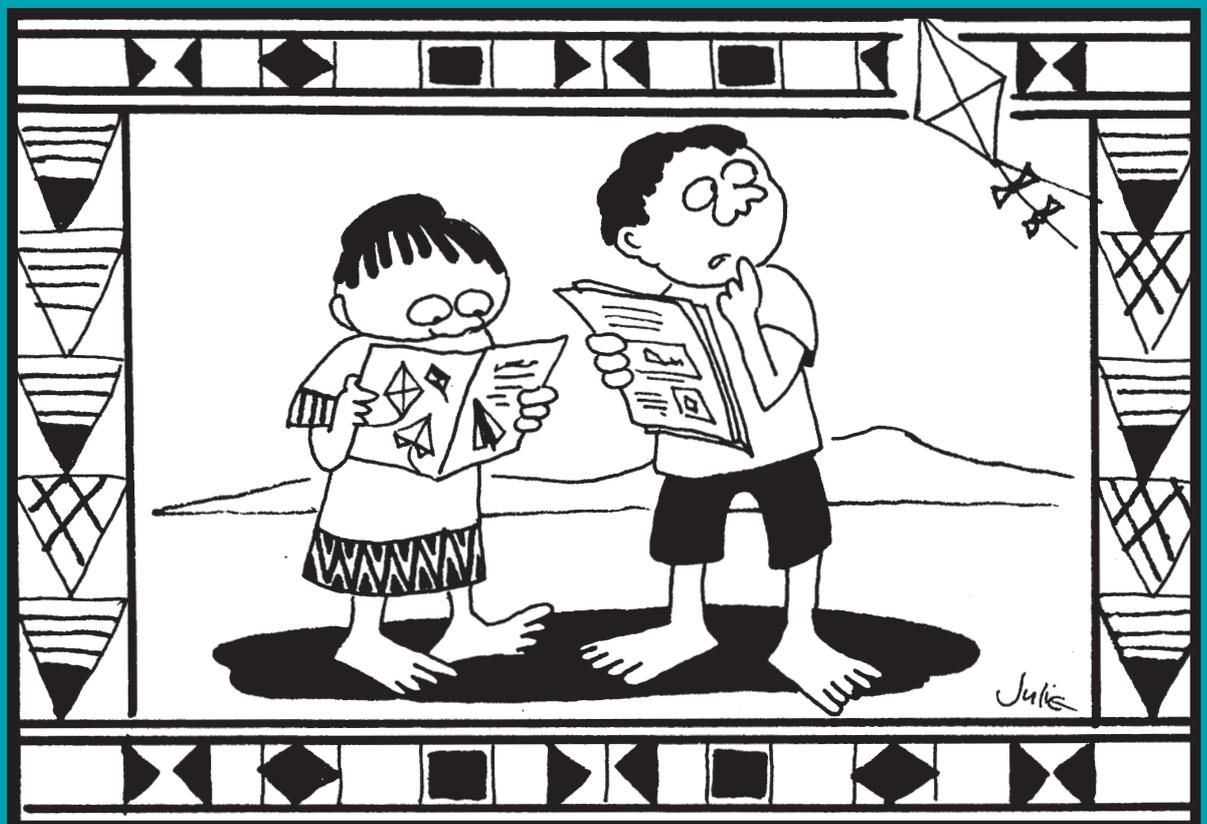


PLANNING FOR ACTION

SECTION 1

First things First



SECTION 1

First things First

First things first! In this Guide to strategic planning to respond to HIV/AIDS and STIs in the Pacific region, there are some preliminary issues that need to be addressed right from the start. Planning to respond to HIV/AIDS and STIs is most effective if it involves the whole community. This means that there may be people using this Guide who are not familiar with HIV. It also means that there may be people using this Guide who are not familiar with strategic planning and the terms used to describe this process. Therefore, section one of the Guide is designed to introduce these topics.

This first section includes three chapters.

The first chapter covers background information on HIV and AIDS.

Whilst this Guide does not intend to be a medical reference book on the specific details of HIV or STI infection, it is important for people planning a response to HIV/AIDS and STIs in a country to have a basic understanding of what the virus is, how it affects people and how it is transmitted. This chapter also includes a list of references where readers can access further information on HIV/AIDS and STIs.

The second chapter gives an overview of what strategic planning actually is, presenting a broad picture of what is involved in the process. It describes the steps necessary for strategic planning, explaining how they all link together. Each step will then be described in detail in subsequent chapters.

Finally, Chapter 3 highlights some particular skills used repeatedly throughout the strategic planning process. Many readers will already be familiar with these skills from other areas of their work. For example, summarising is a skill used by many people who write reports as part of their job. This chapter highlights why these skills are important in the strategic planning process, and gives examples of how they are used.

At the end of each section there are summary pages that reinforce the key points of the preceding chapters. These pages can be photocopied and used as overhead transparencies or handouts if you are teaching other people about HIV and strategic planning.

SECTION 1 First things First

CHAPTER 1

Background Information on HIV

The Human Immunodeficiency Virus (HIV) causes AIDS (Acquired Immune Deficiency Syndrome). The syndrome, or pattern of illness, was first described in the United States in 1981, but the virus that causes the **immune deficiency** was not discovered until 1983. Two **retroviruses** have been discovered that are responsible for immune deficiency: HIV-1 and HIV-2. These viruses are very similar and are transmitted in the same ways. In this manual HIV refers to HIV-1, which is the most common form of HIV.

The virus has now spread to nearly every country in the world although it emerges in different populations and in different ways in each place. Pacific Island Countries and Territories (PICTs) have been affected later than in some other parts of the world, but the numbers of infections are now increasing.

1.1 How does HIV replicate?

Viruses can only survive by living inside the cells of another organism. Like other viruses, HIV is only able to multiply inside the cells of the infected person. Unlike many viruses, the genetic material of HIV integrates with the genetic material of the host cell. In this way, HIV remains *permanently* in the infected person.

One of the favourite targets of HIV are the immune cells known as **CD4 cells**. These cells are responsible for the reaction of the human immune system to unwanted foreign material, like viruses. So HIV works by destroying the very cells which are responsible for mounting a fight against infection. HIV is also able to infect other cells of the immune system, brain cells and gut cells.

ACKNOWLEDGMENT:

The first chapter of this Guide to strategic planning for HIV/AIDS and STI responses gives background information about HIV. Whilst adapted to address issues relevant to the Pacific region, this chapter has been based on the comprehensive “The Basics: Background information on HIV” by Dr. Wendy Holmes, in *Community Action on HIV: A Resource Manual for HIV Prevention, Care and Support (second edition)*. Aboagye-Kwarteng T., Moodie R., Holmes W. (eds.). 2001. International Health Unit, Macfarlane Burnet Centre for Medical Research.

SECTION 1 First things First

1.2 How is HIV transmitted?

HIV spreads from an infected person to another in three ways:

- through sexual intercourse,
- through blood, and
- from mother to child.

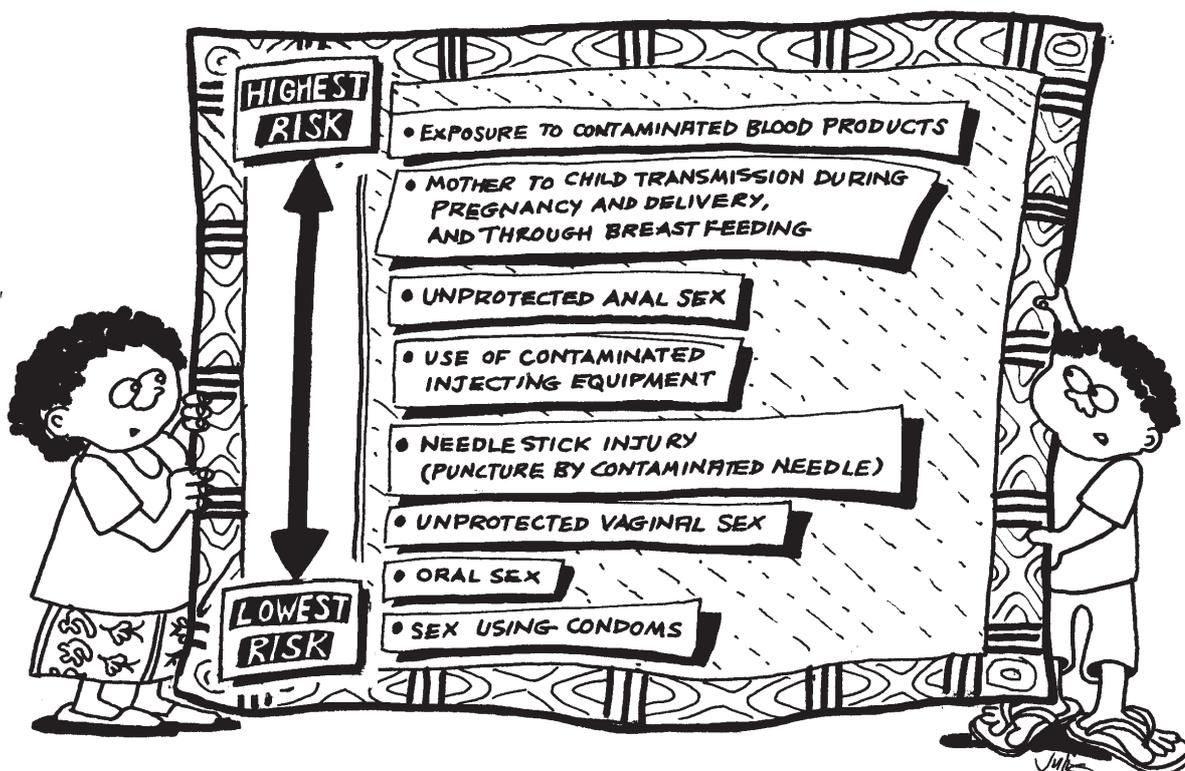
HIV **cannot** be transmitted by coughing or sneezing; by shaking hands; by sharing a drinking glass, kava bowl, plates or cutlery; by hugging or kissing; by insect bites; by walking barefoot where people have spat; or by living or working with someone who has AIDS or HIV.



