Rapid assessment check list

Analysis of plans & systems
for delivering effective HIV prevention

Introduction

Rationale

Global progress in HIV prevention has been uneven. While declines in HIV incidence were achieved in some countries, HIV incidence is stable at high levels or increasing in others. In preparation of a Global HIV Prevention Coalition, UNAIDS and key partners in prevention have agreed to assess the status of HIV prevention in high priority countries. This involves two key activities:

- The preparation of a score card summarizing the status of country HIV responses in relation to key output, outcome and impact indicators;
- An assessment of the current management and delivery system for primary prevention through a rapid assessment by teams of experts and guided by a checklist (this document);

Objectives

The objectives of the rapid assessment of HIV prevention management and delivery systems are as follows:

- Establish how HIV prevention strategies are structured and which priorities are identified;
- Establish to what extent results frameworks for prevention exist and how coherent they are in relation to results logic and quantitative targets;
- Establish how HIV prevention activities are coordinated;
- Establish to what extent core capacities in the HIV prevention responses are in place;
- Establish key implementation arrangements for priority pillars of prevention
    - Condoms
    - Voluntary medical male circumcision
    - Key populations (sex workers, men who have sex with men, people who inject drugs)
    - Programs for adolescent girls and young women (in high-HIV incidence settings)
    - ARV-based prevention (focus on Pre-Exposure Prophylaxis - because HIV treatment is covered by other assessments)

This assessment is designed as a rapid review of the systems, strategies, management arrangements and broad delivery modalities in place for HIV prevention and aims to identify which areas may need additional technical support. It therefore NOT meant to provide a detailed operational review of the five sub-components, and is unlikely to provide a full understanding of detailed challenges in each of them.

Methodology

The checklist should be applied by an expert or team of experts in consultation with key national stakeholders in the specific subcomponent of prevention. The tool could theoretically also be used as a self-assessment tool, but an independent or outside perspective in the assessment is desirable and the tool is therefore not designed as a self-assessment tool. The methodological steps of applying the tool are as follows:

1. Review existing analyses of the country's HIV epidemic such as epidemiological reviews, modelling analyses and recent global AIDS monitoring reports in relation to primary prevention;
2. Review national HIV strategic plans and prevention strategy documents including sub-strategies;
3. Review results frameworks for HIV prevention strategies (or of major HIV prevention grants from Global Fund, PEFPAR or other funding mechanisms)
4. Conduct key informant interviews with

a. national HIV program leadership (both national AIDS co-ordinating body and MOH HIV dept.)
b. government HIV prevention focal points including for sub-components,
c. key NGO implementers (including staff involved in implementation if time allows)
d. representatives of key and priority populations
e. funding partners supporting the HIV prevention response (PEPFAR, GF PRs, others)
f. other technical experts from UN institutions (WHO, UNFPA) and academia

5. If time allows conduct visits to the national prevention coordination unit and implementation sites

The scope of the assessment and of key informant interviews will differ between countries. In countries, where most funding is channeled through different government institutions, more focus of the review will be on those mechanisms. In countries where substantial components of the response are externally funded, there will also be need to assess how different external contributions feed into the national strategy and how different contributions are coordinated.

The persons carrying out the assessments will not have time to ask all questions to all key informants. Questions that focus on information gathering can be asked to one expert. Other questions, which imply a judgement on quality of a process or adequacy of a strategy will require asking several people with different perspectives. The checklist may be used flexibly, using different sequences and skipping questions when appropriate. However, rapid assessment teams need to come to sound conclusions in key issues that may require remedial action.

The tool can be completed in country visits between 3-5 days. It is recommended that UNAIDS country offices develop a schedule of a series of meetings to ensure maximum use of time.

How to record notes

The persons carrying out the assessment are encouraged to take brief notes next to each question in key words (no elaborate narrative is required after each question). After each section there is need to provide a "summary of key findings and issues". These should be clearly formulated in form of short sentences in bullet points. Key information should also be summarized in the tables after each section, which will be used for comparative analysis.

