HIV & AIDS Leadership Development Toolkit
A Tool for Provincial Departments of Health in South Africa

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### Glossary of Terms and Acronyms

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<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretrovirals</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>AZT</td>
<td>Zidovudine</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural sentinel surveillance</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organisation</td>
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<tr>
<td>CCMT</td>
<td>Comprehensive Care, Management and Treatment Programme</td>
</tr>
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<td>CDC</td>
<td>U.S. Centers for Disease Control and Prevention</td>
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<tr>
<td>CDC-SA</td>
<td>CDC South Africa</td>
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<tr>
<td>CME</td>
<td>Continuing medical education</td>
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<tr>
<td>CSW</td>
<td>Commercial sex workers</td>
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<tr>
<td>D4T</td>
<td>Stavudine</td>
</tr>
<tr>
<td>ddI</td>
<td>Didanosine</td>
</tr>
<tr>
<td>DHIS</td>
<td>District health information system</td>
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<tr>
<td>EFV</td>
<td>Efavirenz</td>
</tr>
<tr>
<td>GIPA</td>
<td>Greater involvement of people living with HIV/AIDS</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HBC</td>
<td>Home-based care</td>
</tr>
<tr>
<td>IDU</td>
<td>Intravenous drug use</td>
</tr>
<tr>
<td>LPV</td>
<td>Lopinavir</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MCC</td>
<td>Medicines Control Council</td>
</tr>
<tr>
<td>MEC</td>
<td>Member of Executive Council</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NASTAD</td>
<td>National Alliance of State and Territorial AIDS Directors</td>
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<tr>
<td>NDOH</td>
<td>National Department of Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NVP</td>
<td>Nevirapine</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>U.S. President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People living with HIV &amp; AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing mother-to-child transmission of HIV</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for proposal</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RTV</td>
<td>Ritonavir</td>
</tr>
<tr>
<td>SANAC</td>
<td>South African National AIDS Council</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TOT</td>
<td>Training of trainers</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>UN Joint Programme on HIV/AIDS</td>
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<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>3TC</td>
<td>Lamivudine</td>
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</tbody>
</table>
Introduction
South African provincial departments of health aim to ensure the health of the population from health education to childhood immunisations to disease-specific health programmes. As a manager within the HIV & AIDS Directorate, one’s work requires both an understanding of programmatic issues, as well as budgets, communications and programme management.

Rewards
A senior health department staff discusses the meaningful career as a HIV & AIDS director and its rewards:

Working in public health at the international, national and state level has been rewarding yet challenging. One of the aspects I found the most rewarding was working collaboratively with stakeholders. These stakeholders were sometimes interested public citizens, clients, implementing agencies, legislators and other politicians as well as funders. Often times, I was asked to develop guidance to better explain either what could be expected of our public health service and/or what a particular public health service could be expected to deliver. In Ethiopia, after going out into the field, observing activities and talking with volunteers conducting the Community Conversations intervention we set out to develop a leaflet that would be used by staff as a reminder of the key messages to give the public. I found that responding to these requests not only strengthened relationships with stakeholders but also helped me in critically thinking about our programmes as well as about my own and other staff’s knowledge and skill set. Additionally, having produced reports, manuals and tools for staff gave me products that I could share with our funders and colleagues.

I hope that you regularly reference this toolkit to the point that the edges of the pages are worn and ragged! If this toolkit sits on your shelf and collects dust, then it will not be of any use. Please use it, mark it and maybe even revise it. Thank you for your time and attention. May your work continue to be fruitful and rewarding.

Challenges
• Understanding your HIV & AIDS and STI programme—knowing internal systems, external inputs, provincial policies and the political power structure—to ensure positive outcomes.
• Identifying district, provincial and national reliable and knowledgeable resources.
• Knowing and understanding funding sources of the programmes, in terms of access, requirements and reporting.
• Understanding the scope of work and the resources to accomplish the programme objectives.

Toolkit organisation
The toolkit is organised into three sections: (1) programmes, (2) data and (3) policy:
• Section one provides an introduction to HIV & AIDS and public health, followed by individual chapters on specific components of a comprehensive HIV & AIDS programme including prevention, care and treatment, sexually transmitted infections and blood safety.
• Section two focuses on data, information and data are a cornerstone of effective HIV & AIDS programmes, the subsequent chapters focus on HIV surveillance and programme evaluation, evidence-based planning and monitoring and evaluation.
• Section three represents policy and how the provincial department of health can respond to specific policy issues; the specific chapters cover people living with HIV & AIDS involvement in planning and advising, programme administration, contract management and an overview of key international donors and donor coordination.

In conjunction with the three sections, there is an online resource that contains South African guidelines, sample forms and documents, as well as other resources developed by NASTAD.

This is not an exhaustive list of all issues that you face within the provincial health department; it seeks to provide key issues and resources to assist you in your position. This toolkit is an evolving document as guidelines and policies change to respond to shifting priorities and needs.

See online resource for more information: http://www.nastad.org/Programs/GlobalAIDS/GlobalAIDSRsourceMaterials.aspx
Introduction

Human Immunodeficiency Virus (HIV) is the virus that causes AIDS. HIV invades a certain kind of blood cell—CD4+ T cell (helper cell)—which is crucial to the normal function of the human immune system. Once inside the CD4+ T cell, HIV replicates itself, destroying the T cell in the process. HIV infection therefore results in the gradual destruction of the body’s immune system, leaving the body defenceless against life-threatening infections.

Why don’t our bodies develop antibodies to HIV which could destroy the virus once we are infected?

When a virus or some other infectious agent attacks the body, the body usually responds by developing antibodies to destroy the infection. While the body does produce antibodies to HIV, they are powerless to destroy HIV, since they cannot rid the body of virus that has already penetrated the various cells of the immune system.

Is there a vaccine against HIV infection, or a cure for HIV infection?

There is not a vaccine or cure for HIV infection yet. The HIV virus evolves and changes rapidly, making it very difficult to develop an effective vaccine. However, there is effective treatment and a number of drugs have been developed that can help slow HIV replication. Usually these drugs are prescribed in combination, and decisions on how and when to use these drugs are highly individualised, and require fairly complex diagnostic procedures. Drug treatment for HIV is known as antiretroviral therapy (ART). (See Chapter 4: Care and Treatment, for more information)

How is HIV transmitted?

HIV is contained in blood, semen, vaginal secretions and breast milk, and is transmitted through blood-to-blood and sexual contact, as well as through breast feeding.

Sexual transmission (See both, Chapter 4: HIV Prevention and Chapter 6: Sexually Transmitted Infections)

Risk of acquiring HIV sexually varies according to:

- **Type of sexual practice**—anal sex practices are higher risk for transmission of HIV to the recipient partner, since this practice often results in cuts and tears in the anal area through which HIV can be transmitted. Vaginal sex is lower risk, though women are much more at risk for acquiring HIV through vaginal sex than men. Oral sex is a low-risk sexual practice for both men and women for the transmission of HIV.

- **Use of condoms or other protection during sexual activities**—used consistently and correctly during anal and vaginal sex, condoms greatly reduce the likelihood of HIV transmission.

- **Multiple partners**—unprotected sexual activities with multiple partners greatly increases the likelihood of exposure to HIV.

Blood-to-blood transmission of HIV primarily occurs through: (See Chapter 5: Blood Safety)

- Sharing of syringes and other drug paraphernalia by injecting drug user
- Selling of blood that has not been screened for HIV
- Unsafe medical practices (e.g., reuse of syringes or other surgical tools)
**HIV cannot be transmitted through:**

- Casual contact (in the school, home, or work environment, through hugging, kissing or hand shaking)
- Food or food handlers
- Objects in the environment (tables, door knobs or toilet seats)
- Mosquitoes (the virus can only be transmitted from humans, the virus does not live in insects)
- Swimming pools/lakes—chlorine will kill the virus, infectious fluids would be too diluted in large bodies of water to transmit the virus
- Pets (HIV is a human virus)
- Coughing or sneezing (it is not airborne)

**HIV disease progression**

In most cases, an HIV-infected adult may remain symptom-free for an average of seven to ten years or more. Although the virus is reproducing and compromising the immune system's cells, it is not yet causing enough damage that the person experiences symptoms or life-threatening illnesses. During this time, the HIV infected person may look and feel healthy, and is often unaware of the fact that s/he is infected. However, s/he continues to be infectious, and can transmit the virus to others.

Over time, as the person’s immune system is weakened by HIV, the body has more difficulty in fighting off foreign invaders and is more susceptible to infections as well as various forms of cancer.

**Acquired Immune Deficiency Syndrome (AIDS)**

AIDS is the collection of diseases that result once the immune system has been sufficiently weakened by HIV. A positive HIV test result does not mean that a person has AIDS. An HIV-infected person receives a diagnosis of AIDS based upon a national guideline. (See the National Department of Health standard definition referenced in Chapter 4: Care and Treatment and the National Antiretroviral Treatment Guidelines, First Edition) These clinical criteria are also often used to determine the medical eligibility of people living with HIV for ART.

**Epidemiology**

An estimated 33 million (30 million – 36 million) people worldwide were living with HIV in 2007. An estimated 2.7 million (2.2 million – 3.2 million) were newly infected with HIV, which is a slight decline from 3.0 million (2.6 million – 3.5 million) new infections in 2001. Sub-Saharan Africa remains as the greatest area impacted by the global HIV and AIDS epidemic, as evidenced in the UNAIDS 2008 Report on the Global AIDS Epidemic that stated this region accounts for 67 percent of all PLWHAs and 72 percent of AIDS deaths worldwide in 2007. (See both, Chapter 7: Surveillance and Chapter 8: Evidence-based Planning)

For additional information please see the “UNAIDS 2008 Report on the Global AIDS Epidemic.”

South Africa continues to represent the highest disease burden in the global HIV and AIDS epidemic with its 2007 estimate of approximately 5.3 million PLWHAs and a national prevalence rate of 17.64 percent (16.95 percent – 18.33 percent). These estimates derive from the 2007 National HIV and Syphilis Survey; the survey is conducted in all nine provinces using an unlinked anonymous testing methodology to estimate HIV prevalence within antenatal clinics.

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Overall, the trend for HIV prevalence has slightly declined at the national levels, while prevalence rates vary at the provincial and district levels. With the 2007 prevalence among pregnant women attending public health antenatal clinics (ANCs) decreasing to 28.0 percent (26.9 percent – 29.1 percent) from 30.2 percent in 2005. Please see provincial HIV prevalence estimates from pregnant women attending ANCs.

Figure 1: HIV prevalence in public health antenatal clinics

<table>
<thead>
<tr>
<th>Province</th>
<th>(%*) HIV prevalence, 2005</th>
<th>(%*) HIV prevalence, 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>KwaZulu-Natal</td>
<td>39.1 (36.8 – 41.4)</td>
<td>37.4 (35.0 – 39.8)</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>34.8 (31.0 – 38.5)</td>
<td>32.0 (29.2 – 34.9)</td>
</tr>
<tr>
<td>Free State</td>
<td>30.3 (26.9 – 33.6)</td>
<td>33.5 (28.3 – 39.1)</td>
</tr>
<tr>
<td>Gauteng</td>
<td>32.4 (30.6 – 34.3)</td>
<td>30.3 (29.9 – 32.8)</td>
</tr>
<tr>
<td>North West</td>
<td>31.8 (28.4 – 35.2)</td>
<td>29.0 (24.8 – 33.5)</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>29.5 (26.4 – 32.5)</td>
<td>26.0 (24.0 – 28.1)</td>
</tr>
<tr>
<td>Limpopo</td>
<td>21.5 (18.5 – 24.6)</td>
<td>18.5 (16.7 – 20.4)</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>18.5 (14.6 – 22.4)</td>
<td>16.1 (13.9 – 18.7)</td>
</tr>
<tr>
<td>Western Cape</td>
<td>15.7 (11.3 – 20.1)</td>
<td>12.6 (10.1 – 15.6)</td>
</tr>
</tbody>
</table>

For further information on district HIV prevalence estimates, please see section 4.2.3 in the 2007 National HIV and Syphilis Survey. The District Health Barometer (DHB) developed by Health Systems Trust can serve as an additional tool for health professionals to monitor primary health care at the national, provincial and district levels. Please refer to the most recent 2006/07 DHB.

Myths and misunderstandings, and stigma and discrimination

More perhaps than with any other disease, there are myths and misunderstandings about HIV. Communities find it difficult to talk openly and honestly about HIV because:

- HIV is primarily transmitted through behaviours that most societies find taboo (e.g., sexual contact and drug use).
- HIV is or has been concentrated in disenfranchised groups that many people look down on (e.g., sex workers or drug users).
- HIV and AIDS is deadly and incurable, making people very afraid of it, and because HIV can remain latent for years in individuals, communities find it difficult to talk openly and honestly about it.

Because of these misunderstandings and fears, people living with HIV are often discriminated against. Across the world, people with HIV have lost their jobs, been outcast from their families and homes, and sometimes killed because of their disease. Fear of discrimination and stigma associated with HIV prevents individuals from seeking accurate information about HIV, from getting tested for HIV and from seeking care and treatment for the disease. Balancing the need to respect community norms and values, with the need to challenge discriminatory practices and behaviours is one of the biggest challenges facing the departments of health.

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Figure 2: Spectrum of HIV disease

**High-Risk Behaviour**
Unprotected sexual intercourse (anal, vaginal, or oral) and/or sharing needles/paraphernalia. These high risk behaviours can lead to... HIV infection.

Infection begins the moment one person transmits HIV to another person through specific behaviours.

**HIV can be transmitted to others**

I. The Asymptomatic Stage of Infection (Asymptomatic = without symptoms)
An individual can remain symptom free for many years (10 or more). They may look and feel healthy, but are infected and can transmit the virus to others. Although the virus is reproducing and compromising the immune system, it has not caused enough damage for symptoms to appear.

**HIV can be transmitted to others during this stage**

Window Period - The time it takes for antibodies to develop. Most people will develop antibodies within 2-8 weeks, 97% within 3 months.

Acute Primary Stage of Infection: Flu-like symptoms occurring shortly after infection, lasting 1-2 weeks. This occurs during the development of antibodies.

*Not everyone will experience these symptoms.*

**HIV can be transmitted to others during this stage**

II. The Symptomatic Stage of Infection
The immune system is beginning to weaken and general symptoms start to appear. Individuals can experience many different symptoms that will last for a month or more. There is no set time frame from the start.

**HIV can be transmitted to others during this stage**

II. Advanced HIV Disease (AIDS)
When an HIV infected person’s immune system has weakened to the point where it can no longer fight off serious diseases, opportunistic infections occur. When this occurs, an individual is diagnosed with AIDS (Acquired ImmunoDeficiency Syndrome) or Advanced HIV Disease - the last stage on the spectrum of HIV Disease.

**HIV can be transmitted to others during this stage**

For further information
- The U.S. CDC provides basic information on HIV & AIDS, which can be accessed at http://www.cdc.gov/hiv/topics/basic/index.htm.
- A Q&A on HIV & AIDS is provided by the WHO, the Q&A along with additional information can be accessed at http://www.who.int/features/qa/71/en/index.html.
- Author Elizabeth Pisani, an HIV consultant, wrote The Wisdom of Whores: bureaucrats, brothels, and the business of AIDS. A blog and website provide discussion on HIV & AIDS and various topics, it can be accessed at http://www.wisdomofwhores.com.
Core competencies

• Identifies the individual's and organisation's responsibilities within the context of the essential public health services and core functions
• Defines, assesses and understands the health status of populations, determinants of health and illness, factors contributing to health promotion and disease prevention and factors influencing the use of health services
• Understands the historical development, structure and interaction of public health and healthcare systems
• Identifies and applies basic research methods used in public health
• Applies the basic public health sciences including behavioural and social sciences, biostatistics, epidemiology, environmental public health and prevention of chronic, infectious diseases and injuries
• Identifies and retrieves current relevant scientific evidence
• Identifies the limitations of research and the importance of observations and interrelationships

Introduction

Both distinct from and encompassing clinical services, public health's role is to assure the conditions necessary for people to live healthy lives, through community-wide prevention and protection programmes. As a manager engaged in public health activities, you will be responsible for designing and managing programmes that:

• Help to prevent the spread of HIV
• Promote and encourage healthy behaviours, including mental health
• Assure the quality and accessibility of HIV & AIDS health services

As one involved in public health activities, where efforts are designed to make changes in the health status of entire populations, the programmes must be designed as much as possible to be responsive to the HIV prevention and care needs of everyone in the province. However, some groups in the province are more in need of services than others, and the challenge will be to use limited resources to design a comprehensive system of HIV prevention and care that is accessible to all, while targeting those most in need.

Comprehensive system of HIV prevention and care

Since HIV prevention and care needs are different for different groups across the province and these needs change over time, no one activity or programme can be designed that will be effective for everyone. A variety of targeted programmes and activities must be developed that interconnect with each other to provide a comprehensive continuum of services. There are several ways in which this continuum can be conceptualised.
### Figure 3: Continuum of care for people living with HIV & AIDS

<table>
<thead>
<tr>
<th>Description of target population</th>
<th>General community</th>
<th>At-risk</th>
<th>Undiagnosed infection</th>
<th>Recently diagnosed</th>
<th>Stable</th>
<th>Progressive illness</th>
<th>End of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lacks information on HIV disease, risks, transmission • May have high-risk behaviour • May have biases, phobias, and prejudices</td>
<td>• Engages in high-risk behaviours • May deny risk • May lack information on HIV disease, risk and transmission</td>
<td>• HIV infection undiagnosed • Possible early symptoms • May seek medical care • May have awareness of risk and experience denial • No formal HIV care strategy • May lack information on HIV disease, risk and transmission</td>
<td>• Newly diagnosed • No formal HIV care • May experience symptoms • May lack information on HIV disease, risk and transmission • Person has not integrated HIV into his/her life</td>
<td>• CD4 count &amp; viral load stable • Established care strategy • Experiences HIV-related or AIDS-defining illnesses • Changing care strategy • Illness impairs life activities • Capacity for self care diminished</td>
<td>• CD4 count &amp; viral load unstable • Experiences advanced HIV or AIDS-related complications • Limited treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Services needed by target population | | | | | | | |
| Media campaigns • Public policy • Advocacy • Community education and mobilisation • Health education and risk reduction • School and worksite education | VCT • Screening and treatment for STIs • Health education and risk reduction • Community support for behaviour change | VCT • PMTCT • Medical care • Health education and risk reduction | Medical care • Determine ART eligibility • PMTCT • Emotional support • Primary and secondary health education and risk reduction • Partner counselling • Support services | Medical care • Dental care • ART • Treatment adherence support • Emotional support | Medical care • Dental care • ART • Treatment adherence support • Home-based care • Nutritional services • Legal services | Medical care • Home-based care • Medically based Housing • Nutritional services • Emotional support • Support services for affected individuals and caregivers |

| Activities needed to help target population access needed services | | | | | | | |
| Marketing of available services • Information and referral | Marketing of services • Community outreach • Information and referral • Transportation • Access to medical care | Community outreach • Information and referral • Case management • Transportation • Child care • Housing access and support • Community outreach | Information and referral • Housing access and support • Case management • Transportation | Information and referral • Housing access and support • Case management • Transportation | Information and referral • Housing access and support • Case management • Transportation | Information and referral • Housing access and support • Case management • Transportation | Information and referral • Housing access and support • Case management • Transportation |
In this model, the first row characterises the community according to its relationship with HIV (i.e., those who are at low-risk for HIV, those at high-risk, those who are infected with HIV but do not know it yet and those who have been diagnosed with HIV and/or AIDS). At each stage in this continuum of HIV risk and disease, individuals need different types of HIV prevention and care services. These needed services are described in the second row. Finally, the third row describes the kinds of activities that must occur in order for individuals in those groups to access the needed services.

It is interesting to note that as you move from left to right across this continuum, the size of the groups get smaller (that is, the general population category contains the largest group of individuals, while the end of life category contains the smallest), but that the intensity and expense of needed services gets greater (i.e., the services needed by the general population are broad, widespread, and are provided for groups, not individuals, while those needed by the end of life are much more costly, and are targeted at specific individuals).
This model also shows the same variety of services needed to assure a comprehensive HIV prevention and care system, and demonstrates, in the form of a flow chart, the nature of the connections and relationships that need to be in place between each of the services in order for the comprehensive system to work effectively.
How public health serves (practice of public health)

Public health serves communities and individuals within them by providing an array of essential services. Many of these services are invisible to the public. Typically, the public only becomes aware of the need for public health services when a problem develops (e.g. an epidemic occurs). The practice of public health becomes the list of essential services.

