financial—of inaction, or business as usual. Through counterfactual analysis, ICs can also demonstrate to decision makers that investment works, by highlighting achievements in terms of lives saved and deaths and infections averted.

- Strengthen links to or alignment with broader national development plans or goals. An analysis of how eliminating AIDS contributes to the country's broader development goals and global goals (SDGs) on maternal health, reduction of infectious disease could make investment cases more compelling to decision makers and policy makers. Further investigation is needed on how to integrate investment case analyses with in-country budget cycles in order to ensure adequate and sustained resource allocations. A start could be made by reviewing and updating the investment case on an annual basis, with the participation of all relevant sectors.

- A significant omission in all the NICs studied was the issue of funding for community organisations, despite the fact that all NICs emphasize the critical role of greater community engagement in service delivery in effective prevention and treatment interventions. CSOs have hitherto been sustained almost entirely by external funding - how will domestic resources be channelled to CSOs? Can it all be from philanthropy and corporate social responsibility? This may well be beyond the scope of national AIDS programmes but examples of effective mechanisms for community financing within the region should be identified and assessed, particularly by countries where there are legal barriers to channelling government funds to CSOs.²⁷

There may be lessons to be learned from the Philippines, where various national and local government discretionary funds are available. For example, mayors have the discretion to allocate funds – what kind of mechanisms and safeguards are put in place to ensure accountability and transparency? Although it was not included in this study, Malaysia is another country where NGOs in various sectors receive government funds: there are potential lessons to be learned there. Further research and sharing is needed, as well as investment in such systems, as ensuring sustained, predictable funding for the provision of crucial services by and for communities is critical.

- Strengthen data and evidence to ensure more robust analyses going forward. Plug gaps in data to ensure better targeting for maximum impact. This includes information on costs and expenditure. As countries transition to greater domestic support for their AIDS responses, it will be important to strengthen mechanisms for collecting and analysing expenditure data, particularly from government health facilities.

- Research sustainable financing options that could be replicated across the region. Resources could be allocated to monitoring developments in this field and identifying opportunities for replication. The ASEAN 'Cities Getting to Zero' initiative is a potentially valuable forum for information exchange and shared learnings on city and district level initiatives.

As countries in the region grow more affluent, opportunities to widen the fiscal space will only increase. Universal health coverage schemes, local government financing, cost-sharing with other sectors such as justice and social welfare, innovative taxation ('sin' taxes, levies on mobile phones, air travel, financial transactions, etc.) and public-private partnerships are among the options that could be considered, as well as pushing for increased revenues from existing taxes by adjusting tax rates and optimising collection.

- By articulating the economic benefits alongside the human rights perspective, investment cases could potentially play a key role in overcoming resistance to allocating domestic resources to programmes that are politically unpopular, such as harm reduction and other programmes that benefit, and/or are led by, key populations. Examples of the successful use of investment cases to increase political will amongst decision makers to support and invest in key populations, and civil society in general, should be documented and shared across the region as countries prepare to transition to the post-2017 funding landscape.

- Use the investment case as an initial step in the development of a transition plan. A successful transition to full domestic funding of the response demands substantial preparation, so it is important to initiate the process well ahead of time. With the Global Fund collaborating with the World Bank, UNAIDS, PEPFAR and other partners to work on sustainability and transition planning in a number of countries, there may be opportunities for financial and technical support for the process.

- Update NICs from time to time to adjust to evolving funding/legal/epidemiological landscapes as well as advances in prevention and treatment, such as PrEP. NICs must also take into account the time needed for countries to adapt to new parameters such as the WHO treatment guidelines.

- Engage all relevant stakeholders throughout the investment case cycle: the national AIDS programme, the health department, planners and policymakers from other sectors (i.e. budget and finance, others), epidemiologists, technical partners, donors and communities. This will foster ownership, help to ensure buy-in to the investment proposals, increases access to data sources and build capacity for ongoing investment case analyses.

During the transition, communities will need to be empowered to participate in determining how AIDS budgets are allocated; it is therefore important that they are engaged from the outset in identifying priorities, shaping the messages, planning for dissemination and advocacy and monitoring the implementation of investment plans.