1. National HIV prevention strategy

Question	Notes
1.1. Does the country have a **separate HIV prevention strategy document** or is HIV prevention covered within the overall national HIV strategy?	
1.2. Are there specific **strategy documents for sub-components** of the HIV prevention response?	
1.3. Which **type of evidence-base** (eg. epi-review, mathematical modelling …) was used when developing the national HIV prevention strategy (or prevention component within the national strategic plan)?	
1.4. Are there **gaps in use of epidemiological evidence** in the national prevention strategy (or prevention component of overall strategy)?	
1.5. Which **priority populations** have been identified as relevant and which as highest priority? Is this consistent with the epidemic situation?	
1.6. Are **behavioural risk factors** prioritized (as a basis for design of programmes) in line with the country's epidemic situation?	
1.7. Are **structural vulnerability factors** prioritized (as a basis for design of programmes) in line with the country's epidemic situation?	
1.8. Which **programmes** have been identified as relevant and which as highest priority? *(consider the five priority pillars of prevention as defined in the introduction depending on epidemic context)*	
1.9. Which **other HIV prevention programmes** or contextual interventions ('enablers') outside the five priority pillars have been prioritized?	
1.10. Are the identified **programme areas prioritized** in line with the country's epidemic situation, dynamics and evidence on intervention effectiveness?	
1.11. Are specific **key locations** (geographical areas) prioritized within the national HIV prevention response and which criteria were applied?	
1.12. How strong is the **awareness and ownership of the strategy** by stakeholders (health sector, other sectors, NGO implementers, funding partners and at sub-national level)?	
1.13. What do stakeholders consider **major strengths** of the existing prevention strategy and plans?	
1.14. What do stakeholders consider **major weaknesses** of existing preventions strategy and plans?	

Summary of key findings and issues

1. *..*
2. *..*
3. ***..***

Proposed actions:

1. *….*
2. *…*

2. Results framework and targets

Question	Notes
2.1. Is there an **overall results framework** for HIV prevention in place with an **impact-level target** (reduced new HIV infections or incidence)?	
2.2. Are specific **results statements, indicators and targets** in place for the **five priority pillars** of HIV prevention (as relevant in the specific country context)?	
2.3. Are there **quantified targets for all outcome-level results** (service uptake and utilization and behavior changes) in the results frameworks for the five priority pillars?	
2.4. Would the achievement of the **outcome targets** likely be **sufficient** for achieving impact-level goals (and is there evidence to support this)?	
2.5. Are there **quantitative targets for output-level results** (coverage) for the five priority pillars? • For outputs (services, commodities) • For reach (of communications)	
2.6. Would the achievement of the **output targets** (coverage) be **sufficient** for achieving the outcome-level results (service use, changes in behavior) in each of the five priority pillars or are there specific gaps in the results chain?	
2.7. Have the **output targets** in the five priority pillars been **translated into sub-national targets** (for districts or equivalent units?)	
2.8. Are the **output targets from national strategies actually <u>used</u> at sub-national level** to inform planning, implementation and monitoring of programmes in the five priority pillars?	
2.9. Have strategy documents, results frameworks and operational plans been aligned to the 2016 UN Declaration of Commitment or are there plans to do so?)	

Summary of key findings and issues

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2. ..
3. ...

Proposed actions:

1. …
2. …
3. …

3. HIV prevention co-ordination architecture

Question	Notes
3.1. Which national **government agency** is **responsible for coordinating** the HIV prevention response?	
3.2. Is there a **national HIV prevention working group** and/or is HIV prevention covered in an overall HIV partnership forum involving different stakeholders?	
3.3. How often is **HIV prevention on the agenda** of regular national AIDS co-ordinating body meetings? (always, most of the time, sometimes, rarely, never)	
3.4. Are there **specific sub-working groups in place** for the three (in concentrated epidemics) or five priority pillars of HIV prevention?	
3.5. Are there any **other working groups** in place for any other areas of the HIV prevention response?	
3.6. Do all (required) working groups have **representation** from key stakeholders, e.g. health, non-health sectors, population groups, NGOs/CBOs, private sector when needed?	
3.7. How frequently do the working groups assess **progress against coverage (output) targets** of the national prevention strategy/plan? (Never annually, quarterly)	
3.8. Do the working groups cover both **supply** (eg. service delivery, condom distribution) **and demand generation** (eg. Communication through community workers) to ensure that these two programme components are synchronized?	
3.9. To what extent do national HIV prevention working groups **guide implementers** to ensure that all partners in the national response **align to agreed results and approaches**?	
3.10. In the past 12 months, have the groups met with adequate frequency to perform their core functions?	
3.11. How are the different prevention pillars **coordinated at sub-national level**?	
3.12. Do **sub-national mechanisms monitor progress** towards output targets?	

