UNAIDS 2023

REFERENCE

Checklist and reference list for developing and reviewing a national strategic plan for HIV

2023 version

Contents

Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral
CD4	T lymphocyte cell
COVID-19	SARS-CoV-2
CrAg	cryptococcal antigen
DHIS2	District Health Information System Version 2
DHS	Demographic and Health Surveys
DTG	dolutegravir
eMTCT	elimination of mother-to-child transmission
GAM	Global AIDS Monitoring
GBV	gender based violence
GDP	gross domestic product
GIPA	greater involvement of people living with HIV
HBV	hepatitis B virus
HCV	hepatitis C virus
HPV	human papillomavirus
IBBS	integrated biological and behavioural surveillance
KVP	key and vulnerable population
LF-LAM	lateral flow urine lipoarabinomannan assay
MIS	management information system
M&E	monitoring and evaluation
NCD	noncommunicable disease
NCPI	National Commitments and Policy Instruments
NSP	National Strategic Plan
NTP	national TB control programme
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
RSSH	resilient and sustainable systems for health
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TB	tuberculosis
TLD	tenofovir, lamivudine, and dolutegravir
U=U	undetectable = untransmissible
VMMC	voluntary medical male circumcision

Introduction

National strategic plans (NSPs) for HIV are usually three–five year guiding plans for national multisectoral responses to HIV epidemics. In some countries, HIV NSPs also include strategic plans in response to tuberculosis (TB), sexually transmitted infections (STIs), viral hepatitis and other related diseases. An NSP should serve as a strategic plan for the national response in its entirety, aligning investments, implementation and technical support by multiple sectors and stakeholders, including government, private sector, civil society and community groups, development partners, including bilateral and multilateral organizations, and others with the aim of ending the AIDS epidemic as a public health threat by 2030. NSPs contribute to the efforts of reaching the health-related and other targets of the 2030 Sustainable Development Goals, including universal health coverage.

This updated checklist highlights critical areas of national responses to HIV to guide and ensure that quality strategic planning is based on current knowledge, and is in response to ongoing and emerging needs, challenges and opportunities, in the context of existing and foreseeable technologies, systems and infrastructure. It is intended to be a 'live' document serving the needs of a country's key stakeholders, implementers and partners who are developing a new NSP, reviewing a current NSP (by conducting, for example, a Midterm Review), adjusting a current NSP, or to link with time-sensitive resource mobilization efforts. It includes the development of funding requests to the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as consultants and advisors supporting those efforts.

Any NSP needs to place people's health and rights at the centre and be contextualized by the evidence and type of the HIV epidemic, the strengths, weaknesses, enabling factors and barriers of the national response, and the needs of affected populations and communities to ensure no one is left behind. These principles and the essential components of NSPs are in line with the latest global strategic frameworks and technical recommendations, such as the UNAIDS *Global AIDS strategy 2021–2026: end inequalities. End AIDS* (2021); the WHO *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030* (2022); the WHO 2021 report *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021); *Global Fund Strategy (2023–2028): fighting pandemics and building a healthier and more equitable world*; and others. Countries face different and changing HIV epidemics, have different needs on the ground, and systems, technologies and capacity in place. Thus, not all the elements of the checklist may be relevant to their context. Consequently, in-country partners and the respective stakeholders can use this tool as a prompt to ensure the essential components are included in the NSPs and priorities are set based on evidence, local context and needs, and capacity, resources, cost-effectiveness and impact analyses. This checklist, including the YES, PARTIAL and NO response choices and justification, is not intended to be submitted to UNAIDS but rather is a self-assessment tool to help with the NSP review or development to understand relevant options and make evidence-informed decisions for the country to produce a meaningful, useful and impact-oriented NSP.

This NSP checklist is revised from its 2020, pre-Global AIDS Strategy version (*Checklist and reference list for developing and reviewing a national strategic plan for HIV*) and is now in line with the Global AIDS Strategy 2021–2026 priority strategic and results areas and the 2025 global HIV targets, and complements and builds on the most recent normative and technical guidance developed by UNAIDS, the UNAIDS cosponsors and The Global Fund's Secretariat. It includes hyperlinks for such guidance, technical recommendations and other references for easy reference.

The checklist has two parts for NSP self-assessment: high-level cross-cutting content (Part A) and specific programme content (Part B).

Part A applies to all countries and contains analyses of situations and responses to inform NSP development, the key principles of NSP development process, the goal, targets and priority-setting, and the principles of human rights, equity and sustainability.

Part B contains the policy and programme requirements for HIV prevention, testing and diagnosis, treatment and care, addressing comorbidities and co-infections, enabling implementation and scaling up of integrated people-centred strategies, systems and interventions, social protection, health systems, community engagement and community-led responses, human rights and gender equity, efficiency and effectiveness, governance, management and accountability, HIV in humanitarian crises, and pandemic preparedness and response. Countries need to select the relevant elements of Part B depending on context and consultations with wider groups of stakeholders.

	Included yes/partial/no	Justification
A. High-level cross-cutting content		
A-1 The most current and evidence-informed epidemiological, context and response analysis		
▪ Has a full epidemiological analysis been conducted and referenced for the following? ▪ Demographic data and trends—fertility rates, underlying mortality. ▪ Trends in HIV incidence and AIDS-related mortality with disaggregated patterns (subpopulation, age, sex, behavioural risk, geographical distribution and by key populations) based on latest HIV estimates (Spectrum, NAOMI, other tools for subnational estimates), Integrated Biological and Behavioural Surveillance surveys, household surveys, modes of transmission studies (if appropriate). ▪ Rates of, and trends in, non-AIDS-related morbidity and mortality, comorbidities and co-infections, SRH and other health issues in PLHIV and other relevant population groups, including HIV-TB, HIV-viral hepatitis, HIV-STIs, HIV-NCDs, HIV-cervical cancer, HIV-mental health conditions, female genital schistosomiasis, etc. ▪ Does the NSP consider and capture how the country is progressing towards the global 2025 targets (page 43 onwards in *Prevailing against pandemics by putting people at the centre: World AIDS Day Report 2020*)? ▪ Identification of population groups at highest risk of HIV infection/affected by HIV. ▪ Prevalence (and incidence) in key population and priority groups, and population size estimation. ▪ Gaps identified in population, age and location as informed by epidemiological data.		
▪ Does the analysis of underlying contributing factors include the following? ▪ Macroeconomic situation (poverty rate, GDP increase, budget, etc.).		

	Included yes/partial/no	Justification
▪ The UNAIDS Inequalities Framework and toolkit[1] to present a comprehensive review/analysis of inequalities affecting the response. ▪ The UPROOT Scorecard methodology, which provides information on gaps in the HIV response for young people. ▪ Key risk and vulnerability factors for transmitting and acquiring HIV by population (behavioural, biological and structural factors) ▪ Technical capacity financial and human resources ▪ Are there other contextual factors that affect HIV outcomes? ▪ Legal, economic and political environment. ▪ Social and cultural environment. ▪ Gender equality and gender-based violence (GBV). ▪ Health system factors. ▪ HIV-related stigma and discrimination, including against key and vulnerable populations (KVPs). The latest stigma index information has been *included (see About the Stigma Index | People Living with HIV Stigma Index).* ▪ Humanitarian situation, risks and fragilities, and room for flexibility if a humanitarian crisis emerges. ▪ Other pandemics and crises.		
▪ The response analysis has considered the following: ▪ Whether the response was tailored towards addressing the causes of most new infections and the biggest case load in accordance with factors identified in the epidemiological and underlying factor analysis. ▪ Were the targets set in the previous NSP achieved? For which populations? For which locations? If not, which were not and why? ▪ Are there gaps in the response; for which populations and locations? For example, whether targets in the previous NSP were not achieved and any groups and locations left behind. ▪ Have strengths and weaknesses of the response been identified; for which populations and locations? Have the universality of access to services, the quality of implementation and barriers in key areas of response, such as prevention, testing, treatment, rights, laws, stigma and discrimination, gender norms, social protection and community engagement been identified through an inequality lens (see the *Global AIDS Strategy*) ▪ Have strategies been identified that deliver high impact interventions (for example, differentiated service delivery, dolutegravir, pre-exposure prophylaxis (PrEP), etc.) and need to be amplified? ▪ Have differentiation strategies been considered for urban and rural areas — see cross-cutting issue of HIV in cities for guidance *(toolkit forthcoming).*		

[1] The UNAIDS Inequalities Framework will be published in May 2023. The inequalities toolkit produced by the African Population Health and Research Centre in partnership with the Inequalities Institute at the University of Southern California and UNAIDS is currently being piloted in five countries. Following the pilot tests, the toolkit will be issued in June 2023.

	Included yes/partial/no	Justification
▪ Have emerging trends been looked for and highlighted? Have the major changes in the past trends been identified? ▪ Have the funding landscape and expenditure of the response been analysed? ▪ Have humanitarian, conflict, climate, or other crises changed the response? ▪ Have public health challenges, including COVID-19, changed the response? ▪ Have relevant data and information resulting from community-led monitoring and community-led research been included in the analysis?		
Review question: *Is there a well-evidenced and high-quality situation analysis that uses recent epidemiological data, sufficiently disaggregated (age, sex, gender, population), to enable analysis of the HIV epidemic and related programme coverage data and targets? Is there evidence that the epidemic and response analysis have answered the questions of what has changed and what has remained the same since the previous NSP?*		
A-2. Inclusive process for developing the NSP		
▪ Have the following groups/stakeholders been consulted or engaged in the NSP development? ▪ Government sectors relevant to HIV work (such as health: including HIV, TB, health systems, health policy, SRH, NCDs, and other departments/programmes; education, finance, justice, women and youth affairs, social development and local governments). ▪ Community-led organizations, including those led by key populations, women-led organizations, youth-led organizations and other vulnerable populations[2]. ▪ Civil society organizations and community leaders (religious, traditional, other leaders). ▪ Major development partners and donors (and, as relevant, humanitarian and emergency responders, etc.). ▪ Academia, research institutes and think tanks. ▪ Private sector partners.		
Review question: *Is there a clear and concise description of how the NSP was developed, including how multiple stakeholders such as relevant sectors, community, and civil society members, were involved in the development and endorsement of the NSP? Is there evidence that the NSP reflects the concerns and priorities raised by different stakeholders?*		
A-3. Goals, objectives and targets		
▪ NSP goals and objectives are aligned with the Global AIDS Strategy 2021–2026: end inequalities. End AIDS (2021), and targets are informed		

[2] Key and vulnerable populations (KVPs) at higher risk are groups of people who experience a disproportionate burden of HIV infection and whose engagement is crucial to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs, sex workers and their clients, prisoners and people in close settings, are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. People are said to be vulnerable if their living conditions are prone to shifting factors that would place them at risk of contracting HIV. Examples of these groups are young people, women, migrants, long distance drivers, displaced populations and refugees, men in uniform, and people with disabilities.

	Included yes/partial/no	Justification
by the global 2025 HIV targets and correspond to the epidemic situation and local context.		
▪ NSP goals, objectives and targets are aligned and linked with: ▪ Country socioeconomic development or other relevant plans. ▪ National health sector strategy/plan; universal health coverage road map, if available. ▪ Other strategic/implementation plans for specific diseases and health issues, e.g. TB, sexual and reproductive health and rights (SRHRs), STIs, maternal, newborns, child and adolescent health, viral hepatitis, cervical cancer, NCDs, mental health, nutrition, etc. ▪ The NSP follows a theory of change and results chain.		
▪ Targets are needs-based, ambitious and realistic.		
▪ Targets and interventions reflect the realities of the epidemic and emerging trends, as well as lessons learned from programmes supported within the country at national or local scale.		
▪ The NSP sets coverage, outcome and impact measures for results-centred objectives and targets, with a baseline, over the period covered by the NSP, including for specific populations (the targets should include testing, treatment and prevention targets for key populations, both positive and negative): ▪ People living with HIV (PLHIV), by sex and age. ▪ Key populations: – Gay and other men who have sex with men, and their partners; – Transgender people and their partners; – People who inject drugs and their partners; – Sex workers, their partners and their clients; – Prisoners, people in detention and other closed settings. ▪ Other priority populations (as relevant): – Children; – Adolescents and youth in settings with high HIV incidence; – Adolescent girls and young women in settings with high HIV incidence; – Adult women and men in settings with high HIV incidence; – Ageing/older/elderly populations; – Seronegative partners in sero-discordant couples; – Migrants; – Truck/long distance drivers; – Displaced populations and refugees; – Men in uniform; – People with disability; – City dwellers; – Other groups.		
Review question: *Are the proposed targets (impact, outcome, output, and programme coverage targets) informed by disaggregated data (age, sex, gender, population, location) to maximize programme effectiveness? Are targets disaggregated by different key population groups? Have the strong monitoring and evaluation (M&E) elements been considered in selection and setting up the targets? Are the targets appropriate for making progress towards the end of AIDS by 2030?*		

	Included yes/partial/no	Justification
A-4. Priority setting		
▪ The priority setting process considered the following criteria: ▪ Highly effective, high impact interventions are included and backed by evidence-informed analysis. ▪ High allocative efficiency: the right mix of priority interventions to maximize impact and to achieve measurable results with the available resources and capacity. ▪ Improving operational efficiency by optimizing working processes. ▪ Focus on populations and locations informed by epidemiological and programmatic data. ▪ Selected interventions to achieve sufficient coverage to meet the targets.		
Review question: *Are the identified strategies and interventions for achieving NSP targets well prioritized and coherent? Is there appropriate alignment of priority interventions with epidemiology and priority gaps? How different is the current NSP from the previous ones, what has been added as a priority and what has been dropped or modified?*		
A-5. Community-led response, human rights and gender equity principles		
▪ The NSP described a clear and inclusive mechanism to ensure: ▪ The full implementation of the commitment to the principle of greater involvement of people living with HIV (GIPA) and promote the meaningful engagement and leadership of most affected communities, including key populations, priority and other groups, as key stakeholders and partners in the response. ▪ Community-led organizations[3] have roles in implementing the response and are adequately funded to perform those roles. ▪ Does the NSP adequately consider and address strategies and interventions that will enable progress towards the global targets 30–80–60 and 10–10–10 targets? ▪ All areas of community-led responses[4] are supported, such as leadership, advocacy, service delivery, education and information provision, research and monitoring.[5] ▪ The NSP promotes a comprehensive, multisectoral response to scale up prevention and treatment programmes and to address the societal enablers relevant to the HIV response, including reducing stigma and discrimination, criminalization, etc., through meaningful engagement of the most affected communities at all levels, government (health, education, justice, gender, youth and business) and other sectors, by setting links with sector strategies, where applicable.		

[3] Community-led organizations, groups and networks, irrespective of legal status (whether formal/informal), are entities for which the majority of governance, leadership, staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies and which have transparent mechanisms of accountability to their constituencies.
[4] Community-led responses are actions and strategies that seek to improve the health and human rights of their constituencies, and that are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.
[5] To meet the Global AIDS Strategy (GAS) and Political Declaration (PD) 2021 targets, UNAIDS prioritizes community-led responses that are led by PLHIV, key populations, women and youth.

	Included yes/partial/no	Justification
▪ The NSP includes evidence-informed interventions to reduce societal barriers such as: ▪ Legal, policy, social and human rights-related barriers for accessing HIV and other relevant services: for example, criminalization of HIV transmission; parental consent for underaged; criminalization of key populations; travel restrictions, etc. ▪ Stigma and discrimination faced by PLHIV and key populations in health care, education, workplace, justice, household, emergency and humanitarian settings. Guidance documents include UNAIDS publications such as: *Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses* (2012); *Fast-track and human rights* (2017) and *Evidence for eliminating HIV-related stigma and discrimination* (2020).		
▪ The NSP includes sound approaches for community-led monitoring. UNAIDS guidelines for community-led monitoring: Establishing community-led monitoring of HIV services — Principles and process (2021).		
▪ The NSP analyses and addresses discrimination against women and girls, and gender inequality issues and promotes gender-transformative HIV responses.		
▪ The NSP reflects findings of national gender assessments (on women's rights and sexual and reproductive health), such as gender reviews using *UNAIDS Gender Assessment Tool: Towards a gender-transformative HIV response* (2018).		
A-6. Costing and efficiency		
▪ The NSP includes costing based on up-to-date assumptions and prices, and specifically the following: ▪ Costing covers all years and all interventions of the NSP: ▪ If no, is it clear what has been excluded and why? ▪ Does the value of investments reflect NSP priorities? ▪ Do resource estimates reflect funding thresholds? ▪ Has there been any iterative prioritization and sharing of costs with stakeholders?		
▪ Costing method/s is/are clearly articulated, referenced and applied consistently throughout the document and is/are logical. This must include a table with: ▪ Each cost input. ▪ The fully traceable reference or source. ▪ Output scale for the NSP. ▪ The ingredients included and their quantities, in particular: – The service level costs above, including programme management, M&E, training, and supportive supervision, logistics/supply chain management. – Human resources. – Supplies.		

	Included yes/partial/no	Justification
– Transportation, etc. ▪ Which activities are assumed to be included, and their frequency? ▪ Do costs reflect investments in enabling environment, and scale up of community-led response? ▪ Manipulations applied, e.g. inflation or activity adjustments. ▪ Assumptions that were made and limitations of overall cost estimate. ▪ Costing is clearly linked to the results chain and the expected results for each programme and intervention (and service area as relevant). ▪ The costing plan is summarized by year, programme and subprogramme, by intervention, by goal and by objective (as relevant for the format and layout of the NSP). ▪ Has the workbook been submitted and are the prices and quantities visible for review?		
Review questions: *Are all major interventions included in the costing? If no, is it clear what has been excluded and why? Does the value of investments reflect NSP priorities? Do costs reflect investments in enabling the environment, programme management including M&E, training, and supportive supervision?*		
A-7. Financing and sustainability		
7.1. Finance ▪ The NSP provides a snapshot of macroeconomic status, including GDP growth, debt, government revenue, expenditure and budget allocations for social sectors. ▪ The NSP analyses the status of universal health coverage, including priorities and where HIV is placed within those priorities. ▪ The NSP analyses the current health financing, including domestic and international funding, government health investment as a percentage of GDP, insurance, out of pocket expenditures, analysis of public expenditure (including indications of public financial management efficiency and budgeting system for health), and the proportion of public versus private health service provision. ▪ The NSP analyses funding gaps per NSP component, contextualized by projected new HIV infections and needs, and funding gaps across the full costed plan. ▪ Given the funding gap analysis, how well is the government responding to NSP funding gaps and how will the response need to change over time? ▪ Is the NSP congruent with current national health strategies and policies?		
7.2. Sustainability ▪ The NSP includes sustainability considerations, such as plans to strengthen the sustainability of the national HIV response, including community-led responses. ▪ The NSP includes details of the funding landscape for HIV programmes (including that for multisectoral responses), including: – Fiscal space.		

	Included yes/partial/no	Justification
– HIV programmes that are already funded. – Health sector financing systems and their implications for financing HIV programmes. ▪ Is there a clear resource mobilization strategy? ▪ Is there a clear strategy for social contracting for community-led responses?		
Review questions: *Have authors considered sustainability across the various sustainability domains (financial, programmatic, etc.)? Do suggestions for increased domestic financing rely on research or evidence, or are they generic suggestions?*		
A-8. Operational plan and implementation arrangements (five years, or as relevant)		
▪ Institutional arrangements, including coordination, planning, guidance to all stakeholders (public, community-led, civil society, development and private sector partners).		
▪ For each institutional partner (or partner group), key roles and responsibilities are laid out (for example, for each ministry or service sector key roles are clear, with the same for all community-led organizations).		
▪ Implementation arrangements for the roll-out of the NSP include: timeline, key implementing partners, and an action plan and, if necessary, a description of how a cascade of planning will go from national to subnational levels with resource and output expectations anticipated from each level of implementation.		
▪ The results framework/M&E plan is clearly linked to the operational plan.		
▪ The national M&E plan includes data collection, aggregation, storage, reporting and dissemination details.		
▪ The M&E plan provides for: ▪ Data quality assurance for the generated data. ▪ Routine monitoring and M&E technical support interventions. ▪ M&E capacity strengthening. ▪ Operations research for programme improvement. ▪ Essential reviews and evaluations to gauge the achievement of NSP hierarchy of results (outputs, outcomes and impact).		
▪ Does the NSP provide a concise view of the consequence of non-implementation or delayed implementation?		

	Included yes/partial/no	Justification
B. Specific programmatic areas		
B-1. HIV prevention: all tools are available at https://hivpreventioncoalition.unaids.org		
B-1.1. HIV prevention overall:		
▪ The NSP builds on prevention assessments and data (including population size estimates, score cards, prevention programme self-assessments).		
▪ The NSP sets coverage, outcome and impact targets for the prevention pillars based on a sound results chain and plausible quantification to achieve the expected impact.		
▪ The NSP gives priority to prevention interventions based on sound analysis of the epidemic and considering efficiency and funding.		
▪ The NSP defines specific barriers to HIV prevention and ways to address them.		
▪ The NSP defines an accountability mechanism for HIV prevention in all sectors.		
B-1.2. Programmes for key populations (disaggregate responses for each of the five key populations)		
▪ The NSP gives priority to key populations, defines strategies to reach key populations in line with population size estimates, and defines coverage, key outcomes and barriers.		
▪ The NSP defines service packages for HIV prevention (including condoms, safe injecting equipment, HIV testing, treatment, PrEP and opioid agonist treatment) among all key populations.		
▪ The NSP identifies barriers to HIV prevention access among key populations and structural barriers, and defines actions to address them, including trusted community and virtual service access platforms.		
B-1.3. Programmes for adolescent girls and young women in settings with high HIV incidence		
▪ The NSP provides a synthesis of geographical patterns of HIV incidence and prevalence, size estimates of adolescent girls and young women at higher risk, risk and vulnerability factors and applies these data for priority-setting.		
▪ The NSP defines differentiated approaches and packages of prevention services and outcomes reflecting differences in risk between populations and locations.		
▪ The NSP defines access platforms for HIV prevention actions with adolescent girls and young women, including in the health sector, the education sector, at community level and in the virtual space.		
B-1.4. Programmes for adolescent boys and men including voluntary medical male circumcision (VMMC)		
▪ The NSP provides a synthesis of geographical patterns of HIV incidence and prevalence, size estimates of adolescent boys and men		

	Included yes/partial/no	Justification
at higher risk, and risk factors and applies these data for priority-setting.		
▪ The NSP precisely defines differentiated approaches and packages of prevention services (including VMMC, where applicable) and outcomes reflecting differences in risk between populations and locations.		
▪ The NSP uses platforms for HIV prevention actions with adolescent boys and men, including health, education, community, workplace and online platforms.		
B-1.5. Male and female condoms and lubricants		
▪ The NSP is based on analysis of condom needs, current distribution patterns and channels, demand-side factors and current use by all key and priority populations.		
▪ The NSP defines key strategic directions in the areas of supply, last-mile distribution and demand generation, including relevant innovations.		
▪ The NSP is based on a condom total market approach that defines the roles of public, private and social marketing sectors, community-level actors as well as leadership and market facilitation functions.		
B-1.6. For ARV-based prevention		
▪ The NSP is based on analysis of the current use of antiretrovirals (ARVs) for prevention (undetectable=untransmittable (U=U), PrEP, and post-exposure prophylaxis (PEP)), defines priority populations, targets and coverage gaps (see Section B2.4 for vertical transmission).		
▪ The NSP defines required policy changes relative to ARV-based prevention, including new long-acting prevention technologies (e.g. CAB-LA, Dapivirine vaginal ring, etc.) and ways to address them. The NSP defines relevant service packages for ARV-based prevention, delivery platforms for supply and demand side interventions, including health and non-health sector actors.		
Review question: *Are the identified strategies and interventions for achieving NSP prevention targets prioritized and coherent? Is there appropriate alignment of interventions with epidemiology and priority needs and gaps?*		
B-2. HIV testing, diagnosis, treatment and care. Guidance is aligned with WHO's Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach (2021)		
B-2.1. HIV testing is aligned with two WHO publications: Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach (2021) and Consolidated guidelines on HIV testing services for a changing epidemic: Policy brief (2019).		
▪ The NSP considers the 'HIV Status Neutral' approach and mechanisms linking HIV testing with prevention, treatment and care services.		

	Included yes/partial/no	Justification
▪ The NSP details differentiated HIV testing approaches, including self-testing, to reach people still missing, such as men, adolescents, key populations and priority groups, as relevant, by geographical location.		
▪ The NSP defines strategies on ethical index testing, social network testing, assisted partner notification, community-level testing, self-testing, and repeat testing for higher risk groups.		
▪ The NSP considers linkages with comorbidity and co-infection management and with primary health care, especially for TB, STIs, family planning, and maternal and new born/child health services (see additional guidance in B3)		
▪ The NSP details how HIV testing is linked to treatment and care for those testing positive and to HIV prevention for those testing negative. Reference: International AIDS Society, *Differentiated service delivery for HIV: a decision framework for HIV testing services — mobilizing, testing, linking.*		
B-2.2. HIV treatment is aligned with the WHO's *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021).		
▪ The NSP clearly defines the ways in which HIV treatment overall and HIV treatment for specific populations and by first and second line ARVs will be scaled up, with the yearly targets.		
▪ The NSP provides details on the roll-out of tenofovir, lamivudine and dolutegravir (TLD)/dolutegravir (DTG) and standardized ART regimens (including formulations for children) following the latest WHO guidelines.		
▪ The NSP provides details on how the rapid initiation of ART, including same-day start will be scaled up. Reference: WHO's *Updated recommendations on HIV prevention, infant diagnosis, antiretroviral initiation and monitoring* (2021).		
▪ The NSP provides considerations regarding community-initiated ART.		
▪ The NSP provides details on how differentiated service delivery using health facility-based and community-based models will be scaled up, with a defined role of community-led and community-based service provision, and adherence retention and other support.		
▪ The NSP specifies the methods of scaling up and the targets for multi-month (three–six months) dispensation of ARVs, and frequency of clinic visit as defined in WHO's *Updated recommendations on service delivery for the treatment and care of people living with HIV* (2021).		
▪ The NSP considers the use of CD4 testing at ART initiation, and when to use LF-LAM and CrAg testing according to WHO's Policy Update *Lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis of active tuberculosis in people living with HIV* (2019; WHO-CDS-TB-2019.20-english.pdf).		
▪ The NSP considers measuring HIV treatment adherence and retention in care, as well as tracing and re-engagement in care.		
▪ The NSP considers the screening, diagnosis and management of advanced HIV diseases, particularly TB and cryptococcal meningitis,		

	Included yes/partial/no	Justification
at primary health care level, in line with WHO's *Guidelines for Managing Advanced HIV Disease and Rapid Initiation of Antiretroviral Therapy* (2017), and *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021).		
▪ The NSP considers the specificities of differentiated HIV treatment service delivery for key populations. International AIDS Society, A decision framework for differentiated antiretroviral therapy delivery for key populations: The last mile to universal access.		
▪ The NSP includes provisions regarding HIV treatment literacy tailored to the needs of children, adolescents and older people living with HIV, people with disabilities, and other groups with special needs.		
B-2.3. Viral load suppression and retention		
▪ The NSP considers prioritization of point-of-care viral load testing as the preferred treatment monitoring approach: frequency, uptake and return of diagnostics.		
▪ The NSP provides analysis of those lost to follow-up (who, why, where and when) and presents strategies to increase retention in care.		
▪ The NSP refers to optimized regimens, where relevant		
B-2.4. Eliminating vertical transmission. WHO reference: Children and AIDS, The global alliance to end AIDS in children, Concept Note; and The global alliance resources . The NSP includes elements from pillars 1–4, as appropriate.		
Pillar 1: Accessible testing, optimized treatment and comprehensive care for infants, children, and adolescents living with/exposed to HIV ▪ Multimodality testing programmes to find and link all infants, children and adolescents living with HIV. ▪ Data-driven differentiated service delivery. ▪ Optimal ART for children and adolescents per WHO recommendations. ▪ Improving quality of care, including viral load monitoring, integrated comprehensive care and mental health services. ▪ Addressing the needs of adolescents living with HIV. ▪ Promoting cross-sectoral collaboration, for example, with early childhood development, nutrition, education, mental health and social protection.		
Pillar 2: Closing treatment gap for pregnant and breastfeeding adolescent girls and women living with HIV and optimizing continuity of treatment ▪ Promoting integrated 'triple elimination' of vertical transmission of HIV, syphilis and viral hepatitis B. ▪ Adopting differentiated approaches to increase eMTCT coverage. ▪ Addressing the needs of pregnant and breastfeeding adolescents with HIV.		

	Included yes/partial/no	Justification
▪ Improving quality of care, including viral load testing and mental health. ▪ Sharpening longitudinal data collection and promoting viral load monitoring and psychosocial support to improve continuity of care.		
Pillar 3: Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women ▪ Implementing partner testing and HIV retesting in HIV negative pregnant and breastfeeding women and girls. ▪ Utilizing innovative prevention technologies in antenatal and postnatal care. ▪ Increasing access for adult men to, and uptake of, HIV testing and HIV prevention information and services.		
Pillar 4: Addressing rights, gender equality and the social and structural barriers that hinder access to services ▪ Using gender and age-disaggregated data on coverage to transform programmes. ▪ Supporting countries to adopt and track the 10:10:10 targets defined in Global *AIDS Strategy 2021–2026: end inequalities. End AIDS* to challenge legal impediments to care, promote gender equality and address stigma and discrimination. ▪ Building awareness and capacity in communities to track progress. ▪ Provide resources to community-led monitoring to document rights violations and experiences of quality of care. ▪ Use data from the Stigma Index to strengthen advocacy that furthers human rights and gender equality and challenges stigma, discrimination and criminalization. ▪ Strengthen the meaningful representation of women, children and adolescents living with HIV in decision making processes.		
Review question: *Are the identified strategies and interventions for achieving NSP testing and treatment, and elimination of vertical transmission targets, prioritized and coherent? Is there appropriate alignment of interventions with epidemiology and priority needs and gaps? Is there evidence of new technologies being prioritized (such as HIV self-testing, PrEP)?*		
B-3. Comorbidities, co-infections and integration		
Tuberculosis. This section on HIV-associated TB should be developed with the National TB Programme and should align with, and complement, what is laid out in the TB NSP. The NSP should include a summary of coordination mechanisms for TB/HIV, as well as the level of integration in health system areas such as data systems (including DHIS2) and systems for the procurement and supply of relevant drugs and supplies. It should cover: national guidelines for screening, diagnosis and prevention of HIV-associated TB; service coverage, treatment outcomes for HIV-associated TB; and decentralization of and integration of TB and HIV services.		
B-3.1.1. Background and components: joint burden, access to services, integration, linkage and TB/HIV service delivery.		
▪ A review of the epidemiology of TB among PLHIV and HIV-related mortality, an analysis of the cascade of care for the detection,		

	Included yes/partial/no	Justification
prevention and treatment of HIV-related TB to date as outlined in the WHO series of publications entitled *Consolidated guidelines on tuberculosis* (2021), which contain the latest tools for TB screening, prevention, diagnosis and treatment.		
▪ A specific plan to achieve or exceed the target in the *Political Declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030* of achieving an 80% reduction in TB deaths among PLHIV by 2025 (from the 2010 baseline) and ensure that 90% of PLHIV receive preventive treatment for TB by 2025.		
▪ A mapping of TB and HIV services, including laboratory and sample transportation networks and opportunities for more efficient integrated delivery.		
▪ *Analysis of TB stigma and discrimination* in relation to the risk of acquisition and barriers to accessing services.		
▪ Demonstrate how interventions will reinforce high-quality TB prevention, early diagnosis, linkage to treatment, adherence, leading to treatment success and reduced mortality for drug-sensitive and drug-resistant TB among PLHIV.		
▪ Outline people-centred service delivery models to detect, treat and prevent TB among PLHIV with a focus on specific strategies to reach TB and HIV key and priority populations, using differentiated service delivery where applicable.		
▪ Strengthen integration, referral and links between TB and HIV service delivery points (for all populations at risk, including adult men, children, pregnant women, and key populations and marginalized groups such as prisoners, people who inject drugs, migrants and refugees).		
B-3.1.2. Reducing the burden of TB among PLHIV		
▪ All PLHIV are screened regularly for TB in line with WHO recommendations, tools and strategies for TB screening among PLHIV (2021) and, if they screen positive are fully investigated for TB (and COVID-19) as indicated in WHO guidelines (target >90%) using LF-LAM (for eligible people) (2021) and molecular WHO-recommended WHO TB diagnostic tests for pulmonary, extrapulmonary and disseminated TB where appropriate and receive TB preventive treatment (ideally 3HP if available) or TB treatment, as indicated in WHO guidelines (2020) (target >90%)		
▪ Consideration should be made to the placement of screening tools and diagnostic tools, as well as capacity building and task-shifting to expand access to TB screening diagnostics.		
▪ PLHIV who are diagnosed with TB are treated in accordance to WHO guidelines for drug-sensitive TB or drug-resistant TB as appropriate. Depending on model of integration, there will be need to liaise with NTP for capacity building.		
▪ Planning focused on follow-up of people who have completed treatment and heir linkage to the HIV services to ensure continuum of HIV care.		

	Included yes/partial/no	Justification
B-3.1.3 Reducing the burden of HIV among people with TB		
▪ All people with presumptive TB or who are diagnosed with TB are offered an HIV test (target >90%)		
▪ All people with TB who are newly diagnosed with HIV should start antiretroviral therapy (target 100%) and co-trimoxazole preventive treatment		
▪ Planning should take into consideration the placement and integration of HIV testing and treatment services within the TB services. HIV testing and ART are provided as part of the TB services, where possible.		
B-3.2. Cervical cancer prevention, treatment and care		
This section of the NSP should be in line with the: WHO *Global strategy to accelerate the elimination of cervical cancer as a public health problem (2020);* UNAIDS *Global AIDS Strategy 2021–2026: end inequalities. End AIDS* (2021); WHO global health sector strategy, *Global HIV, hepatitis and STIs programmes* (2022); WHO recommendations, *WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention* (2021), 1st and 2nd editions (including for women living with HIV); *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021); WHO guidance, *Introducing and scaling up testing for human papillomavirus as part of a comprehensive programme for prevention and control of cervical cancer* (2020); WHO position paper, *Human papillomavirus vaccines* (2022); and *Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact* (2022), as well as national cervical cancer strategies.		
▪ The NSP includes: epidemiological and programmatic context of cervical cancer-HIV comorbidity; estimates of needs (screening, diagnostic, treatment and care, and respective commodities); sets coverage, outcomes and impact targets for cervical cancer prevention (including primary prevention with HPV vaccination); secondary prevention (through screening and treatment of cervical precancerous lesions); and treatment and care, including palliative, focused on girls, adolescent girls, women and others with cervix living with/at risk of HIV in line with the WHO *Global strategy to accelerate the elimination of cervical cancer as a public health problem* (2020), and 90–70–90 cervical cancer elimination targets to be reached by 2030.		
▪ The NSP includes targets and M&E indicators for integrated HIV-cervical cancer services in line with GAM and NCPI indicators (GAM: 7.11, 7.12 and 7.13, and NCPI: 98 and 99) (*Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS — Global AIDS Monitoring 2023*).		
▪ The NSP provides: implementation details of cervical cancer screening and treatment of precancerous lesions; diagnosis; continuum of treatment and care for suspected or diagnosed invasive cancer for women living with and at risk of HIV; and community-led actions and respective supportive policies, systems and resources, including leveraging existing resources, integrated systems and service delivery platforms, partnerships, etc., and/or mobilization of new resources, and proposed budgets.		
B-3.3. Noncommunicable diseases prevention and care		

	Included yes/partial/no	Justification
In line with the UNAIDS Global AIDS Strategy 2021-2026: end inequalities. End AIDS and WHO strategies (*Global HIV, Hepatitis and STIs Programmes*) and recommendations (*Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021), Integrating the prevention and control of noncommunicable diseases in HIV/AIDS, tuberculosis, and sexual and reproductive health programmes: implementation guidance (who.int) (2023)) and, if available, the respective national NCD strategy/plan (or/and guidelines).		
▪ The NSP includes epidemiological and programmatic context of NCD-HIV comorbidity, and indicates programmatic approaches for ensuring NCD prevention and care services for people living with and at risk of HIV, as relevant, with a particular focus on most common comorbid NCDs (e.g. diabetes and hypertension).		
▪ The NSP clearly articulates needs in, and ways of, scaling up of screening, diagnostic and treatment services and respective commodities, and sets coverage, outcomes and impact targets for NCD prevention, screening, testing, diagnosis, treatment and care for people living with and at risk of HIV.		
▪ The NSP includes targets and indicators for integrated HIV-NCD services, as relevant.		
▪ The NSP provides details of implementation and scaling up of NCD prevention, screening/testing, diagnosis, treatment and care, and community-led actions, and supportive policies, systems and resources, including leveraging of existing resources, integrated systems and service delivery platforms, partnerships, etc., and/or mobilization of new resources, and budgets.		
B-3.4. Mental health, neurological and substance use conditions		
In line with the UNAIDS Global AIDS Strategy 2021-2026: end inequalities. End AIDS (2021); WHO global action plan, and WHO recommendations, *Management of physical health conditions in adults with severe mental disorders*; *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021) and the guide to *Key considerations for the integration of mental health and HIV interventions* (2022):		
▪ The NSP describes the epidemiological and programmatic context of comorbidities of HIV with mental health, neurological or substance use conditions or disorders, and clearly indicates strategic and programmatic approaches for ensuring mental health services and psychosocial support for people living with and at risk of HIV across the life-course, as relevant, with a particular focus on anxiety, depression, post-traumatic disorders, substance use conditions/disorders, psychosis, as well prevalent issues with stigma and discrimination associated with mental health and substance use conditions/disorders.		
▪ The NSP articulates needs and ways of scaling up screening, diagnosis and treatment services and respective commodities, and sets coverage, outcomes and impact targets for prevention, screening/diagnosis, treatment and care services for mental health, neurocognitive and substance use conditions/disorders and psychosocial support for people living with and at risk of HIV across the life-course, as relevant, and efforts to address the stigma		

	Included yes/partial/no	Justification
(including self-stigma) and discrimination associated with mental health and substance use conditions/disorders.		
▪ The NSP includes targets and indicators for integrated HIV-mental health/neurological/substance use condition services, as relevant.		
▪ The NSP includes details on scaling up of mental health, neurological and substance use condition/disorder prevention, screening/diagnosis, treatment and care for relevant populations, and community-led actions, as well as the respective supportive policies, systems and resources, including leveraging of existing resources, integrated systems and service delivery platforms, partnerships, etc., mobilization of new resources, and budgets.		
B-3.5. Sexually transmitted infections (STIs) prevention and care		
In line with WHO strategies (*Global HIV, hepatitis and STIs programmes*) (2022) and recommendations (*Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021); STI prevention, testing and diagnostics, treatment and care, surveillance and other strategic information met, *Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact* (2022), *Guidelines for the management of symptomatic sexually transmitted infections (*2021)) (also the *Triple elimination initiative of mother-to-child transmission of HIV, syphilis and hepatitis B* (2023).		
▪ The NSP describes the STI burden: prevalence, antimicrobial susceptibility patterns, who are affected; services and policies; the current national response—the status of surveillance, programme structure, operational relationship between STIs and HIV and other programmes (e.g. SRHR, antenatal care, eMTCT, family planning, adolescent health); level, scale and modality of service integration; available policies and guidelines, where services are delivered, how resources are allocated and the support for procurement and distribution; prevention, screening/testing, diagnostic, treatment and care for STIs linked with HIV programmes; existing interventions that need strengthening or expansion and interventions that should be introduced.		
▪ The NSP provides goals, indicators (see *Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact* (2022); and *Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS — Global AIDS Monitoring 2023* (2022): GAM 3.5, 7.5, 7.6; NCPI 81.1.c, 101, 102, 103); targets, priority interventions for STI prevention, screening and testing, diagnosis and treatment, and their costing and budget, with consideration of priority interventions in the WHO's *Global HIV, hepatitis and STIs programmes* based on the context.		
▪ The NSP notes strengthening STI surveillance—by setting up basic STI case reporting and prevalence monitoring, strengthening systems and monitoring trends—and implementation of antimicrobial resistance monitoring for gonorrhoea.		
▪ The NSP describes service delivery models for STIs: update and roll-out treatment and screening guidelines; regular STI check-up of key populations, partner management; linking clinical services to outreach		

	Included yes/partial/no	Justification
and HIV services for key populations; and linking to services for preventing the vertical transmission of HIV, syphilis and viral hepatitis.		
▪ The NSP considers establishment and growth in laboratory services for: gonorrhoea and chlamydial screening, especially among PrEP users; syphilis screening among key populations and pregnant women; and linking HIV testing with syphilis testing.		
▪ The NSP specifies STI prevention linked to HIV prevention interventions, such as condoms, behaviour change communication, peer outreach and STI health care seeking behaviour.		
▪ The NSP notes ways to integrate STI screening, testing, diagnosis and treatment services with HIV services for specific population groups, including adolescents, key populations and adults and adolescents living with HIV.		
▪ The NSP considers community engagement for raising awareness around STIs, generating demand in STI services; referrals, follow-up; and resource mobilization and other advocacy efforts.		
▪ The NSP considers building the capacity of health care providers, laboratory workers and outreach workers, including ensuring age-appropriate services free from stigma, discrimination and violence.		
▪ The NSP includes STI data reporting (MIS, DHIS2), surveillance and M&E.		
▪ The NSP has quantification and procurement of STI drugs, diagnostics and commodities.		
B-3.6. Viral hepatitis prevention and care		
In line with WHO strategies (*Global HIV, hepatitis and STIs programmes* (2023)) and recommendations (*Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach* (2021); *Guidelines on hepatitis B and C testing* (2017); *Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection* (2015); *Guidelines for the care and treatment of persons diagnosed with chronic hepatitis C virus infection* (2018); *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations* (2022); 9789240002708-eng.pdf (who.int), *Consolidated strategic information guidelines for viral hepatitis planning and tracking progress towards elimination: guidelines* (2019) .		
▪ The NSP includes the epidemiology of viral hepatitis B and C—including co-infection of HIV and HCV and of HIV and HBV, and current national response—the status of hepatitis surveillance, programme structure, operational relationship between viral hepatitis and HIV and programmes, such as antenatal care; level, scale and modality of service integration; available policies and guidelines, where services are delivered, how resources are allocated and the support for procurement and distribution; prevention, screening/testing, diagnostic, treatment and care for viral hepatitis in/linked with HIV programmes; existing interventions that need strengthening; and new interventions.		
▪ The NSP provides information on the need for scaling up screening, diagnostic and treatment services, and respective commodities, goals, indicators (see viral hepatitis indicators in *Consolidated strategic information guidelines for viral hepatitis planning and*		

	Included yes/partial/no	Justification
tracking progress towards elimination: guidelines (2019), and in *Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS — Global AIDS Monitoring 2023* (2022), GAM indicator 7.1), targets, priority interventions for viral hepatitis prevention, screening and testing, diagnosis, treatment and care, and their costing and respective budget, with a focus on people living with and at risk of HIV, and pregnant women.		
▪ The NSP includes activities defined for community engagement for raising awareness around viral hepatitis and links with HIV, and service demand creation.		
▪ The NSP includes activities supporting viral hepatitis data reporting disaggregated by age and HIV status (DHIS2, etc.), surveillance and monitoring and evaluation.		
▪ The NSP includes activities to address behavioural and structural factors that drive viral hepatitis B and C by setting links with strategies for addressing gender and social inequalities.		
B-4. HIV-sensitive social protection		
The NSP includes a strategy (or a plan for developing a strategy) for social protection intervention, which serves key and vulnerable populations, including: ▪ PLHIV. ▪ Adolescent girls and young women. ▪ Orphans and vulnerable children. ▪ Key populations. ▪ Unpaid health workers. ▪ People in high-density settings. ▪ People with disabilities. ▪ Other groups as relevant.		
B-5. Health systems		
The NSP includes key approaches and interventions for strengthening health systems with particular focus on the following.		
B-5.1. Integrated procurement and supply chain management systems		
Functional logistic information management system, with early warning elements.		
Close and effective links between programme, forecasting, procurement and transport, which have been considered given the need for multi-month dispensing.		
Attention has been paid to improving the quality of systems and health commodities at all levels.		
B-5.2. Adequate laboratory capacity for HIV, TB, COVID-19, early infant diagnosis and blood safety		
Optimized laboratory networks and proposed activities for capacity strengthening are defined.		

	Included yes/partial/no	Justification
B-5.3. Ensuring access to equitable and sustainable access to affordable and quality medicines and diagnostics		
Definitions of, and activities for, amelioration of barriers to access to major and basic health technologies are well defined.		
Activities for strengthening joint price negotiation/pool procurement mechanisms for commodities for HIV, co-infection and comorbidity services are well articulated.		
B-5.4. Human resources for health, including the mobilization and utilization of community health workers and delivering integrated, stigma and discrimination-free, people-centred service packages		
B-5.5. National health information system		
A functional HIV information system with a clearly articulated policy framework and arrangements that has the following. ▪ HIV indicators and targets, with a baseline whenever possible. ▪ The ability to monitor performance and the quality of services. ▪ The ability to sensitively reflect who has been left behind in HIV services. ▪ Efforts to remove duplicated data, including through a unique identifier system. ▪ Initiated movement towards a unified facility and case surveillance management information system (MIS) monitoring performance and service quality. ▪ Expanded a community-led monitoring system that links to national or local HIV programme monitoring (see UNAIDS Establishing community-led monitoring of HIV services — Principles and process (2021). ▪ National AIDS spending assessments and resource tracking conducted at a regular interval (e.g. every three years). ▪ Data from all HIV services (facility and community level) provided by public, private and community groups, when applicable.		
B-5.6. NSP provides an HIV monitoring and evaluation plan as a contribution to a national health information system, which includes the following		
▪ HIV indicators integrated into national health information systems and other relevant information systems, such as education and social affairs.		
▪ Indicators for comorbidities and co-infections, such as TB, STIs, cryptococcal meningitis, viral hepatitis B and C, cervical cancer, NCDs, and mental health.		
▪ A clear plan for ensuring data quality and using data to improve programmes.		
B-5.7. Health financing and strengthening financial management		
▪ Transparent public funding with no user fees for people who use HIV services.		

	Included yes/partial/no	Justification
Review question: *How well are strategies and interventions for resilient and sustainable systems for health (RSSH) addressing identified health system gaps and weaknesses (e.g. relating to the health sector strategy, specific building blocks, integration of HIV systems and services, inclusive governance)?*		
B-6. Community engagement		
Using some of the latest guidance from UNAIDS: *Communities at the centre: defending rights, breaking barriers, reaching people with HIV services* (2019); WHO, *Establishing community led HIV monitoring services* (2021); The Global Fund, Technical Brief: *Community systems strengthening 2023–2025* (2022); Technical Brief: *Decision-making guide for community systems strengthening interventions in Global Fund grants 2023–2025* (2023).		
The NSP contains an analysis of the current state of: ▪ Community-led networks and how they contribute to the national HIV response. ▪ Barriers to their engagement, including barriers to registration and funding and for the provision of HIV services.		
The NSP suggests: ▪ Community-led responses for implementing HIV prevention, testing, treatment and care programmes identified, costed and resources secured, including for PLHIV, key populations, community-led organizations, youth-led organizations and faith-based organizations, when relevant. ▪ Tactics for expanding the civic space for community-led organizations and relevant civil society organizations for HIV and broader health programmes.		
Review question: *How well are community system-related strategies and interventions addressing identified gaps and weaknesses, and supporting the scale-up of prevention, testing and treatment services to be delivered by community-led organizations?*		
B-7. Human rights and gender equity programmes		
Using the latest guidance (WHO: *Key considerations for differentiated antiretroviral therapy delivery for specific populations* (2017); UNAIDS: *Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses* (2012), *Fast-Track and human rights: advancing human rights in efforts to accelerate the response to HIV* (2017); *Evidence for eliminating HIV-related stigma and discrimination* (2020); The Global Fund: *HIV programming at scale for and with key populations* (2022)), the contextual information (usually presented in the situation analysis) describes structural barriers and societal enablers linked to the 10–10–10 targets, i.e. harmful punitive and discriminatory laws, access to justice, stigma, discrimination and violence as related to PLHIV, key populations and priority groups. Information on laws and policies can be found at https://lawsandpolicies.unaids.org. Information should also be taken from recent Stigma Index Surveys, IBBS or DHS surveys, as well as other community collected data and research.		
The NSP includes: ▪ Targeted, evidence-informed anti-stigma and discrimination activities, including community-led activities. ▪ Empowering key populations with legal literacy and access to HIV legal services. ▪ Monitoring and reforming laws affecting the HIV response, regulations and policies, such as, criminal laws, age-of-consent laws, travel restrictions, mandatory testing and forced and coerced interventions. ▪ Interventions to sensitize lawmakers and law enforcement agencies.		

	Included yes/partial/no	Justification
▪ Interventions to eliminate GBV and serve survivors, including post-exposure prophylaxis (PEP), shelter and legal services. ▪ Acknowledges specific contributions of community-led groups for encouraging societal enablers ('60' of the 30–80–60 community-led response targets). ▪ Includes community-led monitoring, analysis and reporting of violence, stigma, discrimination and other barriers to accessing services. ▪ May also include a specific human rights and gender equity operational plan which is implemented and monitored through a multistakeholder mechanism.		
Review question: *How well are strategies and interventions targeting human rights, gender, age, and economic-related barriers, addressing priority needs and gaps, and supporting scale-up of activities to be delivered by community-led organizations? What are the gaps and how could these be addressed?*		
B-8. Efficiency Analysis		
B-8.1. The NSP analyses allocative efficiency		
The NSP analyses the number of additional people prevented from acquiring HIV by focusing HIV interventions on gaps.		
B-8.2. The NSP analyses technical efficiency		
The NSP analyses the number of evidence-informed policy changes and changes to delivery modalities.		
B-8.3. The NSP analyses efficiency per person reached		
B-8.4. Financial sustainability		
▪ The NSP provides a snapshot of macroeconomic status, including GDP growth, debt, government revenue, expenditure and budget allocations for social sectors.		
▪ The NSP analyses the health and HIV funding outlook.		
▪ The NSP analyses the status of universal health coverage, including priorities.		
▪ The NSP analyses of health funding status: domestic and international funds; government health investment as a per cent of GDP; insurance; out of pocket expenditure; analysis of public expenditure (indications of public financial management efficiency and budgeting system for health); and public versus private service provision.		
▪ The NSP analyses of funding gaps by component, in the context of projected new HIV infections.		
B-9. Governance, management and accountability		
B-9.1. The NSP includes an overview of HIV leadership, governance and accountability arrangements		
▪ Description of key governance and coordination bodies for coordinating the multisectoral and multistakeholder response to HIV.		

	Included yes/partial/no	Justification
▪ Description of who is responsible for monitoring HIV programme implementation and progress towards meeting targets and how this will be done.		
▪ Plans for integrating and harmonizing HIV and wider health sector or central ministry (economic planning, education, finance, etc.).		
▪ Governance and coordination bodies.		
▪ Defines the role of community engagement plans in accountability, including decision-making power and all relevant communities.		
B-9.2. The NSP includes an overview of management and implementation arrangements		
▪ Description of the programme management/implementation organizations and institutions — public and private.		
▪ Governance and management arrangements, including accountability for ensuring the NSP is operationalized with capacity and resources available.		
▪ Mitigation plan for continuing HIV services in major public health crises, including that caused by COVID-19.		
B-10. HIV and humanitarian response (as relevant)		
B-10.1. The NSP includes a description of the humanitarian context		
▪ Identifying factors increasing vulnerability and driving humanitarian needs.		
▪ Population and health information on refugees, internally displaced people and cross-border population flows.		
▪ Details on alignment with country humanitarian plans and/or frameworks.		
▪ Details on key populations at increased risk of exposure to HIV.		
▪ Details on how sexual and GBV will be addressed.		
B-10.2 The NSP includes a planning framework specific for populations affected by humanitarian crises		
▪ The NSP's goals and objectives include elements aligned to meeting humanitarian concerns.		
▪ Populations affected by humanitarian crises have been consulted.		
▪ Description of strategic partners engaged in the humanitarian response.		
▪ Readiness and response plans support data flow, measures to ensure uninterrupted crucial services (ART, condoms, test kits, contraceptives, etc.) during sudden emergencies and shutdown of service delivery, including during pandemics.		
B-11. Pandemic preparedness and response		
The NSP includes: ▪ A description of the extent of HIV service disruption during the Covid-19 pandemic, showing how PLHIV and other vulnerable groups were		

	Included yes/partial/no	Justification
affected, including how it has, or may have exacerbated, inequalities by age, gender, population, socioeconomic vulnerabilities, etc.		
▪ Identifies effective service adaptations and innovations that can allow continuity of HIV services in future pandemics (e.g. UNAIDS, *Consultation calls for the global AIDS response to build on emergency adaptations to COVID-19, tackle structural barriers and ensure that country programmes fully recover from COVID-19 disruptions and end AIDS* (2022).		
▪ Analysis of actions needed to end AIDS that are also needed to end pandemics such as COVID-19 and others and be prepared for future pandemics.		
▪ Review of how HIV guiding principles, infrastructure, resources and tools have been leveraged to respond to the current pandemic (COVID-19) and can strengthen robust pandemic preparedness and response for the future (Collins C, et al. *Leveraging the HIV response to strengthen pandemic preparedness PLOS Global Public Health* 3(1): e0001511; 2023).		

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