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Endnotes

- 1 UNAIDS, 2015: How Asia Pacific Countries Can Invest For Ending AIDS.
- 2 UNAIDS, 2015: How Asia Pacific Countries Can Invest For Ending AIDS.
- 3 UNAIDS, 2015: How Asia Pacific Countries Can Invest For Ending AIDS.
- 4 www.aidsdatahub.org
- 5 The World Bank reclassified Bangladesh as a lower-middle-income country in July 2015.
- 6 As reported in the Investment Case.
- 7 SUFA aims to maximise the preventive benefits of ART through early treatment for KPs and other priority population groups: pregnant women and TB patients who are living with HIV, and the HIV-positive partner in sero-discordant couples.
- 8 Figures from the NASA 2012-3, as reported in Myanmar's Global AIDS Response Progress Report for 2014.
- 9 Nepal's 2014 Country Progress Report on the HIV/AIDS Response reports that US\$22 million was allocated for 2013-2014, of which 10% was from domestic sources.
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Annex 1. Countries by Epidemic Indicators

Country	Population 2014	Total PLHIV women 2014	New infections AIDS-related deaths 2014	Key populations						ART 2014 (% of all PLHIV)	PMTCT 2014 (HIV+ pregnant women on ART out of estimated # of HIV+ pregnant women)
				MSM #	HIV Prev.	FSW #	HIV Prev.	PWID #	HIV Prev.		
Bangladesh	158,513,000 (2014)	8,900 2,900	1000 900	110,581 (2010)	MSM 0.7% MSW 0.6% Hijra 0.5% (2013-14)	74,300 (2010)	0.3% (2013-14)	23,800 (2009)	1.1% (2011)	1287 (14%)	18% of <200
Indonesia	252,812,000 (2014)	660,000 230,000	69,000 34,000 ↑	1,095,970 TG: 37,998 (2012)	8.5% (2011)	229,856 (2012)	7.0% (2011)	74,326 (2012)	36.4% (2011)	50,400 (8%)	10% of 14,000
Myanmar	53,719,000	210,000 70,000	8700 10,000 ↓	230,000 (2010)	6.6% (2014)	70,000 (2010)	6.3% (2014)	75,000 (2010)	23.1% (2014)	85,626 (40%)	79% of 4600
Nepal	28,121,000	39,000 13,000	1500 2600 ↓	196,270 (2012)	3.8% (2012)	26,504 (2012)	1.7% (2011)	52,174 (2012)	6.3% (2011)	10,407 (27%)	33% of <500
Philippines	100,096,000	36,000 4,100	6400 <500	540,400 TG 27,000 (2011)	MSM 3.3% MSW 1.1% TGSW 3.7% (2013)	80,000 (2011)	0.4% (2013)	14,400 (2011)	44.9% (2013)	8481 (24%)	data not available of <500 (2013)
Thailand	70,243,000	450,000 290,000	7900 19,000 ↓	550,571 (2009-10)	7.1% (2012)	123,530 (2010)	2.2% (2012)	40,300 (2009)	25.2% (2012)	271,652 (61%)	95% of 4800
Viet Nam	92,548,000	250,000 77,000	15,000 11,000 ↓	382,506 (2013)	3.7% (2013)	71,936 (2013)	2.6% (2013)	271,506 (2013)	10.3% (2013)	93,262 (37%)	54% of 3000
										http://www.aidsdatahub.org/Country-Profiles	

Source: AIDS Data Hub <http://www.aidsdatahub.org/Overview-in-Slides>

Annex 2. Countries by Economic and AIDS Spending Indicators

Country	Income status	GDP per cap (PPP USD)	Spending on HIV&AIDS					
			Per cap. total health expenditure	Total AIDS expenditure	Domestic share of total AIDS spending	Domestic share of prevention spending	Domestic share of care & treatment spending	Proportion of total prevention spending on KPs
Bangladesh	LI now LMI	829 (2013)	67 (2011)	\$21.1 million (2013) ↑	16% (2013)	16% (2013)	15% (2013)	80% (2013)
Indonesia	Upper LMI	3,475 (2013)	132 (2011)	\$87.5 million (2012) (NASA 2011-12, in IC) ↑	42% (NASA 2011-12, in IC) ↑	29% (2012)	75% (2012)	4% (2012)
Myanmar	LI now LMI	1,126 (2012)	23 (2011)	\$53.5 m in 2013 (NASA 2012-13, in GARP 2015)	4% (IC)	11% (2011)	5% (2011)	68% (2011)
Nepal	LI	694 (2013)	85 (2011)	\$19.9 m (2009) (\$22 m allocated for 2013-4: GARPR 2014)	10% (GARPR 2014)	negligible (2009)	negligible (2009)	43% (2009)
Philippines	Upper LMI	2,765 (2013)	182 (2011)	\$10.3 million (2013)	43.9% (2013)	48% (2013)	31% (2013)	18% (2013)
Thailand	UMI	13,586 (2012)	327 (2009)	\$314.4 million (2011)	85% (2011)	44% (2011)	99% (2011)	23% (2011)
Viet Nam	Lower LMI	1,911 (2013)	227 (2011)	\$95.4 (2012)	31% (2012) external 75% (IC)	18% (2010)	9% (2010)	29% (2010)
Source	GF Eligibility List 2015 /World Bank	AIDS Data Hub http://www.aidsdatahub.org/Overview-in-Slides unless otherwise indicated						