Summary of key findings and issues

1. *…*
2. *...*
3. *...*

Proposed actions:

1. *…*
2. *…*

4. HIV Prevention Management Capacities

Question	Notes
4.1. Is **political leadership and senior management** in health and relevant non-health sectors adequately briefed and capacitated to provide leadership in the prevention response?	
4.2. In which areas are there **gaps in political leadership** for HIV prevention?	
4.3. Is there **openness among the government leadership** on the legal and policy environment which may hamper the implementation of prevention programmes, particularly the programmes targeting key populations?	
4.4. Which agencies have been assigned **programmatic leaderships for the five priority pillars** of HIV prevention?	
4.5. Is there adequate national **programmatic leadership** in key prevention components, e.g. the five priority pillars of HIV prevention?	
4.6. To what extent do government lead agencies for the different pillars have adequate **capacity in place to fulfill the following functions**? Highlight any good practices or gaps. • Strategic epidemic analysis • Knowledge on effectiveness of interventions and modalities for delivering them • Market and social analysis for understanding determinants of prevention uptake • Evidence-based strategy development and national planning • Decentralized planning, implementation, and tracking • Procurement and supply-chain management • Design of effective interpersonal, media, and information technology based communications • Selecting, contracting, and management of non-governmental organizations • Community engagement, advocacy with leadership, and popular opinion leaders	
4.7. In areas, in which capacities are not available within government, are other agencies (such as international agencies or NGOs) covering these functions or are there **capacity gaps**?	
4.8. Are programmes supported by international agencies aligned to the national HIV prevention response?	
4.9. Are international agencies and NGOs using technical capacities primarily for their own programmes or is expertise availed for the wider national response?	

Summary of key findings and issues

1. ..
2. ..
3. ...

Proposed actions:

1. …
2. ...

5. Implementation

This section does not aim to provide for comprehensive programmatic assessments of national programs in all five components, but seeks to guide a review of selected critical components for success.

5.1. M&E and cross-cutting implementation issues

Question	Notes
5.1.1. Is **prevention communication** (eg. counselling on HIV risk practices or demand generation for prevention services) integrated and actively practiced in other health service platforms (HTS, ART, SRH services)?	
5.1.2. In what ways are **mass media** (eg radio, TV, newspapers), and **new media** (internet, mobile phones, other) currently utilized for HIV prevention?	
5.1.3. Is **real-time data** (e.g. monthly) being collected from implementers and utilized in programming and performance management?	
5.1.4. Does the national government and local authorities have **administrative modalities in place to contract and finance NGOs** and community-based organizations for HIV prevention?	
5.1.5. Do national government agencies have **capacity in place to manage HIV prevention contracts with NGOs** from planning to implementation and evaluation (consider dimensions of technically guiding NGOs, support their capacity development, tracking progress against key targets and motivating them to provide excellence in program delivery)	
5.1.6. How frequently are **HIV bio-markers** collected through population-based surveys (consider different priority populations)?	
5.1.7. Can biomarkers and other outcome results measured in population-based **surveys be linked to programme exposure** (ie is programme exposure measured in the same surveys)?	
5.1.8. Is there a roadmap for **increasing domestic financing** of the HIV response, which includes specific provisions to ensure continued prevention funding for health and community components of prevention?	

Summary of key findings and issues

1. ..
2. ..
3. ...