CHAPTER 1 Background information on HIV

Behaviours that carry a high risk of infection include unprotected (i.e. without a condom) anal or vaginal sex, and sharing needles or syringes when injecting drugs, with an infected person. Infection through blood transfusion is a common problem in areas where blood donations are not screened for HIV.

The pattern of transmission depends on behaviour patterns and varies from place to place, and in different groups within a population. The picture below shows a range of risk and risky behaviours. It is also important to note that HIV spreads more rapidly where there is poverty or inequality.



Because HIV remains permanently in the infected person, people living with HIV can infect others from the time they become infected, and they will remain infectious for the rest of their lives. People are most infectious shortly after they become infected themselves, and again after they develop serious immune deficiency (at a late stage of infection), because the amount of virus in the body (the 'viral load') is highest at these times.

SECTION 1 First things First

Transmission through sex

The major means of HIV transmission in the Pacific is unprotected sexual contact. Sexual behaviour and social norms vary considerably across the region. High risk behaviours such as unprotected sex with many partners are denied in many communities, but they happen nevertheless. Sex work is increasingly common in the region. Condoms are often unpopular, not always easy to access, and people may have difficulty using them.

A person with another sexually transmitted infection (STI) has an increased risk of becoming infected with HIV, and also of transmitting HIV infection to others during sex. This is true for both men and women. Because STIs cause inflamed surfaces and broken skin, the HIV virus passes more easily through the skin. So the presence of STIs such as gonorrhoea, chlamydia, bacterial vaginosis and especially ulcerative infections such as syphilis, **increases** the risk of HIV transmission.

STIs may have no symptoms and therefore remain untreated. Effective STI treatment is an important way of reducing vulnerability to HIV. A key study from rural Tanzania demonstrated that an affordable program of training health workers, providing simple antibiotics and public education to prevent and treat STIs reduced the incidence of HIV by about 40%.¹ STIs such as gonorrhoea, chlamydia, syphilis and other ulcerative conditions are relatively common in the Pacific region, and lessons from research such as the Tanzanian study are important to incorporate into a Pacific response.

HIV passes from an infected man to a woman during sex more easily than it passes from an infected woman to a man.² Young women are especially vulnerable to HIV.

It is also important to note that HIV is more likely to spread when sexual activity is rough or damages the lining of the vagina or anus – this increases the vulnerability of those who are subject to sexual violence or abuse. Anything that increases the risk of vaginal abrasion such as use of sex ‘toys’, twigs or herbs to dry the vagina also increases the risk of transmission.

The risk of transmission through sexual intercourse is reduced by the correct use of condoms.³ Water-based lubricants, such as KY jelly, should be used for anal sex and when the vagina is dry. Oil-based lubricants such as Vaseline should be avoided as they may weaken the latex rubber that condoms are made of, causing condom breakage.

CHAPTER 1 Background information on HIV

Transmission through blood

There are several ways that people can become infected with HIV through blood. These include transfusion with infected blood; procedures where **Universal Precautions** (see box below) are not followed; and through the sharing of needles and syringes.

Transfusion of infected blood or blood products can transmit HIV. Whilst many PICTs import blood products, blood for transfusions is obtained from local blood donors, often family members.

Since 1985 it has been possible to test donated blood for HIV **antibodies** before transfusion. Routine testing of all blood for transfusion greatly reduces the chances of transmitting HIV this way, but there always remains a risk because a donor can give blood during the **window period** (see over page). This risk is greatest in areas where many people are becoming infected with HIV.⁴ In many PICTs routine screening of blood for transfusion is still not available. Therefore detailed interview, history taking and counselling, in addition to blood testing for HIV antibodies, is very important in screening of blood donors.

WHAT ARE UNIVERSAL PRECAUTIONS?

Universal Precautions are a particular set of practices that minimise unnecessary exposure to blood and body fluids. They are important for all health care workers, traditional birth attendants, and other people who may be exposed to blood and body fluids through their work (such as police or emergency service providers). Universal Precautions are based on the assumption that all blood and body fluids are potentially infectious (capable of transmitting HIV or other blood borne infections).

Universal Precautions consists of 5 standard practices:

- Careful handling and disposal of sharps
- Proper disinfection of instruments and other contaminated equipment
- Handwashing and the use of protective barriers (such as gloves or eye glasses) to prevent direct contact with body fluids
- Proper handling of soiled linen
- Safe disposal of waste contaminated with body fluids.

For more information about implementing Universal Precautions in the health care setting or workplace, please refer to the WHO Fact Sheet 11 *HIV and the Workplace and Universal Precautions* which can be obtained from WHO offices or at www.who.int/HIV_AIDS/Nursesmidwivesfs/fact-sheet-11/index.html

SECTION 1 First things First

WHAT IS THE 'WINDOW PERIOD'?

Tests for HIV detect HIV antibodies, rather than HIV itself. The 'Window Period' refers to the period after a person becomes infected, but before they have mounted an immune response and developed antibodies which will be detected by a HIV test.

During this period a person may have a negative test result, but actually be infected with HIV and be able to transmit infection to others.

This period of time may be three months or more.

The facts about HIV transmission, HIV testing and the 'window period' should be discussed with all blood donors prior to them donating blood. Many people assume that blood from family members is safe – however it is important to reinforce the need for thorough history taking and counselling of blood donors in all situations.

Whether blood for transfusion is screened or not, it is important to give blood transfusions only when it is absolutely necessary. Strict criteria for blood transfusion can reduce the number of transfusions greatly, without any increase in mortality.⁵ It is sometimes possible to use the patient's own blood for transfusion (if taken before an operation for example).

HIV can also be spread through blood during medical, dental or other procedures. This includes delivery of babies either in the health care setting or by traditional birth attendants at home.

Traditional cultural practices that involve bleeding or use of instruments that cut or pierce the skin, such as circumcision, scarification and tattooing, may also transmit HIV.

The risk of HIV transmission (either from, or to, health care and traditional practitioners) during procedures can be minimised by taking Universal Precautions with all blood and body fluids.

HIV is only able to survive outside the body for brief periods, (the specific length of time being influenced by the environment). The virus is sensitive to heat and is killed at 56°C. It is best to sterilise needles, instruments and equipment by autoclaving, boiling or steam sterilisation. Studies show that commonly used chemical germicides also kill HIV. A solution of sodium hypochlorite (household bleach) in a dilution of 1:10, prepared daily, is an inexpensive and effective germicide.

Injecting drug use is becoming increasingly common in many countries, including some PICTs. HIV spreads very easily between people who inject drugs together and share needles, syringes and other injecting equipment. Blood drawn back into the syringe can pass directly into the bloodstream of the next person to use the syringe. Infected drug users can then spread HIV to others in the population through sexual intercourse or through blood transfusion. Needles, syringes and other injecting equipment must not be shared – either use new equipment or thoroughly clean all the equipment with bleach and water. Needles that are used for **tattooing** must not be shared either, unless properly cleaned between use.

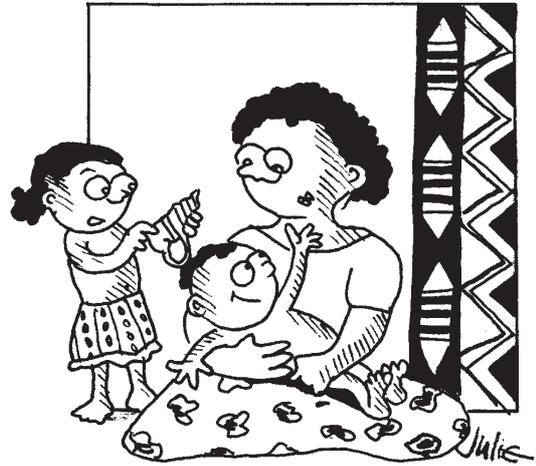
CHAPTER 1 Background information on HIV

Transmission from mother to child

The risk of HIV being transmitted from an infected mother to her child is between 15% and 48%.

Transmission may occur across the placenta, at delivery, or after birth through breastfeeding.⁶ Maternal HIV antibody crosses the placenta so the HIV antibody test of the baby is positive whether the baby is infected or not. This has made it difficult to study the timing of transmission.

The number of children infected with HIV is increasing rapidly in countries where HIV has spread widely in adults, as most women who become infected with HIV are in the reproductive age group. It is not yet well understood why some babies become infected and others do not. However research from around the world has shown that there are several strategies which can be implemented to reduce the risk of **mother to child transmission** of HIV. These are discussed on page 100 of this Guide.



1.3 Tests for HIV infection

Rapid and simple HIV tests are now widely available. These tests detect the presence of HIV antibodies rather than the presence of the virus itself. Therefore, in the early phase of infection before antibodies have been produced, it is possible for infected persons to have a negative test result (this early phase is the 'window period'). HIV antibody tests are used for diagnosis, screening of donated blood for transfusion, surveillance of HIV infection, and research.

SECTION 1 First things First

1.4 Stages of infection

1 Exposure to the virus

Through unprotected sex with an infected person, transfusion with infected blood or blood product, sharing or reuse of needles or syringes that have been used by an infected person, or through maternal infection.