Annex 3. Checklist of Key Features in the National Investment Cases

Country	NIC publication date	Items addressed or included in the document						
		Consultation process	Key inputs data	Social enablers	Links to national health & development objectives (other than AIDS)	Efficiencies and cost savings	Sustainable financing	Full analysis and assumptions
Bangladesh	draft as of Sep 2015	✓	✓	✓		✓		✓
Indonesia	2012-15	✓	✓			✓	✓	✓
Myanmar	2013		✓	✓		✓		
Nepal	end 2013	✓	✓	✓		✓		
Philippines	2014-15	✓	✓	✓		✓	✓	
Thailand	2013		✓	✓		✓		
Viet Nam	Oct 2014	✓	✓	✓		✓	✓	✓

Annex 4:

Utilisation of Investment Cases for Advocacy Purposes

BANGLADESH

The investment case was used in the development of Bangladesh's Global Fund NFM concept note; the request was approved and funding has been secured until 2017.

The draft IC has been disseminated, through presentations and emails, to government departments, communities and potential donors; an advocacy brief is in development. Once the IC is formally approved by the Technical Committee of the National AIDS Committee (TC-NAC), endorsement will be sought from the Minister of Health and Family Welfare.

The IC will be used in the revision of the health sector plan as well as the forthcoming (2017) revision of the national AIDS strategic plan. The IC will therefore likely be updated with new evidence in 2016. Agencies and organisations are free to use the report in the development of funding proposals.

INDONESIA

The investment case analysis has already been used to advocate to national and local governments for increased budgets for the HIV response, and to the Global Fund for an optimal allocation for the HIV programme under the NFM. At the end of 2015/beginning of 2016 the analyses will be brought before the Ministry of Planning and the Chair of the Parliamentary Commission on Health and Labour. Most recently, the investment case data were used by UNAIDS Special Envoy Mr. Prasada Rao when he met Indonesia's Vice President and Health Minister to make the case for increasing domestic investment for the response.

The investment case modelling has been used to develop the national Fast Track Scenario and the Jakarta City Fast Track Initiative, and will be used for other fast track cities and the costing of the Strategic Use of ARV (SUFA) initiative.

MYANMAR

The investment case was used as a reference in the preparation of funding proposals to the Global Fund and 3MDG Fund. It was also used to advocate for additional resources to the government, which responded by allocating US\$5 million for ARVs and US\$1 million for methadone in 2014 to address a gap in Global Fund support. HIV prevention and treatment programmes have now been expanded across the country to decentralized sites.

Of all the advocacy materials, the presentations were particularly effective in highlighting the potential impact of different scenarios in terms of numbers of new infections and deaths averted.

The IC is currently being updated and will complement the evidence base for the new HIV National Strategic Plan for 2016-2020.

NEPAL

Since the Nepal HIV Investment Plan was launched, the government share of HIV spending has increased from 3% to 21%; a number of public-private partnership initiatives have begun; and a NASA is being carried out.

The NHIP will be updated in the near future using new data from the latest IBBS.

PHILIPPINES

The investment options paper has been widely endorsed by civil society. It was disseminated through an NGO partner, the Philippine Legislators Committee on Population and Development, Inc. (PLCPD), to the House of Representatives and the Senate through various forums, including committee hearings and one-on-one discussions with key parliamentarians. CSO/NGO representatives were present at several such meetings.

A series of dissemination forums through a national network of MSM and TGW groups—DANGAL Pilipinas—led to the endorsement of the Investment Options by Dangal, signifying that they will use the investment case as their main tool for budget advocacy. The network has been actively advocating for the amendment of the AIDS Law, and many of the member organizations were instrumental in influencing local investments in AIDS through the national Anti-Poverty Commission's Bottoms-Up Budgeting Process, which started in 2012.