Proposed actions:

1. …
2. …

5.2. Condoms

Question	Notes
5.2.1. Does the country apply a **condom total market approach** considering the roles of public, social marketing and private sector programmes based on audience segmentation?	
5.2.2. Are national **condom procurement and distribution plans** in place including quantification and forecasting?	
5.2.3. Has a **bottleneck analysis** been performed in the past 3 years to understand major supply, demand, social, economic and cultural barriers to condom uptake?	
5.2.4. Are **standard operating procedures** in place and being followed, which cover condom distribution in health facilities, including the following • Provider-initiated offer of condoms in health facilities to all sexually active including adolescents • Suggested quantities of condoms offered to all sexually active (eg offer 3-month supply of condoms to all SRH clients) • Guidance on counselling on correct use of male and female condoms to all sexually active including adolescents	
5.2.5. Are standard procedures/guidelines/**tools in place for condom promotion**, demonstration and distribution by community health workers, NGOs, CBOs and community volunteers?	
5.2.6. Is the logistics system adequate to ensure **continuous condom supply and track distribution** at decentralized levels and at facility/ service delivery points?	
5.2.7. Were any condom **stock-outs** recorded in the past 12 months, in any health facilities /other service delivery points?	
5.2.8. Are there sufficient **distribution points/outlets** where **adolescents and young people** can access free condoms?	
5.2.9. Is condom education provided in schools and are condoms available in or near schools?	
5.2.10. What is the current role of the **social marketing sector** and has funding been secured to sustain coverage of the current network of social marketing outlets up to 2020?	
5.2.11. Is a systematic large-scale effort for **condom demand generation** currently ongoing and what is its coverage?	
5.2.12. Has there been **quantification of the condom needs and targets** set for condom distribution for different programmes?	
5.2.13. What are the **main strengths and weaknesse**s of the current condom program implementation in the country?	

Summary of key findings and issues

1. *..*
2. *..*
3. *...*

Proposed actions:

1. *…*
2. *…*

5.3. Voluntary medical male circumcision

Question	Notes
5.3.1. Has a **bottleneck** or cascade **analysis** been performed in the past 3 years to understand major barriers to VMMC uptake (including factors influencing demand)?	
5.3.2. Are **standard operating procedures** in place and being followed, which also cover demand generation for VMMC in the health sector • Provider-initiated offer of VMMC in all health facilities offering VMMC to all men 10-29 (or other age group – including HTS, STI and other male clients) • Provider-initiated referral of all men 10-29 (or other age group) to a VMMC facility • Integration of wider HIV prevention and sexual and reproductive health communication and referrals into VMMC services	
5.3.3. Are **standard procedures/guidelines/tools** in place for VMMC promotion and referral by community health workers, NGOs, CBOs, traditional leaders and community volunteers?	
5.3.4. Is the **logistics system** adequate to ensure continuous VMMC commodity supply including at decentralized levels?	
5.3.5. Is there an **updated plan for training**, coaching of the service providers to perform VMMC, including for task shifting and task sharing?	
5.3.6. Is there an **institutional mechanism between the education and health sectors** in place to facilitate routine collaboration in offering VMMC services to adolescent boys?	
5.3.7. Is a systematic **large-scale effort for VMMC demand generation** currently ongoing (independently or as part of broader prevention communication)?	
5.3.8. What is the current access level of VMMC services?	
5.3.9. What are the main **strengths and weaknesses** of the current VMMC program implementation in the country?	

Summary of key findings and issues

1. ..
2. ..
3. ...

Proposed actions:

1. …
2. ..

5.4. Pre-exposure prophylaxis

Question	Notes
5.4.1. What is the current **policy position of the country on PrEP**?	
5.4.2. Have **national guidelines** for delivery of HIV treatment been revised to reflect recommendations on PrEP?	
5.4.3. Are the necessary **drugs registrations and regulatory approvals** for PrEP in place?	
5.4.4. Have relevant tools, standard operating procedures, communication materials and job aides been developed?	
5.4.5. Have potential **priority populations for the use of PrEP** been defined? Which are they (check for sex workers, men who have sex with men, discordant couples, adolescent girls and young women)? If yes, is the focus on those at highest risk? Was this done through an inclusive consultative process?	
5.4.6. Has (a) **service delivery model(s)** for PrEP been agreed?	
5.4.7. Have service providers been **trained** in the delivery of PrEP?	
5.4.8. Has the delivery of PrEP been **piloted** in the country? If yes, what were the outcomes?	
5.4.9. What is the **envisaged coverage level of PrEP** (for identified priority populations)? Consider • Proportion of priority sub-national admin. areas (district or equivalent) covered • Proportion of priority population covered; • Total numbers to be on PrEP	

Summary of key findings and issues

1. ..
2. ..
3. ...