Monitor health status to identify and solve community health problems

This service includes accurate diagnosis of the community's health status; identification of threats to health and assessment of health service needs; timely collection, analysis and publication of information on access, utilisation, costs and outcomes of personal health services; attention to the vital statistics and health status of specific-groups that are at higher risk than the total population; and collaboration to manage integrated information systems with private providers and health benefit plans.

Diagnose and investigate health problems and health hazards in the community

This service includes epidemiologic identification of emerging health threats; public health laboratory capability using modern technology to conduct rapid screening and high volume testing; active infectious disease epidemiology programmes; and technical capacity for epidemiologic investigation of disease outbreaks and patterns of chronic disease and injury.

Inform, educate and empower people about health issues

This service involves social marketing and targeted media public communication; providing accessible health information resources at community levels; active collaboration with personal healthcare providers to reinforce health promotion messages and programmes; and joint health education programmes with schools, churches and worksites.

Mobilise community partnerships and action to identify and solve health problems

This service involves convening and facilitating community groups and associations, including those not typically considered health-related, in undertaking defined preventive, screening, rehabilitation and support programmes; and skilled coalition-building ability in order to draw upon the full range of potential human and material resources in the cause of community health.

Develop policies and plans that support individual and community health efforts

This service requires leadership development at all levels of public health; systematic community-level and provincial-level planning for health improvement in all districts; development and tracking of measurable health objectives as a part of continuous quality improvement strategies; joint evaluation with the medical healthcare system to define consistent policy regarding prevention and treatment services; and development of codes, regulations and legislation to guide the practice of public health.

Enforce laws and regulations that protect health and ensure safety

This service involves full enforcement of sanitary codes, especially in the food industry; full protection of drinking water supplies; enforcement of clean air standards; timely follow-up of hazards, preventable injuries and exposure-related diseases identified in occupational and community settings; monitoring quality of medical services (e.g., laboratory, nursing homes and home healthcare); and timely review of new drug, biologic and medical device applications.
Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable

This service (often referred to as outreach or enabling services) includes assuring effective entry for socially disadvantaged people into a coordinated system of clinical care; culturally and linguistically appropriate materials and staff to assure linkage to services for special population groups, ongoing care management, transportation services, targeted health information to high-risk population groups and technical assistance for effective worksite health promotion/disease prevention programmes.

Assure a competent public and personal healthcare workforce

This service includes education and training for personnel to meet the needs for public and personal health service; efficient processes for licensure of professionals and certification of facilities with regular verification and inspection follow-up; adoption of continuous quality improvement and life-long learning within all licensure and certification programmes; active partnerships with professional training programmes to assure community-relevant learning experiences for all students; and continuing education in management and leadership development programmes for those charged with administrative/executive roles.

Evaluate effectiveness, accessibility and quality of individual and population-based health services

This service calls for ongoing evaluation of health programmes, based on analysis of health status and service utilisation data, to assess programme effectiveness and to provide information necessary for allocating resources and reshaping programmes.

Research for new insights and innovative solutions to health problems

This service includes continuous linkage with appropriate institutions of higher learning and research and an internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.

For further information

- The American Public Health Association represents public health professionals and has been working to strengthen public health since 1872. It provides a key fact sheet on “What is Public Health” and can be accessed at http://www.apha.org/about/.
- What is Public Health? is an online project to answer several questions including: (1) what does public health encompass and (2) what impact does public health have on our lives. A resource page on public health topics can be accessed at http://www.whatispublichealth.org/resources/index.html.
Introduction

Designing and managing comprehensive programmes to prevent transmission of HIV is one of the primary functions of the HIV & AIDS and STI (HAST) Director and managers. While ways to prevent transmission of HIV have been clearly understood for decades, providing the information, skills and circumstances necessary for whole populations to take actions to protect themselves from HIV is complex and challenging. The following provides an introduction to HIV & AIDS prevention methods and their rationales.

What is prevention?

As a manager within the HIV & AIDS and STI Directorate, one’s role is to prevent HIV infection as well as mortality and morbidity (death and disease) associated with HIV. That means that being responsible for both designing programmes that prevent uninfected populations from becoming infected (primary prevention) and for preventing infected populations from experiencing unnecessary disease or early death as a result of their infections (secondary prevention).

Preventing HIV includes:

For sexual risk–behaviours:
- Abstinence from sexual activity is 100 percent effective in preventing HIV transmission.
- Only engaging in sexual activity with one HIV-negative partner is also 100 percent effective in preventing HIV transmission.
- Condoms used consistently and correctly are effective in preventing HIV transmission.
- Reducing the number of sexual partners can greatly reduce the risk of HIV transmission.

For injecting drug using behaviours:
- Abstinence from injecting drug use is 100 percent effective in preventing HIV transmission.
- Never sharing needles or drug paraphernalia is also 100 percent effective in preventing HIV transmission.
- Cleaning shared needles every time they are used with bleach and water greatly reduces the risk of HIV transmission.

In reference to the South Africa National Department of Health National Strategic Plan 2007 – 2011 for HIV & AIDS and STI (NSP 2007 – 2011), HIV prevention is a cornerstone of the NSP 2007 – 2011. The Priority Area 1 is prevention and aims to achieve the following target through four specific goals:

**Target: Reduce the national HIV incidence rate by 50 percent by 2011**
- **Goal 1:** Reduce vulnerability to HIV infection and the impact of AIDS
- **Goal 2:** Reduce sexual transmission of HIV
- **Goal 3:** Reduce mother-to-child transmission of HIV
- **Goal 4:** Minimise the risk of HIV transmission through blood and blood products

Prevention strategies: understanding behaviour change

Preventing the spread of HIV requires behaviour change. The goal of prevention activities is to get people to adopt new behaviours.

To want to change their behaviour, people must see the desired change as important and possible. The health belief model helps us to understand what particularly motivates people to make behavioural changes when faced with a health threat.

The health belief model identifies six key concepts that motivate people to take healthy action. By addressing these concepts, prevention efforts can help to increase people’s sense of motivation.
### Figure 5: The health belief model

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Definition</th>
<th>How prevention programmes can address</th>
</tr>
</thead>
</table>
| Perceived susceptibility | A person’s perception of his/her risk of getting a condition: I believe that my behaviour puts me at-risk of acquiring HIV. | • Define population(s) at-risk and their risk levels  
• Help people understand their behaviours that lead to personal risk  
• Heighten perceived susceptibility if too low |
| Perceived severity   | A person’s perception of how serious the condition and its consequences are: Acquiring HIV would have serious consequences for my family and me. | • Specify and describe consequences of the risk and the condition                                       |
| Perceived benefits   | A person’s belief in the effectiveness of the strategies designed to reduce the threat: I know of effective ways to prevent myself from contracting HIV. | • Define action to take — how, where, when  
• Clarify the positive effects to expected  
• Describe evidence of effectiveness |
| Perceived barriers   | A person’s sense of the potential negative consequences that might result from taking particular health actions: I believe I can handle any conflicts or problems that might result from making changes in my behaviour. | • Identify and reduce barriers through reassurance, incentives and assistance                           |
| Cues to action       | Events, either internal (e.g., physical symptoms of a health condition) or environmental (e.g., community campaign) that motivate people to take action: I receive messages from my environment that support my behaviour change goals. | • Provide how-to information  
• Promote awareness  
• Provide reminders |
| Self-efficacy        | A person’s confidence that he or she can successfully do the behaviours required for the desired outcome: I feel that I can successfully perform the actions required for the new behaviour. | • Provide training, guidance and positive reinforcement                                               |


People generally do not make big behavioural changes instantly. Rather, they typically go through a process of more gradual change over time.

The stages of change model helps us to understand the steps people are likely to go through in making changes. In recognition of this, prevention efforts should provide support to people at each of these steps.
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<th>Definition</th>
<th>How prevention programmes can address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Individual is unaware of the problem, has not thought about change. Example: No consideration of using condoms</td>
<td>Increase awareness of need for change, personalise information on risks and benefits</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Individual recognises the problem and is seriously thinking about changing. Example: Understands the need to use condoms</td>
<td>Motivate, encourage to make specific plans</td>
</tr>
<tr>
<td>Preparation</td>
<td>Individual recognises the problem and intends to change the behaviour within the next month. Some behaviour change efforts may be reported, such as inconsistent condom usage. However, the defined behaviour change criterion has not been reached (i.e., consistent condom usage). Example: Thinking about trying to use condoms</td>
<td>Assist in developing concrete action</td>
</tr>
<tr>
<td>Action</td>
<td>Individual has enacted consistent behaviour change (i.e., consistent condom usage) for less than six months. Example: Has begun to use condoms on a regular basis</td>
<td>Assist with feedback, problem solving, social support and reinforcement</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Individual maintains new behaviour for six months or more. Example: Is always using condoms</td>
<td>Assist in coping, reminders, finding alternatives and avoiding slips/relapses</td>
</tr>
<tr>
<td>Relapse</td>
<td>Individual resumes old behaviour. Example: Slipping-up with respect to condom use</td>
<td>Assist in restoring motivation, removing barriers and developing better coping strategies</td>
</tr>
</tbody>
</table>


Characteristics of effective prevention strategies

As we work to prevent the spread of HIV by getting people to change their behaviours, there are a number of personal, social and environmental factors (determinants) that can help or hinder our efforts. These include:

- Knowledge—people's awareness of the facts about HIV, its transmission and its impacts
- Attitudes and motivation—one's feeling about how important it is to take action and one's ability to do so
- Skills—knowing specifically what to do, when to do it and how to do it to avoid risk
- Community norms—prevalent attitudes, beliefs and practices related to HIV and HIV risk-reduction approaches
- Access to resources—people's ability to obtain the information, services and supplies necessary to reduce their risk of HIV transmission

The chart on the following page summarises how these determinants can work for or against positive change and identifies some of types of prevention strategies that can help to address each determinant.

In addition, research has shown some types of prevention activities to be more effective than others in terms of producing behaviour change:

- Programmes that address multiple determinants of behaviour are more effective than those that address only one.
- Programmes that utilise a structured approach or curriculum are more effective than those without a well-defined format.
- Programmes involving multiple contacts with the same participants are more effective than one-time only workshops.
- Programmes developed in collaboration with the target group are more effective than programmes developed without their involvement.
- Interactive activities are more effective than those that are aimed at information-giving alone.

Success in moving people towards healthier behaviours will be determined by how well these factors are addressed. It should be noted that most highly effective prevention strategies address many of these factors simultaneously.
## CHAPTER 3 HIV PREVENTION

### Prevention Strategies: Understanding Behaviour Change

#### Target: Reduce the national HIV incidence rate by 50 percent by 2011

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Detrimental</th>
<th>Helpful</th>
</tr>
</thead>
</table>
|           | • Not having basic knowledge about HIV transmission and consequences  
  • Believing myths about causes and prevention | • Having accurate knowledge about what HIV is, how it is transmitted and its impact on individuals, families and the community |

<table>
<thead>
<tr>
<th>Attitudes and motivation</th>
<th>Detrimental</th>
<th>Helpful</th>
</tr>
</thead>
</table>
|                         | • Feeling that “this has nothing to do with me”  
  • Engaging in risky behaviours and not perceiving any need to change  
  • Engaging in risky behaviours and feeling too ashamed to admit it  
  • Feeling that “it makes no difference what I do” | • Perceiving HIV as: a) having severe consequences; b) that you personally are at-risk; and c) that you are capable of doing what’s necessary to avoid risk |

<table>
<thead>
<tr>
<th>Skills</th>
<th>Detrimental</th>
<th>Helpful</th>
</tr>
</thead>
</table>
|        | • Not feeling able to say no to sex  
  • Not knowing how to use condoms properly  
  • Not being able to get partner’s cooperation to use safe sex practices | • Girls and women feeling able to refuse undesired/ unprotected sex  
  • Knowing how and feeling comfortable using condoms  
  • Sexual partners being able to talk honestly about risk and actions for risk reduction  
  • Sex workers and clientele taking preventive measures |

<table>
<thead>
<tr>
<th>Community norms</th>
<th>Detrimental</th>
<th>Helpful</th>
</tr>
</thead>
</table>
|                 | • Generally-held beliefs and practices that promote unsafe behaviours  
  • Generally-held beliefs and practices that make it difficult or unacceptable to practice risk-reduction behaviours  
  • Generally-held beliefs and practices that stigmatise PLWHA | • Community encourages/ supports adoption of risk-reduction behaviours  
  • Community holds risky behaviour unacceptable  
  • Community accepts and supports PLWHA |

<table>
<thead>
<tr>
<th>Access to resources</th>
<th>Detrimental</th>
<th>Helpful</th>
</tr>
</thead>
</table>
|                     | • Resources (information, condoms, pre-natal care and ARVs) not being available at all  
  • People not being able to get to where resources are  
  • People not being able to afford resources  
  • People feeling uncomfortable about accessing resources | • Having services and supplies available to and used by populations in need |
Useful types of interventions

- HIV education in schools
- Community fairs/events
- Media campaigns

- Peer outreach/story-telling
- Promoting abstinence as an option
- Information and activities in “natural community” settings (churches and kgotlas)
- PLWHA activism
- Activities in high-risk settings (STI & ANC clinics and shebeens)
- Messages delivered by local opinion leaders (kgosi, traditional healers, athletes and media figures)

- Teaching how to use condoms
- Teaching life skills to youth
- Modelling positive behaviours through entertainment
- Teaching communication and relationship skills to women
- Educating PLWHA about risk reduction strategies

- Public dialogue about risks, consequences and strategies
- Recruitment of community norm-setters/opinion leaders as champions of the cause
- Creating attractive cultural heroes who exemplify new way of thinking
- Stigma reduction programmes
- Activities to improve the status of at-risk people
- Involvement of PLWHA in programme planning and design

- Condom distribution
- PMTCT programmes
- Community mobilisation to build stronger service networks
- Referral programmes to help people obtain services
- Programmes that help people gain employment and income
- Media campaigns about where to obtain condoms
**Intervention ideas**

This section contains some examples of promising prevention strategies that have been implemented in sub-Saharan Africa and other places. They are presented here to stimulate your ideas to develop new and effective prevention activities in your district.

As you review these strategies, you will notice that a single strategy often will touch on many of the determinants of behaviour change—

---

![Diagram of determinants of behaviour change](image)

---

These examples are just a few of many proven and promising HIV & AIDS prevention programmes that are currently available.
**Example 1: Working in partnership with traditional healers**

Training traditional healers as educators and counsellors to disseminate information on HIV and sexually transmitted infections in their communities and to their peers

In much of sub-Saharan Africa, a high percentage of people make use of traditional healers’ services in both rural and urban areas. Traditional healers tend to be the first ‘professionals’ consulted by people with a sexually transmitted disease, including HIV. Healers are more easily accessible geographically and provide a culturally accepted treatment. They have credibility, acceptance and respect among the population they serve, and thus form a critical part of the health-care delivery system.

Leaders in one community in South Africa identified local traditional healers as having an important role to play in strengthening their response to the AIDS epidemic. In response to their request, community service providers and medical doctors began working in partnership with the local traditional healers on HIV prevention projects.

Over a two year period, a group of around 16-20 healers attended a monthly one-day workshop where they learnt about HIV transmission, prevention, treatment and care. Discussions took place around traditional and cultural sexual practices that could prevent HIV transmission and safer sexual practices involving more than just condoms.

Herbal treatments were debated alongside other traditional medicines used by the healers. Guest speakers were invited to talk about the use of medicinal plants and the healers, who were invited to attend a course at a medicinal plant nursery, later established a medicinal plant garden.

Through the regular meetings, the healers have established an informal support network and rely on each other for referral and resources. Increasingly, ways are being found to stimulate both referral networking with the formal health sector and with the traditional healers.

The ripples of the healers’ work have become increasingly widespread and more and more people are requesting HIV testing, counselling and support through the healers.

**Example 2: Stepping stones**

An award-winning training package on HIV & AIDS, gender issues, communication and relationship skills for people of all ages

Stepping stones is a life skills training package in gender, HIV, communication and relationship skills.

The stepping stones package is designed to enable women, men and young people of all ages to explore their social, sexual and psychological needs, to analyse the communication blocks they face and to practise different ways of addressing their relationships. Workshops aim to enable individuals, their peers and their communities to change their behaviour—individually and together—through the “stepping stones” which the various sessions provide.
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Most sessions are designed for people in small groups of 10–20, of their own gender and age. Occasional sessions bring everyone together. It has been used successfully with groups of HIV positive people and with groups of people who are HIV-free or who do not know their status. The whole package is based on a human-rights based approach, assuming that we all share certain challenges in our lives, which the package aims to help us address.

- All sessions use a participatory approach of adult learning through shared discussions.
- Exercises are all based on people’s own experiences, and role play and drawing exercises enable everyone to take part. No literacy is needed.
- Participants discuss their experiences, act them out, analyse them, consider alternative outcomes and then rehearse these together in a safe, supportive group. People feel safe because most sessions take place in groups of their own gender and age.
- Though designed with HIV & AIDS in mind, the package covers many related topics such as gender violence and alcohol use.

Stepping stones is designed for use by a team of skilled people—ideally two male, two female—who work with peer groups of community members. Experienced trainers should be able to use the material straight away. Less experienced trainers may need a training course to help them start to use it.

Example 3: Youth-friendly clinic services
Improving young people’s access to, and the quality of, reproductive health services

Youth-Friendly Services (YFS) are services that attract youth, meet a variety of young people’s needs comfortably and responsively, and succeed in retaining them for continuous care.

In 2000 Pathfinder International launched The African Youth Alliance programme (AYA) to develop YFS clinics in Botswana, Ghana, Uganda, and Tanzania. AYA/Pathfinder sought to address the factors that hinder young people from seeking sexual and reproductive health (SRH) services and to improve the overall quality of services.

What makes services youth-friendly? Pathfinder developed a list of the key elements, categorised into essential and supportive elements as shown in the following chart.
Example 4: Community capacity enhancement programme (CCEP)
Engaging communities in open discussions on issues of sexuality and HIV & AIDS

This programme was developed by the United Nations Development Projects and has been implemented in many African countries. CCEP is based on the recognition that communities have the capacity to prevent, care, change and sustain hope in the midst of the HIV & AIDS epidemic. The CCEP process creates opportunities for people to understand, discuss, decide and act on issues affecting their lives.

Facilitators, either United Nations Volunteers or community volunteers, are recruited from villages and provided extensive training on the CCEP model. Volunteer facilitators are expected to engage communities in open discussions on issues of sexuality and HIV & AIDS. CCEP targets behaviour change, seeking solutions that are based on the community’s concerns, opinions and ideas. This programme is designed to involve communities in addressing local issues associated with HIV & AIDS. The facilitators are put through a rigorous training programme and provided with a facilitation guide that emphasizes a series of steps that must be taken in the proper order for a successful CCEP meeting to have occurred. The CCEP meeting will most likely not be a single event, but will be a series of meetings that each focus on different parts of the process. This process works on developing problem solving and empowerment skills for community members and is intended to fully address issues of community norms. As communities meet to discuss issues, the norms that underlay issues are brought to the surface and examined as a part of the decision making process.

Example 5: U.S. Peace Corps Life Skills Programme
Teaching communication and decision-making skills to help youth and other vulnerable groups avoid contracting HIV

The Peace Corps Life Skills programme is a comprehensive behaviour change approach that concentrates on developing the skills needed for life, such as communication and critical thinking. Additionally, it addresses the important related issues of empowering girls and guiding boys towards new values. The Life Skills approach is completely interactive, using role plays, games, puzzles, group discussions and a variety of other innovative teaching techniques to keep the participant wholly involved in the sessions.

The manual consists of over 50 different lesson ideas that you can use with any group: anti-AIDS clubs, girls clubs, boys clubs, youth clubs, women's groups and so forth. The manual is written with a strong bias towards youth work and health issues. These lessons are quite easy to adapt to any age and other topics. Consider them as a starting point, so that you will have initial lesson plans ready as you begin to work with participants. Working with your colleagues, you can develop other lesson ideas and activities that will continue to challenge your participants to critically think about and modify their behaviours. In addition to the lesson plans, some lessons learned regarding peer education are included, as are some sample schedules, and tips to facilitators.
Example 6: Abstinence & behaviour change for youth (ABY)
Behaviour change programme for in-school youth

Hope Worldwide, a faith-based organisation in Botswana, is leading a well-regarded programme in schools called Abstinence & Behaviour Change for Youth (ABY). The main objective of ABY is to empower in-school youth with the knowledge and communication skills necessary to prevent teenage pregnancy and to stop the spread of HIV.

The ABY approach involves weekly interactive lessons by Hope Worldwide's trained volunteers to students at junior and senior secondary schools. After obtaining parent/guardian permission to participate, ABY participants receive a pre-test of their knowledge and attitudes about HIV & AIDS and health behaviours. Following this assessment, Hope Worldwide volunteers lead students through various session topics such as Finding ‘True’ Friends, Love & Dating, Teenage Pregnancy, Abstinence—Advantages & Consequences. There are also take-home exercises to do with parents/guardians. The programme typically takes place over 14-16 weeks.

Although abstinence is the desired behaviour of the programme, participants come to understand the meaning of abstinence and gain the skills necessary to commit to it in their daily lives. The ABY programme ends with a post-test and a graduation ceremony for participants, parents and the school.

Example 7: Forum Theatre
Using entertainment as a vehicle to educate and engage

Edutainment refers to a wide variety of arts-related activities – including magazines, story books, radio and television dramas, song and dance programmes and community theatre productions – that seek to provide health promotion while they also entertain. Edutainment can be helpful for providing HIV prevention messages in ways that are more engaging, less threatening and culturally appropriate to the audience. Edutainment activities are particularly effective when they are designed as educational opportunities both for the performers and the audience, and where the audience actively participates.

Forum Theatre uses interactive theatre as a powerful tool for behaviour change. Forum Theatre was developed as a tool for HIV and AIDS education with special consideration for youth groups and amateur theatre groups in English-speaking Africa who wish to address HIV- and AIDS-related issues in ways that are creative and engaging. Forum Theatre is designed to get audiences to discuss difficult issues in the open that they would otherwise be uneasy about in personal life. In the open and in fictitious settings, audiences can take ownership of issues and their solutions. After collectively debating the challenges and identifying some problematic behaviour of the players, people are often motivated to avoid similar behaviour of their own that they might have been unconscious of before.

A toolkit and associated material, including a CD-ROM are available to introduce users to the concepts and goals of this modality, and provides detailed guidance for developing plays and performances.

Example 8: Grassroot Soccer / Seboza Soccer
Using the power of soccer to provide youth with the knowledge, skills and support to live HIV free

The Grassroot Soccer (GRS) programme has been implemented in a number of African countries. This is a multi-session, curriculum-based group intervention aimed at youth under age 18. Grassroot Soccer's mission is to mobilise the global soccer community in the fight against HIV & AIDS. The GRS approach uses the power and popularity of soccer to break down cultural barriers, educate young people and bring communities together around this important issue. GRS uses a unique activities-based curriculum to prepare trainers and peer educators to reach out to their communities and educate the population at large about how to avoid HIV infection.
The programme has developed an HIV prevention curriculum that uses adult soccer players as “coaches”. The programme addresses knowledge, attitudes and skills. It is a comprehensive, multi-session programme and highly participatory. Participants are led through 22 separate activities that address the topics: values assessment, resiliency, peer socialisation, decision making, HIV basics, VCT, stigma, positive living, abstinence, partner reduction, risk awareness, peer pressure, gender roles, behaviour development, peer education and goal setting. Participants in the programme meet regularly and progress through the activities and are allowed to “graduate” at the end of the programme with a ceremony and soccer or netball game or drama presentation.

The benefit of a structured programme such as “Grassroots Soccer” over the usual soccer tournament is the opportunity for frequent and in-depth skills building among the participants. Soccer tournaments have been effective in mobilising men for voluntary counselling and testing, but do not allow for more focused behaviour change work.

**Example 9: Bridges of Hope**

Bridges of Hope is a programme that has been implemented in over 50 countries around the world. The goal of the programme is to create rich learning experiences around issues of HIV & AIDS prevention, support and positive living.

The programme focuses on participants examining their attitudes and motivations for behaviour change. In addition, the programme guides participants through a series of skills-building exercises and places a great emphasis on accessing resources. The activities do not depend on high literacy among the participants; most of the work in the sessions involves very small amounts of information being provided by the facilitator with most of the learning occurring through group discussions among the participants. This is a highly participative programme, with elements of storytelling and role-playing. The programme is suited for all kinds of groups of people, people living with HIV & AIDS, younger and older people, specific populations of sex workers, or others at increased risk. The programme utilises a package of instructional materials and a curriculum to be followed.

**Example 10: Harm reduction/Syringe exchange**

Providing clean syringes to injecting drug users has been shown worldwide to be effective in reducing HIV transmission among injecting drug users without increasing rates of drug use. Generally effective programmes have the following characteristics:

- Exchange used syringe for a sterile one
- Exchange as opportunity to provide education, counselling and referral
- Non-judgmental
- Overdose prevention activities and drug treatment opportunities
- Engagement of police/judicial authorities in the conceptualisation and implementation of the programme
CHAPTER 3 HIV PREVENTION

Figure 8: Strengthening provincial prevention practices

As part of the HIV & AIDS and STI Directorate, you will be required to identify the important HIV-related issues that need to be addressed, and define the objectives to be achieved in addressing those issues. Then, strategies are developed in response to those issues and objectives.

In order to select strategies that will be most effective, it is suggested that the following criteria be used to evaluate potential approaches.

| 1. Does this strategy address a high priority issue and target group? | □ No □ Yes |
| 2. Are there meaningful, clearly defined behavioural changes that are anticipated to occur as a result of this strategy? | □ No □ Yes |
| 3. To what extent will this strategy impact the participants’ HIV-related: | □ Little or not at all □ Somewhat □ Very much |
| Knowledge | □ |
| Attitudes and motivation | □ |
| Skills | □ |
| Community norms | □ |
| Access to resources | □ |
| 4. Does this strategy: | No □ Yes |
| Address multiple determinants of change? | □ |
| Utilise a structured approach or curriculum? | □ |
| Involve multiple contacts with the same participants? | □ |
| Involve collaboration with the target group? | □ |
| Use interactive activities rather than simply information-giving? | □ |
Biomedical interventions

Biomedical interventions are interventions that seek to prevent transmission of HIV, through use of medical and other technology, rather than through encouraging individuals and groups to change high-risk behaviours. Research is continuing in a number of areas (described below under future options), but unfortunately, the range of existing biomedical interventions is limited.

Antiretroviral therapy (ART)

Antiretroviral therapy has dramatically increased the well-being and life-span of people infected with HIV. It works by greatly reducing the levels of virus in the blood, often to the point of becoming undetectable by current tests. One outcome of ART is that lower blood levels of virus tend to correlate with lower genital fluid levels of virus, translating to a lower likelihood of sexual transmission. It is not always appropriate however to use and promote ART as a means of preventing HIV transmission because:

- Even in patients on ART, virus remains in many tissues of the body despite being undetectable with tests. While it is probably true that a low viral load makes someone less infectious, viral loads fluctuate over time due to changes in adherence, the development of drug resistance or the natural history of infection. Until the conditions when someone is not infectious are well-defined, it is safest to assume that an HIV-positive person remains potentially infectious for life.
- It is possible that people are more likely to engage in sexual risk behaviour because they believe treatment will make them or their partners less infectious or they believe that HIV is a less serious a disease than before.
- In some circumstances, however, use of ART to reduce likelihood of HIV transmission is appropriate, and these include prevention of mother-to-child transmission, post-exposure prophylaxis (PEP), and pre-exposure prophylaxis.

Prevention of Mother-to-Child Transmission (PMTCT)

Mother-to-child transmission of HIV, also called perinatal or vertical transmission, occurs when HIV is spread from an HIV-positive woman to her baby during pregnancy, labour and delivery or breastfeeding. For an HIV-positive woman not being treated for HIV, the chance of passing the virus to her child is about 25 percent during pregnancy, labour and delivery. If she breastfeeds her infant, there is an additional 12 percent chance of transmission.

Provision of ART to the mother after the first trimester of pregnancy and during labour, and to her infant for the first six weeks of life greatly reduces the likelihood of HIV transmission to the infant. An effective Prevention of Parent-to-Child Transmission programme will provide all pregnant women with access to free or low-cost prenatal care and voluntary HIV testing and counselling and access to antiretroviral treatment both to treat HIV and improve her own health, and to decrease the chances of HIV infection in her infant. Systems for follow-up and monitoring of the family after labour and delivery must also be in place to make sure that the infant completes the ART regimen, to provide education and support around infant-feeding practices, as well as counselling, risk reduction education and support to the infected woman and her family. (See the revised PMTCT guidelines issued by the National Department of Health, which can be found in the resource CD prevention section)


## Chapter 3 HIV Prevention

### Post-exposure prophylaxis (PEP)

A study of healthcare workers showed that treatment with zidovudine (AZT) after needle-stick exposure to HIV-infected blood reduced the odds of HIV infection by 81 percent. Thus for HIV-uninfected persons who are exposed to HIV, there may be a window of opportunity in the first few hours or days after exposure in which ART may prevent HIV infection. Most forms of PEP involve providing one or several anti-HIV drugs within 72 hours of possible exposure. These drugs are then taken for a four to six week period. PEP regimens can be both complicated and prohibitively expensive to follow. Many believe that a person with a single case of unprotected sexual- or needle-related exposure to an HIV-positive partner would be a good candidate for PEP. However, many people worry that providing PEP repeatedly to a person with ongoing high-risk behaviour may cause disinhibition for unsafe sex and could also be toxic. Another fear is that misuse of PEP drug therapies may cause a person to develop a resistant strain of HIV. If PEP drug therapy is unsuccessful and a person does develop a drug-resistant virus, the new anti-HIV drugs may not be as effective for treating that person. This can occur not only with PEP, but with any combination therapy treatment.

### Reducing STI burden

Transmission of HIV and transmission of other sexually transmitted infections (STI) are very closely related. Studies have shown that an HIV-negative person who has an STI is two to five times more susceptible to HIV acquisition because the lesions and immune response associated with STIs make it easier for HIV to enter the body. At the same time, an HIV infected person who has an STI can be more infectious and more easily transmit HIV to an uninfected partner. Detecting and treating STIs in populations where there are high rates of disease can help reduce the likelihood of HIV transmission.

### Future biomedical interventions

Research is currently being conducted into all of the biomedical interventions described below. While not available currently, HAST Directors and senior/junior managers should be thinking about how to integrate these interventions into a comprehensive provincial HIV & AIDS and STI programme when they do become available. Questions to consider might include: “For which risk groups are these interventions most appropriate?” “Are these interventions more effective and cost-effective than existing ones?” “What kinds of delivery systems must be developed to ensure that people have access to these interventions?”

### Microbicides

Current primary prevention methods do not allow women to protect themselves from HIV infection if their partners do not use male condoms or allow female condoms to be used. Nor will abstinence and being faithful protect married women or those who are sexually abused. In addition, all of these methods are contraceptive, forcing couples to choose between procreation, or protecting themselves from HIV. Microbicides are a substance in the form of a gel or suppository that can substantially prevent or reduce transmission of HIV when applied within the vagina, while allowing for the possibility of pregnancy. It is estimated that a 60 percent efficacious microbicide introduced into 73 low-income countries and used by only 20 percent of women would avert 2.5 million HIV infections over three years in women, men and infants. Research trials are currently being conducted and it is estimated that women in developing countries should have access to effective microbicides within the next five to ten years.
Male circumcision

Numerous studies have noted a decreased risk of HIV infection in circumcised men as well as continued low HIV prevalence rates in populations that traditionally practice male circumcision. (For example a randomised controlled trial in South Africa in 2005 found a 60–75 percent reduction in HIV risk, and a UNAIDS multi-site study found male circumcision to be the principal factor in the large and pervasive disparities in HIV prevalence across different African regions). Research continues to confirm these findings, and experts are beginning to discuss programmatic implications. Male circumcision will not provide full protection against HIV, and there will be an urgent need to address possible behavioural “disinhibition” among circumcised men who may continue or return to high-risk behaviours if they feel they are protected. It will also provide little or no protection against urethral STIs such as gonorrhoea and chlamydia and obviously will not prevent unwanted pregnancies. Effective behaviour change programmes will therefore still be needed to address these risks.

Vaccine

A successful HIV vaccine would train the body's immune system to recognise and destroy HIV before it does damage. There are multiple challenges to developing an effective vaccine, including (1) traditional approaches to vaccine design (i.e. use of inactivated or attenuated viruses) are considered too dangerous with HIV; (2) the virus is highly variable and mutates rapidly; (3) the viral infection is permanent, full recovery from HIV has not been documented, and thus, it is unclear how the body could mount an effective immune response and (4) there is no perfect animal model for use in AIDS vaccine research. Although vaccine research is continuing, an effective vaccine is not anticipated for five to ten years. If and when a vaccine becomes available, the HAST Director and senior managers should consider that:

- Existing vaccination programmes which typically focus on children and youth. With HIV, it is sexually active adolescents and adults who will need a vaccine most immediately, necessitating new approaches to immunisation.
- Vaccine acceptance may be problematic in communities where there is a distrust of government or stigma in being associated with HIV & AIDS.
- Behavioural interventions would still be needed in concert with a vaccine programme.

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) refers to an experimental HIV-prevention strategy that would use antiretrovirals to protect HIV-negative people from HIV infection. PrEP is not proven to work; in the strategy that is currently being tested, HIV-negative people would take a single drug, or a combination of drugs, daily in hopes that this would protect them against HIV infection. Along with AIDS vaccines and microbicides, PrEP is one of the experimental HIV-prevention strategies being tested in clinical trials today.
Characteristics of current PrEP candidates:

- Established safety as HIV treatments
- Potent antiretrovirals
- Long duration of action
- Once-daily dosing
- Low-levels of resistance

The potential benefits of PrEP include:

- PrEP might give individuals some level of protection even if they failed to use other protective measures (like wearing a condom) or if a condom broke.
- Using PrEP would be particularly advantageous for people in sero-discordant relationships, people who may feel unable to insist on condom use, including sex workers or people who feel relatively less powerful than their partners in sexual situations or people at a higher-risk due to sexual or drug-use behaviours.
- PrEP (along with vaccines and microbicides) would be a female-controlled prevention method—it could protect women (and men) who are victims of sexual violence or coercion, or are afraid to insist that their partners use condoms.

The U.S. Centers for Disease Control and Prevention (CDC) is funding international and domestic clinical trials for PrEP. On the CDC website, one clinical trial of interest is being conducted in Botswana in collaboration with the Botswana government.

- Trial will enroll 1,200 HIV-negative heterosexual men and women
- Participants’ age range is from 18–39 year old
- Participants are being recruited from Gaborone and Francistown

The potential challenges of PrEP include:

- If PrEP fails and an individual becomes HIV positive, they would in the time between becoming infected and being diagnosed with HIV in effect be taking monotherapy (single drug therapy) for HIV infection, meaning they would be on a treatment regimen that is not considered optimal against HIV disease and which runs the risk of making the PrEP ineffective as treatment later in the course of disease.
- Development of HIV resistance to the antiretroviral being used for PrEP is possible, raising the prospect of creating resistant HIV strains.
- Taking PrEP might lead to disinhibition where people feeling protected by PrEP engage in high-risk behaviours. If that happens, and if the drug does not confer 100 percent protection (a near certainty), or is taken irregularly, people could actually be putting themselves at increased risk of infection.
- The world is currently struggling to provide antiretrovirals to all the HIV-positive people who need them, let alone all individuals who may be at-risk for HIV. If PrEP became available, the HAST Director and senior staff would be faced with the same, yet hugely magnified issues of cost, distribution and adherence that are currently affecting ART programmes.
Targeting prevention interventions

It is probably already clear from this discussion of types of prevention interventions that not all interventions are suitable for every person. It is critical as a senior manager to use available prevention resources to the best effect. One of your ongoing tasks will be to use available data to describe the populations most at-risk for HIV in your province, and to learn specifically what those populations need in order to prevent HIV transmission (See Chapter 8: Evidence-based Planning). You will need to target your prevention interventions because:

- Not all primary prevention interventions work equally well for all people
- Not all people are equally at-risk for HIV
- Resources are limited

While every jurisdiction will be different, some populations most likely to be at-risk for HIV that you might want to consider learning more about will likely include:

<table>
<thead>
<tr>
<th>High-risk population</th>
<th>Why are they at-risk?</th>
<th>Examples of likely effective prevention interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV</td>
<td>They can transmit HIV to their sexual partners</td>
<td>Couple and family counselling, condom distribution, and social marketing of condoms</td>
</tr>
<tr>
<td>Commercial sex workers</td>
<td>Multiple sex partners, lack power to insist on condom use</td>
<td>Outreach, male and female condom distribution, peer education and microbicides (if available)</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>Opportunity to prevent mother to child transmission</td>
<td>PMTCT and social marketing</td>
</tr>
<tr>
<td>Truck drivers/immigrant workers</td>
<td>Frequent commercial sex workers</td>
<td>Outreach, condom distribution, social marketing and peer education</td>
</tr>
<tr>
<td>Those infected with STIs</td>
<td>Synergy of HIV and STI transmission, engaged in high-risk sexual behaviours</td>
<td>Brochures, social marketing, and HIV testing offered at STI clinic</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>Sharing of syringes and other drug paraphernalia</td>
<td>Syringe exchange interventions</td>
</tr>
</tbody>
</table>
Transition from prevention to care: Voluntary counselling and testing

Primary prevention interventions should always include a way to refer participants for additional services, to recruit their sexual and drug using partners to education and care, and ultimately, if needed, refer participants to HIV care and treatment programmes. The critical link in this system of services is voluntary counselling and testing (VCT), since VCT is an opportunity to:

- Perform an individual risk assessment and provide health education and risk reduction counselling that has been shown to be effective in increasing condom use and preventing STIs
- Refer individuals, regardless of their HIV status to more intensive behaviour change interventions
- Ensure that HIV positive clients are referred to appropriate care and treatment, including PMTCT, TB testing and treatment and STI testing and treatment
- Help HIV positive clients inform their sexual and needle sharing partners of their possible exposure to HIV

Since rapid testing is widely available, there are many possible venues for VCT. VCT can take place in testing centres, community health clinics, community-based organisations, outreach programmes, prisons, hospitals, drug treatment centres, mobile vans, STI and family planning clinics, as well as in the doctor’s office. Characteristics of effective VCT include:

- An assurance of client confidentiality
- Obtaining informed consent for testing from the client
- Pre-test risk assessment and client-based counselling
- Post-test counselling and referral

In the past, before ART was widely available, there was little incentive for people to learn their HIV status, while stigma associated with the disease was a huge disincentive. Now that effective treatments are available for HIV disease, it is critical that communities learn of the benefits of VCT, and that the stigma that helps prevent individuals from learning their status is comprehensively addressed. An effective VCT programme will be supported by social marketing campaigns and outreach efforts, and will receive referrals from STI and TB clinics.

For further information
- The WHO provides an excellent overview of prevention programmes with basic information, technical documents and reports, policy advocacy materials and recommended readings. These prevention resources can be accessed at http://www.who.int/hiv/topics/prevention/en/index.html.
- Please refer to the prevention section on the resource CD which contains South Africa guidelines as well as NASTAD publications on prevention efforts, especially within the African-American community.
CHAPTER 4 HIV CARE AND TREATMENT

Introduction

HIV is a virus that gradually destroys the immune system, leaving the body open to a series of opportunistic infections that together are called AIDS (Acquired Immune Deficiency Syndrome). There is no cure for HIV infection, however, antiretroviral therapy (ART) does exist which can significantly slow the replication of the virus in the body, and prevent progression of the infection to AIDS. However, ART is a treatment, it is not a cure. Once a person stops taking ART, HIV is free to replicate in the body again, eventually leading to AIDS. That means that an HIV-positive person must take ART for the rest of their life.

An HIV-positive individual does not only need ART. They will also need treatment and care for the symptoms of AIDS they exhibit—including nutritional support, treatment of pneumonias, fungal and bacterial infections and TB.

Antiretroviral therapy (ART) guidelines

In 2004, the South African National Department of Health issued the first edition of ART guidelines. Over time as new drugs receive approval, first- and second-line regimens will be modified. The information below is derived from the 2004 first edition guidelines; please use any provincial guidelines or future national treatment guidelines.

Criteria for ART initiation in adults and adolescents

- CD4 < 200 cells/mm² irrespective of stage or
- WHO Stage IV AIDS-defining illness, irrespective of CD4 count and
- Patient expresses willingness and readiness to take ART adherently

Table 1: WHO clinical staging tables of HIV & AIDS for adults and adolescents

Primary HIV infection
- Asymptomatic
- Acute retroviral syndrome

Clinical stage 1
- Asymptomatic
- Persistent generalised lymphadenopathy (PGL)

Clinical stage 2
- Moderate unexplained weight loss (<10% of presumed or measured body weight)
- Recurrent respiratory tract infections (RTIs) (e.g., sinusitis, bronchitis, otitis media or pharyngitis)
- Herpes zoster
- Angular cheilitis
- Recurrent oral ulcerations
- Papular pruritic eruptions
- Seborrhoeic dermatitis
- Fungal nail infections of fingers
Clinical stage 3
Conditions where a presumptive diagnosis can be made on the basis of clinical signs or simple investigations

- Severe weight loss (>10% of presumed or measured body weight)
- Unexplained chronic diarrhoea for longer than one month
- Unexplained persistent fever (intermittent or constant for longer than one month)
- Oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis (TB) diagnosed in last two years
- Severe presumed bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infection, meningitis or bacteraemia)
- Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis

Conditions where confirmatory diagnostic testing is necessary

- Unexplained anaemia (< 8 g/dl) and/or neutropenia (<500/mm3) and/or thrombocytopenia (<50,000/mm3) for more than one month

Clinical stage 4
Conditions where a presumptive diagnosis can be made on the basis of clinical signs or simple investigations

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent severe or radiological bacterial pneumonia
- Chronic herpes simplex infection (orolabial, genital or anorectal of more than one months duration)
- Oesophageal candidiasis
- Extrapulmonary TB
- Kaposi’s sarcoma
- Central nervous system (CNS) toxoplasmosis
- HIV encephalopathy

Conditions where confirmatory diagnostic testing is necessary

- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculoc mycobacteria infection
- Progressive multifocal leukoencephalopathy (PML)
- Candida of trachea, bronchi or lungs
- Cryptosporidiosis
- Isosporiasis
- Visceral herpes simplex infection
- Cytomegalovirus (CMV) infection (retinitis or of an organ other than liver, spleen or lymph nodes)
- Any disseminated mycosis (e.g. histoplasmosis, coccidiomycosis or penicilliosis)
- Recurrent non-typhoidal salmonella septicaemia
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Visceral leishmaniasis

Table 2: CD4 levels in relation to the severity of immunosuppression

- Not significant immunosuppression >500/mm3
- Mild immunosuppression 350 – 499/mm3
- Advanced immunosuppression 200 – 349/mm3
- Severe immunosuppression <200/mm3
ART Initiation

Once a patient has met the clinical requirements (CD4 >200/mm3 or WHO Stage IV AIDS-defining illness), he/she will commence the treatment readiness assessment to prepare the patient and ensure ART adherence.

Table 3: Treatment Readiness Assessment
First screening visit: 2-4 weeks before starting ART
Treatment counsellor conducts a home visit
Second visit
Multi-disciplinary team discussion
ART commencement visit

Table 4: Recommended regimens (adults)

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>d4T/3TC/efavirenz</td>
</tr>
<tr>
<td>1b</td>
<td>d4T/3TC/NVP</td>
</tr>
<tr>
<td>2</td>
<td>AZT/ddl/lopinavir/ritonavir (Second-line therapy)</td>
</tr>
</tbody>
</table>

For further information on the drug regimens and time-events schedule pre- and post-initiation of ART please refer to the National Department of Health guidelines. An electronic version has been included at http://www.nastad.org/Programs/GlobalAIDS/GlobalAIDSResourceMaterials.aspx

Many drugs or treatment protocols have been developed to inhibit HIV and new drugs continue to be developed. These include:

- Reverse transcriptase inhibitors—inhibit or prevent the reverse transcriptase process (the process during which the virus changes from RNA to DNA inside the T-Cell).
- Protease inhibitors—inhibit or prevent the production of protease, which is needed to cut the newly replicated virus into smaller pieces before they are released from the infected T-Cell into the body.
- Fusion inhibitors—prevent HIV from attaching to the T cell in the first place.

Most individuals are prescribed a combination of drugs. Benefits and risks must be taken into consideration. Controlling and reducing viral load, preventing the immune system from weakening further, delaying progression of the virus to AIDS are all advantages. However, adverse side effects (i.e. nausea, vomiting, weight gain/loss, elevated cholesterol levels, diabetes, kidney stones, liver problems and earlier development of drug resistance, as well as unknown long-term effects) are also important factors to take into consideration.

ART is still fairly complex and complicated. The drugs are costly, the regimens are complex, and PLWHAs must stay on the regimens for the rest of their lives. There is a danger of drug resistance. As well as providing ART, the health professional will also want to treat any opportunistic infections that occur, and will need to consider multiple treatment regimens and drug interactions. The National Department of Health contains additional resources and guidelines for ART.

Treatment adherence and drug resistance

HIV is highly mutable—that is, as it replicates, it can change its internal structure so that subsequent generations of the virus are different in nature to previous ones. Even in a person taking ART, the virus may continue to replicate, though at a slower rate. When resistance emerges, an anti-HIV drug that was once effective becomes less able to fight the virus. That drug will need to be switched to a more expensive second-line alternative. The consequences of drug resistance include treatment failure, increased direct and indirect health costs, transmission of the resistant strain to treatment-naive subjects and the need
to develop new anti-HIV drugs. Thus, HIV resistance has been recognised as a serious threat to the efficacy of current HIV treatments. This means that it is critical for HIV infected individuals to consistently and regularly take their ART as prescribed. The following components of an ART delivery system help to assure treatment adherence and avoid drug resistance:

- Quality assurance for drugs
- Adequate and continuous drug supplies
- Standardised individual treatment records
- Support for and monitoring of adherence
- Removal of barriers to continuous access
- Prevention programmes to reduce HIV transmission from persons in treatment
- Monitoring of key indicators for resistance containment
- HIV drug resistance (HIVDR) lab-based surveillance

**TB and HIV**

One of the most concerning opportunistic infections experienced by people living with HIV is tuberculosis. Tuberculosis (TB) is a disease that is spread from person to person through the air. The risk of developing TB disease is much greater for those infected with HIV and living with AIDS. Because HIV infection so severely weakens the immune system, people dually infected with HIV and TB have 100 times greater a risk of developing active TB disease and becoming infectious compared to people not infected. The spread of the HIV epidemic has had a significant impact on the TB epidemic—one-third of the increase in TB cases over the last five years can be attributed to the HIV epidemic. At the same time TB is the cause of death for one out of every three people with AIDS worldwide.

This high level of risk underscores the critical need for integrated TB and HIV screening, treatment and referral programmes. All people infected with HIV should be tested for TB, and, if infected, complete preventive therapy as soon as possible to prevent TB disease. Similarly, all people diagnosed with TB should be screened for HIV.

Unfortunately, like HIV, strains of TB are rapidly becoming resistant to drugs. People living with HIV & AIDS are at greater risk of developing Multi-Drug Resistant (MDR)-TB and Extremely-Drug Resistant (XDR)-TB. MDR/XDR-TB is extremely difficult to treat and can be fatal. To prevent the continued emergence of drug-resistant strains of TB, treatment for TB must be improved, and innovative strategies to help patients with treatment adherence developed. Inconsistent or partial treatment is the main cause of TB that is resistant to available drugs. The most effective strategy for ensuring completion of treatment is Directly Observed Therapy (DOT), and its use must be expanded. Another challenge that individuals co-infected with HIV and TB face is the possible complications that can occur when taking HIV treatment regimens along with drugs commonly used to treat TB. Health professionals prescribing these drugs must carefully consider all potential interactions.

**Secondary prevention**

Secondary prevention is the term used for the concept of preventing HIV infected populations from being exposed to compounding diseases or early death as a result of their infections. Secondary prevention helps people living with HIV to avoid becoming infected with other illnesses (co-infections), especially sexually transmitted infections (STIs). HIV-positive individuals should practice general prevention for all illnesses including chronic (long-lasting) diseases, such as diabetes and hypertension, and acute (lasting for a short time) illnesses such as the flu or chicken pox —just like HIV-negative people. It is important for people with HIV to be aware that any health/prevention messages for the general public may be extra important for themselves because of the weak status of their immune system.

In addition, HIV-positive people can get infected with another strain of HIV that may be different from the strain they already have, including drug-resistant strains of HIV.
Prevention with positives

Research has shown that most people who know of their HIV status refrain from sexual activities likely to transmit the virus to others, and often, particularly after their initial diagnosis refrain from any kind of sexual activity for fear of transmitting it to others. Supportive programmes can assist HIV-positive people to achieve full and satisfying emotional and sexual lives. As people gain access to ART, and live longer and healthier lives with the disease, they need to learn long-term strategies to help them establish satisfying sexual relationships, including having children, while avoiding transmitting the virus to their loved ones. Prevention for positive strategies include:

- Individual counselling/Prevention case management—can help an HIV-positive person accept and adjust to the diagnosis, learn critical information about HIV transmission and treatment, and explore strategies and options for disclosing to a sexual partner.
- Couples counselling—can be a safe environment for an HIV-positive person to “break the news” and wrestle with issues such as how to maintain sexual satisfaction and trust.
- HIV-positive peer “buddies”/PLWHA support groups—can provide opportunities to learn from and receive support from peers.
- Community level forums and social events—can help address stigma, reinforce messages that HIV-positive people are valued members of society and empower HIV-positive people to disclose their status to their sexual partners.

Continuum of care

Caring for people living with HIV & AIDS involves much more than provision of ART and treatment of OIs. As shown in Figure 2 (see Chapter 1), a continuum of services are needed. In an ideal world, community outreach or prevention interventions will recruit an individual to a VCT programme. This programme would provide an HIV-positive person with immediate post-test counselling and partner services, and make referrals to initial diagnostic testing, PMTCT, TB and STI, ART and prevention with positive programmes. Once enrolled in these programmes, the HIV-positive person must have ongoing clinical management to assess their disease status. Just as important, is ongoing social case management, through which the HIV-positive person can receive support around treatment adherence, nutrition and palliative care, and through which individual and family psycho-social education and counselling can be provided. All of these services must be linked to each other with an effective referral and monitoring system.

In resource constrained environments, there are many challenges to creating a continuum of care. It is important to use existing resources effectively. That means, for example:

- Integration and cross-training: Placing VCT and PMTCT activities within existing family planning, TB or STI clinics not only makes use of existing facilities and human resources, but most effectively reaches those most likely to be infected with HIV, and promotes ease of co-treatment of HIV, TB and STI.
- Appropriate use of community resources: People suffering from HIV & AIDS require long, continuous treatment. Hospital care in such a situation is neither feasible nor appropriate. In many instances community and home-based care is more cost-effective and acceptable to the patient. See the National Strategic Plan for HIV and AIDS and STIs 2007–2011 for additional information:
  - Home and neighbourhood: Community volunteers, family members and traditional health attendants can all be trained to provide day-to-day care, basic treatment and palliative care for common symptoms such as cough or diarrhea, psycho-social support and education. Volunteers at this level can be critical in helping the patient to adhere to their ART treatments. They can also be trained to recognise when more serious complications occur that require referral to a health sub-centre.
  - Health clinics: Staff here are responsible for providing support and supervision to community and family volunteers, as well as for managing most common day-to-day problems of HIV & AIDs. They too must be trained to recognise when there is a need to refer a patient with more complicated care needs.
o District hospitals provide the next level of clinical, nursing and specialist care.
o Provincial and regional hospitals are referral institutions for the most complex cases, where major clinical specialties are available.

**Role of HAST in care and treatment of PLWHA**

The roles of the HAST Director and senior staff are to make sure that the services constituting the continuum of care are:

- Easily available and accessible to all HIV-positive individuals in the province.
- Efficiently coordinated to avoid duplication of effort and to promote cost effectiveness.
- Effectively monitored to assure quality of services, and to learn about the changing needs of HIV infected people in the province.

This may involve:

- Funding services that may be missing in the continuum of care
- Providing training to service providers
- Assuring the quality of the services that are provided
- Distributing treatment for OIs to service centres
- Working to develop a referral system that ensures that patients are tracked through the system, and not lost to care
- Working to develop a monitoring system that collects data confidentially on aspects of care and treatment that are important to understand future needs and trends

**Funding issues and cost-containment strategies**

With increased persons receiving treatment through public health facilities, the overall budget for provincial treatment programmes will continue to grow. As a senior department of health staff, you face the responsibility to ensure public health for the province as well as ensure sound fiscal management and budget planning. How does the provincial department of health ensure access to lifesaving ART while containing programme costs and not experiencing budget shortfalls? Issues of budget shortfalls and waiting lists to begin ART initiation will continue to impact provincial departments of health.

**For further information**

- The WHO provides the latest updates, information, and guidelines on ART. Information can be accessed at http://www.who.int/hiv/topics/treatment/en/index.html. In addition, the WHO provides recent ART publications for review, these can be accessed at http://www.who.int/hiv/pub/arv/en/.
- The U.S. CDC website provides a compendium of treatment resources, while these are targeting U.S. state health departments, these resources may be of us to your provincial health department. Treatment resources can be accessed at http://www.cdc.gov/hiv/topics/treatment/index.htm.
CHAPTER 5 BLOOD SAFETY

Introduction

Since HIV is carried and transmitted in the blood, a well organised national blood service is a vital component of South Africa’s healthcare delivery system. An integrated strategy for blood safety is necessary to eliminate transfusion transmitted infections and to provide safe and adequate blood transfusion services to all people.

Blood safety in South Africa

The collection and storage of blood is primarily performed by the South African National Blood Service (SANBS), which is a non-profit organisation that operates nation-wide. It issues clinical guidelines for the use of blood products in South Africa with the 2003 third edition as the most recent set of guidelines. The donor and blood screening protocols ensure extremely low-risk of HIV transmission via blood donation. The NSP 2007–2011 indicated that the existing blood safety protocols and high-level of compliance resulted in a very low-risk for transfusion transmitted infections.

Blood safety protocols

- Health screening—potential blood donors must complete a written questionnaire on health and behaviours; verbal questioning may be required prior to selection for blood donation.
- Testing—all donated blood units are screened for syphilis, hepatitis B and C and HIV 1 and 2.
- Look back programme—prior to SANBS, the Blood Transfusion Services of South Africa established this programme in 1985 to assess incidence of transfusion-related infection.
- Viral inactivation—technology permitting, certain blood products undergo further procedures to inactivate latent infections.

Occupational exposure

In healthcare settings HIV can be transmitted between patients and healthcare workers in both directions via blood on sharp instruments, and may also be transmitted between patients through re-use of contaminated instruments. A number of studies have highlighted the importance of infection control measures in such settings as well as PEP in the case of sharp instrument injuries. Exposure to blood can also occur in a wide range of institutional settings and in emergency situations where people are injured. Not much is known about the extent of the risk in informal healthcare settings and with traditional practices. Universal precaution practices including use of gloves and other protective measures are recommended.

NSP 2007–2011

As one goal of the Priority Area 1: prevention to reduce new infections by 50 percent, blood safety and reductions in HIV transmission is outlined below:

- Minimise the risk of HIV transmission from occupational exposure among healthcare providers in the formal, informal and traditional settings through the use of infection control procedures.
- Minimise exposure to infected blood through procedures associated with traditional and complementary practices.
- Investigate the extent of HIV risk from intravenous drug use (IDUs) and develop policy to minimise risk of HIV transmission through injecting drug use and unsafe sexual practices.
- Ensure safe supplies of blood and blood products (HIV screening tests for measuring both virus and antibodies).
For further information

- SANBS conducts an annual “Haemovigilance Report,” the 2006 report can be found in the resource CD policy section.
CHAPTER 6 SEXUALLY TRANSMITTED INFECTIONS

Introduction

Prevention and treatment of STIs represent one facet of the South Africa Comprehensive Care, Management and Treatment Programme (CCMT) and the NSP 2007–2011 implemented by the national and provincial departments of health. As reported in a recent article, South Africa continues to experience high incidences of STIs. STI treatment is provided by the public and private sectors, where the public sector uses syndromic STI case management and the private sector relies upon the individual general practitioner (GP). Syndromic case management was adapted and implemented in 1995 by the national department of health based upon 1994 WHO guidelines.

STI management is critical for departments of health to respond to the HIV & AIDS epidemic due to the following:

- Since behaviours that expose people to syphilis, gonorrhea, chlamydia and herpes are the same ones that expose them to HIV, community interventions designed to impact STI incidence will also impact HIV incidence.
- For the same reason, changes in trends in sexually transmitted disease incidence or prevalence may also act as an “early warning” for changes in HIV trends.
- Transmission of HIV and transmission of other STIs are very closely related. Studies have shown that an HIV negative person who has an STI is two to five times more susceptible to acquiring HIV because the lesions and immune response associated with STIs make it easier for HIV to enter the body. At the same time, an HIV infected person who has an STI can be more infectious and more easily transmit HIV to an uninfected partner. Detecting and treating STIs in populations where there are high rates of disease has been shown to reduce HIV incidence.

As indicated by the National Department of Health, STI management will incorporate the following elements:

- Improve the quality of STI management in the public and private sector.
- Establish Provincial STI Management Task Teams that ensure adequate training of health workers on the syndromic management of STIs and also ensure adequate supply of the essential drugs in appropriate health facilities.
- Ensure that private practitioners adopt the syndromic management of STIs by using continuing medical education (CME) to update them.
- Encourage the inclusion of the syndromic management of STIs in the curricula of all health professionals.
- Collaborate with traditional healers to improve health seeking behaviour for HIV & AIDS, TB and STI treatment.

Types of STIs

There are many different sexually transmitted infections which have symptoms that range from itchiness, rashes, sores, and discharge to the more serious pelvic inflammatory disease, infertility, neurological issues, cancer and even death. Most STIs can be “silent” causing no noticeable symptoms. These asymptomatic infections can be diagnosed only through testing. Unfortunately, routine screening programmes are not widespread, and social stigma and lack of knowledge prevent many from pro-actively seeking help.

- Bacterial STIs—are curable, and respond effectively to antibiotic treatment. They include syphilis, gonorrhea and Chlamydia. They respond effectively to antibiotic treatment.
- Viral STIs—as yet are incurable, although symptoms can be treated. They include genital herpes, human papillomavirus (HPV), hepatitis B and C and HIV.
For further information

- The WHO provides a 2007 training for the syndromic management of STIs, for all seven modules, please refer to http://www.who.int/reproductive-health/stis/training.htm. The modules include:
  - Introduction to STI prevention and control
  - Introducing STI syndromic case management
  - Diagnosis and treatment
  - Education and counselling the patient
  - Partner management
  - Recording and development plan

- The 2007 Trainer's guide to the above syndromic management training modules can be found at http://www.nastad.org/Programs/GlobalAIDS/GlobalAIDSResourceMaterials.aspx

- The WHO provides comprehensive information on the etiology, prevention, and treatment of STIs, for more information on specific STIs please refer to http://www.who.int/topics/sexually_transmitted_infections/en/.
Introduction

Managers in the provincial department of health oversee HIV programme planning and development for prevention, care and treatment services in the province. This oversight includes making budgetary decisions related to support of these services. To make these important and sometimes difficult decisions, you will need to obtain and understand information, or data, that will allow you to estimate the number of people with disease, identify trends in disease and characterise populations at-risk of contracting disease. These data will give you a better understanding of the epidemic so you can predict resource needs and plan for them, as well as information about whether the programmes that you are providing resources for are reaching the populations most in need. The collection of these data is called “public health surveillance” and surveillance activities are conducted by staff you oversee, who are specifically trained to do so. As managers, you do not need to understand all of the technical details of public health surveillance activities. However, you do need to understand that surveillance data are an essential tool for guiding decision-making on the allocation of limited resources, the strengths and limitations of different data sources and the methods by which surveillance data are collected and protected.

“Public health surveillance is the ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with timely dissemination of these data to those who need to know. The final link in the surveillance chain is the application of these data to prevention and control. A surveillance system includes a functional capacity for collection, analysis and dissemination linked to Public Health programmes.”

Purpose of surveillance

HIV & AIDS surveillance should be used as a means to ensure that national response to the epidemic is well-focused. HIV & AIDS surveillance activities are carried out for a number of reasons:

- To allow for assessment of the status of HIV & AIDS within a country and to clarify the factors driving the epidemic.
- To facilitate the design, assessment and adjustment of the response to the epidemic.
- To estimate the number of people living with HIV & AIDS in a district, province or country.

Benefits of HIV & AIDS surveillance

The immediate, direct benefit of collecting data about or from those with or at-risk for HIV infection is that you can achieve better-designed, more relevant programmes with implementation based on knowledge gained from the collected data. Indirect benefits might include:

- Greater collaboration among the various agencies participating in the response to HIV & AIDS, including government agencies and NGOs.
- More information about the needs of vulnerable populations that results in provision of additional services.
- Increased trust of vulnerable and often stigmatised populations, resulting in demand for HIV & AIDS-related health services and other services.
Figure 9: Target points for HIV surveillance within the natural history of HIV without treatment

<table>
<thead>
<tr>
<th>HIV seroconversion</th>
<th>Primary HIV infection</th>
<th>Asymptomatic HIV infection</th>
<th>Advanced HIV disease</th>
<th>Death</th>
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</thead>
<tbody>
<tr>
<td>HIV incidence</td>
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<tr>
<td>Incidence</td>
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<td>Advanced HIV disease</td>
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<td>Prevalence</td>
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<td></td>
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<td>advanced HIV disease</td>
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<td>HIV prevalence (all clinical stages)</td>
<td></td>
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</table>

Populations of interest for surveillance

Understanding HIV prevention and care needs in South Africa means understanding the needs of several different but not always exclusive populations. These include:

- High-risk populations (e.g., sex workers, injection drug users and men who have sex with men)
- Bridge populations (e.g., men who have sex with sex workers and also have sex with their wives, interactions with both the high-risk population and the general population)
- General population

Surveillance methods

There are several approaches to HIV surveillance:

- Routine surveillance based on case reporting.
- Sentinel surveillance which allows the adequate collection of HIV, STI and behavioural data concerning specific vulnerable subpopulations, such as injecting drug users, sex workers and prisoners.

Surveillance activities can either be active or passive. The following describes the two systems:

- In an active surveillance system, public health officials seek out cases and collect data on each case. They may do this by routinely visiting clinics and/or by re-examining records for new cases.
- In a passive system, health officials rely on GPs or other healthcare workers to collect and report cases.

In addition to the ongoing routine and sentinel surveillance activities conducted by provincial and district health departments, a number of other studies can be carried out in a region. These studies can identify specific risk factors for HIV infection within the study area. Some of these studies include:

- Community-based cross-sectional sero-surveys among commercial sex workers and behavioural studies among men who have sex with men.
- Population-based cross-sectional sero-surveys representative of the general population.
Conducting behavioural surveys and sero-surveys requires resources in term of staff time and money, so it is important to understand what the data will be able to tell you and how you will use them before you make an investment in collecting them. You will want to understand:

- The population that you are trying to get more information about and, in the case of vulnerable subpopulations, how they will be approached and recruited for the study.
- The number of people needed for the study.
- Methods by which the study can obtain a sample that is representative of the population (e.g., if you study only sex workers who work in brothels, you may not be able to describe the needs of sex workers who work on the street). Sampling methods include:
  - Simple random samples
  - Convenience samples
  - Respondent-driven samples

Mapping exercises can be used to identify community-based entry points for accessing vulnerable populations and estimating the size of vulnerable populations. These exercises include ethnographic assessments and are often conducted in collaboration with NGOs who serve the populations.

Focus on vulnerable populations

- Vulnerable populations should be the cornerstone of the surveillance system in most countries.
- In general, the sentinel surveillance system is focused on vulnerable subpopulations, particularly IDUs, sex workers, MSM and prisoners.
- However, a surveillance system also includes STI patients and pregnant women, who are often considered as proxies for the general adult population.
- The surveillance scope needs to be expanded to include other vulnerable people, such as youths, immediate family and friends of IDUs, military recruits and patients with hepatitis or TB.

Frequently asked questions about surveillance

Following are some questions that you may have or receive from others as you try to plan and evaluate HIV prevention, care and treatment services and the sources of surveillance data that may help to provide answers to these questions.

How many people in my province have HIV?

Obtaining an exact number of people who have HIV is difficult for a number of reasons. Many people who are infected have never been tested so do not know that they are infected. When someone is tested for HIV and is positive, there is no consistent mechanism that exists for reporting the newly diagnosed case. Several sources of information about the number of people who have HIV are:

- AIDS case reporting or AIDS case surveillance—is the regular identification and reporting of persons who meet the AIDS case definition. The number of reported AIDS cases will be an underestimate of people who are HIV infected because not all individuals with HIV have advanced to AIDS and reporting is not consistent across providers.
- Sentinel surveillance and estimates—every year, anonymous blood samples are collected from specific populations to see how many of these individuals are infected with HIV. These populations include those who may be at higher risk for infection, such as attendees of STI clinics or drug de-addiction centres, or at low-risk, such as mothers attending antenatal clinics. HIV prevalence (percent of people from these populations who have HIV) is estimated using these studies and the results are used to make estimates of the number of all people living with HIV.
What are the sizes of the vulnerable populations in my region?

This is not a systematic part of the surveillance system. Usually, there is very little information on the number of members of vulnerable populations. A rapid assessment using ethnographic methods and mapping can be carried out to estimate the number of injecting drug users, sex workers and prisoners. NGOs can be very helpful in estimating the sizes of these vulnerable populations.

Is the number of people becoming infected with HIV every year getting bigger or smaller?

Since data are collected at the sentinel surveillance sites (see above) annually, it is possible to look at whether a higher or lower proportion of those getting tested are HIV-positive compared to the previous year. Over time, the direction of the change in these proportions will help to estimate whether infections are increasing or decreasing.

Who are the people who have HIV in my province?

It is important to understand the characteristics of those who have HIV or are at high-risk for acquiring HIV in order to most effectively target prevention and care programmes. Are they primarily male or female? How old are they? Where do they live? What types of employment are they involved in? What is their education level? What is their marital status? It is important to focus on the characteristics of groups of people, not individuals, in trying to understand the epidemic in your province. Protecting the confidentiality of individuals with HIV and being careful not to inadvertently identify them through presentations of data is a responsibility that should be taken very seriously.

Who are the high-risk populations in my province?

High-risk populations have a higher prevalence of HIV infection in comparison to the general population and high-risk individuals are at greater risk for contracting HIV. For these reasons it is important to determine the HIV prevalence in high-risk groups. High-risk populations play a central role in the spread of HIV infection. They may also serve as bridges to other populations including the general population since they can introduce HIV into these groups. An example of this is male clients of female sex workers, who become infected and bring the infection home to their wives.

How were people who have HIV exposed to the virus?

The predominant route of HIV transmission in South Africa is heterosexual transmission. However, it is important to monitor exposure risks over time in order to better target prevention programmes.

Are there ways to describe/identify people who are at higher risk for HIV infection?

In addition to understanding the characteristics of those who are HIV infected, it is also important to understand the characteristics of those who are at higher risk for infection. As an example, it is important to understand the characteristics of people who are attending clinics for treatment of sexually transmitted infections (STIs); they are people who may have multiple casual sex partners and/or are engaging in unprotected sexual activity and are at higher risk. They may also be at higher risk because some STIs facilitate the transmission of HIV infection. People at high-risk for HIV infection may be highly vulnerable to social and economic conditions that increase their risk of HIV infection. These same conditions may also hinder their involvement in regular surveillance activities. Examples of these conditions include: extreme poverty, reduced opportunities for education, increased risk of violence or discrimination.
Are there ways to learn more about people’s risk behaviours?

Most of the time, very little information is collected about the behaviours that put people at-risk for HIV. While it is useful to know that the majority of individuals who have HIV in South Africa were infected through heterosexual transmission, it would be useful to know more in-depth information such as whether these people had multiple casual sexual partners, if they ever used condoms, or if they didn’t use condoms, why not? While it is impractical to collect such extensive information on all individuals with HIV studies in which these data are collected from a sample of individuals can be very useful for guiding programme planning.

How do I know that my province’s HIV prevention and care programmes are reaching the right people?

As described above, it is important to understand both the demographic and behavioural characteristics of people with HIV infection in your province. You can then look at information about the people who are being reached with your HIV prevention and care programme services to see if they have the same characteristics or if there are gaps in who is being served.

Data analysis, presentation and dissemination

- Data can be used positively to design and modify programmes. For example, if data show that 50 percent of prisoners inject drugs, it may lead to piloting harm-reduction programmes in a prison.
- Data can be used at the national, provincial and district levels. Data can be shared with departments of health, local authorities and other ministries through roundtable meetings and presented at national meetings.
- Since data are used for programme planning, it is important that study data get analysed and disseminated in a timely way.
- Data feedback is critical to NGOs and vulnerable people, especially those who participate in studies, and should be done in appropriate, understandable ways.
- Different audiences will have different needs in regards to how they will be use data, and presentations should be tailored to meet these specific needs.
- HIV & AIDS and STI Directorates need to hire or have access to individuals with strong analytic skills in order to process and present data accurately.

Surveillance capacity development

- Human capacity—ability to train government specialists through various means, including workshops, study tours, peer professional training and on-the-job training.
- Laboratory capacity—ability to provide laboratories with training, quality assurance and technical support.
- Information systems capacity—ability to collect data in electronic formats in sustainable ways.
- Transportation capacity—ability to provide vehicles for surveillance activities.

Environmental issues in conducting surveillance

- Policies regarding needle-exchange
- Attitudes toward persons living with HIV or AIDS and members of vulnerable populations
- Use of identifying information and weak controls for protecting confidentiality
- Segregation of HIV-positive prisoners
- Mandatory HIV testing
- Medical scientific ethics
- Social norms, values and culture; and how these values are affected by the attitudes of people in authority
- Centralised decision-making framework
- Vertical, fragmented health systems
- Political context
HIV & AIDS testing and surveillance

- Effective surveillance for HIV depends on availability and reliable HIV testing
- Testing purpose
- Sensitivity and specificity of HIV tests
- HIV prevalence

Collecting surveillance data to meet donor reporting requirements

Requirements to collect data about certain populations are often made by donor organisations. Since a surveillance system is based on “ongoing, systematic” collection of data, relying on these data can lead to limitations in surveillance activities:

- Often, data are collected for a short period of time and there’s an absence of baseline data.
- Many organisations receiving donor funds do not have staff with the technical abilities to analyse data.
- Coordination of surveillance efforts becomes fragmented.
- There may be limited focus on certain high-risk, vulnerable populations and over-reliance on other methods of data collection, such as case reporting or data from HIV testing sites, that are biased.
- It can divert from the government taking responsibility for ongoing, systematic surveillance as an important part of the core public health infrastructure.

The sections in Chapter 8, Evidenced-based Planning, provide more detail on how to get information about high-risk populations and what these data means. Data about high-risk populations are available to you through:

Surveillance data

Surveillance data characterise individuals diagnosed with HIV infection, and generally include such characteristics as age, gender, primary risk factor, residence at time of diagnosis, etc. By grouping information, it is often possible to identify characteristics of infected populations and those at increased risk of infection. For example, you might find that most of the cases of HIV diagnosed in your province in the previous year were among young men whose primary risk factor was injecting drug use. You would then use this information to make a generalisation about the risk of injecting drug users, and identify them as a high-risk population. As you do so it is important to remember that individuals diagnosed with HIV represent a subset of all individuals who actually have HIV – a subset that has been tested for HIV. Often people access VCT or medical care only when they become ill. Since HIV takes an average of 10 years to incubate in the body and produce symptoms, it may be that this group was at high-risk for HIV ten years ago, and may not be an indicator of which groups are at-risk now. In addition, this subset may be more likely to access VCT if they have financial resources, and/or if they are close to a testing site and/or are literate. It may well be, therefore that this subset is for example, wealthier, and more urban, than the entire group of individuals currently living with HIV in your province who you may wish to target for services.

Existing information about high-risk populations (e.g., data from STI, antenatal clinics or hospitals)

You will want to round out your picture of who is at-risk by using multiple sources of data. Information from STI, TB or antenatal clinics and other sites reaching people at high-risk of HIV infection can provide additional insight. For example, data from an STI clinic can tell you which groups are engaging in high-risk sexual behaviours that result in STIs.
Special studies (surveys, interviews or needs assessments) of high-risk populations

It is often very important to implement special studies among populations you suspect of being at high-risk in order to answer questions that cannot be answered through analysis of existing data. For example, if surveillance data suggest that young men engaging in unprotected sex are at increased risk, you may want to conduct a special study of that population to determine whether the sexual risk behaviours include male-to-male sex, whether there are any specific venues or geographic areas where these behaviours occur. Such studies are best conducted by recruiting members of the at-risk population to participate in surveys or in focus groups (in settings accessible and familiar to them, and conducted by trained peers). NGOs who work with the high-risk populations about whom you wish to have more information may also be engaged to participate in the process.

Potential sources of relevant data include:

- Information about populations at increased risk of HIV infection: Routine reporting of AIDS and/or HIV diagnoses from public health facilities
  - Aggregated data on diagnosed cases of HIV & AIDS and their associated socio-demographic data can assist you to identify and detect trends in populations affected by HIV and in need of services.
- Limitations: these data reflect characteristics of diagnosed and reported cases rather than all individuals with HIV infection. The characteristics of reported cases may not be representative of the broader population of people with HIV infection. Additionally, risk information on cases of AIDS may reflect trends in HIV transmission from 5–10 years earlier since most people are infected long before becoming symptomatic, the point at which most are diagnosed.

- Sero-surveillance (proactive HIV testing among particular populations to determine prevalence of HIV infection)
  - Sero-surveillance data provide objective measures of HIV prevalence among the defined populations tested and can, over time, indicate trends in infections in these populations. This data source is useful in all populations but can be especially useful in high-risk populations that, due to stigma or oppression, may not otherwise seek HIV testing. Data from sero-surveillance among antenatal women are sometimes considered to reflect infection trends in the broader population. Data on persons seeking care in STI clinics provide information about populations with sexual risk behaviours.
  - Limitations: Survey findings represent the specific populations from which participants have been drawn (e.g., those seeking care at STI clinics) and may not be representative of all persons within that population or any other population. Additionally, unrelated events may cause changes over time in the types of people seeking care in the sites from which the testing data are drawn, making trends more difficult to interpret.

- Data from behavioural surveillance surveys
  - Behavioural surveillance surveys are conducted periodically on the general population and also on specific risk populations. Provincial-level data from these surveys provide useful information about surveyed populations’ HIV-related knowledge and risk behaviours, and can help guide prevention interventions.
  - Limitations: Data on those surveyed in any one period may not be representative of that population as a whole.

- Information from VCT, PMTCT, STI and TB clinics
  - Voluntary counselling and testing (VCT): Data on characteristics of those tested at VCT are useful both for those testing HIV-positive and those testing negative. Characteristics of those testing HIV-positive provide insight into HIV risk behaviours (e.g., sexual and drug injecting). These data may provide a basis for reviewing prevention interventions to see if they are targeting those populations found to be at increased risk. Data on persons testing positive in VCT can be also compared to HIV & AIDS case data reported by medical providers to see if the populations involved are similar or if, perhaps, some populations may not be receiving medical care. VCT data on those testing negative for HIV can provide information about risk behaviours and test-seeking behaviours in the populations accessing these services.
• Limitations: VCT data of greatest importance to programme planning may be incomplete or inaccurate, as counsellors may be unaware how useful they can be. Counsellors may not ask questions about risk at all, may ask them in settings (e.g., group counselling) unlikely to elicit accurate information, may make assumptions about risk rather than directly asking patients, or may not probe when patients’ answers are vague. Some VCT populations may not be representative of populations at-risk in their areas because HIV-positive patients tested in other settings or areas may be referred to the VCTC for confirmatory testing or counselling.

  o Prevention of Mother to Child Transmission (PMTCT) services: Data on PMTCT services provide insight into the proportion of pregnant women who are HIV-positive. Useful information may be collected about how on HIV-positive women were exposed to HIV, the HIV status of their spouses, delivery outcomes and referral patterns.

• Limitations: Populations screened through PMTCT services may not be representative of women using private providers for antenatal care or of women receiving no antenatal care. Group counselling may preclude collecting accurate risk information unless this information is also sought during post-test counselling for HIV-positive women.

  o Sexually Transmitted Infections (STI): Considered proxy measures or indicators for unprotected sexual activity that may result in HIV transmission. Since symptoms appear fairly rapidly after infection with STI, information gained on risk behaviour may be more timely than is the case with HIV. Persons with STI often have engaged in sex with multiple partners and/or prostitutes (or their spouse has done so). Having an STI may additionally cause persons to be more susceptible to HIV infection, if exposed, and more likely to transmit HIV to partners, if infected. Socio-demographic and behavioural data on persons using STI clinics may provide further insight into populations at increased risk of HIV.

• Limitations: STI clinic data are likely to be drawn from public sector clinics that have laboratory access, and populations using them may not represent those treated in the private sector or elsewhere.

  o TB: Often the first opportunistic infection to be diagnosed in an individual with undiagnosed HIV infection. Data on TB/HIV co-morbidity may be helpful in identifying populations at increased risk of HIV and/or clusters of infected individuals.

• Limitations: Testing for HIV may be limited in TB treatment settings due to concerns that the stigma associated with HIV may cause persons with TB to avoid or fail to complete their treatment. Completion of a full course of TB therapy is critical since TB is transmitted more readily than HIV, is transmitted through the air and therefore through public interactions involving no risk behaviour, and because incomplete treatment may lead to infections resistant to current TB medications.

• Other potentially useful data sources:
  o Population census (comparison of whole population data to data on at-risk populations)
  o National Department of Health provides the annual HIV and Syphilis Prevalence Survey for comparison of provincial data
  o SANBS (issues a haemovigilance report annually which includes a summary of adverse events (e.g. transfusion transmitted infections)

For further information
• The WHO provides general information as well as technical reports on HIV public health information, please refer to http://www.who.int/hiv/strategic/surveillance/hivpubsurveillance/en/index.html.

• UNAIDS and WHO issued revised surveillance guidelines “Initiating second generation HIV surveillance systems: practical guidelines” for health departments, the guidelines can be accessed at http://data.unaids.org/Publications/IRC-Pub02/1C742-InitiatingSGS_en.pdf.

• A recent article in the Journal of the American Medical Association details a new HIV incidence surveillance system that can be used for subpopulation estimates, for the complete article please refer to http://jama.ama-assn.org/cgi/content/full/301/2/155.

• The U.S. CDC provides the latest HIV statistics and surveillance resources, which can be accessed at http://www.cdc.gov/Hiv/topics/surveillance/index.htm.

• On the website, there are a series of NASTAD Global Program materials on how to create an epidemiologic profile, as well as the 2006/07 District Health Barometer published by Health Systems Trust.
**Introduction**

Planning is simply the process of using information to make decisions. Planning can range from the quick, implicit processes that senior managers use every day to guide staff in their work and where the information used is the individual HAST Director’s knowledge and experience, to comprehensive planning processes that document many formal sources of information. Developing a written plan is one way to organise information and articulate critical thinking. Examples of types of planning:

- Daily decision-making
- Operational planning (work/activity planning) to determine who will do what, when, where and why. This type of planning is often called programme planning when intended to achieve a set of similar goals
- Strategic planning considers resources and activities, including policy development, required to achieve future strategic outcomes

**Benefits of planning**

Planning is particularly important for health managers because:

- You may have more flexibility in accessing and directing resources than you have had in other administrative positions
- Particular characteristics of HIV infection (e.g., long latency period before symptoms appear, stigma for those affected and the need to focus first on those who are infected to prevent further transmission) may require specialised knowledge and prevent the most effective approaches from being intuitively obvious
- Because HIV is an infectious disease transmitted through behaviours that are private and sometimes taboo, people at greatest risk or infected may not seek care or openly provide information about their behaviours. Special efforts may be necessary to acquire information sufficient to inform prevention and care programme decisions
- Also because of the nature of HIV, some decisions may be more political or subject to a higher degree of external scrutiny than is normally the case in other programmes. Selecting particular planning processes (e.g., ones that involve other stakeholders), systematically sharing data and other information and documenting the resulting decision-making processes may help to sustain important efforts if decisions are challenged

Developing a document showing the evidence and processes you have used to reach decisions (i.e., developing a plan) can additionally be of benefit:

- To describe and justify your work to the head of department, MEC for Health and health minister
- To describe and justify your work to medical providers, community-based organisations, consumers and other stakeholders
- To support your requests for additional resources to carry out these decisions/plans
- To help guide independent projects funded by other agencies to work in areas of need rather than in areas of special interest to them or those that are relatively easy to address
- To allocate your limited resources to activities likely to be effective in preventing new HIV infections
- To help coordinate among activities and avoid unnecessary duplication; and
- To monitor and evaluate activities to determine if they are working as planned and, if not, whether and how to modify or replace them
How to plan

Evidence-based planning consciously sets out to use defined sources of objective information to inform programmatic or strategic decisions. Objective data are sought to learn (1) what the current situation is and (2) to identify what the situation should be. Decisions can then be made about how best to fill the gaps or move toward the desired ends.

Planning is a dynamic process. Once a decision is made and an activity or intervention is selected, monitoring the implementation and evaluating the outcome of the intervention help to determine the extent to which the identified need was met, and at what cost. This data should be used to inform future plans.
Hierarchy of plans
Strategic Plan

A strategic plan is a disciplined effort to produce fundamental decisions and actions that shape and guide what an organisation (or other entity) is, what it does and why it does it. Strategic planning requires broad-scale information gathering, an exploration of alternatives, and an emphasis on the future implications of present decisions. It can facilitate communication and participation, accommodate divergent interests and values and foster orderly decision-making and successful implementation. Strategic planning considers resources and activities, including policy development, required to achieve future strategic outcomes.

Most countries have developed their own national strategic plans. SANAC issued a second national strategic plan for 2007–2011 that outlines the next five year strategies and goals (e.g., increase the number of persons within the sexually active population who adopt HIV prevention behaviours in South Africa by 2010), as well as indicators of success and desirable long term targets (e.g., percentage increase of HIV prevention knowledge of people aged 15–49). Strategic plans often outline broad roles and responsibilities of different stakeholders in addressing the strategies and goals (e.g., national government will develop an ART programme or districts will coordinate CBOs). The Three Ones represented an ongoing discussion on how to ensure effective national-level coordination of the HIV & AIDS response. A UNAIDS document on the Three Ones states, “To leverage resources and have the maximum impact on the global response to AIDS, all parties should strive to target their programmes on the priority needs of affected countries strive, seeking to avoid duplication of effort.”

Three Ones key principles:
- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners
- One National AIDS Coordinating Authority, with a broad based multi-sector mandate
- One agreed country-level monitoring and evaluation system

Comprehensive planning

Because strategic plans focus on the big picture, they do not usually describe exactly what should be done in order to achieve the goals (e.g. what activities should take place to increase HIV prevention knowledge of people aged 15–49).

Comprehensive planning is often a district or regional response to a national strategic plan. A comprehensive plan guides allocation of resources from multiple funding sources to assure a coordinated response to HIV in a specific jurisdiction. It considers a specific geographic region and location, its existing resources and activities and the HIV prevention and control needs of communities and groups in the region. It uses this information to develop a set of recommendations for action that will comprehensively address the needs of the region as a whole. It results in specific goals and objectives for specific target populations (e.g., increase the use of condoms among commercial sex workers at the x truck stop through the implementation of peer outreach campaigns).

While comprehensive plans describe what should be done for whom and where they do not usually describe how the activities should be done.

There are many ways to go about developing a comprehensive plan. In general:
- A comprehensive HIV & AIDS plan addresses the greatest needs for HIV prevention and care services in the province.
- The needs are determined by reviewing the HIV & AIDS situation in the province and by conducting assessments of target populations.
- Stakeholders work together to set priorities for the most important services for the coming year.
- The plan is comprehensive for the province and guides different budgets from different funding sources.

Appendix A describes steps and activities you can follow to develop a comprehensive plan.
Operational plan (programme plan, work plan or activity plan)

An Operational Plan is used to show how the recommendations in a comprehensive plan should be implemented. It takes specific recommendations for action from the comprehensive plan and to articulate the specific activities needed to implement them. For example, it would list the specific step necessary to implement a peer outreach campaign to distribute condoms to commercial sex workers at the x truck stop. It considers who will do what, when, where and why.

It is important to develop a plan before implementing a programme or specific intervention. Different frameworks can be used to organise plans but the following elements are central to all of them. Plans need clearly defined goals, objectives and activities (SMART objectives as described in Chapter 7: Surveillance) moving from the broader goals to the narrower objectives and to the specifics of the activities.

Epidemiologic Profile 2007—Le Grand Sud, Haiti
NASTAD-MSPP Collaboration

An epidemiologic profile serves to compile data from many sources, to interpret these data and describe the impact of HIV/AIDS, and can be used to provide recommendations for the allocation of financial and human resources. There are many HIV-related data collected and aggregated in Haiti, including PEPFAR-related data that has grown in both volume and quality in recent years. However, no document has yet been available that compiles multiple data sources and presents an integrated profile of the HIV/AIDS epidemic in Haiti.

The NASTAD Haiti Team developed an HIV/AIDS Epidemiologic Profile for the Haitian Ministry of Health (MSPP) in 2007. This epidemiologic profile is summary document highlighting socioeconomic and HIV/AID-related data from ten or more existing data sources. The profile focused on Le Grand Sud, a geographic region, which includes four of Haiti’s nine departments: Department du Sud, Department de la Grande Anse, Department du Nippes, and Department du Sud-Est. This region was selected by MSPP and NASTAD for the profile, due to completeness of HIV-related data collection in the region.

The epidemiologic profile contains four parts based on the U.S. CDC Integrated Guidelines for Developing Epidemiologic Profiles (2004):

- Patterns of HIV & AIDS-related service availability and service use will be presented using the Cartographie de l’Offre de Service en Matiere de Lutte Contre l’Epidemie du VIH/SIDA en Haiti (2006), the Haitian Monitoring and Evaluation System Interface (2005-2007), and the Haitian PEPFAR-ARV site Electronic Medical Record (2005-2007).
- A fifth component of the epidemiologic profile listed observations and recommendations based on the summarised data.

The NASTAD Haiti team will additionally prepare a Process Manual describing the development of the Epidemiologic Profile to ensure that additional epidemiologic profiles can be created for other departments, regions, or the country as a whole.

Appendix B describes steps and activities you can follow to develop an operational plan.
CHAPTER 8 EVIDENCE-BASED PLANNING

For further information
- NASTAD Botswana in partnership with the Botswana District Multi-Sectoral AIDS Committees (DMSACs) developed the “Evidence-Based Planning Toolkit: Evidence-Based Planning Strategies for an Effective District Response to HIV/AIDS,” which can be found in the resource CD surveillance and evidence-based planning section.
- The NASTAD program in India worked with a state government (equivalent to a province) to develop an epidemiologic profile. On the website’s surveillance and evidence-based planning section, there is an outline of an epidemiologic profile, a sample epi profile, and how to create an epidemiologic profile.
Appendix A:

Evidence-based comprehensive planning

Steps for performing evidence-based comprehensive planning include:

Step One: Describing the AIDS situation in the province, and identifying priority populations
Step Two: Identifying service needs of those priority populations
Step Three: Describing which of the service needs have already been met by developing a service inventory
Step Four: Using the service inventory to identify service gaps
Step Five: Developing specific activities to fill the service gaps
Step Six: Setting and assigning priorities

Step One: Describing the AIDS situation in the province, and identifying priority populations

An HIV & AIDS epidemiologic profile, one of the components of a comprehensive plan, is a formal compilation of data from multiple sources that describe populations with HIV infection and those at increased risk of infection, and provides a graphic picture, outline or representation of the HIV & AIDS situation at a point in time. (See also Chapter 7: Surveillance)

An epidemiologic profile presents available data to address questions such as:

- What are the socio-demographic characteristics of the general population in the defined area covered?
- What is the scope of the HIV & AIDS epidemic in the defined area? Describe the population infected with HIV & AIDS by socio-demographic variables such as sex, age, occupation (if relevant to HIV risk), geographic location (e.g. district or neighbourhood) and mode of exposure to HIV and behaviours that placed them at risk for HIV infection.
- What are the indicators of risk for HIV & AIDS infection in the defined area? Describe the characteristics of individuals not known to be infected but who may be at increased risk for HIV infection (e.g., those with STI or TB) using available socio-demographic indicators and relevant clinical information.
- From this discussion identify the groups most in need of HIV services. Perhaps they will include populations with the most new cases of HIV in the previous year; perhaps those with the highest prevalence of HIV; or perhaps populations in which HIV is not yet prevalent, but in which risk behaviours are widespread.

Potential sources of relevant planning data

Much of the data needed to develop an epidemiologic profile can be collected through routine surveillance activities and special surveillance studies. (See Chapter 7: Surveillance for more information)

Other potentially useful data sources

- Population census (comparison of whole population data to data on at-risk populations)
- National AIDS agency monthly HIV & AIDS reports and HIV & AIDS trend reports for comparison of provincial data to data from other provinces
- Blood banks (may provide indicator data on HIV infection in the general population, depending upon how prospective donors are screened prior to donation. These data may also include information on the occurrence of other conditions such as hepatitis B and C, syphilis and malaria among donors)
- Private hospital data (may provide basis for comparing persons reported with HIV by public hospitals to those receiving care in private settings)

Service inventories identify existing services in the area in question as well as what the services do, what specific population(s) they serve (e.g., HIV positive persons or female sex workers) and how many people in these populations they serve. Such inventories can facilitate networking and referrals between services. Comparing available services to those needed by the target populations can help identify where activities may need to be altered or new ones introduced to fill service gaps.
Monitoring and evaluation (M&E) data provide specific information from contracted agencies regarding the populations they serve; the services they provide; and the impact they may have had. These data can provide information about the needs and preferences of target populations and potentially about the feasibility and effectiveness of specific interventions.

- Limitations: This information may be applicable only to the population and/or to the area, since activities need to be tailored to specific populations and environments.

Information about activities/services that are needed and/or how they should be implemented.

- Information on existing interventions conducted in your country and other countries can help you avoid “reinventing the wheel.” There are many rigorously evaluated activities that may be replicated in, or tailored to, settings and populations in your jurisdictions.
- Seek input from populations to be served (those with HIV and high-risk behaviours) about their needs and preferences for HIV prevention interventions or HIV care services. Stigma and oppression may prevent these populations from saying what will attract them to use and stay in needed services (in many cases, these services benefit others by helping to prevent transmission rather than directly benefiting the person living with HIV).

**Step Two: Identifying HIV service needs of priority populations**

As you consider the data on the priority populations a number of questions may arise that cannot be answered with the existing information. Needs assessment activities can help answer those questions.

For example, data collected from PMTCT clinics and VCT clinics might show you that while 500 pregnant women tested positive for HIV in a year, only 150 of these accessed PMTCT. Clearly, the PMTCT intervention is not serving the population of HIV positive pregnant women appropriately. A survey or focus group of the pregnant women and/or of the PMTCT and VCT sites might ask: what happens at the VCT site that prevents pregnant women from going to the PMTCT site once they have left the VCT site? Is the PMTCT site inaccessible to pregnant women (is it closed when they wish to go there? Are there too few counsellors? Are the counsellors poorly trained?)? Perhaps women do not access the PMTCT site because of family or community reasons: What kind of support are pregnant women receiving from their husbands and families to access PMTCT?

**What questions ought to be asked?**

Once you have clarity about what additional information you require to understand the needs of the priority populations you have identified, you should determine a method for collecting that information.

**Needs assessment methodologies**

Sometimes, because of stigma, people are reluctant to answer questions about HIV. Often you will get better information from a client if an assessment is as short and simple as possible, if you do not ask unnecessary questions, and if you can clearly explain to a client how collecting the information will benefit them or their community.

A needs assessment must be conducted in a way that is appropriate to the target group’s culture and language. It is important to translate a survey or interpret an interview carefully and sensitively. Use experts (elders, traditional leaders) to help you design your assessment. Test the assessment on a few people first and ask them if it was understandable and appropriate.

Select from this list of three simple ways to collect information from your target group. The list of benefits and disadvantages will help you decide.

Survey—Written questions are given to a client to read and answer
Benefits

- Confidentiality—it is easier for a client to answer sensitive questions.
- Cost efficient, since it does not need anyone to administer it.
- Mailed or distributed widely—it does not depend on a client being in one place to complete.
- Client can answer the survey in a time and place convenient to him/her.

Disadvantages

- Not appropriate for clients who cannot read or write.
- There is no one available to answer questions as the client answers the survey, so the survey needs to be short, simple and easy to follow. It is best to pilot such a survey with one or two people before you give it to everyone.
- It can be hard to make sure that completed surveys are returned.

Interview—An interviewer asks the client questions

Benefits

- Good for getting information from someone who cannot read or write.
- The interviewer can explain if the questions are not clear.

Disadvantages

- People are less likely to give personal or sensitive information.
- People may be more likely to give an answer they think the interviewer wants to hear, rather than the answer they really think.
- The interviewer needs to go to the client, or the client needs to come to the interviewer to answer the questions.

Focus groups—An interviewer asks a group of people the questions

Benefits

- People are often more creative in a group—they get ideas from listening to each other.
- The interviewer can probe—ask more questions about a topic that interests them.
- Good for getting opinions or ideas from people.
- Good for getting a sense of what a community as a whole might think.
- Sometimes a focus group can be used to help explain or explore a finding you have made in a survey or interview activity (e.g., “we found that 50 percent of the people we interviewed are afraid to get an HIV test … tell us more about that—why do you think people in this community are afraid of getting a test?”).

Disadvantages

- It is difficult to get the same kinds of information from each individual in the group.

Because you want to get a variety of opinions and ideas from a focus group you should use open-ended questions – that is, questions that cannot be answered with a Yes or No. For example, instead of asking “Was your experience at the VCT good?” say “Tell me about your experience at the VCT.”
Step Three: Describing which of the service needs have already been met by developing a service inventory

Once priority populations and their HIV service have been identified, it is important to inventory the resources and services that are already available to them, so you do not duplicate them.

A community services inventory describes the programmes currently in place in your province. It is useful for two purposes:

- As a community resource to make it easier for programmes to refer clients to another programme.
- To help community members know what services exist, and identify which services are missing.

The inventory format should include the following:

- Name of organisation
- HIV & AIDS contact person/title
- Phone number
- Fax number
- Email address (if available)
- Postal address
- Physical address
- Type of organisation
- Target group
- Category of service
- Days and hours of service

Step Four: Using the service inventory to identify service gaps

A service gap can be:

- There is no service at all for this population
- There is a service, but not enough people know about it
- There is a service, but there are barriers to access (hours are inconvenient, it is not easy to get to, it is too expensive; it is overcrowded)
- There is a service, but people do not like to use it because of stigma, or poor service

The community service inventory (Step 3) can be compared to the needs of the population identified in (Steps 1 and 2) to see:

- Which services are still needed by the population
- Which services there might need to be more of
- Which services might need to be improved

Sample table that could be used in performing gap analysis

<table>
<thead>
<tr>
<th>Priority population</th>
<th>Name of organisation providing this service</th>
<th>Location (village, ward, town, etc.)</th>
<th>Gap—different or more services needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service: VCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of school youth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truck drivers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial sex workers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step Five: Developing specific activities to fill the service gaps

Once priority populations and the gaps in their HIV service needs have been identified, specific interventions must be identified to fill the gaps.

Refer to the prevention module for examples of HIV prevention interventions that might be appropriate for different target populations.

Each activity should consider:
- Target Group—the people who will benefit from the activity
- Intervention—the service that will be provided — for example, IEC, VCT, or PMTCT
- Strategies—the methods that will be used to deliver the service. It is important not only to name the service, but also HOW the service will be provided or improved. (For example, a method for delivering PMTCT might include daily visits by an outreach worker to pregnant HIV positive women in the community to ensure that they take their medications)
- Location—where the intervention strategy and methods will take place

A table such as this might be helpful in determining specific activities to fill the service gaps:

<table>
<thead>
<tr>
<th>Strategic Plan Goal: Prevention of HIV infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Plan Objective/Intervention: Increase access to and utilisation of VCT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>One</th>
<th>Two</th>
<th>Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups that most need to be targeted for each objective</td>
<td>Activities/Services that are already reaching this group</td>
<td>What activities are still needed by this group?</td>
</tr>
<tr>
<td>Strategy/Methods</td>
<td>Location</td>
<td></td>
</tr>
</tbody>
</table>

Step Six: Setting and assigning priorities

In most jurisdictions senior health staff will find that resources for HIV interventions are limited, and in this instance, prioritisation of the most critical HIV service needs must occur.

Inclusion of key partners/stakeholders in this decision-making process, while often time consuming and difficult, is generally very beneficial.

- Broad stakeholder involvement in prioritisation assures transparency and accountability in the decision-making process.
- Involvement can broaden the base of political support for a potentially controversial decision.
- Involvement in making decisions can increase participants’ willingness to collaborate in important activities.
- Involvement can increase the number of individuals potentially available to communicate with others about how and why decisions were reached.
- Broader involvement can also slow decision-making processes, introduce individuals’ agendas and generate conflict.
CHAPTER 8 EVIDENCE-BASED PLANNING

Before beginning the prioritisation process, ensure that all partners/stakeholders are clear as to who will influence the decision and to what extent. Examples below reflect a continuum of decision-making:

- Individual alone makes decision
- Individual seeks input from others, then makes decision
- Individual shares information with representative group of stakeholders who jointly make decisions on behalf of the larger group
- All stakeholders share in available information and jointly make decision

Develop objective criteria for how the decisions will be made in advance of making the decisions. This is especially critical when groups of individuals will be involved in this process. Sample criteria for evaluating whether or not a service should be a priority might include:

- Cost effectiveness: Compare the cost of the service with its likely impact. Reach (numbers vs. impact): How many people will be reached through this service? What will the impact be on each of them?
- Social/Cultural acceptability: Is this service likely to be accepted and used by the community it targets?
- Political considerations: Are there political reasons why the chosen service may be especially difficult or especially appropriate to implement at this time?
- Availability of needed (non-financial) resources: Non-financial resources include trained personnel and facilities.

As stakeholders make their decisions, it might be helpful to ask them to justify their choices based on the criteria that the group has chosen.

Examples of decision-making methods involving groups of people:

- Voting (each participant declares a preference, and a simple majority or some previously-determined proportion of votes constitutes the group’s choice).
- Nominal group process (individuals generate ideas, ideas are shared in round robin format, there is feedback and discussion, each individual selects a pre-determined number of ideas, and ideas are mathematically aggregated). This process is effective only in certain circumstances.
- Consensus (participants discuss ideas, reaching no decision until all participants either agree on one course of action or those with reservations agree to let a decision on that course of action move forward without him/her).

In many instances, health staff may find that there are sufficient resources to implement a plan, but that these resources are held by donors, who have their priorities for delivery of services.

In this instance, the comprehensive plan developed by the jurisdiction is especially helpful. It can be used to provide guidance to donors for allocation of their resources, ensuring that available resources are directed to the highest priority needs, and avoiding duplication of efforts between multiple donors.
Appendix B:

Operational planning

Operational planning is simply a system by which you can think about all the steps needed to implement the priorities you have identified in your comprehensive plan. Each step helps you to think specifically about what you are trying to achieve, and what you need to do in order to achieve it.

To begin with you need to clearly define your proposed project priorities. In your comprehensive plan, your priorities usually are defined as a population or group you want to reach, and the kind of activities you might want to do with them. This priority could be described as a goal.

Goals are generally broadly defined, include a longer time frame and encompass all the objectives. Example: Increase HIV testing in truck drivers in District One over the next three years.

Outcomes or objectives of a programme or intervention now should be selected to address the goal that you have identified. Objectives need to be stated in terms of impacting knowledge, attitude, beliefs or behaviours. We know that risk is reduced only by changes in practice or behaviour and that is the ultimate desirable programme outcome. However, it needs to be recognised that lack of knowledge and/or inappropriate attitude or beliefs may need attention prior to changing behaviour.

Outcomes or objectives should also be stated in measurable terms to monitor and evaluate the success of an intervention in meeting its objectives. An objective must state what is being measured (indicators) and what quantity or level is expected.

A simple acronym used to set objectives is SMART, which stands for:

- **Specific** – Objectives should specify what they want to achieve.
- **Measurable** – You should be able to measure whether you are meeting the objectives or not.
- **Achievable** – Are the objectives you set, achievable and attainable?
- **Realistic** – Can you realistically achieve the objectives with the resources you have?
- **Time** – When do you want to achieve the set objectives?

Example of SMART objectives: “to increase the knowledge of HIV testing resources among truck drivers in District One by 25 percent by the end of the year”, or “to increase the numbers of truck drivers receiving an HIV test at rest stop X in District One by 20 percent by the end of the year.”

Activities—are listed under the objectives and are the specific actions that need to be taken to ensure that the objective is achieved. If your objective is to “increase the knowledge of HIV testing resources among truck drivers in District One by 25 percent by the end of the year”, you should consider exactly how you will increase knowledge. Will you distribute brochures, hold town hall meetings, perform street outreach, or train peer educators to talk to truck drivers? What will you need to do to make your selected activities happen? Will you need to write and print or purchase brochures? Will you need to recruit and train peer educators?

- Example—distribute 5,000 brochures on HIV testing resources monthly to truck drivers visiting five rest stops in District One.

As you are considering your activities, it is often helpful to lay them out in a work plan. The work plan should clearly identify: what is going to be done, how, where, by whom, at what cost and in what time frame. It should also include a time frame to train staff and volunteers to implement the plan. The time frame should take account of the existing procurement procedure and the estimated time that is needed to receive the desired goods or services.
It is often very useful at this stage to identify the key components of the intervention and which may be most problematic or require the most attention to have prepared. For example these could be recruiting and training of personnel, accessing and building trust with the target population, developing materials or procuring supplies. The components will likely require more careful monitoring.

The budget should be carefully developed in as specific terms as possible before final approval to ensure that it can be appropriately resourced to achieve the desired outcomes. Budgets and programme spending need to be monitored in an ongoing manner to determine that expenditures are in line with projections and that funds are being used in a timely manner.

<table>
<thead>
<tr>
<th>SMART Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td>Who is the target audience?</td>
</tr>
<tr>
<td>What is the intervention?</td>
</tr>
<tr>
<td>Where will the intervention be provided?</td>
</tr>
<tr>
<td>What is the expected effect?</td>
</tr>
<tr>
<td>What is the expected magnitude of the effect?</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Is the amount or magnitude (of change) specified?</td>
</tr>
<tr>
<td>Is a baseline stated?</td>
</tr>
<tr>
<td>Is the method of measurement described?</td>
</tr>
<tr>
<td>Can the change be measured objectively?</td>
</tr>
<tr>
<td><strong>Appropriate</strong></td>
</tr>
<tr>
<td>Does the objective address the identified needs?</td>
</tr>
<tr>
<td><strong>Realistic</strong></td>
</tr>
<tr>
<td>Is the level of service feasible?</td>
</tr>
<tr>
<td>Is expected change reasonable?</td>
</tr>
<tr>
<td>Is the change consistent with science and practice?</td>
</tr>
<tr>
<td>Is there enough time to accomplish the objective?</td>
</tr>
<tr>
<td><strong>Time Phased</strong></td>
</tr>
<tr>
<td>Is the interval for measurement specified?</td>
</tr>
<tr>
<td>Is an end date specified?</td>
</tr>
</tbody>
</table>

**Example**
Process objective: By December 2006, conduct five “Prevention Options for Positives”, three session skills-building workshops, for 50 infectious disease clinicians”. Achievement of this objective will be measured through session sign-in sheets.

Outcome objective: Three months after completion of the three-session training series, 60 percent of clinicians will report conducting HIV-risk assessments with HIV-positive patients. Achievement of this objective will be measured through follow-up telephone interviews.
### Activity Responsibility (Who in your organisation will take the lead on implementing this activity?)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Resources (If possible, assign the actual amount, calculated from your budget)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop draft brochure listing available HIV testing resources for distribution at truck stop</td>
<td>Communications manager</td>
<td>Communications manager stipend/salary</td>
</tr>
<tr>
<td>Pilot and refine with truck driver focus group</td>
<td>Communications manager</td>
<td>Refreshments, focus group facilitator</td>
</tr>
<tr>
<td>Finalise brochure</td>
<td>Communications manager and project manager</td>
<td></td>
</tr>
<tr>
<td>Obtain quotes for brochure printing</td>
<td>Communications manager</td>
<td>Printing costs</td>
</tr>
<tr>
<td>Print 5,000 copies of brochure</td>
<td>Printing vendor</td>
<td></td>
</tr>
<tr>
<td>Recruit peer educators through community outreach, direct mailing and newspaper advertising</td>
<td>Training coordinator</td>
<td>Outreach, mailing expenses, newspaper advertising</td>
</tr>
<tr>
<td>Train peer educators to distribute brochures, answer questions and make referrals to HIV testing resources</td>
<td>Training coordinator</td>
<td>Training expenses: room and AV rental, refreshments, travel and per diem costs, certification, etc. Peer educator stipends/salaries</td>
</tr>
<tr>
<td>Peer educators distribute 1,000 brochures</td>
<td>Peer educators</td>
<td></td>
</tr>
<tr>
<td>Peer educators refer 200 truckers to HIV testing resources</td>
<td>Peer educators</td>
<td></td>
</tr>
</tbody>
</table>

**Objective 1:** To increase the knowledge of HIV testing resources among truck drivers in District One by 25 percent by the end of the year
Core competencies

- Identify the basic purposes and scope of M&E
- Define monitoring and evaluation
- Describe how a conceptual frameworks assists in M&E planning
- Differentiate between assessment, monitoring and evaluation
- Describe data collection methods
- Differentiate between goals and objectives
- Develop M&E questions
- Select appropriate indicators and understand how they are linked to M&E framework
- Identify monitoring methods and develop appropriate tools
- Identify the main components of an M&E work plan
- Describe how information can be used for decision-making

Introduction

One of the principal roles of the provincial department of health is to be accountable for the way resources are spent, as well as for the impact the programmes are having and the quality of the services that are being provided. To be accountable means measuring and documenting (i.e. monitoring and evaluating one’s programmes). How one goes about ensuring accountability, or monitoring and evaluating your activities will depend upon how the programme is structured, and the reporting requirements from your government and other funders.

NSP 2007–2011 and the National M&E Framework specify the requirements for programme evaluation. There may also be the programme monitoring and evaluation efforts your state undertakes on its own to help better understand the programmes you are funding or services being provided. If you also receive support from private or international donors, additional M&E requirements may exist.

Many programmes have dedicated staff, if not a distinct section or division, that is responsible for programme evaluation and quality management. As senior department of health staff, you must know enough about monitoring and evaluation to understand whether the monitoring and evaluation activities your staff are performing are sufficient and appropriate to collect the data you need to be accountable to your stakeholders in a timely fashion.

What is monitoring and evaluation (M&E)?

Monitoring is the routine process of data collection and measurement of progress toward programme objectives. Monitoring involves counting what we are doing and routinely looking at the quality of our services. Evaluation is the systematic collection of information about a programme in order to make a judgment (assess and explain) about that programme and to guide decisions about that programme.

Why do evaluation? We do evaluation for many reasons: to ensure accountability to stakeholders and funders, to design effective programmes, to achieve intended outcomes and to ensure effective use of resources. Evaluation is best completed using a study design and will involve measurements over time.

Programme monitoring and evaluation mirrors programme development and design. That is, since the process of designing and developing a programme has many steps and components, there are also many steps and components to ask questions about. We differentiate these kinds of monitoring and evaluation not only because they ask different questions, but because they require different kinds of methods to perform.
M&E framework

Monitoring and evaluation takes place at multiple stages of a programme. At each stage we gather different information that comes together to demonstrate how the project has been conducted and what has occurred.

As a result it is important to identify at the outset how we will gather the information for each level of evaluation.

It is also important to keep in mind that some of these stages overlap and can, in different situations, represent different levels. For example, outcome level data on risk behaviours of target groups can be used to evaluate the effectiveness of a programme or set of programmes without associating the changes with any single programme.

The monitoring and evaluation framework below illustrates the stages that you want to consider for collecting information or data. The assessment stage is about analysing and helping with developing a programme concept and design. Monitoring includes inputs, activities and outputs. The evaluation stage is about assessing outcome and impact. We now will discuss each of these stages below.

**Assessment:** Situation analysis, response analysis, resource analysis, determinants analysis, stakeholder needs, collaboration plans, etc.

**Inputs:** Human resources, financial resources, facilities, drug and commodities, policies, etc.

**Activities:** Products and services, communications, advocacy, logistics, training, etc.

**Outputs:** Products distributed and used, services accessed, personnel trained, etc.

**Outcomes:** Knowledge, attitudes, perceptions, behavioral change, quality of services, etc.

**Impacts:** HIV prevalence, mortality, morbidity, disability, life expectancy, quality of life, etc.

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**Formative evaluation**

- Describes the needs to be addressed through your programme (i.e. “needs assessment”) and suggests approaches to address identified needs.
- Answers the question: What should we do?

**Process evaluation:**

- Describes the programme as it is delivered.
- Is the most basic form of evaluation, like counting widgets: who, what, where, when, how many, what kind, how often, how much?
- Answers the question: Did we do what we said we were going to do?

**Quality assurance**

- Answers the question: Did we do what we said we were going to do as well as we said we were going to do it?

*Process Evaluation informs Outcome Evaluation. If you cannot determine whether your programme was implemented as plan, you cannot distinguish whether or how your programme was responsible for outcomes observed.*

**Outcome evaluation**

- Tells you whether the expected outcomes are being achieved and whether your programme was responsible for achievement of these outcomes.
- Focuses on biologic, behavioral, cognitive/psychological, structural/environmental change or results.
- Answers the questions: Did the programme make a difference?

**Impact evaluation**

- Done at the community or population level.
- Looks at longer term change.
- Is conducted on a large scale.
Assessment

Assessment should be conducted during the planning stage of a programme to identify programme needs and resolve issues before a programme is widely implemented. This is the point where flexibility is greatest and programme sponsors have more freedom to make decisions about how to proceed with implementation.

During an assessment, the following issues are explored:

- Identifying the need for interventions
- Defining realistic goals and objectives for interventions
- Identifying feasible programme strategies
- Setting programme targets

An assessment can be used as an exploratory tool and to help project managers adjust objectives to changing situations. It is also used to identify unacceptable or ineffective intervention approaches, designs and concepts.

Methods of conducting an assessment include:

- Reviews of information you already have
- Focus group discussions
- Key informant interviews
- Participant observations
- Brief surveys using structured questions

Monitoring

Again, monitoring is the process of regularly collecting data and measuring the progress toward programme objectives. There are three types of information necessary in a monitoring system including inputs, activities or processes and outputs.

- Inputs include resources going into conducting and carrying out the project or programme. These could include staff, finance, materials and time.
- Process include the activities in which programme resources are used to accomplish the results expected from the programme, for example, the number of workshops or training sessions.
- Outputs include the immediate results obtained by the programme by completing the specific activities (e.g., number of staff trained, number of people reached).

Monitoring answers the following questions:

- To what extent are planned activities implemented? Are we making progress toward reaching our objectives?
- What services are provided, to whom, when, how often, for how long and in what context?
- How well are the services provided?
- How is the quality of the services provided?
- What is the cost per unit of service?

Monitoring also assesses the extent to which a programme or project:

- Is consistently implemented with each design or implementation plan
- Is directed toward the specified target group
**Evaluation**

Evaluation uses social research methods to systematically investigate a programme’s effectiveness.

**Evaluation is used for:**

- Assessing the changes in the target group, for example, changes in risk behaviour.
- Assessing the extent to which objectiveness have been met, this is part of determining a programme’s effectiveness.
- Tracking outcomes and impacts of programmes at the broader population level as opposed to the programme level:
  - Outcomes are short term or intermediate results obtained by the programme via completion of activities.
  - Impact is about long term effects, for example, changes in health status.

**Evaluation answers the following questions:**

- What outcomes are observed?
- What do the outcomes mean?
- Does the programme make a difference?

Evaluations are done to find out what has happened as a result of implementing a programme. Conducting evaluations is challenging because:

- Study designs to be used include a comparison or control group
- You have to find a way to measure the effects of your programme from other programmes in the same area or with the same groups
- You have to have enough staff to help with the evaluation design and implementation
- Lack of skill in evaluation design, data collection methods, analysis, write – up and distribution
- Not enough financial resources

Outcome and impact evaluation is connected to process monitoring. Process information can help the evaluator understand how and why interventions have accomplished their effects and what specifically is making the difference.

**Data collection**

Different methods are used for different types of evaluation. Non-experimental/descriptive methods (e.g. survey/questionnaire) may be used for formative, process, quality or outcome evaluation. Experimental methods are more appropriately used for outcome or impact evaluation.

An experimental design involves the random assignment of a population of subjects to either an intervention group or to a comparison(s) or a control group. You can then compare outcomes observed in the intervention group with the outcomes observed in the comparison or control group. Using an experimental design allows you to study only the variables you are interested in, since all other variables are controlled for through random assignment. Experimental design allows you to look at cause and effect, and therefore is needed for outcome and impact evaluations, which ask the question “did the programme make a difference?” Quasi-experimental design also entails an intervention and comparison(s) or control group, but has non-random assignment to these.

In non-experimental or descriptive design, there is no control or comparison, and multiple methods are used, with primary and secondary data sources.
Descriptive methods include: focus groups, interviews, ethnographic observation, case studies, archival work, sign in-sheets, facilitator notes, programme logs, budgets, staffing, materials supplied/used and call logs; for outcome: policy, regulatory and protocol/procedures) or some combination thereof. Descriptive methods allow you to observe and describe what exists or to collect information about what should exist (needs assessment), and are best used for formative and process evaluation which asks the question “what should we do?” and “did we do what we said we were going to do?”

Programme managers and M&E planners must balance what is ideal and preferred against what is feasible, relevant and essential when deciding how to evaluate a particular intervention or programme.

As you apply this specifically to HIV & AIDS, you get the stair case model.

<table>
<thead>
<tr>
<th>Problem identification</th>
<th>M&amp;E national programmes</th>
<th>Understanding potential responses</th>
<th>Outcomes &amp; impacts</th>
<th>Monitoring</th>
<th>Determining collective effectiveness</th>
<th>Are collective efforts being implemented on a large enough scale to impact the epidemic (coverage; impact)? Surveys and surveillance</th>
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<tr>
<td>What is the problem? Situation analysis and surveillance</td>
<td>Inputs:</td>
<td>Outputs:</td>
<td>Activities:</td>
<td>Outcomes:</td>
<td>Are interventions working/making a difference?</td>
<td>Outcome evaluation studies</td>
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<td>Are we implementing the programme as planned?</td>
<td>Outputs monitoring</td>
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<tr>
<td></td>
<td>What interventions and resources are needed?</td>
<td>Needs, Resource, Response Analysis &amp; Input Monitoring</td>
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<td>What interventions can work (efficacy &amp; effectiveness)? Are we doing the right things?</td>
<td>Special studies, operations and formative research and research syntheses</td>
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<td>What are the contributing factors?</td>
<td>Determinants research</td>
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Descriptive methods allow you to observe and describe what exists or to collect information about what should exist (needs assessment), and are best used for formative and process evaluation which asks the question “what should we do?” and “did we do what we said we were going to do?”

Programme managers and M&E planners must balance what is ideal and preferred against what is feasible, relevant and essential when deciding how to evaluate a particular intervention or programme.

As you apply this specifically to HIV & AIDS, you get the stair case model.
M&E framework summarises the M&E terms and the relationships between M&E processes:

- First, problem identification. In the case of HIV & AIDS, we initially seek to identify the nature, magnitude and course of the overall epidemic. This information typically comes from surveillance systems, special surveys and epidemiological studies. This first step may also include questions about the nature and magnitude of the programmatic response to date. Situation analysis, gap analysis and response analysis are the typical information-gathering activities that seek information about programme status from, for example, document reviews, informant interviews and field observations. The methods used in this first step are also used in the last step when we determine overall impact and collective effectiveness of combined programme efforts at the national level, thus closing the loop in the iterative process of programme planning, implementation and evaluation.

- Second, determine the contributing factors and determinants for risk infection. This information is usually obtained from knowledge, attitude and behaviour surveys, epidemiological risk factor studies and determinants research. The results at this step help in the design of appropriate interventions.

- Third, what interventions might work? Typical evaluation methods include intervention outcome studies with control or comparison groups, operations research, health services research, formative research and other special studies.

- Fourth, what specific interventions and resources are needed? This question is usually addressed through analysis of programme coverage data from special surveys or from the national health management information system.

- Fifth, assess the quality of programme implementation. This is done through process monitoring, evaluations and other forms of quality assessments.

- Sixth, examine the extent of programme outputs achieved. This answers questions of “how many?” and whether the programme is implemented as planned. Typically this information is routinely collected from health management information systems.

- Seventh, examine programme outcomes. Typically, applied outcome evaluations studies are employed at this stage.

- Eighth, determine programme effects and collective effectiveness. Building on the answers to the questions at previous steps, information from population-based surveys and other surveillance activities are once again used to answer questions at this final step.

**Using SMART objectives:**

**Process objective:** By December 2006, conduct five “Prevention Options for Positives”, three session skills-building workshops, for 50 infectious disease clinicians. Achievement of this objective will be measured through session sign-in sheets.

**Outcome objective:** Three months after completion of the three-session training series, 60 percent of clinicians will report conducting HIV-risk assessments with HIV-positive patients. Achievement of this objective will be measured through follow-up telephone interviews.

**Goals and objectives**

The core of any M&E system is the goals and objectives of the programme to be monitored and evaluated. If the programme goals and objectives are written in such a way that they can easily be distinguished from one another and measured, the job of the M&E specialist will be much easier.
In this section, we focus on how to write goals and objectives so that they are easily monitored and evaluated. We then look at the questions you and your team would like to have answered as the result of your programmes.

What are goals and objectives?

- **Goal**—a general statement that describes the hoped for result of a programme. Goals are accomplished over the long term and through the combined efforts of multiple programmes.
- **Objective**—specific statement detailing the desired accomplishment of the programme. A properly stated objective is action-oriented, starts with the word “to” and is followed by an action verb. Objectives address questions of what and when but not why or how. Objectives are stated in terms of results to be achieved, not processes or activities to be performed.

Clearly articulated goals and objectives include within them measureable indicators that allow you to know whether or not they have been achieved. Such goals and objectives represent the SMART objectives (see Chapters 8: Evidence-based planning for additional information on SMART).

Developing M&E questions

Careful selection of the questions you want answered through monitoring and evaluation will help you develop your M&E processes and work plan. At the beginning of the planning process, programme managers should ask themselves where they want the programme to take them. Many of these questions will be reflected in the goals and objectives.

These questions may also be identified by key stakeholders in your project, such as your funders, your clients and the community you are serving.

Selecting indicators

Once you have articulated clear objectives, you will want to select the most appropriate things to look at that will help you monitor how you are progressing in achieving your objectives. Indicators are clues, signs and markers as to how close you are to your path and how much things are changing. These point to or indicate possible changes in the situation that may lead to improved health status.

Examples of indicators for HIV programmes could include:

- # of HIV counselling and testing sites in the past year
- # of HIV-positive pregnant women started on dual-therapy
- # of men who have sex with men reporting condom use at their last act of anal intercourse

One of the most important steps in designing and conducting an M&E system is selecting the most appropriate indicators. Indicators should always be directly related to your project or programme objective, so the process of selecting indicators can be straightforward if the programme objectives have been clearly presented and in terms that define the quantity, quality and timeframe of a particular aspect of the programme.

Even with well defined objectives, however, selecting evaluation indicators requires careful thought of both the theoretical and practical elements. The following questions can help in selecting indicators:

- Have the definitions of the indicators been tested and can objectives be measured accurately and reliably?
- Will the indicators measure only what they are supposed to measure?
- Are there areas of overlap in the content of the indicator with that of other indicators; is it specific, or is it too general?
- Will the indicators be able to measure changes over time?
- What resources do the indicators require?
- Are there alternative measures that should be considered?
- Will multiple indicators be able to help clarify the results of the primary objective?
Selecting indicators and setting targets is usually done during programme planning, preferably with input from the implementing agency and key stakeholders. To establish benchmarks and activities that are measured as either done or not done and that are realistic for the target population, resource allocation and type of intervention, it is useful to refer to previous interventions done in similar settings.

Finally, be aware that funders, international agencies and government and local stakeholders have an interest in the work and may have indicators to be collected and reported on.

**Monitoring methods and tools**

**Methods for M&E**

Method refers to the approach to a monitoring, evaluation, or research activity. There are quantitative and qualitative methods.

Quantitative monitoring documents numbers associated with the programme, such as how many counselling sessions were completed. It focuses on which and how often programme activities are being carried out. Quantitative monitoring involves record keeping and numerical counts. The programme activities should be examined to establish the kinds of monitoring activities that might be used to assess progress. The method for monitoring and its associated activities should be integrated into programme timelines.

Quantitative methods rely on structured approaches to collect and analyse numerical data. Some common quantitative methods include population census, provider interviews or observations.

Qualitative monitoring addresses questions about how well the programme activities are being carried out. Includes questions about people’s attitudes, the influence of the programme activities, and how the information saturates the at-risk community.