2 Sero-conversion

During the first few weeks after exposure to the virus, HIV multiplies very rapidly. Then the body's immune system mounts a massive response, which includes the production of antibodies. This happens usually within three months and this process is called **sero-conversion**. Antibodies are formed to a variety of components of the virus. They cannot overcome the infection, but this antibody process lowers the amount of virus in the body and slows the rate of HIV replication. From this point and for many years the amount of virus produced is basically equal to the amount of virus that the body is able to kill. So the viral load (the actual amount of virus in the blood) remains relatively steady. Many people experience an acute illness at the time of sero-conversion, with fever and enlarged lymph glands. This illness may be mistaken for glandular fever or flu.⁷

3 Silent infection

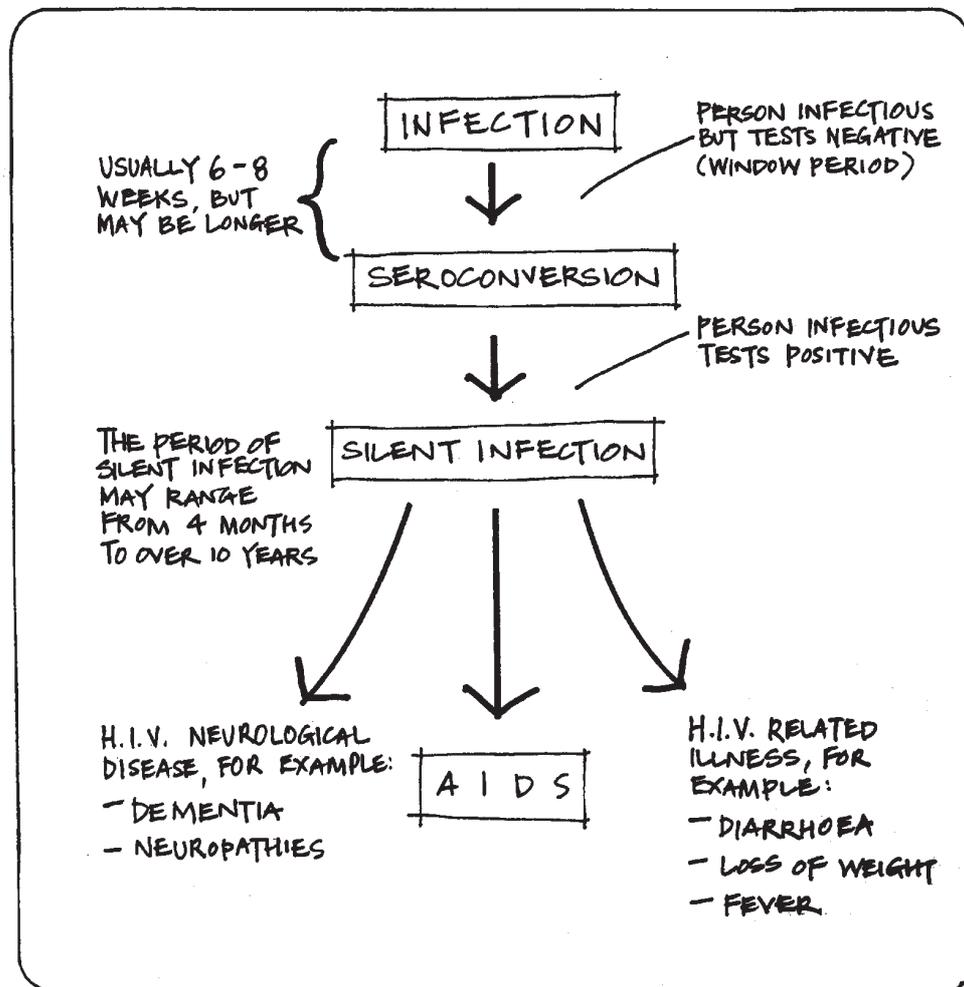
Subsequently, most people infected with HIV have no symptoms for a long time; this period of silent infection may range from 4 months to over 10 years. This period of time may be shortened in individuals with poor nutritional status, chronic anaemia due to parasitic diseases (such as malaria or worm infestation) or other conditions endemic in tropical areas. During this period the virus is replicating slowly and eventually infected people will develop symptoms of HIV related illness. These may include loss of weight, tiredness, intermittent fever, chronic cough and diarrhoea.

CHAPTER 1 Background information on HIV

4 AIDS

Acquired Immune Deficiency Syndrome, or AIDS, is the name given to the final stage of HIV infection when the immune system is very weak. Many micro-organisms then have the opportunity to infect the person so these infections are called **opportunistic infections**. The weak immune system may also allow cancers to develop. Neurological disease, due to direct infection of brain cells by the virus, may occur early or late in the course of HIV infection.

The diagram below illustrates the stages of HIV infection:



Between 10% and 30% of people infected with HIV will develop AIDS within 5 years and another 25% to 30% will develop HIV-related symptoms. Approximately 60% develop AIDS within 12 to 13 years. In countries where these drugs are affordable, new combination anti-retroviral therapies (in the form of HAART – highly active anti-retroviral therapy), and drugs that treat and prevent opportunistic infections, are increasing the time between HIV infection and the development of AIDS.

SECTION 1 First things First

1.5 Case definition of AIDS

The definition of AIDS is based on a list of diseases which indicate immune deficiency, and includes laboratory evidence of HIV infection and a low T4 white cell count (US Centers for Disease Control and Prevention).⁸

Where there are no facilities for the diagnosis of indicator diseases or the detection of HIV antibodies, the World Health Organisation (WHO) clinical definition may be used (see table 1.1 below).⁹ However, this definition is not very accurate in diagnosing persons with HIV infection because it includes symptoms and signs, such as chronic cough, weight loss and recurrent fever, that may be common in uninfected individuals in developing countries.¹⁰ In the Pacific these symptoms may be due to other common conditions such as tuberculosis and malaria.

TABLE 1.1
WHO GUIDELINES FOR DIAGNOSIS OF AIDS IN ADULTS

Major signs	→	weight loss of over 10% of body weight
	→	fever for longer than one month
	→	diarrhoea for longer than one month
Minor signs	→	persistent cough for more than one month
	→	general itchy skin rash
	→	recurring shingles (herpes zoster)
	→	thrush in the mouth and throat
	→	long-lasting, spreading and severe cold sores (herpes simplex)
	→	long-lasting and symmetrical swelling of the lymph glands (general lymphadenopathy)
	→	loss of memory
	→	loss of intellectual capacity
	→	peripheral nerve damage

In an adult, AIDS is defined by the presence of at least two major and at least one minor sign, in the absence of any other clear explanation for the signs (such as cancer or malnutrition).

CHAPTER 1 Background information on HIV

1.6 Treatment for HIV infection

At present, there remains no cure for AIDS. However there are treatments for the relief of symptoms, treatments for opportunistic infections, and an increasing range of anti-retroviral drugs that attack HIV itself.

Unfortunately the countries that have the largest numbers of people infected with HIV are unable to afford the high cost of the new anti-retroviral drug combinations; many cannot afford to provide treatment for opportunistic infections; and many people affected by HIV are unable to afford even medicines to relieve symptoms. Countries in the Pacific region have all made different decisions about national policies on the provision of anti-retroviral treatment, based on local circumstances, budgets and priorities.

Treatment for HIV-related symptoms

Good nursing care can do much to relieve the symptoms of HIV-related disease such as fever, sweating, itching, diarrhoea, pain, headache, and cough. Local homemade remedies and traditional healers can be very helpful. Paracetamol, aspirin, oral rehydration solution, gentian violet and antiseptic cream are useful, and morphine helps to relieve pain in dying patients. Other aspects of holistic care, such as counselling, nutrition and food preparation advice, are also very important.¹¹ *

Prevention and treatment for opportunistic infections

Prevention and treatment for opportunistic infections such as tuberculosis, diarrhoea, fungal infections and *Pneumocystis Carinii* pneumonia can extend and improve the life of people living with HIV and their family.

The World Bank has published a policy research report called '*Confronting AIDS*'.¹² This recommends that effective low-cost generic drugs for opportunistic infections should be on '**essential drugs**' lists and made more widely available. Some of these drugs are useful for preventing a person getting an opportunistic infection in the first place, as well as for treating a person once they have developed an opportunistic infection.

* SPC HIV/AIDS and STD Project provide free information booklets on home-based care.

SECTION 1 First things First

Tuberculosis is the most common opportunistic infection in developing countries. Clinical tuberculosis develops again in about 30% of HIV infected people who have had tuberculosis in the past. There are also new cases of TB in HIV infected patients.¹³ In addition, tuberculosis spreads to non-HIV infected people in the population. Major epidemics of tuberculosis therefore accompany epidemics of HIV infection, making it important to treat tuberculosis both for the individual and the community. It is also important that countries develop policies and services offering HIV testing to people presenting with TB.

Short-course treatment of TB, with three drugs used for six months has been shown to be effective, but it has been difficult to ensure compliance with treatment. An approach of directly observing patients taking their treatment (DOTS – Directly Observed Treatment Short course) has been promoted by WHO and adopted in many countries of the world, including those in the Pacific region.¹⁴ The clinical condition of some patients with HIV/AIDS makes home-based care a necessity so there is a need to incorporate DOTS for TB into HIV/AIDS home-based care programs. This must be well managed to avoid the risk of increasing spread of tuberculosis and resistance to anti-TB drugs.¹⁵

Highly active anti-retroviral therapy (HAART)

There are three classes of drugs which act to prevent HIV from multiplying; though they do not remove the virus from the body. They are the nucleoside reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs) and the newer protease inhibitors (PIs). Zidovudine (or ‘AZT’) is an NRTI, which improves clinical signs and delays death from AIDS for a time; however, it has severe side effects and is expensive. These expensive anti-retroviral drugs need to be used in combinations that require close specialist surveillance of the patient, with good laboratory support and infrastructure.

TABLE 1.2
DRUGS USED IN HAART

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Protease Inhibitors (PIs)
Zidovudine (AZT)	Nevirapine (Viramune),	Indinavir (Crixivan)
Zalcitabine (Ddc)	Delavirdine (Rescriptor),	Nelfinavir (Viracept)
Didanosine (Ddi)	Efavirenz (Sustiva)	Ritonavir (Norvir)
Stavudine (D4T Or Zerit)		Saquinavir (Invirase)
Lamivudine (3TC Or Epvir)		
Abacavir (Ziagen)		

Name in brackets is the commercial brand of the drug

CHAPTER 1 Background information on HIV

Whilst the cost of anti-retroviral drugs is a major factor preventing many countries from making HAART available to people with HIV infection, it is not the only factor. Where health infrastructure is limited, this in fact may be the limiting factor to the delivery of HAART. The logistics of ensuring the patient has access to a continuous supply of several different drugs, that need to be taken regularly throughout the day, with extensive clinical/laboratory monitoring and management of side effects, is a major limitation to the provision of anti-retroviral therapy in many countries.

Current evidence indicates that HIV cannot be entirely eradicated with these drugs. HAART is *not* a cure. Rather the goal of anti-retroviral therapy is to keep the viral load as low as possible for as long as possible. When treatment stops, the amount of virus in the body increases again. Therefore the patient has to take the drugs for life, under constant supervision.

For further information about anti-retroviral therapy, and access to these drugs, please refer to the UNAIDS website: www.unaids.org

Where anti-retroviral treatment and prophylaxis for opportunistic infections are not available, people usually die within a short time of diagnosis of AIDS. Where intensive monitoring and treatment are available, people with AIDS may live for many years. In PICTs, the main causes of AIDS-related death are chronic diarrhoea, chest infection, cryptococcal meningitis, tuberculosis and disseminated Kaposi's sarcoma.

HIV vaccine development

Researchers are trying to develop two types of vaccine: one to prevent infection with HIV and the other to prevent progression to AIDS once someone is already infected with the virus. Researchers do not believe that there will be a vaccine widely available for at least 5 years.

Several potential preventive vaccines have undergone small trials in different parts of the world, but there have been no large-scale trials to test the efficacy of any HIV vaccine so far.

SECTION 1 First things First



1.7 Surveillance

Surveillance means collecting data regularly and systematically so that it is possible to follow trends in the prevalence of HIV infection in different groups within a population. It is not necessary to test everyone in a country to get a good picture of the extent of spread of HIV infection; it is more cost-effective to choose several groups from which samples are tested intermittently to build up a picture. This is called '**sentinel surveillance**'.

Unlinked anonymous testing is recommended. This means that blood specimens taken for other purposes has all identifying information (such as the person's name and address) removed, and is *then* tested for HIV antibodies. Voluntary, named testing should always be accompanied by counselling. Some people will decline to be tested and this means that the results of voluntary testing are biased and not useful for the purpose of surveillance.

It is important to understand the difference between anonymous unlinked testing for surveillance purposes, and mandatory or compulsory testing. In mandatory testing the person is tested for HIV antibodies without their informed consent. Mandatory testing infringes human rights and dignity, is impractical, extremely expensive and ineffective as a prevention and control measure.

CHAPTER 1 Background information on HIV

WHAT MAKES HIV INFECTION A PARTICULARLY DANGEROUS DISEASE?

- There is no cure or vaccine for HIV infection
- Anyone can become infected regardless of culture, custom or religion
- HIV/AIDS is a new epidemic
- HIV is still surrounded by widespread myths
- It is transmitted through private/sexual activities
- There is no way of telling if a person is infected just by looking – a blood test is required
- Millions of people are already infected
- The epidemic spreads very rapidly
- There is a long period of infectivity, when people with HIV are able to transmit the virus to others, but may not know that they are infected
- The long period of time between infection and illness makes the epidemic difficult to see
- HIV infection has an unpredictable course; people don't know when or how they might get sick
- HIV mutates (changes) regularly through an infected person's lifespan
- The infection of people in their most productive years (15-44 years) intensifies the economic and social impact of the disease
- HIV particularly affects minorities or stigmatised groups in many countries
- People living with HIV are still subject to widespread discrimination
- HIV is linked to poverty, areas of conflict, migration, lack of human rights, silence and shame.

1.8 The wave effect of the HIV epidemic

The impact of HIV is not just on the health of individuals – it affects the health of the community, it increases the burden of disease on the country and as such affects the whole nation. One way of understanding this is to see HIV as a wave.

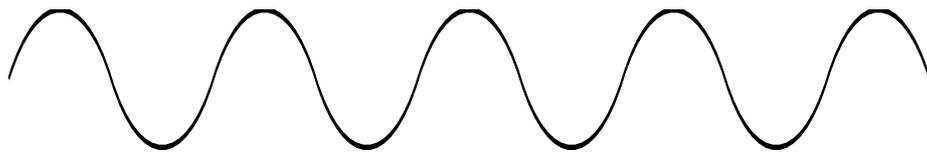
The HIV epidemic has an effect like the waves that are caused when a stone is dropped in a pond.

The way the waves evolve depends not just on where the stone is dropped and what's happening in that part of the pond. It also depends on the shape of the pond, how deep it is, and what else is going on in the pond at the same time.

SECTION 1 First things First

We can think about the way HIV relates to development in similar ways, as we will see in this exercise. The impact of the virus depends not just on who gets infected and what happens in their lives. It depends also on what is happening in the broader environment. For example, the impact will be affected by what is happening in the social, cultural, economic, religious and governance environments. Below, we have included an exercise that your team may want to complete, considering this idea of waves by taking a 'cross-section of the pond'. This exercise is a useful way to get team members to consider the wider impact of HIV/AIDS, beyond the health sector.

FIRST WAVE	SECOND WAVE	THIRD WAVE	FOURTH WAVE	FIFTH WAVE
Impact on the individual	Impact on others	Immediate social impact	Community impact over long term	Longer term impact on national development



The next section should be completed for each country situation

What might be happening now?

What influences this impact?

What can people do to change that?

References

1. Grosskurth H, Mosha F, Todd J, et al. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial. *Lancet* 1995;346:530-537
2. European Study Group on Heterosexual Transmission of HIV. Comparison of female-to-male and male-to-female transmission of HIV in 563 stable couples. *BMJ* 1992; 304:809.
3. Detels R, English P, Visscher BR, et al. Seroconversion, sexual activity, and condom use among 2915 HIV seronegative men followed for up to 2 years. *J Acquir Immune Defic Syndr*, 1989;2(1):77-83
4. Savarit D, De Cock K, Schutz R et al. Risk of HIV infection from transfusion with blood negative for HIV antibody in a West African city. *BMJ* 1992;305:498-501.
5. Davachi F, Nseka M, N'Galy B et al. Effects of an educational campaign to reduce blood transfusions in children in Kinshasa, Zaire. Fifth International Conference on AIDS, Montreal, 1989
6. Gibb D, Newell ML. HIV infection in children. *Arch Dis Child* 1992;67:138-141.
7. Tindall B, Barker S, Donovan B, et al. Characterization of the acute clinical illness associated with human immunodeficiency virus infection. *Arch Intern Med* 1988; 148 (4):945-9
8. From the Centers for Disease Control and Prevention. 1993 revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *JAMA*, 1993;269(6):729-30
9. WHO case definitions for AIDS surveillance in adults and adolescents. *Wkly Epidemiol Rec*, 1994;69(37):273-5
10. Duncan LE, Elliott AM, Tembo G, et al. Limitations of the WHO/CDC clinical case definition for AIDS in Africa. *Trop Doct*, 1994;24(1):11-2.
11. Nerad JL, Gorbach SL. Nutritional aspects of HIV infection. *Infect Dis Clin North Am*, 1994;8(2):499-515
12. Mead Over. *Confronting AIDS*. World Bank report: 1997
13. Narain JP, Raviglione MC, Kochi A. HIV-associated tuberculosis in developing countries: epidemiology and strategies for prevention. *Tubercle lung dis* 1992;73:311-21.
14. Morse DI. Directly observed therapy for tuberculosis. *BMJ*, 1996;312(7033):719-20.
15. Wilkinson D. High compliance tuberculosis treatment programme in a rural community. *Lancet* 1994;343:647-48.

SECTION 1 First things First

CHAPTER 2

Overview of the Strategic Planning Process

2.1 What is Strategic Planning?

Strategic Planning for HIV is a process that involves answering the following questions:

- | | |
|-------------------------------------------------|----------------------------------------------------|
| → What is the HIV/AIDS situation now? | Situation Analysis |
| → What has been done about HIV/AIDS/STI so far? | Response Analysis |
| → Where do we want to be in the future? | Goal formulation |
| → How do we get there? | Strategy formulation |
| → How are we going to do this? | Resource mobilisation and ways to sustain the plan |



Early in the global HIV/AIDS pandemic, most responses were based within the health sector. Planning of these responses tended to assume that the same intervention would produce the same result in every setting. As more was learnt about the epidemic, nations began to realise that what worked in one setting, would not automatically work everywhere.

SECTION 1 First things First

Understanding grew that to be able to plan effective responses, it was important to identify factors driving or slowing the epidemic in each setting. Instead of focusing on interventions or **activities** that had worked in other places, planning became more strategic in order to address specific situations.

2.2 Why do Strategic Planning?

HIV is a pandemic from which the people of the Pacific Islands are not isolated. The very real vulnerability of Pacific societies highlighted in the *Time to Act* report (UNDP, 1996) means that **now** is the time for Pacific Islanders to plan how to protect their communities, their families and themselves. Many responses to HIV/AIDS and STI have already been made in PICTs. Strategic planning builds on these efforts, and works to develop an expanded, coordinated, and locally appropriate response to HIV/AIDS and STI.

DEVELOPING LOCAL RESPONSES FOR THE DIVERSE PACIFIC ISLAND COUNTRIES AND TERRITORIES.

The 22 sovereign states of the Pacific Region are very diverse. Whilst there are some similarities between countries in the three sub regions of Melanesia, Polynesia and Micronesia there are also many differences. One of the key concepts of Strategic Planning is to investigate the specific situation in each country to find a locally appropriate solution. Each of the 22 Pacific Island Countries and Territories has specific strengths to build on, and may be vulnerable to the epidemic for quite different reasons. For example Tuvalu and the Cook Islands are both Polynesian nations, and there are some similarities between these two small countries. However there are also significant differences – the Cook Islands receive many thousands of international tourists every year, whereas Tuvalu is rarely visited by tourists. Therefore a response to HIV that works in Tuvalu can not just be transplanted to Rarotonga or Suva or Honiara or any where else for that matter – Strategic Planning is all about identifying local issues and developing local responses.

HIV/AIDS is a community responsibility. It is not just a problem for the health sector; there is a place for *everyone* to be involved in a strategically planned response to the epidemic. Expanding input beyond health officials and planning officers to include the views of a wide range of sectors, organisations and individuals is a key feature of the strategic planning process.

The experience gained over the last 20 years of the HIV pandemic has shown that the most effective national responses are those that have been designed by local people to address the specific situations that make people vulnerable to HIV in that country, as well as using the particular strengths of their country's people and institutions.

It is only by understanding what is actually happening in a country, what has worked in the past, and why responses haven't worked, that those developing a plan can decide their nation's priorities in responding to HIV/AIDS.

CHAPTER 2 Overview of the Strategic Planning Process

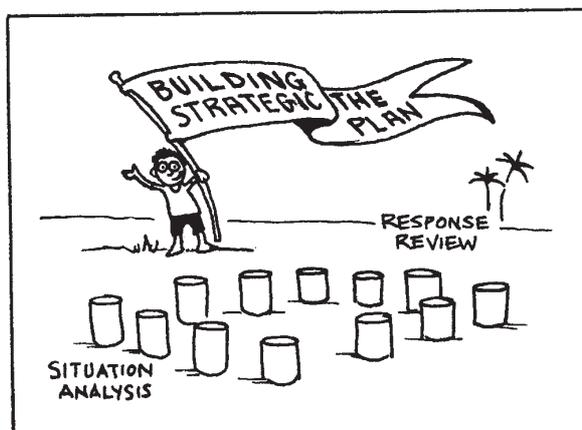
2.3 What are the features of a Strategic Plan?

A good strategic plan:

- is multi-sectoral, i.e. involves a variety of organisations, government, non government, community based, church and private sector (business), in the response
- is one where all stakeholders participate in its development from the beginning, working as a team
- identifies resources available, and resources required
- defines strategies to obtain the support of key leaders, influential individuals and groups
- includes initiatives (activities) that are technically sound
- includes initiatives that are feasible in that community
- includes strategies to build the capacity of those who will implement the plan
- is not based on one or two people, their personality and energy, but rather is institutionalised (part of the way organisations operate) to ensure its sustainability.

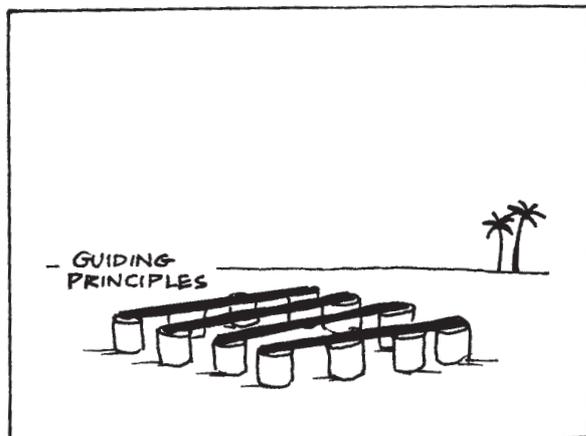
2.4 How do you build a Strategic Plan?

It's not an easy job to build a plan with all these features – there is no simple formula, and care must be taken to include all the components. Building a strategic plan can be pictured in a similar way to building a house.

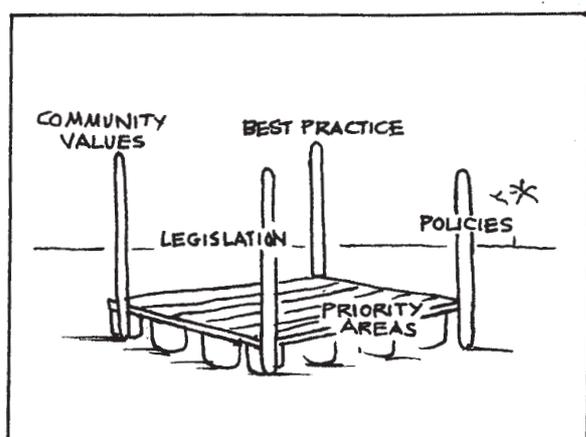


The **Situation Analysis** and **Response Analysis** are the foundation for the strategic plan. In order to have a solid house, we need strong information gathering and analysis, which involves a lot of digging and excavation. The foundations must be broad and strong enough to last.

SECTION 1 First things First



Guiding principles are the bearers or timbers laid down on top of the foundation posts. Guiding principles are the moral and ethical values that underpin a strategic plan.

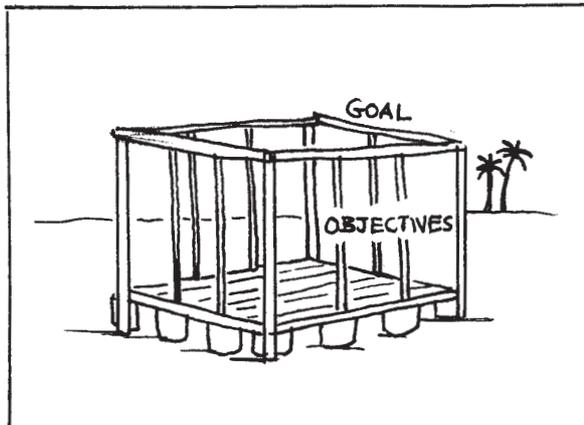


The corner posts of the strategic plan are **community values, best practices, legislation and policies**.

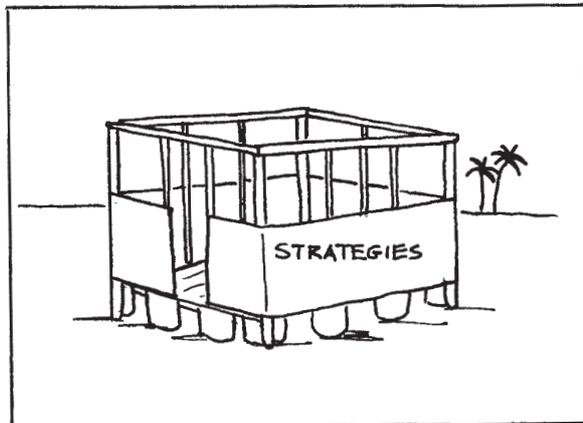
- Community values can strongly influence and support protective behaviours and preventive interventions.
- 'Best practice' comes from lessons, and experiences of what has worked well in dealing with HIV/AIDS/STI, in that country and also lessons from other countries.
- Legislation (national and international laws), and policies create the official written framework for consistent and effective ways of dealing with HIV/STI.

The house floor can be divided into rooms, each with a different focus – for example an area for eating, and an area for sleeping. The plan will also focus on different priorities – the **priority areas**. For example your country may decide that you need a 'room' for control of STIs, a 'room' for ensuring safe blood products, and a 'room' for people living with HIV/AIDS. There can be as many 'rooms' as the country needs.

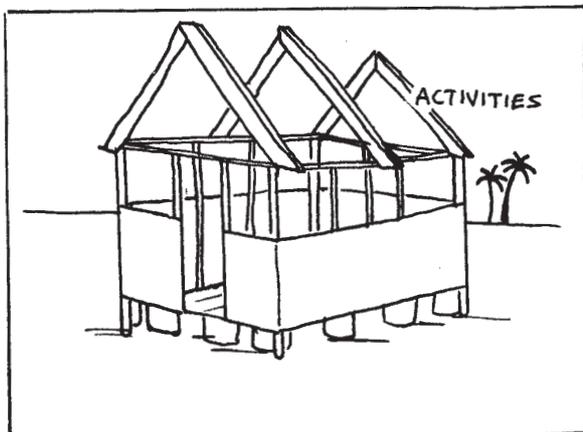
CHAPTER 2 Overview of the Strategic Planning Process



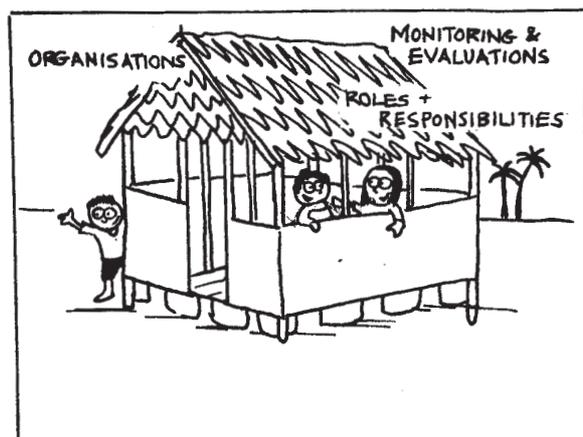
The wall frame and wall studs of this house are formed by the **goals** and **objectives** of the plan. Defining the right goals is a key feature of developing the plan. Within each goal you need to develop objectives, which define different behaviours or situations that need to be addressed, to reach your goals.



The walling represents **strategies**, which are the methods we use to cover or achieve the objectives. They provide the protection for the people and rooms inside.



Once we have enough strong walls we can plan **activities**. The activities are the rafters which will support the roof, and provide the protection for the people underneath.



The roofing material is what is needed to complete this house. To complete the strategic plan we need to specify

- Which **organisations and individuals** are to be involved?
- What are their **responsibilities**?
- How are we going to **monitor and evaluate** the plan?

Then we will have a complete plan 'house'.

SECTION 1 First things First

2.5 Where to start?

It is often difficult to see where to start, especially in the face of resistance and sometimes hostility to the issues of HIV/AIDS/STI. It is important to remember to start with what you **can** do. Why were you, or your organisation, chosen to be part of the HIV/AIDS/STI response? What role can you play? What strengths do you and your organisation have that you can build on? It is important to remember to work within your resources and within your mandate – strategic planning for HIV/AIDS/STI can be a long process, and no one person should try to do everything.

A good place to start is to work in partnership with organisations that have already shown their interest and commitment to the issue. Others can be brought into the process through lobbying, advocacy and by demonstrating the success of those activities that are already underway. Chapter 11 discusses developing an institutional framework – allocating roles and responsibilities, and pulling in commitment of new organisations.

Planning for HIV/AIDS/STI should not be done in isolation. Working with a range of organisations and sectors broadens the planning knowledge base, and ensures that any plan developed fits in with existing planning frameworks, policies and priorities. By trying to integrate HIV/AIDS/STI responses into other plans and policies, there is less competition for resources, greater sustainability and an increased sense of community ownership.

FITTING IN WITH EXISTING PLANNING PROCESSES – AN EXAMPLE FROM GUAM

To qualify for US Federal HIV prevention funding, the Guam health department must meet the requirements of the US Centers for Disease Control and Prevention (CDC). One of CDC's requirements is that Guam has an active Community Planning Group (CPG), which is mandated to develop an annual HIV prevention plan. This planning process involves review of the epidemiology of HIV/AIDS and STI, and development of annual activities to address the needs of the Guam community.

It was vital that any strategic planning process in Guam was integrated with this existing planning process. The CPG played an integral part in the development of a five-year Strategic Plan for Guam, which addressed cultural, socio-economic and demographic factors fuelling the epidemic in Guam and Micronesia as a whole. In the words of Bernie Provido-Schumann, Supervisor of the HIV/STI Prevention Program, "This Strategic Plan is a complimentary extension of the CPG HIV Plan. It is intended to further address the threat of HIV/AIDS in our island with the ultimate goal of preventing much devastation to our people as well as our fellow Micronesian brothers and sisters... This Strategic Plan provides broad guidelines and objectives from which specific programs can be developed for specific situations".

CHAPTER 3

Strategic Planning Skills

This chapter describes the skills we need to break down the planning for a complex problem such as HIV/AIDS and STI, into manageable parts. These strategic planning skills are:

- analysis
- gap analysis
- summarising
- prioritising
- objective based planning
- identifying obstacles
and
- identifying opportunities

All these skills are involved in strategic thinking and planning. In this chapter we will briefly explain these skills and some simple tools to use.

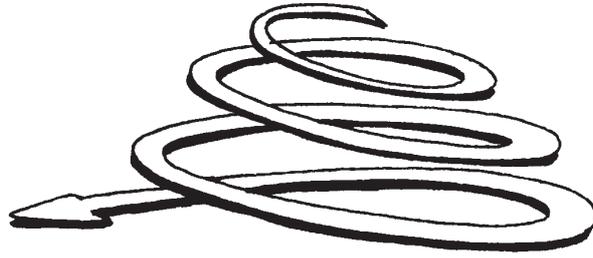
3.1 Analysis

Analysis means to break things down or separate them into components or parts. Analytical skills are needed to break down the many behaviours and situations that inhibit or enhance the spread of STI/ HIV/AIDS and a country's responses to the problem. We have seen in the overview in Chapter 2 that the first stage of building the strategic plan is to conduct a Situation Analysis and Response Analysis. We also use analysis when designing the plan to examine each aspect of the **multisectoral** response and what interventions need to be included.

If the quality of our analysis is weak or limited, then the plan that results will also be weak and limited.

SECTION 1 First things First

Strategic planning is a cyclical process, with analysis used throughout. You may not have all the information that you require at the start, but can collect and analyse it as you go.



A simple method of analysis is to ask **key questions** about any situation. Key questions:

- allow us to look at component parts of an issue, situation, or problem and to be specific;
- help us to ask the right questions to get the right information;
- are like keys to the door of a house that let us look inside the situation or problem.

The six key questions are:



We use key questions in many parts of the strategic planning process. You will see that we use this approach throughout this manual. For example in the introduction we asked: **What** is HIV? **How** do you get it? **What** puts people at risk? And so on.

In a Situation Analysis, the overall question we ask is “**Where are we now?**”. Then we break down the problem of doing the Situation Analysis by asking key questions such as: **What** situations do we need to analyse? **What** information is needed? **How** can we gather information? **Where** are the most cases? **Who** is vulnerable to HIV infection? **Why** are they vulnerable?

3.2 Gap analysis – what is missing?

Key questions can be applied to identify **gaps** in our knowledge, i.e. to identify what is known and also what is **not known** about the HIV situation. Gaps analysis also examines gaps in programs, activities, services and target groups.

Gap analysis is a vital skill that is applied throughout the process of analysis and planning. For example in a Response Analysis we ask: **What** is working/not working? **Why** is the response working/not working? **What** is working and can be expanded? **What** is not working and needs a new approach? **What** is not relevant and could be dropped? **What** has not been addressed at all?

Gap analysis should be also be applied when a plan is being reviewed or revised. We can also ask questions like **What** new issues need to be addressed? **What** is no longer relevant?

3.3 Summarising

A summary is a brief abstract or list of important points. It is easy to become lost in details that emerge from analysis of a complex issue like HIV/AIDS. An important skill is to summarise the main issues and details in a list or a matrix in order to keep sight of the essential points. When the situation and response analyses have been completed, the results need to be summarised in point form or tables.

For example, the original *Situation and Response Analysis from the Solomon Islands* is a very thorough and complete document of several hundred pages. However, by producing a summary matrix of only 21 pages, it was possible to focus on the most important points from all the information gathered. This summary matrix made it easy to get to the key facts quickly.

There is no one correct way of summarising a large document such as a Situation Analysis. Lists of key points may be helpful, as may be tables listing factors which inhibit the spread of HIV/AIDS in one column (protective factors), with factors which drive the spread of HIV/AIDS in another. An example of summarising text that was done by the authors of the Solomon Islands Situation and Response analysis “*Chance Chance Nao Ia*”, Holly Buchanan, Ken Konare and Abraham Namokari, is shown on the next page.

SECTION 1 First things First

SUMMARISING

– AN EXAMPLE FROM THE SOLOMON ISLANDS SITUATION AND RESPONSE ANALYSIS “CHANCE CHANCE NAO IA”

ORIGINAL TEXT: AN EPIDEMIOLOGY OF STI

Sexually transmitted infections are listed as a major cause of morbidity for adults and young people, and are increasing in urban and rural urbanizing centres. There have been steady increases between 1992 and 1998. The most common are gonorrhoea, syphilis, chancroid, genital warts and genital herpes; chlamydia, gonorrhoea, and syphilis are the most prevalent, and PID and infertility is increasing in young girls. Penile and vaginal discharges are signs related to gonorrhoea, chlamydia and trichomonas. Honiara and Rennel and Bellona have the highest incidents of gonorrhoea (Konare 1999).

Table 1: STI Penile and Vaginal Discharges 1992 – 1998 Source: HIS

Year	1992	1993	1994	1995	1996	1997	1998
Cases	398	902	944	1182	1876	1801	2134

Penicillin resistance to gonococcus infections was a major problem but new treatment protocols with the syndromic approach have had positive effects as it has reduced from 54% to 15 % over the past ten years.

Table 2: Penicillin Resistant Gonorrhoea 89 – 98 Source: GASP Central Hospital

Year	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
% Resistant	54%	57%	40%	41%	37%	38%	30%	32%	33%	15%

Genital ulcers have also increased and are caused by syphilis, chancroid, and genital herpes. These are higher in the Western Province and are of concern as they can increase risks of HIV infection (Konare 1999).

Table 3: Genital Ulcers 1982 – 1998 Source: HIS

Year	1992	1993	1994	1995	1996	1997	1998
Cases	44	101	226	282	383	396	381

Cases of primary and latent syphilis are also tested using VDRL at Central Hospital and these are not included in the above cases of genital ulcers.

Table 4: TPHA (VDRL) Tests 1990 – 1998 Source: C. H. Medical Lab.

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998
Positive Cases	234	510	435	470	789	802	1,097	1,333	2,075

So while rates of genital ulcers may appear low from a variety of possible causes, of which syphilis is one, the actual rates of reported cases of syphilis must be understood from all sources. As such the actual overall total for reported STI in the Solomon Islands in 1998 would include 2,075 cases of syphilis, 2,134 cases of penile and vaginal discharges and 381 cases of genital ulcers, totalling 4,590.

CHAPTER 3 Strategic Planning Skills

SUMMARISING (CONTINUED)

STI are underestimated as poor documentation does occur in the health system, and not all case data from service points outside the health system are available. For example those who go to private doctors, kastom healers, those who go to Central Hospital, or who treat themselves with antibiotics (Afeau and Nukuro 1995, Konare 1999). The inadequate supply of VDRL testing kits limit the people who would otherwise be tested from particular groups, e.g. ante-natal mothers thus diminishing the possibility of detecting existing STI. There are times when Central Hospital runs out of VDRL testing kits because of delays in their arrival. For example, from September to early November 1999 there were no testing kits at Central Hospital. Discrepancies can also occur in the data in Honiara and from the provinces. Ages given in the HIS are not useful as they are indicated as <5 and >5, thus it is difficult to determine the actual age groups with the highest prevalence rates of STI. In one set of data from the Honiara Town Council ages were recorded. In 1998 over 87% of all cases treated in town clinics were between the ages of 15 and 30, 45% were between the ages of 15 and 20, and the majority were unmarried and male (Punufimana 1999). This data reinforces the importance of a focus on youth.

STI and increasing teenage pregnancies are indicators of unsafe sexual practices and show increased risk behaviors in relation to HIV/AIDS (Konare 1999). STI are also cofactors in the transmission of HIV, particularly those where genital ulceration occurs.

Treatment Seeking Behaviors and Kastom Medicines for STI

Treatment seeking behaviors to kastom healers, hospitals, clinics or self-treatment, are based on a complex of factors. Some of the reasons given for delaying treatment, or for choosing one particular treatment or service over another were based on economics, proximity to particular services, embarrassment, fear of having one's name written in the STI book, fear of information not being kept confidential, the belief in the efficacy of one treatment over another for sexually transmitted infections, and the negative attitudes and questions of health workers (Field data, 1999).

Kastom medicine has a long history in the Solomon Islands and it can be the first treatment by young people for STI (Hall et al. 1998b). In interviews young people also commented on their knowledge of kastom medicines for gonorrhoea and syphilis. Health policies exist that support the integration of healers into the health system (MHMS 1986, MHMS 1990, MHMS 1997a), but little progress has been made in the implementation of objectives concerning kastom healers (Buchanan 1998). There is a gap in our understanding of the roles of kastom healers in relation to the treatment of STI, of their knowledge and attitudes towards STI/HIV/AIDS, their attitudes towards condom use, and of the roles that they could play in the prevention of STI/HIV/AIDS.

SECTION 1 First things First

SUMMARISING (CONTINUED)

SUMMARY

This page and a half of dense text was summarised into the following easy-to-read, manageable table:

EPIDEMIOLOGICAL CONTEXT

	Facilitating factors which will enhance the ability of the nation to prevent the transmission of HIV/STI (Opportunities)	Inhibiting factors which frustrate or impede the ability of the nation to prevent the transmission of HIV/STI (Obstacles)
Health Profile	<ul style="list-style-type: none"> • Reduction in Penicillin Resistant Gonorrhoea • People use Kastom healers and collaboration with Kastom healers is crucial for STI treatment, condom distribution and education 	<ul style="list-style-type: none"> • Endemic diseases in the country e.g. Malaria, ARI and TB cause high morbidity and mortality and this makes HIV seem not as important • High rates of genital ulcers caused by syphilis, chancroid & herpes • Lack of confidentiality re: STI treatment • Increasing Penile and Vaginal discharges • High levels of teenage pregnancy • Lack of integration of Kastom healers into the health system • Lack of understanding about the knowledge of kastom healers re: HIV and their potential roles
STI		
Pages 9 – 11		

CHAPTER 3 Strategic Planning Skills

3.4 Prioritising

Prioritising means putting things in order of importance. Once an analysis has been completed and summarised, we need to place the issues in the summary matrix into levels of importance or priority. We need to decide:

- what aspects of the response to STI/HIV/AIDS are the most important to work on
- what situations and behaviours are the most important to address first
- what are the most important or useful strategies to use
- what is achievable with the resources available.



Tools for prioritising

Following is a description of two simple tools for prioritising: a scoring tool and a priority-mapping tool.

A **scoring tool** requires a value or score to be given to an issue or an area of the HIV/AIDS response. If a strategic planning committee or workshop is using the tool, individual members of the committee/workshop can give their own score for each area and the results can be totalled. The scoring tool helps the committee or workshop to allocate which areas to work on and to plan the order of their work.

SECTION 1 First things First

For example, in developing a strategic plan for Pohnpei (Federated States of Micronesia), the response to HIV/AIDS was divided into seven focus areas, which are shown in the table below. The participants in the planning workshop were asked to think about each focus area, as they moved through the following process:

1. For each focus area, participants were asked to give a score from 1 to 4, where 1 is a very high priority, 2 is a medium priority, 3 is a low priority and 4 is not a priority at all.
2. It is important to clarify that participants were asked to score *each* area, not to pick their top four. If a person thought three different areas of the plan were a 'very high priority' for Pohnpei then they gave each of these focus areas a score of 1. If they thought two areas were very unimportant in Pohnpei, then they could give both those areas a score of 4.
3. The scores given by the 20 workshop participants were then added up. For example seventeen people thought the area of "Support and caring for people living with and affected by HIV" was a very high priority for Pohnpei, two people thought it was a medium priority and one a low priority. To get a score for this focus area you can multiply the number of people by each score (e.g. 17 x 1 added to 2 x 2 added to 3 x 1 = 24).
4. Because the highest priority is given the lowest score, the focus area that has the lowest score is the highest priority.

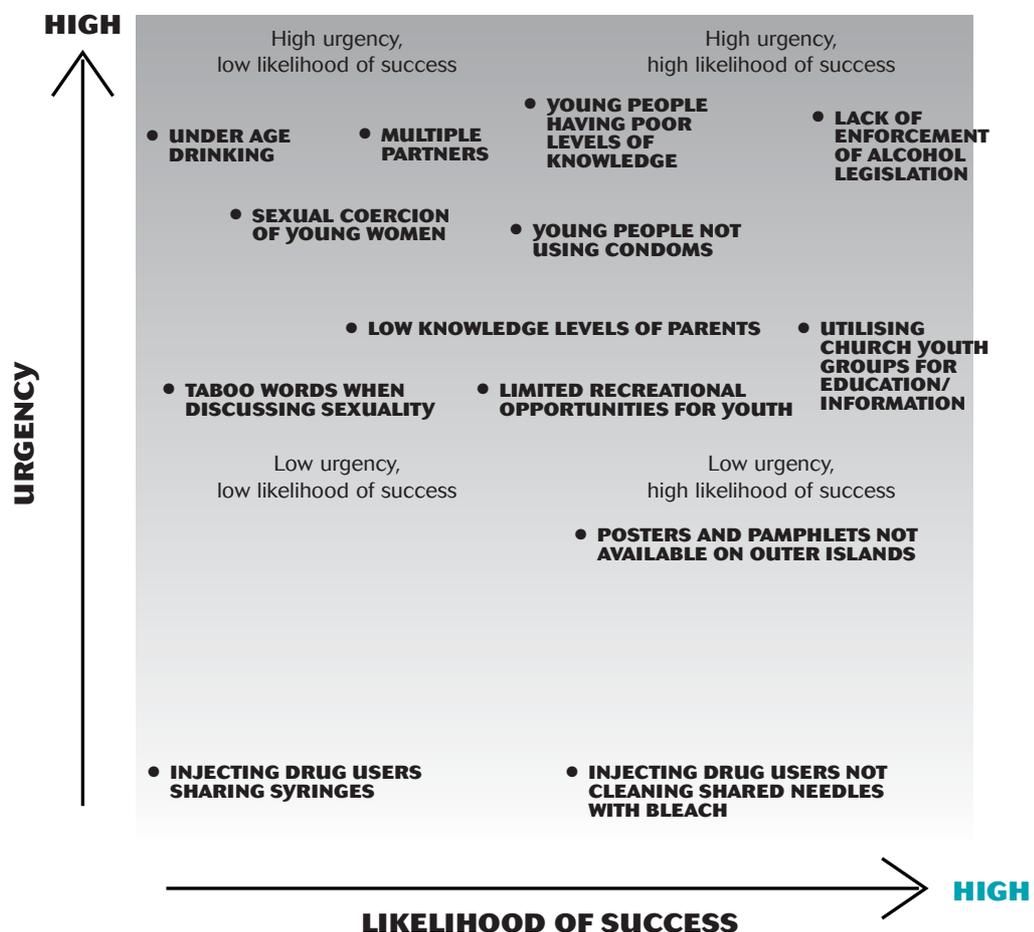
Focus Areas of the STI/HIV/AIDS response	Number of people scoring				Total score	Priority ranking
	1	2	3	4		
Reducing the vulnerability of specific groups and promoting safer sexual behaviours	20	0	0	0	20	=1
Coordinating the multisectoral response to STI/HIV/AIDS	20	0	0	0	20	=1
Preventing and controlling Sexually Transmitted Infections	18	2	0	0	22	2
Provision of safe blood supplies	18	1	1	0	23	3
Support and caring for people living with and affected by HIV	17	2	1	0	24	4
Human rights and HIV/AIDS	16	3	1	0	25	5
Promoting safer drug injecting behaviour	0	4	2	14	70	6

From this scoring tool, the workshop participants were able to see that the most important priorities for Pohnpei were coordination of the multisectoral response and reducing the vulnerability of specific groups and promoting safer sexual behaviour. Four of the other focus areas were also ranked as high priorities, with only one (promoting safer drug injecting behaviour) not ranked as important at all. This exercise made it easy for the workshop participants to know what focus areas to start work with first.

CHAPTER 3 Strategic Planning Skills

A different method of prioritising is to use a mapping tool. A **mapping tool** can be used to rank items according to urgency (how urgent it is) and likelihood of success (how successful interventions are likely to be). Behaviours, situations, or risk groups can be mapped like a graph with the behaviour, situation or group positioned higher up the map if it is thought to be more urgent, and further across the map if intervention in this area is thought more likely to succeed.

The example below shows how workshop participants in Tuvalu prioritised behaviours and situations that needed to be addressed to reduce the vulnerability of young people in their community:



If it is difficult to decide exactly where along the continuum to place a behaviour or situation, we can just place it in one of the four quarters. Then when it comes to planning it is easy to start with priorities in the top right hand quadrant (high urgency, high likelihood of success), then the left hand quadrant (high urgency, low likelihood of success).

We can also use this type of mapping tool to prioritise strategies (see Chapter 9 on strategies). You can also change the parameters to another criteria such as cost, rather than likelihood of success.

SECTION 1 First things First

3.5 Objective based planning

Objectives answer the questions:

- What behaviour or situation do you want to address?
- What change do you want to achieve?

Having prioritised which behaviours, situations and groups are most important in each area, the next essential skill is to develop objectives. This is key to strategic planning. If the behaviour or situation and groups are well defined and the *changes* to be achieved are also clearly defined, then the plan can specifically outline how this is going to be done using strategies and activities. It is important to understand the differences between objectives, strategies and activities. We will be defining these in Chapter 7 and help you to write them in such a way as to make the distinctions between these levels of a strategic plan clear.

3.6 Identifying obstacles and opportunities

Another essential skill in strategic planning is to identify **obstacles** and **opportunities** for changing behaviours and situations that lead to HIV/AIDS. Changes of behaviour or in situations will not happen unless obstacles can be overcome. Opportunities can be identified which already exist and have the potential to become strategies or activities. These opportunities can be used to create change or overcome obstacles. An example of an obstacle may be that young people do not worry about the risk of STI/HIV (they don't think it will happen to them). Another obstacle may be that young people say they do not like using condoms, they prefer 'skin to skin'. An opportunity however may be that youth and parents worry about unintended pregnancy and its effects. This opportunity could be utilised to overcome the obstacles mentioned above. Condoms could be promoted for their benefits in preventing pregnancy and reducing anxiety.

Everyone involved in responding to HIV/AIDS/STI will bring their own ideas and agenda to the response. Conflict between stakeholders is potentially a significant obstacle to successfully expanding the response to HIV/AIDS and STI. Facilitation of groups working together, negotiating conflict and ensuring ongoing dialogue between all involved in the response is an important strategic planning skill – and builds on the important opportunity that exists when a wide range of people bring their ideas and experiences into the planning process.

CHAPTER 3 Strategic Planning Skills

Conclusion

Strategic planning is a structured process of thinking about a problem and its solutions. By using the tools and questions outlined in this chapter, we can begin to break down the complex problem of STI/HIV/AIDS to develop a clearly structured multisectoral plan. The skills of strategic planning are very useful and can be applied to many other problems in our work and our lives. We do not have to be overwhelmed or made helpless by problems if we can systematically tackle them with clear steps, clear thinking, and clear planning.

OVERHEAD

What is HIV?

- HIV is the Human Immunodeficiency Virus. HIV causes the body's immune system to break down. A person infected with HIV is less able to fight off bacteria, other viruses and some cancers. Eventually a person infected with HIV will develop illnesses that they can't resist. The pattern of illness caused by HIV infection is known as the Acquired Immune Deficiency Syndrome or AIDS.
- Once infected with HIV, a person is infected for life.

How do you test for HIV?

- Rapid and simple tests for HIV infection are now widely available, using a person's blood or saliva. These tests do not test for HIV itself, but rather for HIV antibodies (molecules formed by the body in response to infection).
- Because the test is for antibodies, there is a *window period* of up to three months where a person may be infected with HIV but not have made enough antibodies to show up on a test. In this case a person will have a negative test result, even though they actually have been infected with HIV and are infectious.

OVERHEAD

How is HIV spread?

- Through sexual intercourse
- Through blood
- From mother to child

How do you treat HIV?

- There is no cure for HIV.
- Treatment is available for the infections and illnesses that a person may develop as their immune system weakens. Often this treatment involves simple and inexpensive drugs.
- Treatment is also available for HIV related symptoms such as fever, headache, sweating and diarrhoea.
- Treatment to prevent HIV from multiplying in the body is known as anti-retroviral therapy. *Anti-retroviral therapy* does not cure a person from HIV infection, but keeps the amount of virus in the body low. Anti-retroviral drugs are currently expensive (though getting cheaper), and require close medical surveillance of the patient. These drugs need to be taken regularly and for life.



SECTION 1 First things First

OVERHEAD

What is Strategic Planning?

A process that involves answering the following questions:

- Where are we now?
- What has been done about HIV/AIDS/STI so far?
- Where do we want to be in the future?
- How do we get there?
- How are we going to do this?

OVERHEAD

What are the features of a good Strategic Plan?

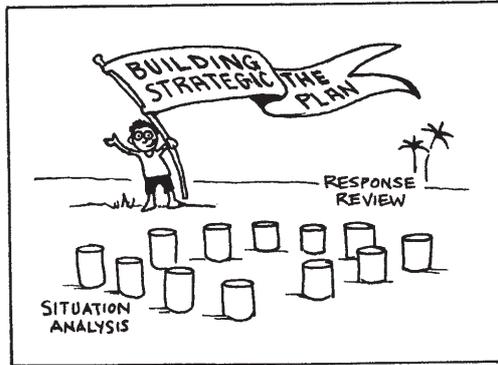
A good strategic plan:

- is multi-sectoral, i.e. involves a variety of organisations, government, non government, community based, church and private sector (business), in the response
- is one where all stakeholders participate in its development, working as a team
- identifies resources available, and resources required
- defines strategies to obtain the support of key leaders, influential individuals and groups
- includes initiatives (activities) that are technically sound
- includes initiatives that are feasible in that community
- includes strategies to build the capacity of those who will implement the plan
- is not based on one or two people, their personality and energy, but rather is institutionalised to ensure its sustainability.

SECTION 1 First things First

OVERHEAD

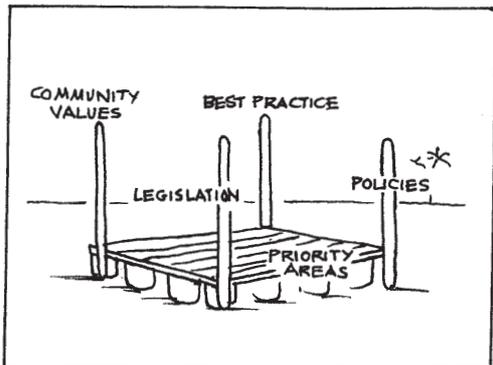
The House Model of Strategic Planning



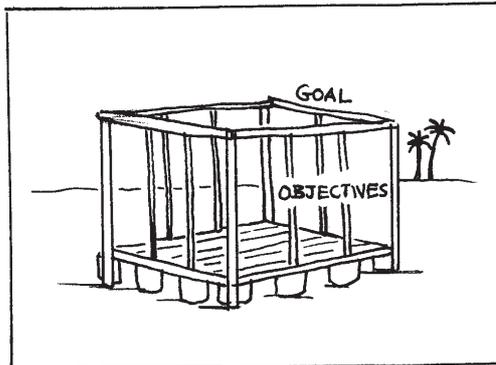
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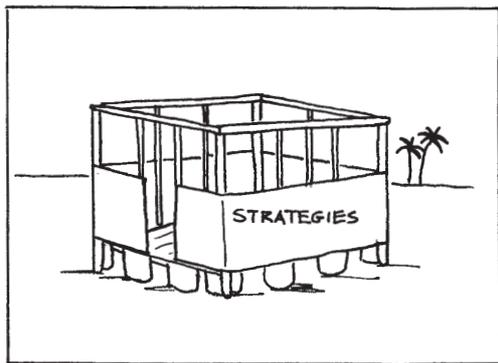
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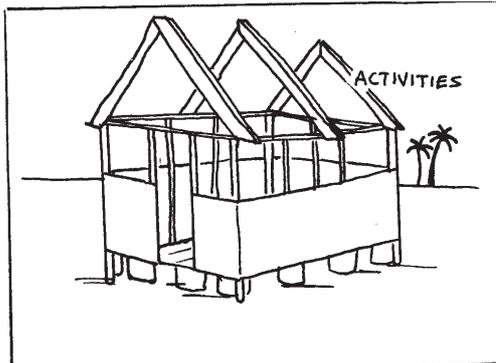
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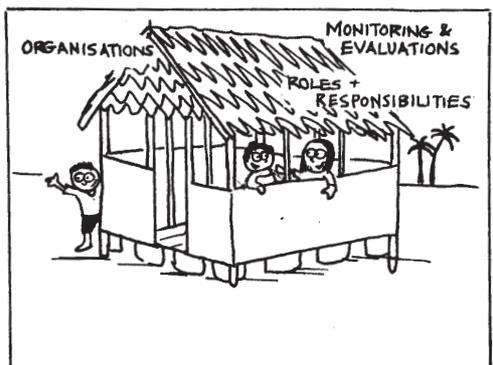
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5



6



7

OVERHEAD

What are the key skills required for Strategic Planning?

- Analysis
- Gap analysis
- Summarising
- Prioritising
- Objective based planning
- Identifying barriers
- Identifying opportunities

The six key questions for analysis are:

What? Why? When? How? Where? and Who?

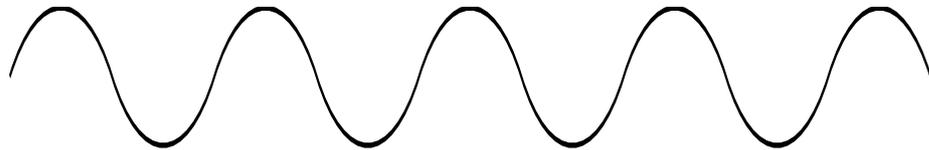


SECTION 1 First things First

OVERHEAD

The Wave Exercise

FIRST WAVE	SECOND WAVE	THIRD WAVE	FOURTH WAVE	FIFTH WAVE
Impact on the individual	Impact on others	Immediate social impact	Community impact over long term	Longer term impact on national development



The next section should be completed for each country situation

What might be
happening
now?

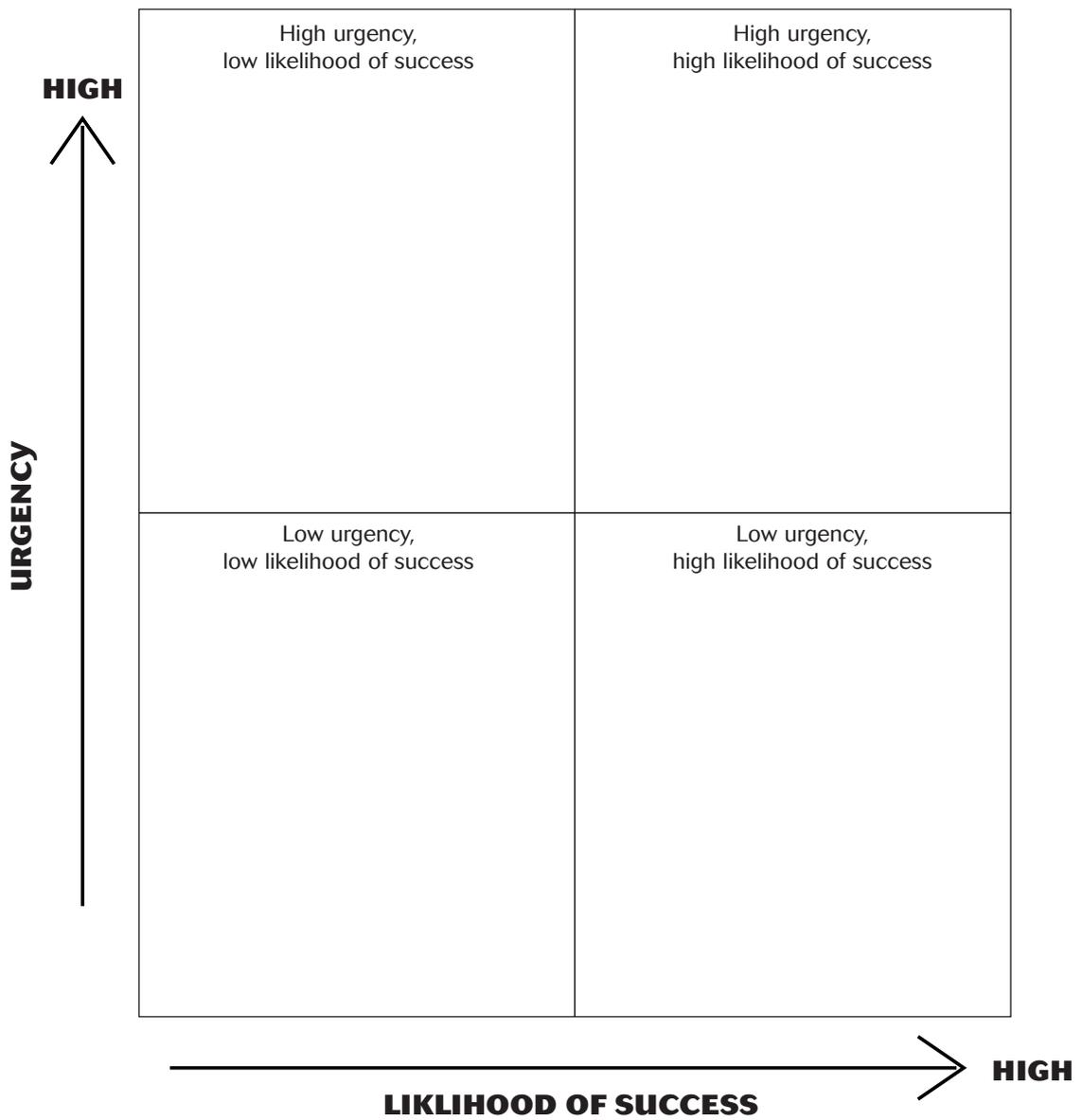
What
influences this
impact?

What can
people do to
change that?

SECTION 1 First things First

OVERHEAD

Prioritisation tool



SECTION 1 First things First