Proposed actions:

1. …
2. ..
3. ...

5.5. Key populations

Conducting a full assessment of all social, economic, cultural and legal issues affecting key populations is not possible in the scope of this analysis. The focus will be on specific questions in relation to HIV prevention.

Sex workers

Question		Notes
5.5.1.	Has a **bottleneck or cascade analysis** of the national program (or other large programs) for HIV prevention among sex workers been performed in the past 3 years to understand major barriers for scale up of HIV prevention program delivery and adoption of safer practices among sex workers?	
5.5.2.	Has the country committed to a **service delivery model** (or different service delivery models) for HIV prevention among sex workers, which includes dedicated outreach focused on sex workers plus specific referral clinics with service providers specifically trained to provide HIV prevention services to sex workers?	
5.5.3.	What are the **main barriers to scale up** of HIV prevention programs among sex workers?	
5.5.4.	What are the **main barriers** for sex workers **to access** HIV prevention programs including condoms, STI services,HIV testing and counselling, post-exposure prophylaxis and gender-based violence support?	
5.5.5.	Do HIV prevention programmes for sex workers include a **community empowerment component**? (such as collectivization, legal support, prevention of abuse by law enforcement agencies)	
5.5.6.	Are national **standard operating procedures** for core components of HIV programs for sex workers (peer/community outreach, counselling, clinical services) in place in line with global guidelines?	
5.5.7.	Are there any areas, in which national **implementation practice** deviates from current global guidance?	
5.5.8.	Are **population size estimates** including a sub-national breakdown and are they being used for planning outreach and setting coverage targets?	
5.5.9.	Is there a **national agreement, on which implementers cover** different priority areas, in order to ensure nation-wide coverage of all priority locations?	
5.5.10.	Is a **unique identifier code** system in place to track coverage ofs prevention programs for sex workers?	
5.5.11.	What is the **current coverage** level of HIV prevention programmes for sex workers? Consider • Proportion of priority sub-national admin. areas (cities, district or equivalent) covered) • Proportion of priority communities covered • Proportion of sex workers in priority areas covered	
5.5.12.	What are the main **strengths and weaknesses** of the current implementation model for HIV prevention among sex workers in the country?	

Summary of key findings and issues

1. ..
2. ..
3. ...

Proposed actions:

1. …
2. ..
3. ...

Men who have sex with men

Question	Notes
5.5.13. Has a **bottleneck or cascade analysis** been performed in the past 3 years to understand major barriers for scale up of HIV prevention program delivery and adoption of safer practices among men who have sex with men?	
5.5.14. Has the country committed to a **service delivery model** (or different service delivery models) for HIV prevention among men who have sex with men, which includes dedicated outreach focused on men who have sex with men plus specific referral clinics with providers specifically trained to provide HIV prevention services to men who have sex with men?	
5.5.15. What are the main **barriers to scale up** of HIV prevention programs among men who have sex with men?	
5.5.16. What are the main **barriers to access** HIV prevention services for men who have sex with men?	
5.5.17. Are national **standard operating procedures** for HIV programs for men who have sex with men in place in line with global guidelines?	
5.5.18. Are there any areas, in which **national implementation practice** deviates from current global guidance?	
5.5.19. Are **population size estimates** including a sub-national breakdown in place and being used for planning outreach and setting coverage targets?	
5.5.20. Is there a **national agreement**, on which implementers cover different priority locations, in order to ensure nation-wide coverage of all priority locations?	
5.5.21. Is a **unique identifier code** system in place to track coverage of prevention programs for men who have sex with men?	
5.5.22. Are **interventions** in place to reach men who have sex with men using **online dating applications**?	
5.5.23. What is the **current coverage level** of HIV prevention programmes for men who have sex with men? Consider • Proportion of priority[1] sub-national admin. areas (district or equivalent) covered • Proportion of priority communities covered • Proportion of adults in priority areas covered	
5.5.24. What are the main **strengths and weaknesses** of the current implementation model for HIV prevention among men who have sex with men in the country?	