The Philippines National AIDS Commission (PNAC), which has seven member-CSO/NGOs (out of the 26 organizations/agencies), endorsed the Investment Options last June 2014.

A number of different investment advocacy products have been derived from the original AEM report. Two versions of the Investment Options paper itself were produced. The simpler, '3 Scenarios' version has been distributed to high level partners or those who have very limited time to review the paper, such as Mayors, Members of Congress, and a Cabinet Secretary. The 5 scenario version is designed for a more technical audience: technical planning officers, advisers, and so on.

The epidemiological data and projections from the Investment Options paper have been widely used and quoted by the Department of Health Secretary, Members of Congress and others to increase awareness about the HIV epidemic in the country. The added value of the paper in terms of advocacy, is the cost estimates, particularly those that highlight the high cost of doing business as usual.

The full investment need recommended by Investment Options has been endorsed by, among others, Congressman Teddy Baguilat, in a series of meetings on the AIDS Law Amendment in 2014; DOH Under-Secretary Belizario, in 2015; DOH Assistant Secretary Eric Tayag, in 2014; PNAC, at their 2015 Plenary Meeting; selected UN Heads of Agencies and senior staff (UNFPA, UNICEF, WHO), in 2014-2015.

Following a change of administration in 2016, an updated national HIV and AIDS investment case is expected to inform the following plans:

- The Philippine Development Plan (PDP), 2017-2022: this is expected to include the eradication of HIV and AIDS as one of the country's national development priorities.
- Public Investment Plan (PIP): the companion document to the PDP, which articulates the financing and budgetary requirements of the national development priorities.
- Budget Priorities Framework for developing the annual budget priorities of national agencies and local government units.
- Health sector plans such as the medium-term National Objectives for Health and the short-term Health Sector Strategic Plan.

THAILAND

The investment case has informed the following strategic documents and policy milestones:

- The development of the Global Fund NFM concept note: a grant of USD 39.755 million has been approved for 2015-2016.

- The Ending AIDS Operational Plan 2015-2019. The plan prioritises combination prevention (including treatment as prevention), early treatment, and the reduction of stigma and discrimination; places a strong emphasis on reaching key populations (MSM, people who use drugs, sex workers and migrant workers) with quality services; and promotes a shift to community-based, community-led service delivery.
- In November 2014, the cabinet endorsed the 'Ending AIDS' strategy as a 'national agenda,' informed by the investment case.
- The National Treatment Guidelines, launched in 2014. ART is now offered to everyone who tests HIV-positive, irrespective of CD4 count.
- The National Health Security Office allocated approximately USD 1 million in 2014, increasing to USD 6.25 million in 2016, for prevention programmes for MSM and FSW.
- The HIV budget for BMA increased from USD 1.7 million in 2013 to USD 2.5 million in 2016.
- PEPFAR committed an additional USD 2 million in 2014-2015 to develop a test and treat model for MSM, TG and MSW as part of the 'Ending AIDS' initiative in major cities.

VIET NAM

The 'Ending AIDS' scenario in Viet Nam's investment case has been used in the development of the country's national strategic plan, particularly to estimate HIV resource needs and identify priority actions for the coming years. The investment case has also been used in the preparation of a concept note for the Global Fund. In addition, it has formed the basis of advocacy efforts to the national assembly and government for increased funding for the response as the country prepares to transition towards more sustainable funding. To this end, the Prime Minister has recently requested provinces to guarantee budgets for HIV for the next five years.

Annex 5. List of Key Informants

NAME	DESIGNATION/ OFFICE	
Asep Eka Nur Hidayat	Planning Coordinator, National AIDS Commission, Indonesia	interview
Bayu Taruno Nugroho Putro	M&E Officer, Ministry of Health, Indonesia	interview
Cho Kah Sin	UNAIDS Country Director for Indonesia	email
Krittayawan Boonto	Investment and Efficiency Adviser, UNAIDS Myanmar	email, interview
Lely Wahyuniar	Strategic Information Adviser, UNAIDS Indonesia	email
Patchara Benjarattanaporn	Strategic Information Adviser, UNAIDS Thailand	email
Saima Khan	Strategic Information Adviser, UNAIDS Bangladesh	email
Ruben F. Del Prado	UNAIDS Country Director for Nepal and Bhutan	email
Zimmbodillion Mosende	Strategic Information Adviser, UNAIDS Philippines	email

The following informants provided input by email or through brief face-to-face interviews:

