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United Nations Development Programme

HIV/AIDS

UNDERSTANDING AND ACTING ON CRITICAL ENABLERS AND DEVELOPMENT SYNERGIES FOR STRATEGIC INVESTMENTS

A. BACKGROUND AND PURPOSE

The AIDS response needs a people-centred investment approach so that returns are maximized. For the response, the returns are clear - zero new infections, zero discrimination and zero AIDS-related deaths. AIDS-related investments must be smart and produce results for people; results that matter – lives saved, keeping people from acquiring HIV infection, keeping people alive and keeping people and families healthy and productive *(1)*. The Investment Framework is based on a compilation and analysis of evidence of interventions proven to reduce HIV risk, transmission, morbidity and mortality and models the investments required globally between 2011 and 2020 to reverse the HIV epidemic *(2)*. The Framework describes key elements of HIV responses in three categories – "basic programme activities", "critical enablers" and "synergies with development sectors" – to help countries and implementation partners focus and prioritize their efforts to achieve targets of the 2011 United Nations Political Declaration on HIV and AIDS *(3)*. Strategic investments posit a human rights–based approach in which all the activities and programmes are delivered in a manner that is "universal, equitable and ensures inclusion, participation and informed consent and accountability" *(1, 2)*.

Gender Equality, Human Rights and the Investment Framework:

Human rights and gender equality are essential considerations across the Investment Framework. Each basic programme activity has gender and rights dimensions that must be understood and incorporated into design and delivery. At the same time, certain kinds of focused action on gender equality and on human rights are 'critical enablers' for the HIV response. Other kinds of work on rights and gender contribute to many outcomes, including some related to HIV: they are 'development synergies'. This paper does not focus on the overall gender or rights dimensions of the Investment Framework; instead, it discusses how these principles fit into the specific ideas of enablers and synergies.

UNAIDS will produce separate discussion and guidance materials on gender and rights dimensions of the Investment Framework and implementation of investment thinking.

Key Messages: Critical enablers and development synergies:

- are those programmes necessary to enable the efficacy, equity and roll-out of basic programme activities
- encourage sustainability of AIDS responses through integration into broader health and non-health sectors
- are determined and prioritized by country contexts, like basic programme activities
- support the human rights and empowerment of people affected
- require mechanisms for multi-sectoral financing and governance

UNAIDS Cosponsors and the Secretariat have prepared this document focused on critical enablers and development synergies as an additional component to existing guidance. The purpose of this document is two-fold: *(1)* to elaborate on the concepts of critical enablers and development synergies and *(2)* to demonstrate why and how they are necessary components of national AIDS responses. The audience is broad and includes, but is not limited to: planners and implementers of basic programme activities and critical enablers; development sectors (including government and civil society partners within and outside of health sector) who wish to understand how their core business can affect HIV outcomes; and international and national financing institutions that invest in HIV, health and/or development.

This document is organized around two themes:

- defining critical enablers and development synergies: why they matter and how they interact for HIV outcomes; and
- implications for financing and governance.

B. DEFINING CRITICAL ENABLERS AND DEVELOPMENT SYNERGIES

Proposals for a more strategic approaches for resourcing the HIV response to ensure that better investments now will reduce the need to pay more later *(1, 2)*. The Framework proposes three categories of investment: basic programme activities, critical enablers and synergies with development actors.

Basic programme activities are generally well understood. Together with enablers and synergies they are the core building blocks of national AIDS responses. It is important to highlight that different basic programme activities overlap with each other. The Investment Framework defines behaviour change as mainly directed towards reducing multiple, concurrent and age-disparate partnerships, but the awareness and norm-changing also drives condom use as well as treatment uptake and adherence and the use of other biomedical services. Programming with key populations at higher risk of HIV infection includes work with key populations as leaders and political actors, key populations as drivers of behaviour change and key populations as beneficiaries of treatment. As a package, "basic programme activities" require both biomedical action and action outside the health sector.

The Framework emphasizes the importance of critical enablers and development synergies as integral components of AIDS responses that are prerequisites for the success of basic programme activities. Although enablers and synergies are crucial for HIV outcomes, they are often less well understood, and how they apply in different contexts is less clearly articulated. The Investment Framework offers the following definitions as a starting-point:

- **Critical enablers** are "activities that are necessary to support the effectiveness and efficiency' of basic programme activities" *(1)*.* The Investment Framework divides critical enablers into two subcomponents: social enablers and programme enablers.
- **Development synergies** are "investments in other sectors that can have a positive effect on HIV outcomes" *(1)*. The Framework identifies a few key development sectors that present opportunities for synergies in multiple contexts: social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems (including treatment for sexually transmitted infections and blood safety), community systems and employment practices.

There is some overlap between these two concepts. The distinction is largely based on how closely linked they are to basic programme activities and, ultimately, HIV outcomes (Fig. 1).

Critical enablers tend to be more HIV-specific. One of their primary purposes is to contribute to HIV-related outcomes. That means critical enabler programmes should be primarily assessed in terms of their effectiveness in increasing the uptake, equitable coverage, rights-based delivery and quality of basic programme activities. Critical enablers overcome major barriers to service uptake, including social exclusion, marginalization, criminalization, stigma and inequity. Critical enablers are crucial to the success of HIV programmes in all epidemic contexts. Although local actors are often best placed to determine where the most important barriers and bottlenecks to programme success lie and therefore how critical enablers can be implemented to best effect, the underlying principles apply globally. Research for better prevention tools can and should have global relevance and benefit. Stigma needs to be reduced everywhere, and human rights principles are universal.

Development synergies, on the other hand, are less HIV-specific. They tend to have a broader range of impacts across health and development sectors. Although development synergies can have a profound impact on HIV outcomes, their reason for being is not typically for HIV. Maximizing the HIV-related benefits and minimizing the HIV-related harm of development synergies would make them HIV-sensitive. Unlike critical enablers, the most relevant development synergies for HIV will vary according

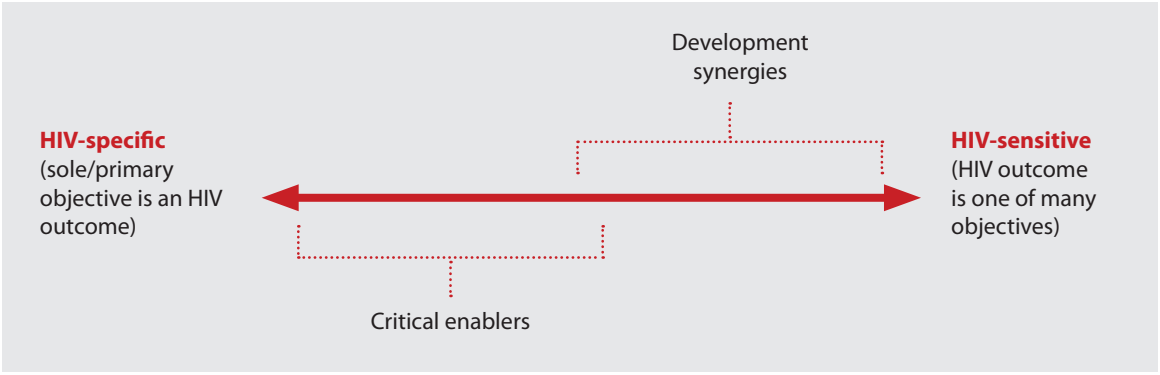
* The Investment Framework identifies six categories of basic programme activities: preventing the mother-to-child transmission of HIV; condom promotion and distribution; treatment, care and support for people living with HIV (including facility-based testing); male circumcision; behaviour change programmes; and activities integrating key populations at higher risk, especially sex workers and their clients, men who have sex with men, transgender people and people who inject drugs.

to epidemic and social contexts. For example, most changes to Canada's social welfare system would likely have relatively little impact on that country's epidemic, while increased social protection for girls and young women in Malawi might be very influential at reducing the number of people newly infected with HIV.

A broad category of activities can have elements that are enablers and others that are synergies. Legal policies and reforms, gender equality and social protection provide three examples.

- The legal reforms that are significantly associated with HIV (such as decriminalizing HIV transmission, removing laws that are barriers to the uptake of HIV services, such as in the context of sex work; and decriminalizing sex between men) are critical enablers. Broader law reforms that primarily contribute to other outcomes but also may also influence HIV epidemics are development synergies, such as strengthening national human rights systems, gender equality legislation mandating equal pay for work of equal value.
- Gender equality programming can be specifically designed and targeted with HIV prevention as a primary goal and thus be seen as a critical enabler, such as the work of Yaari Dosti and GEMS (Gender Equality Movement in Schools) with men and boys to change gender norms and bring about greater condom use.* In contrast, national efforts to strengthen responses to gender-based violence can be seen as a development synergy: very important for HIV responses but primarily relevant in and of itself as a human rights and public health issue.
- Most social protection policies and programmes offer the possibility of development synergies, reducing inequalities and therefore indirectly reducing vulnerability to HIV. In contrast, cash, food, transport allowances and other transfers associated with the uptake of HIV services can also operate as critical enablers.

Fig. 1. **Clarifying the difference between critical enablers and development synergies**



* Use in relation to Program H *(4)*, a community-education and social marketing campaign originally developed in Brazil to promote gender-equitable attitudes and action among young men. The programme has since been expanded to India, the United Republic of Tanzania, Croatia, Viet Nam and other countries in Central America. The One Man Can campaign *(5)* is a multifaceted, multisectoral, multimodal mass media and community mobilization campaign by Sonke Gender Justice in South Africa. One Man Can supports men and boys to take action to end domestic and sexual violence, reduce the spread and impact of HIV and AIDS and promote healthy and equitable relationships. The campaign's content and strategies are based on extensive formative research, including focus groups, field testing, surveys and dialogue with women's rights organizations.

The example of the education sector is pertinent here also. Education attainment is a synergy, as it results in many positive outcomes, including an important protective factor in HIV prevention, particularly for girls. In addition, through HIV and comprehensive sexuality education, learners acquire knowledge and develop skills for healthy decision-making and healthy sexuality. These skills are also integral to overcoming social stigma and promoting human rights and positive gender norms. The role of HIV and comprehensive sexuality education as a critical enabler for basic programme activities is a more limited one of ensuring that the necessary factual knowledge and attitudinal preconditions are met in populations to enable biomedical, behavioural and structural interventions to be effective and sustainable.

Programming for sexual and reproductive health may incorporate both critical enablers and development synergies, depending on the epidemic context and the structure of the services. For example, sexual and reproductive health services for people living with HIV are an essential aspect of treatment, care and support and are therefore a critical (programme) enabler. More general links between sexual and reproductive health and HIV policies, programmes and services comprise a development synergy that can yield significant benefits to sexual and reproductive health as well as HIV prevention, treatment, care and support.

C. CRITICAL ENABLERS AND DEVELOPMENT SYNERGIES: WHY THEY MATTER AND HOW THEY INTERACT

Critical enablers and development synergies are essential in national AIDS responses for five main reasons. They:

- support and increase the effectiveness, efficiency, equity and reach of basic programme activities;
- can act directly to reduce (or exacerbate) risk to HIV;
- can help to protect and promote human rights and human rights principles: participation, accountability, inclusion, non-discrimination and informed consent;
- can result in a multitude of positive development and health outcomes across the Millennium Development Goals; and
- encourage the sustainability of national AIDS responses.

First, basic programme activities are most effective – or indeed only possible in some cases – when the broader human rights and development environment, through enablers and synergies, is supportive. Progressive political leadership, an educated population, protective legal and policy frameworks and law enforcement, gender equality and equitable social norms are a few of the many possible examples. Full alignment with the greater involvement of people living with HIV (GIPA) principle within and across the Framework is also an imperative: that is, a principle equally applicable to programme activities, critical enablers and development synergies.

Critical enablers and development synergies can also open up the space for introducing programme activities, drive efficiency and ensure that the people who are most severely affected and most vulnerable have their needs addressed. For example, the costs of antiretroviral therapy can be reduced significantly when countries fully leverage existing intellectual property flexibilities within existing trade regimes. Moreover, broader development programmes can be opportunities for basic programme activities, potentially expanding reach and reducing costs. Promising approaches include integrating HIV prevention and gender empowerment into microfinance programmes and into environmental impact assessment for large capital projects. Social protection instruments that increase household incomes can result in increased access to a range of health and HIV services.

Second, critical enablers and development synergies matter because, in some cases, they can operate to reduce the risk of HIV. The Investment Framework alludes to this mechanism of action in mentioning "local responses to change risk environments" *(1)*. Examples of such local responses that address context-specific HIV risk would include, among others, working with local stakeholders to change policies on harmful alcohol use (such as restricting the operating hours of beer halls and working with bar owners to limit harmful alcohol use), poverty reduction programmes to reduce food insecurity or initiatives to change cultural norms related to widow inheritance. A recent cash transfer study in Zomba, Malawi showed that cash transfers to adolescent girls led to a 60% reduction in HIV risk after 18 months (case study 1). The mechanism of action was neither increased HIV knowledge nor increased use of condoms but rather that receiving the cash enabled the girls to change their sexual partners from older men to younger men, who are less likely to have HIV. Although many of these examples are about "behaviour change" broadly defined, the key point is that they target transformation

in the environment rather than individual HIV-related behaviour directly. Understanding the causal pathways and how they influence the structural determinants of behaviour is key to making the most of development synergies in the response to HIV. Such transformations in the socioeconomic environment, using critical enablers and development synergies, can be crucial complements to conventional behaviour change programmes aimed at individuals. Indeed, they can make a critical difference in shaping HIV-related risk behaviour (case study 2).

The specific critical enablers and development synergies that are most relevant for supporting basic programme activities will depend on several factors, including the basic programme activities in question, type of epidemic, existing law and policy frameworks and the political context. The respect and protection of human rights is an a priori enabler. It is also important to "know your epidemic" and to consider the key structural factors that contribute to HIV vulnerability and risk so that they can be applied to have greatest impact. For example, in concentrated epidemics in which injecting drug use is a key driver of people acquiring HIV infection, gender-based violence as it affects women who use drugs and the female partners of men who use drugs may be a significant factor in people acquiring HIV infection and should be addressed through a basic programme activity for key populations at higher risk, whereas population-wide programmes to address gender-based violence may be less relevant to HIV goals.

Case study 1. **Cash transfers reduce girls' risk of acquiring HIV infection – evidence from a randomized controlled trial in Zomba, Malawi**

Cash transfers have been used in many countries, especially in Latin America, to provide cash to low-income households in exchange for active participation in educational and health care services. In 2007, 29 low- and medium-income countries had some form of conditional cash transfer in place. Although growing evidence suggests that even small financial incentives can influence the uptake of services and health behaviour, to date this approach has not been commonly considered in HIV prevention.

A recent randomized control trial in Zomba, Malawi, that linked a cash transfer to girls' school attendance showed an approximately 61% reduction in HIV risk after 18 months among girls receiving the transfer. The girls also experienced an increase of approximately 62% in school attendance. The positive effects observed applied both where the cash was conditional on school attendance and where it was unconditional. This suggested that the effect seemed to be driven by the impact of cash on changes in sexual networks (girls choosing younger partners) and fewer sexual acts rather than by changes in condom use or improved HIV knowledge.

Source: Baird et al. *(6)*.

Case study 2. **The IMAGE project in South Africa**

Evidence from a randomized cluster trial indicates that a combination of microfinance, gender equality training and HIV education reduced levels of physical and sexual violence in rural South African communities. The study found a 55% reduction in self-reported experiences of physical or sexual intimate partner violence in the past 12 months among participants receiving the intervention. IMAGE provides women with short-term business loans of up to US$ 1300, operating on the premise that an increase in earning power will empower women to be more vocal at home, confronting unfaithful husbands about issues such as condom usage. People receiving loans are required to participate twice a week in gender equality training workshops called "Sisters for Life". In these workshops, women learn to communicate with their husbands about domestic violence, rape and the importance of using condoms. The results of IMAGE very clearly showed that it was the gender equality training combined with microfinance that improved communication between couples about HIV that increased the uptake of voluntary counselling and testing and reduced unprotected sex. The effect of the HIV education did not spread through the community as hoped (that is, there was no diffusion effect). The synergy within IMAGE is achieved through integrating basic programme activities, enablers and synergies. Interventions in isolation have less likelihood of success when a critical mass of influences is needed, especially when looking at the complexities of behaviour. IMAGE is also an illustration of using a development intervention as a delivery platform, including for basic programme activities. For IMAGE to succeed, different service providers and skills sets are combined.

Source: based on a citation in Temin *(7)*.

Food and nutrition interventions also act as both critical enablers and development synergies for treatment, care and support programme activities, depending on the exact context. Evidence indicates that economic strengthening programmes to support household consumption and/or provide food and nutrition assistance to food-insecure people living with HIV initiating antiretroviral therapy are feasible and may reduce mortality and improve adherence to medication and retention in care.* Food and nutrition interventions also play an important role in wider development outcomes, such as reducing poverty, enabling people to return to the workforce and/or schooling, which in themselves are synergistic with HIV outcomes.

Third, critical enablers and development synergies matter because some protect and promote human rights, which are ends in themselves and are state obligations in accordance with international norms and standards. Non-discrimination laws that protect people living with HIV are an example. Indeed, a human rights-based approach to national HIV responses is impossible without implementing critical enablers that protect and promote human rights: that is, those that improve the social environment, which determines access to and uptake of HIV services. Stigma reduction

* A pilot study in Lusaka, Zambia *(8)* showed that food supplementation was associated with better adherence to therapy (95% versus 48% in the control group). A second prospective observational cohort study in Haiti *(9)* revealed improved clinical attendance and body mass index. A third study in rural Uganda *(10)* suggests that severe food insecurity was associated with worse quality of life, opportunistic infections and increased hospitalization. Vulnerable people living with HIV who may be unable to obtain or adhere to antiretroviral therapy and are prone to food insecurity and malnutrition are a target group for assistance through food-by-prescription programmes. In this approach, the health sector determines the eligibility for food support of people living with HIV and, possibly, their household members; support is provided as cash or a voucher that can be redeemed for specific foods at a store or outlet in the community. This limits the burden on the health care system and brings services closer to clients.

Case study 3. **An effective approach to empowering sex workers for protection: the Durbar Mahila Samanway Committee**

In India, the Sonagachi Project, through the Durbar Mahila Samanway Committee, is an excellent example of the power of sex worker collectives changing the legislative and social environment as a way of reducing the risk of HIV infection and other risks. The Songachi project staff moved from a more traditional public health approach for HIV prevention to one that empowered sex workers, including activities to address gender issues, negotiation skills with clients, training and capacity-building. This empowering approach, led by sex workers themselves, reduced rates of HIV transmission. Condom use in project areas has increased to up to 85%, and the prevalence of HIV infection among sex workers decreased to 4% - much lower than rates reported in other sex work districts of India. The Committee provides services for the children of sex workers, including access to education and has established self-regulatory boards to address issues of trafficking and the commercial sexual exploitation of children working in partnership with local authorities. The approach has been replicated in other sites in India and in Bangladesh.

Sources: Temin *(7)*; UNAIDS, 2005 *(11)*.

programmes are a major critical enabler, as are programmes that mobilize communities to know their rights and relevant laws in the context of HIV and to use these to make HIV-specific demands for prevention and treatment. Programmes to train health care workers in non-discrimination, informed consent, duty to treat and confidentiality and to help them protect themselves from HIV also critically enable the basic programmes these health care workers are delivering. Health care services that are client-friendly, accepting and supportive, rather than judgemental and coercive, are more efficient.

Fourth, critical enablers and development synergies matter not just for national HIV responses but for achieving broader health, human rights and development goals, including the Millennium Development Goals. It is important to recognize also that achieving broader health and development Millennium Development Goals will contribute to achieving Millennium Development Goal 6. Reforming intellectual property laws, for example, to reduce the costs of antiretroviral medicines, creates a platform through which other critical diagnostics and medicines, such as those for diabetes, cardiovascular disease and cancer, could also be reduced. Similarly, law, policy and justice reforms that reduce the marginalization of key populations at higher risk may not only improve their access to basic programme activities for HIV but also their access to important health, social welfare or legal services *(12)*. Promoting access to the comprehensive package for people who use drugs *(13)*, also referred to as harm reduction, matters not just for HIV but also for tuberculosis and hepatitis.

Fifth, integrating HIV into broader development planning processes and frameworks promotes requisite political leadership and fiscal space. Moreover, it ensures that national HIV responses work coherently – and not at cross-purposes – with other health and development objectives. The ability to integrate HIV meaningfully into other development sectors not only creates opportunities for increasing the effectiveness of the national AIDS response but also broadens and diversifies its financing base, helping to promote sustainability. In quantifying the return on an investment, it is therefore important to calculate or at the very least consider the wider developmental return as well as the return on HIV outcomes.

Finally, critical enablers and development synergies ensure that HIV is a pathfinder for social transformation and an investment opportunity in development more generally. As stated in the UNAIDS Strategy for 2011–2015 *(14)*:

> A wider recognition that the HIV response has been a pathfinder must confront and replace the myth that the HIV response undermines progress on other global priorities. Getting to zero requires a global response that sees power in solidarity and rejects the trap of destructive competition for finite resources. As such, it is imperative that investment in the response through long-term and sustainable financing continue to be made and be scaled up.

The two key features of the Investment Framework need to be re-emphasized: (1) the emphasis on focusing limited HIV resources on delivering the most impact, in a prioritized and integrated way; and (2) the relationship between basic programme activities, critical enablers and development synergies. Annex 1 contains more in-depth examples of how activities, enablers and synergies interact.

D. IMPLICATIONS FOR FINANCING AND GOVERNANCE

How should HIV resources be used for critical enablers and development synergies?

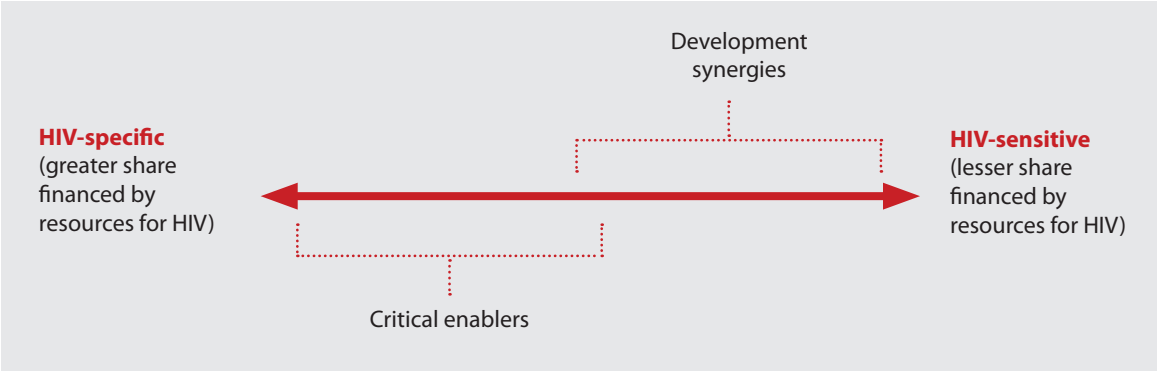
The Investment Framework modelling suggested that, at an aggregate global level, US$ 22 billion to US$ 24 billion will be required for bringing basic programme activities to scale in all low- and middle-income countries by 2015 *(1)*. Of that total, the model proposes that about 40% be invested in enablers and synergies (15% and 25% respectively), while 60% should be invested in basic programme activities. The Investment Framework does not translate this global estimate into costs and funding arrangements at the country level. Applying investment thinking at the country level would require assessing the state of scale-up and the costs associated with the basic programme activities, assessing which critical enablers are most critical in the local context and how they can be most effectively and efficiently delivered and assessing the potential leverage of HIV-sensitive approaches within key wider development sectors.

The point of the Investment Framework is not to supply firm prescriptions for cost allocations but rather to provide conceptual frameworks that may help in shaping country-level discussions. Fig. 2 offers one approach to determining the extent to which resources for HIV at the country level might contribute to critical enablers and development synergies. The interventions that are more HIV-specific or have a specific HIV outcome would warrant a greater share of resources for HIV; those that primarily contribute to other health or development outcomes while being HIV-sensitive might cost more overall but would warrant a much smaller share of HIV-specific funding.

This framework suggests that resources for HIV will cover a larger proportion of the cost of interventions that are classified as critical enablers and a smaller share of the costs of those classified as development synergies. Although investments in development synergies are higher than that for enablers, it is important to note that their relative share of the overall development budgets (costs associated with combating gender-based violence, health service provision, education and child welfare, for example) is

small but nevertheless catalytic. The indicative modelling of the total low- and middle-income country needs in 2015 provides a rule of thumb for countries to assess whether their current resource allocation patterns between these categories of expenditure are appropriate and how their resources are distributed across the need to deliver basic programme activities at scale, ensure the uptake and quality of these activities through critical enablers and maximize broad benefits through synergies. Although this framework will not provide answers and cannot substitute for country-level dialogue among development partners working across a variety of sectors and between government and civil society actors, it is a useful starting-point to frame the discussions.

Fig. 2. **Using HIV-specificity and HIV-sensitivity to conceptualize the financing of critical enablers and development synergies with resources for HIV**



The discussions around how best to generate catalytic and leveraging impact in development synergies are likely the most challenging. This is because, even though development synergies can profoundly affect HIV outcomes positively or negatively, development approaches exist for reasons other than HIV outcomes and lie squarely under the leadership of their respective line sectors and ministries. There is less justification for funds that are nominally HIV-specific to be used to finance these synergies, yet some types of development interventions could warrant HIV investments of both financial and technical resources. Three general categories of development interventions present different opportunities for HIV actors that can be further discussed with partners at country level:

1. pilot projects or operational research for development interventions with, as yet, unproven HIV impact;
2. scaling up development interventions with proven HIV impact; and
3. development interventions operating at scale.

1. *Establishing proof of concept of development interventions with as yet unproven HIV impact* (potential for significant or sole use of resources for HIV)

   In some cases, development interventions that could significantly affect HIV (such as changing alcohol regulations and providing street lighting where women are vulnerable to violence) are not being considered for implementation by the lead sector responsible for that intervention. In such cases, it is worth considering using resources for HIV to demonstrate proof of concept (that is, efficacy, especially for HIV outcomes, and feasibility) through operational research, with the understanding that such an approach would be scaled up with resources from the lead sector (or under some co-funding arrangement). In such cases, resources for HIV should be complemented, to the extent possible, by other sectors that might benefit from a pilot project.

2. *Scaling up development interventions with proven HIV impact* (potential for modest HIV co-financing commensurate with the value achieved)

   Ideally, a development intervention with proven HIV impact would be scaled up with the resources of the lead sector concerned. In some cases, however, those resources from the lead sector are not available. Resources allocated to HIV outcomes could support a share of the scaling up under a co-financing agreement such that the resources allocated for HIV contribute up to the relative value that is achieved in terms of HIV outcomes. For development approaches with small and/or unlikely HIV outcomes, the share from HIV resources should be smaller. Conversely, if HIV outcomes are significant, than a greater share from resources for HIV could be considered. As in the case with pilot projects, the lead sector and the HIV sector should involve other sectors that benefit from the scaling up in an attempt to pool resources. Greater pooling of resources across sectors means a lesser share required by HIV resources and the more cost-effective the development intervention becomes from an HIV perspective once the proof of concept is achieved. For example, the Zomba cash transfer study is, at its core, a social protection intervention with multiple impacts. The financing of such interventions from a variety of partners would make sense and achieve HIV outcomes without HIV-specific funds shouldering the entire costs.

3. *Development interventions operating at scale* (minor HIV investments to promote HIV-sensitivity)

   Some development interventions may already be resourced and operating more or less at scale. In these situations, HIV funding for scaling up or ongoing operations are not necessary. Nevertheless, opportunities might exist to modify or further sensitize such programmes, rather than significantly reform them, to maximize HIV outcomes. In some cases, such sensitization might first involve incorporating a monitoring element to demonstrate the nature and depth of HIV impact before the programme itself is further modified. Any such sensitization will likely require some technical contributions from HIV actors as well as the ability to communicate the benefits not just for HIV but for the core business of the development actor that is implementing the intervention. Some modest investments of resources for HIV funding may be required to sensitize such projects and monitor impact, but co-financing of operations with scarce HIV funds is not likely necessary or desirable.

What governance arrangements are required for critical enablers and development synergies?

Responsibility for any given critical enabler depends on the critical enabler in question but most likely involves leadership from beyond the health sector. Using the Investment Framework entails a dialogue between development partners in the various sectors and between government and civil society, including people living with HIV. For some enablers, particularly for programme enablers, actors within the HIV (and health) space will play a lead role, in partnership with other actors. Designing community-centred programmes will probably require managers of HIV-related basic programme activities to work with local community structures and networks of people living with HIV in design and monitoring. Improving procurement and distribution will probably require HIV specialists working with their colleagues to improve health system–level components. For other enablers, especially for social enablers, leadership will rest with other actors. Responsibility for approving legal reform and improving law enforcement as it affects the people vulnerable to HIV, for example, rests primarily with parliamentarians, associated law commissions, and justice and interior ministries. This is not to say, however, that HIV actors do not play any role at all. The principle of the greater involvement of people living with HIV needs to be reiterated, and advocacy efforts are crucial for encouraging those responsible for critical enablers to act.

HIV actors are potential partners in and not the leaders of the core business of development sectors. As such, generally it cannot be expected that HIV money funds the core business of development sectors in any significant way. This does not mean, however, that HIV actors do not have a role to play. On the contrary, HIV-specific actors have a responsibility to help development partners understand their potential contributions to achieving HIV outcomes, since development partners are not typically HIV experts nor do they consider how their core business affects HIV. For example, in several countries the AIDS sector and the movement of women living with HIV have catalysed gender equity discussions, helped to put gender violence on the policy and political map and, by insisting that gender programmes and women's affairs ministries not neglect women and girls living with HIV, have increased the inclusiveness of these programmes. The unique role of HIV actors in these types of partnership goes beyond advocacy to assisting in designing and especially monitoring development activities to maximize positive synergies and minimize negative impact on HIV. It could also involve, though likely to a lesser extent, implementation support as well as some financial support that is commensurate with the value or return on investment achieved in terms of HIV outcomes.

HIV actors should be strategic in selecting development sectors with which to engage. Not every development sector matters for HIV outcomes, and some matter more than others, depending on the country context. In hyperendemic countries*, a greater number of development partners can and should be involved in promoting development synergies as part of a comprehensive, multisectoral national HIV response. In concentrated epidemics, a smaller, more strategic set of development sectors, such as education, social welfare and justice, is most relevant.

* Countries where prevalence is more than 15%.

E. CONCLUSIONS

The Investment Framework is a platform for HIV and development discourse. It is not envisioned to be prescriptive or used as a template for resource allocation. It is also at the heart of ongoing debates around sustainable AIDS financing and the importance of multisectoral responses to HIV. The efficiency gains from correct use of the Investment Framework, if demonstrated, have the potential to expand the investor pool, particularly at the domestic level, where HIV outcome objectives and broader development objectives are integrated into national development planning.

The Investment Framework reiterates the core concept of multisectoral and whole-of-government responses. It would be misunderstanding the Framework to use it to argue for a medicalization of the response to AIDS in response to funding constraints or an increasingly domestically financed AIDS response. Equally, it would be a misuse of the Framework to argue that setting priorities for funding requires diluting the rights of people to access HIV services; instead, human rights underlie and reinforce the Framework.

The Framework emphasized the question of what suite of complementary activities is required to make prioritized basic programme activities as effective and efficient as possible. These are the removal of constraints, blockages and bottlenecks and facilitation of access, uptake, acceptance and optimal coverage. The consideration of how HIV specific the activities are and who would typically be responsible for implementation and financing is integral to this analysis.

Enablers and synergies are integral to national AIDS responses. They are not optional. They support and increase the effectiveness, efficiency and reach of basic programme activities to ensure more equitable outcomes while acting directly to reduce (or in their absence, exacerbate) susceptibility to HIV. They promote an integrated analysis of HIV and suggest multisectoral perspectives, even if national responses emphasize specific sectors. Some protect and promote human rights, and some support achieving other health and development goals, including the Millennium Development Goals. Universal access cannot be achieved without addressing enablers and synergies.

ANNEX 1
INTERRELATIONSHIPS BETWEEN PROGRAMME ACTIVITIES, ENABLERS AND DEVELOPMENT SYNERGIES

The following examples explore which specific critical enablers and development synergies might be most relevant for two basic programme activities in two different epidemiological settings: *(1)* treatment in a concentrated epidemic and (2) behaviour change in a generalized epidemic. These two examples in different epidemiological settings are meant to illustrate the kinds of critical enablers and development synergies that could apply to other basic programme activities as well. The examples simplify real-world complexity. First, enablers and synergies are interrelated and interact; they do not necessarily fall into such neat categories. The importance of the categories is to make the identification process more manageable and to ensure that the possibilities are covered comprehensively. Second, not all enablers and synergies are equally important. Some matter more than others, depending on the basic programme activity and the context. They similarly vary in the degree of evidence to support the efficacy.

Example 1. **Relevant critical enablers and development synergies for treatment programmes in a concentrated epidemic**

Critical enablers: social	Rationale	Activities	Responsibility
Political commitment and advocacy	Supports reducing HIV-related stigma Unhindered service provision to those in need	Authorization of compulsory licensing. High-level negotiation over securing treatment provision. Resource mobilization and allocation. Ensuring accountability and oversight, such as preventing stock-outs. Signing and ratifying relevant international agreements	Heads of state. Executive offices. Cabinet. Parliamentary standing committees. National AIDS councils. National narcotic drugs control authority Ministries of Health.
Stigma reduction	Encourages uptake of voluntary counselling and testing and reduces barriers to treatment access and adherence. Increased social and family cohesion, reduction of suicide ideation	Supporting networks of people living with HIV support. Outreach education. The principle of the greater involvement of people living with HIV in education campaigns. Role models to influence norms	Civil society, United Nations, health, interior, justice and broadcasting ministries. Health staff. Workplace programmes
Laws, legal policies and practices	Ensure that no legal barriers to treatment provision exist. Eliminate discrimination in relation to treatment access	Legal review and change. Training of law enforcement. Access to justice and legal support for key populations at higher risk	Health, interior, justice and labour ministries. Labour administrations (including labour inspectorates), trade and industry, municipal authorities, civil society organizations
Mass media	Normalizing treatment acceptance, encouraging adherence and notifying treatment advances	Notification and education of patients' rights and service access opportunities. Human interest stories to promote treatment service and acceptance	Ministry of broadcasting, health, NGOs
Community mobilisation	Stigma reduction and patient support to optimize adherence. Reduce loss to follow-up and maximize treatment coverage	Engagement with community-led organizations of key populations at higher risk. Patient support groups. Cross-referral between service providers. Visitation and counselling services. Monitoring service quality	Local government health offices, community health workers, community-led organizations of key populations at higher risk, community-based organizations and NGOs, employers and work organizations. Prison administrations, local community leaders
Local responses to change the risk environment	Optimizing treatment uptake, adherence and coverage	Sensitizing law enforcement agencies. Patient protection near the point of service. Drug data transparency and communication	Local government health staff, NGOs, community-led organizations of key populations at higher risk, police and law enforcement officials
Critical Enablers: Programme			
Community-centred design and delivery	Create conducive environments that are efficient, friendly and welcoming. Build local ownership	Management of feedback loops and data on service coverage and quality. Group support schemes to reduce access to treatment costs (such as transport pooling). Community consultation on point of service type, placement and operations	Local government health staff, prison administration, NGOs, employer and worker organizations, outreach workers, community leaders
Synergies			
Social protection and poverty reduction	Empowers affected households and communities to seek services	Social health insurance programmes. Targeted cash and food transfer programmes. Targeted social health insurance. Economic strengthening and livelihoods support households affected by AIDS	National AIDS programme, ministries of health, interior and labour, criminal justice, local health staff, outreach workers, local ministry of social services staff, NGOs
Education sector	Stigma reduction. Increased service demand and uptake. Increased treatment literacy	Provide regular age-appropriate life skills–based education to all learners	Ministry of education, local government, teacher's organizations and civil society
Criminal justice and prison reforms	To reduce HIV-related and TB mortality in prisons; to ensure the continuity of treatment when people enter prisons. To improve access in prisons to rights and evidence-based voluntary counselling and testing and treatment equivalent to the community Reduce the overuse of imprisonment and pretrial imprisonment	Prison management programmes aiming at reducing violence, stigma and discrimination; improve prison conditions (nutrition, ventilation, natural light); reduce overcrowding; establish mechanism to ensure continuity of treatment; develop linkages with the health ministry or national AIDS programme to ensure same access (guidelines; supplies and quality standards) to HIV prevention, treatment and care in prisons; establish health in prisons programmes	Prison administrations; ministry of justice; ministry of health
Employment practices and legal reform	Treatment awareness and demand creation	Workplace voluntary counselling and testing programmes and service access. Insurance that covers treatment access	Employers, unions, ministries of health, interior and labour, labour administrations and inspectorates, parliamentarians, criminal justice, private insurance

Example 2. **Relevant critical enablers and development synergies for behaviour change programmes in a generalized epidemic**

The Investment Framework defines behaviour change programmes as those "programmes that focus on the reduction of risk of HIV exposure through changing people's behaviour and social norms". Behaviour change is complex and can be accomplished in many ways. The primary method is social and behavioural change communication strategies that reach individuals, communities and societies. Assuming a generalized epidemiological context, the table lists some of the critical enablers and development synergies that should be considered.

Critical enablers: social	Rationale	Activities	Responsibility
Political commitment and advocacy	Enables political leadership to engage and raise awareness about HIV	Statements from the head of state on HIV transmission Commitment to address HIV through multisectoral responses by including HIV in social protection programmes, poverty reduction, education and gender empowerment initiatives	Head of state's office, parliamentarians and lawmakers, national political parties. Ministries of Health.
Stigma reduction	Reduction in discrimination against people living with HIV and key populations at higher risk Enables uptake of HIV prevention services, such as engaging religious leaders	Increasing knowledge about HIV transmission and its causes and impact Engaging community, religious and political leaders to challenge stereotypes and norms, values and culture that fuel stigma	People living with HIV Local community leaders, activist and religious leaders Employers and workers' organizations HIV caregivers Relevant government agencies – health, interior, criminal justice, prison administration
Laws, legal policies and practices	Enables a favourable environment for the protection of rights of people living with HIV, such as accelerating HIV law reform	Conducting a thorough review of existing laws to identify laws that impede HIV response and advocating for repeal of laws such as criminalization of HIV transmission etc. Promoting human rights for all including people living with HIV and key populations at higher risk Promoting laws against gender-based violence and gender equality Promoting the development and adoption of anti-discrimination legislation in all areas, including in access to health services, education and employment Revising laws and implementation to prohibit marital rape Ensuring links between HIV and gender equality policies	Human rights groups, journalists, academe, international organizations Women's health and rights organizations Networks of women living with HIV and key populations at higher risk Relevant government agencies – interior, criminal justice, gender and women
Mass media	Enables promotion of safer behaviour by challenging the norms, values and culture that fuel risky behaviour	Involving role models to raise awareness about safer sexual behaviours, voluntary counselling and testing uptake and risk reduction methods Using the media as a tool as well as platform to promote knowledge about HIV and challenging norms, values and culture such as masculinities that heighten risk behaviour	Media outlets, journalist, religious leaders and champions Organizations working on men and boys as partners for gender equality
Community mobilisation	Enables the mobilization and organization of groups such as sex workers and other key populations at higher risk, as their participation in HIV prevention services is essential	Identification of key populations at higher risk that need HIV services and key hotspots through which information and services will be disseminated Establishing networks of people living with HIV and other key populations for sharing information, education and communication Engaging the family members of people living with HIV and wider community to support information, education and communication initiatives Community empowerment and violence reduction strategies among sex workers	Community leaders, activists, local government and networks of people living with HIV, key populations at higher risk
Local responses to change the risk environment	Enable positive changes at the local level by addressing norms, values, culture and religious beliefs that negatively influence risk behaviour, such as through community conversations	Data about local HIV prevalence and mapping of local HIV service providers Engagement of local government, religious and traditional leaders and networks of people living with HIV and key populations at higher risk Engagement of local government, religious and traditional leaders to promote gender equality and reduce harmful gender norms	Traditional leaders, local decision-makers, religious leaders and caregivers

Critical Enablers: Programme			
Community-centred design and delivery	Enables community participation and ensures the sustainability of the behaviour change programme	Participatory needs assessments and planning of the programme activities to identify key high-risk behaviour and its causes and consequences Participatory monitoring of programme activities to identify bottlenecks, lessons learned and corrective actions	Community leaders, activists, employers and workers organizations, local government and networks of people living with HIV
Programme communication	Enables galvanization of support for the behaviour change programme activities Possible replication and scaling up of programme activities	Developing strategic information about programme achievements and impact Sharing information about the impact through brochures, radio, TV and local community meetings	Media, journalists, local community, donors, government and programme staff
Food and nutrition support	Enabler for treatment care and support	May reduce mortality and improve adherence and retention in care	Government entities (national AIDS council and health ministry) and NGOs
Health education	Develops healthy attitude and skills so learners and youth reduce their HIV risk Help reduces stigma and discrimination of people living with HIV	Incorporating skills-based activities for HIV into information, education and communication and curricula Train and support teachers Regular assessment of knowledge, attitudes, skills and behaviour	Ministry of education, schools, teachers, teachers training institutions, private and public schools, formal and non-formal education providers such as religious schools, community-run schools and civil society
Gender equality and gender-based violence interventions	Enables promotion of safer sex negotiation and behaviour by transforming harmful gender norms and empowerment of women, including key populations at higher risk such as sex workers	Empowerment of women through gender equality and HIV training Community mobilization, peer-based participatory education challenging harmful gender norms, particularly among men, boys and girls	Community leaders, women, men, microfinance institutions, schools, police, sex workers, media
Synergies			
Social protection and poverty reduction	Provides protection to households affected by HIV from economic shocks Reduces risky behaviour, such as by building information, education and communication into existing microfinance programs and other initiatives for women's economic empowerment	Integrating HIV sensitivity into social protection frameworks and guidelines Including HIV sensitivity in social protection programmes, such as protective, promotive, preventive and transformative For example, India recently passed new guidelines on health and life insurance to include people living with HIV	Ministry of finance, labour, ministry of social welfare and women's empowerment, microfinance institutions and ministry of planning
Education	Educates students and youth about HIV and its key drivers and impact Help reduces stigma and discrimination of people living with HIV School attendance is a protective factor for young people	Incorporating HIV information, education and communication into existing textbooks, curricula and appraisals for teachers Regular surveys and tests of acquired knowledge and attitudes that are linked to performance assessment Increase school enrolment and completion rates, for example by providing tuition support to orphans and vulnerable children	Ministry of education, schools, teachers, teacher training institutions, private and public schools, formal and informal education sectors such as religious schools, community-run schools etc.
Gender equality and gender-based violence	Provides protection to women who are susceptible to HIV Empowers women to mitigate the disproportionate impact of HIV	Economic empowerment of women Enforcing laws against gender-based violence Promoting equal inheritance, housing and property rights Ensuring linkage between sexual and reproductive health and HIV	Ministry of gender, planning, justice; women's health and rights groups, grassroots women's organizations, religious leaders, community leaders, sex workers. All government agencies, United Nations agencies, bilateral assistance
Employment practices and legal reform	Increases access of HIV services to vulnerable workers (such as migrant and mobile workers) Reduces stigma and discrimination through law reform, policies and avenues to seek redress Addresses income generation and the empowerment of vulnerable workers	Promote development and implementation of enabling employment-related laws and policies (at the state and provincial and federal levels) Create demand for voluntary counselling and testing services Identify and train peer educators and implement information, education and communication and behaviour change communication approaches Provide access to condoms Scale up social protection coverage for vulnerable workers	Ministry of labour, national employers' organizations, national workers' organizations, national business coalitions on AIDS

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