Summary of key findings and issues

1. *..*
2. *..*
3. *...*

Proposed actions:

1. *…*
2. *...*

[1] Priority areas means those area where demand generation should be implemented given the epidemic burden (eg. If a country has 100 districts of which 30 are very low risk and 70 medium to high risk and if 35 of these districts are covered, then coverage of demand generation would be 50%.

People who inject drugs

Question	Notes
5.5.25. Has a **bottleneck or cascade analysis** been performed in the past 3 years to understand major barriers for scale up of HIV prevention program delivery and adoption of safer practices among people who inject drugs?	
5.5.26. Has the country committed to a **service delivery model** (or different service delivery models) for HIV prevention among people who inject drugs, which includes dedicated outreach focused on people who inject drugs plus specific referral clinics with providers specifically trained to provide HIV prevention services to people who inject drugs?	
5.5.27. What are the **main barriers to scale** up of HIV prevention programs among people who inject drugs?	
5.5.28. What are the **main barriers to access** HIV prevention services for people who inject drugs?	
5.5.29. Are national **standard operating procedures** for HIV programs for people who inject drugs in place in line with global guidelines?	
5.5.30. Are there any areas, in which **national implementation practice** deviates from current global guidance? Consider • Needle and syringe exchange • Provision of opioid substitution therapy	
5.5.31. Are **population size estimates** including a sub-national breakdown in place and being used for planning outreach and setting coverage targets?	
5.5.32. Is there a national agreement, on which implementers **cover different priority locations**, in order to ensure nation-wide coverage of all priority locations?	
5.5.33. Is a **unique identifier code** system in place to track coverage of programs for people who inject drugs?	
5.5.34. What is the **current coverage level** of HIV prevention programmes for people who inject drugs? Consider • Proportion of priority[2] sub-national admin. areas (district or equivalent) covered • Proportion of priority communities covered • Proportion of adults in priority areas covered	
5.5.35. What are the main **strengths and weaknesses** of the current implementation model for HIV prevention among people who inject drugs in the country?	

Summary of key findings and issues

1. ..
2. ..
3. ...

Proposed actions:

1. …

[2] Priority areas means those area where demand generation should be implemented given the epidemic burden (eg. If a country has 100 districts of which 30 are very low risk and 70 medium to high risk and if 35 of these districts are covered, then coverage of demand generation would be 50%.

2. ..

HIV prevention programs for young women (and adult women + men) in high-prevalence settings

Question	Notes
5.5.36. Are **geographic focus areas and demographic target subgroups** of programs for young women clearly defined?	
5.5.37. Are **specific prevention packages** in place for adolescent girls, young women, and adult women and men in geographic priority areas? Do these suitably combine behavioral, biomedical and structural components?	
5.5.38. Are **standard operating procedures** for HIV programs for young women in place in line with global guidance?	
5.5.39. Are there any components, in which **national implementation practice** deviates from current global guidance?	
5.5.40. Is the **implementation model** for community-based HIV prevention for young women, adult women and men based on an implementation model that was previously tested in research settings (such as Stepping Stones, SHARE, SASA! etc)?	
5.5.41. Do programs systematically include **cash or other social transfers** or other economic empowerment elements for young women?	
5.5.42. Would there be opportunities to **expand the cash transfer scheme** to increase benefit for adolescent girls and young women at high risk of HIV?	
5.5.43. Is there **national agreement** on which implementers cover different **priority locations**, in order to ensure coverage of all priority locations?	
5.5.44. What is the **current coverage level** of HIV prevention programmes for young women? Consider • Proportion of priority sub-national admin. areas (district or equivalent) covered • Proportion of priority communities or age groups covered • Proportion of adults in priority areas covered	
5.5.45. What are the main **strengths and weaknesses** of current approaches to HIV prevention among young women in the country?	

Summary of key findings and issues

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2. ..
3. ...

Proposed actions:

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2. …