Qualitative methods rely on semi-structured or open-ended methods to produce in-depth, descriptive information. Some common methods include key informant interviews and focus group discussions.

**M&E tools**

A data collection tool is the instrument used to record the information that will be gathered through a particular method. Tools are central to quantitative data collection because quantitative methods rely on structured standardised tools like questionnaires. Tools are also used in qualitative data collection as a way to guide standardised implementation of a qualitative method.

Tools may be used by programme staff or may be self-administered. If the tools are to be self-administered, there should be procedures in place to collect the data from clients who are illiterate. Space, privacy and confidentiality should be observed.

**Some examples of quantitative tools include:**

- Sign-in logs
- Registration forms
- Checklists
- Programme activity forms
- Logs and tally sheets
- Patient charts
Some examples of qualitative tools include:

- Focus group discussion guide
- Observation checklist
- Interview guide

**M&E work plan**

**Why develop an M&E plan work plan? Some reasons may include to:**

- Show how goals/objectives are related to results
- Describe how objectives will be achieved/measured
- Identify data needs
- Define how the data will be collected and analysed
- Describe how results will be used
- Anticipate resources needed for M&E
- Show stakeholders how the programme will be accountable

The content and organisation of an M&E plan are flexible. They should be appropriate for the jurisdiction level and the programme area. The following is an outline for an M&E work plan:

- Introduction
- Goals and objectives of the programme
- M&E questions
- Methodology
  - Monitoring
  - Evaluation research
  - Monitoring quality of services
- Any special studies
- Data flow
- Management Information System and data feedback
- Implementation
- Evaluation Matrix and Proposed Timeline
- Reporting requirements
  - Data dissemination and use
  - Process monitoring tools

An M&E work plan work book is included to assist you with developing your work plan. Please refer to Appendix A for the M&E work plan workbook.

**For further information**

- The NSP 2007–2011 South African National M&E Framework can be found on the website's surveillance and evidence-based planning section.
- A new web resource Global HIV M&E Information provides comprehensive information related to M&E and is managed by the U.S. Government and UNAIDS with input from other international partner agencies, for more information please refer to http://www.globalhivmeinfo.org/ Pages/HomePage.aspx.
- Family Health International, an international NGO, has a free publication “Monitoring HIV/AIDS Programs: A Facilitator’s Training Guide,” which is designed to strengthen M&E skills, the complete guide can be accessed at http://www.fhi.org/en/HIVAIDS/pub/ guide/meprogramguide.htm.
- Africa Palliative Care Association published a manual for palliative care organisations, that was based upon work of the Hospice Palliative Care Association of South Africa. It includes a chapter on M&E and can be accessed at http://www.apca.co.ug/publications/mentorship.htm.

**Acknowledgment**

Information in this module is taken from the Family Health International (FHI) Monitoring HIV & AIDS Programme: A Facilitator’s Training Guide, September 2004. FHI allows for use or replication of this information in part or in full as long the FHI source is acknowledged.
Appendix A:

M&E work plan
Country
Programme name

Table of contents

- Introduction
- Goals and objectives of the programme
- M&E questions
- Methodology
  - monitoring
  - evaluation research
  - monitoring quality of services
- Any special studies
- Data flow
- Management information system (MIS) and data feedback
- Implementation
- Evaluation matrix and proposed timeline
- Reporting requirements
  - Data dissemination and use
  - Process monitoring tools

Introduction

Monitoring and evaluation (M&E) is an important activity of every programme, providing a way to assess progress toward achieving programme goals and objectives and to inform stakeholders about the results. M&E should be integrated into the programme at the design stage to be the most useful. All programmes should include an M&E work plan. This plan guides the design of M&E, identifies what information or data needs to be collected and how to best collect it; and identifies how to disseminate and use the results.

This M&E work plan work book describes the content to include in a work plan.

Programme goals and objectives

M&E questions

Clearly state the important questions of interest to be answered by M&E activities. Stating these questions at the beginning allows for better preparation for designing approach and tools to best gather the needed information.
CHAPTER 9 MONITORING & EVALUATION

Methodology

Monitoring
• Explain how the work plan will record the activities and processes to be used in programme implementation

Evaluation research
• Describe the methods used or to be used in answering the M&E questions

Monitoring quality of services

Special studies

Data flow

Describe how the data will flow or get from frontline workers, responsible for implementing the activities, to funders and how feedback will be provided to frontline workers.

Management information system (MIS) and data feedback

Implementation

For main data collection activities, organisations and/or individuals will be identified to oversee the data collection.

Activity organisation/Person to oversee data collection
Evaluation matrix and proposed timeline

A sample matrix is included in this work book but you may find that you need to alter it or develop another one to best fit your needs. The matrix includes the objectives, the variables to be monitored and evaluated and the methods for conducting the evaluations. The M&E framework provides the concepts used in developing this matrix. The input variables include the resources to implement a programme. The output variables include the things expected as a result of the programme. Outcomes are immediate effects resulting from the programme.

Reporting requirements

- What are the reporting requirements?
- How will you assure that the information required is submitted and done so in time?

Data dissemination and use

- What information will be distributed?
- Who needs the information?
- How does the information get distributed?

Process monitoring tools

The information from these tools will be used to monitor programme activities.
### Appendix B: 
**M&E Matrix**

Objective:

<table>
<thead>
<tr>
<th></th>
<th>Indicators</th>
<th></th>
<th>Data sources and collection methods</th>
<th>Frequency of data collection</th>
<th>Responsible person</th>
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<tbody>
<tr>
<td></td>
<td>Input (activities/resources)</td>
<td>Outputs</td>
<td>Outcomes</td>
<td></td>
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<td>2.</td>
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</table>

<table>
<thead>
<tr>
<th>Activities to assess</th>
<th>Year</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
<th>4th Quarter</th>
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</table>
Core competencies

- Recognition of need for meaningful and organised PLWHA involvement
- Establishment of a consumer advisory board system (CAB)
- Appropriate and encouraged CAB activities
- Establishment of a code of conduct
- Recruitment and retention of CAB members
- Addressing conflict of interest and grievances

Introduction

Developing a formal structure through which to involve community helps you, the provincial department of health, to educate the public about what you are doing, what resources are available and the limitations that you are confronting. With this understanding, the community is empowered to advocate on behalf of the HIV & AIDS and STI Directorate when you may be unable to do so.

A formal structure provides a supportive environment and platform for community and government to confer about HIV free from many of the usual political dynamics. In this setting, community and government can learn from each other, (which builds trust), and together begin to confront some of the social barriers (gender, race and behaviour) that contribute to the HIV epidemic.

Within the NSP 2007–2011 one of the key goals is to empower and engage PLWHAs:

- Goal 16: Mobilise society, and build leadership of people living with HIV, to protect and promote human rights
  - Objective: People living with HIV are organised, empowered and mobilised to protect human rights at national, provincial and district levels
  - Interventions: Develop a nationally relevant human rights package setting out key rights and responsibilities for PLWHA, including for children and people with disabilities. Establish and offer training programmes to PLWHAs in all districts on HIV treatment and prevention literacy, and on human rights and the law. Provide PLWHAs with information regarding access to legal support.

Community involvement improves the impact and sustainability of HIV services

Since the community is the recipient of HIV services, their early engagement in HIV service selection and design improves the responsiveness and effectiveness of the services, and promotes service buy-in and utilisation.

What is an HIV prevention intervention?

Involving community in the HIV response promotes awareness in the community of the epidemic, and builds community capacity and understanding of how to respond.

A community planning group helps members address stigma and denial by providing a supportive environment and structured forum for consumers to learn how to speak out about the disease.

A community planning group builds its own norms and expectations which influence the individual behaviours of its members—therefore, community involvement can be an intervention for HIV risk reduction and behaviour change.
Building community capacity

Community involvement builds community leadership and human resources: it places community advocates in positions where they can learn about the epidemic, how to work with others in the community and how to articulate a position.

Introduction to consumer advisory board (CAB)

A CAB system provides a way for PLWHA to have meaningful input into the development of policies and programmes that address their needs. CABs support the creation of comprehensive, community-based HIV & AIDS prevention, care and support services that are accessible, inclusive, responsive and high quality.

As service users, PLWHA are well positioned to assess the quality, appropriateness and effectiveness of services. In the pursuit of this mission, the CAB system seeks to fulfil the following goals:

- To provide PLWHA input into the development and implementation of HIV & AIDS programmes, policies and community-based providers.
- To ensure significant PLWHA input to community programmes providing HIV & AIDS related services through the development of local CABs or the inclusion of PLWHA on an agency’s Board of Directors.
- To act as a liaison between PLWHA, district government and service providers.
- To educate and bring together PLWHA through a variety of activities that support health promotion and encourage PLWHA involvement.

PLWHA and provider benefits

A CAB system allows for the development of PLWHA self-determination and independence through increased knowledge, the fellowship and support of other PLWHA and an environment of decreased stigma and isolation. The development of leadership skills and a sense of empowerment among PLWHA that helps them in their roles as advisors to local agency CABs.

The relationship between PLWHA and service providers creates an environment that fosters the following benefits:

- The maintenance of a partnership in wellness with PLWHA helping providers in improving service quality, informing type of service, informing programme evaluation and focusing provider programmatic policies on PLWHA needs and concerns.
- The creation of networking opportunities that increase PLWHA knowledge and provider sensitivity to PLWHA needs.

Establishing a CAB system

Ideally, a CAB system would be composed of a district-wide CAB and local agency CABs.

Establishing a district-wide CAB

- Limit membership to a pre-determined number preferably less than 30 persons.
- Recruit members through an annual application process.
- Select candidates that are reflective of the HIV epidemic in the area in terms of race/ethnicity, gender, sexual orientation, age and mode of transmission as well as geographic representation.
- Appointment terms should be pre-determined but preferably not more than a three-year term.

The district-wide CAB would provide advice to staff and senior management of the HIV & AIDS government apparatus and collaborate on strategies, policies and programmatic issues affecting the lives of PLWHA. Specific goals could be developed to focus attention on a particular issue, for example, increasing the number of people who know their status.
The district-wide CAB will want to create an annual plan in collaboration with staff and senior management of the district HIV & AIDS apparatus that articulates the work of the CAB for the coming year. Individual CAB members will want to visit local CABs in their geographic area to provide support and exchange information.

The district-wide CAB should consider structuring its work through project based teams in broad areas such as influence and visibility. Each team should have at least a leader but preferably two leaders who are elected by the other CAB members to guide the work. The leaders should be elected at the beginning of the project and serve for the duration of that project. A management team, at least four to six members, should also be elected. The management team would be responsible for setting the agenda for the full district-wide meetings and facilitating that meeting on a rotating basis. Such organisation allows for more equality and more leaders are developed with each project.

Establishing local community-based or non-governmental organisation CABs

Local agency CABs should ideally be made up of current or past HIV-positive clients who advise the CBO or NGO on policy and programmatic issues. The district HIV & AIDS apparatus would require agencies they fund to support and maintain a CAB. If a CBO/NGO is unable to meet this requirement they would identify an alternative means by which PLWHA would be involved. This alternate way would need to be allowed and approved by the district HIV & AIDS apparatus.

As advisory bodies to CBOs and NGOs, the CABs require active engagement and support of agency staff. These organisations are responsible for their CAB’s actions and for the needs and safety of its members. The CBO/NGO CAB is responsible to the organisation itself as it represents an aspect of the organisation’s work and reflects its goals and mission. Through this collaboration CBO/NGO CABs represent a meaningful link to the organisation and to the services the organisation provides. Local CBO/NGO CAB requirements:

- Relationship with CBO/NGO—CABs and agencies work together to achieve their goals. The organisations have the responsibility for the functioning of their CAB and final decision-making authority. Organisations have the responsibility of bringing issues and/or projects to the CAB, as well as for providing support to the CAB, including securing a location for meetings and work, providing staffing to assist and providing food and other incentives. CABs should have significant input into development of all documents affecting CAB operations, such as by-laws and annual plans, with organisations having the final approval. The same applies to CAB membership and agenda setting. CABs are not independent bodies, they are partners with the organisation, and both the CAB and organisation must work together to develop a meaningful and productive partnership.
- CAB membership—CABs will be composed of current or past HIV-positive clients. CABs and organisations should work together to decide on member recruitment and the process of selecting and seating members, with final decision-making authority resting with the organisation.
- Meetings—every agency CAB is required to meet at least four times per year. At each meeting, minutes must be recorded and then forwarded to the district office of the HIV & AIDS apparatus. CABs may assign a member to take minutes, however, it is ultimately the organisation’s responsibility to assure minutes are taken and distributed.
- Articles of organisation—by-laws, guidelines and other documents that describe how a local CBO/NGO CAB function should be established. By-laws describe the purpose of the CAB, how it operates, who can participate and what is expected of members and leaders. While some CABs create their own articles of organisation, it is the responsibility of the CBO/NGO to ensure that these articles exist and are current, to provide support to the CAB for developing appropriate documents and to ensure that the documents are in line with agency policies. All by-laws will include the following sections:
o Mission of CABs
o When and how leaders are elected (chair, vice chair, secretary, treasurer, etc.)
o The roles and responsibilities of the leaders
o Membership requirements and joining process
o Rules regarding attendance and voting procedures, including quorum
o Behaviour expectations (code of conduct)
o How grievances are addressed

- Annual plan—local CBO/NGO CABs are encouraged to develop an annual plan that describes the CAB's proposed work/projects and budget needs for the year.
- Other ways of involving PLWHA—local organisations that are unable to maintain a CAB must document their recruitment efforts and reasons for lack of success. These organisations will also be expected to demonstrate other ways they have sought PLWHA involvement in agency programmes.

Encouraged CAB activities

There are other activities that all CABs are encouraged to engage in, including:

- Reaching out to HIV-positive persons who may or may not know their HIV status but are not receiving medical care and social support.
- Supporting newly diagnosed persons.
- Educating the larger community about issues and challenges raised by the epidemic through speaking engagements, HIV & AIDS literature, radio spots and television.
- Volunteering at provider organisations to assist organisations with operations.
- Raising funds.
- Participating in community events, this is discussed further later.
- Any other activity that advances the goals of the district HIV & AIDS apparatus that promotes prevention and treatment of HIV & AIDS.

Community events

CAB visibility contributes to the reduction of HIV-related stigma by putting a face on the epidemic and debunking myths and misconceptions about HIV and those living with it. Thus, a CAB should be visible within the community it represents. World AIDS Day, fundraising events, festivals or political events would be opportunities for a CAB to make its role and purpose known within a community. It also provides an opportunity to recruit new members or to encourage others to know their HIV status and get care.

Not all CAB members may be ready to disclose to the community in general and instead choose only to disclose in smaller circles. These persons can still participate in public events if they wish to and identify as PLWHA advocates, community health advisors or community representatives. Progressive disclosure may occur with these persons as their experience of living with HIV & AIDS evolves over time. CABs must respect and support a person's decision about how widely s/he wishes to disclose their HIV status.
Code of conduct

In order to promote civility and effectiveness of the CAB system, members are to be held accountable to a fair and clear code of conduct. Each CAB will include a code of conduct in their CAB by-laws. The following are suggestions for including in a code of conduct:

- CAB members will demonstrate respect for fellow members during CAB meetings.
- CAB members will respect the opinions of others, even if they disagree, and engage in open and productive discussions.
- Confidentiality of all CAB members will be protected.
- CAB members will be on time to meetings and remain until the end, unless an exception was granted by a CAB leader.
- CAB members will complete their fair share of the work.
- CAB members will conduct themselves in accordance to guidance regarding CAB membership and participation.
- CAB members will attend meetings fully prepared to address the meeting’s business.
- CAB members will attend meetings free of the influence of alcohol and/or drugs. CAB members under the influence will be asked to leave the meeting.
- CAB members will focus on the issues, and refrain from making derogatory remarks, using rude language or otherwise disrupting the course of the meeting.

PLWHA recruitment

CABs should recruit a diverse membership that is reflective of the local epidemic in terms of race/ethnicity, gender, sexual orientation, age and mode of transmission. Successful recruitment is usually accomplished through carefully planned outreach into different communities with the help of a variety of people, providers and other community groups. CAB recruitment is a CBO/NGO responsibility. Effective recruitment of PLWHA to participate in CABs requires understanding and overcoming barriers that prevent or discourage membership. Barriers may include:

- Lack of knowledge as to how to become involved
- Lack of confidence in ability to serve as a CAB member
- Difficulty with travel
- Language barrier
- Lack of written criteria for membership
- Unclear member roles, responsibilities and expectations
- Belief that PLWHAs are not given serious attention
- Perception that participation will not make a difference in one’s personal circumstances
- Fear of disclosure of HIV status, sexual orientation or drug use
- Limited physical or mental capacity
- Unfamiliarity and/or discomfort with formality of meeting procedures

Some of these barriers may be overcome by having a nomination process that:

- Is broadly announced and publicised
- Indicates time commitments
- Coordinates recruitment through a committee of the CBO/NGO
- Explains how training, orientation and on-going support is provided
- Clearly communicates expectations, roles and responsibilities and public visibility
- Clearly describes available support (e.g., stipends or transportation assistance)
- Assures confidentiality outside meetings
- Assures language interpretation and translation of written materials
- Describes benefits to PLWHA
Retaining PLWHA involvement in the CAB

Sustaining and maintaining effective PLWHA involvement requires on-going attention and recruitment. On-going recruitment is required to replace members who become too ill to serve, return to work, change their family status, move, burn-out or change their priorities for community involvement. Other barriers include:

- Lack of clearly defined roles and responsibilities
- Lack of orientation and training or mentoring of members
- Conflict between CAB members or CAB and agency
- Time, length and frequency of meetings
- Poor relationships within the CAB
- Long delays before results are provided or seen
- Lack of support for members with special needs
- Large geographic area requiring time consuming long distance travel

Many of the approaches that help with recruitment also help with sustained involvement. Additionally, an orientation helps new members to participate actively in the CAB. Without a complete understanding of the CAB’s function and purpose, a member cannot fully and effectively participate in the process. Thus, existing members should orient new members to the CAB and how it works. Each CAB should have a new member orientation plan that explains the CAB process and describes the member’s role within the CAB. An orientation packet should be developed and include:

- Meeting schedule
- Explanation of structure (i.e. meeting format or CAB leaders)
- By-laws
- Minutes from the last two meetings
- Relevant policy statements (e.g., reimbursement and/or stipend)
- Annual plan
- Agency services and structure, and where the CAB fits in
- Other relevant information

Conflict of interest

CAB members are expected to openly identify any potential areas of conflict of interest in fulfilling their responsibilities. Identification of conflict of interest should be made verbally during any meeting in which a conflict arises and in writing to the chairperson if possible. Conflict of interest is defined as participation in any decision that might result in actual or perceived, direct or indirect financial benefit to the CAB member or a member of their family.

Grievances

If a CAB member has a problem or is dissatisfied with a service that person must follow the agency’s grievance procedure in addressing it. The best way to handle a grievance or potential grievance is to prevent it. Grievances may be prevented if the CAB engages in consistent, open and fair practices that allows for broad input. CAB members should consult their grievance procedures identified in their by-laws to resolve a situation if an informal discussion about the situation does not resolve it.
For further information
- NASTAD Cambodia “Community Planning Summary Primer” can be found in the resource community involvement section.
- NASTAD South Africa – Developing a PLWHA Network in Partnership with Government. A toolkit can be found in the resource community involvement section.
- NASTAD South Africa – South African Support Group Baseline Survey can be found in the resource community involvement section.
- Massachusetts Department of Public Health Consumer Office has several useful resources on establishing a CAB, for the Advisory Board Handbook please find the handbook on the website’s community involvement section.
- For additional resources from Massachusetts, please find the CAB application at http://www.hcsrh.com/sc/Site-Wide_/CAB_Application.pdf.
- The Global Network of PLWHA (GNP+) provides general information and technical resources on involving PLWHAs in a meaningful way, for more information please refer to http://www.gnpplus.net/.

Acknowledgement
CHAPTER 11 PROGRAMME ADMINISTRATION

Core competencies

- Self-assessment of management skills
- Team work
- Supervision
- Staff development
- Budget and resource management
- Communication
- Rules and regulations
- Departmental policies
- Staff roles and responsibilities
- Office management
- Reports
- Professional etiquette

Assessment of management skills

Make the time to complete an assessment of your own management skills. This can be a self-assessment where you simply reflect on what your strengths as a manager are and what areas for improvement you have. Create a list for each of these areas, identifying three to five items for each list. You will then want to develop a plan of action for each item so that you are actively working or addressing the items on your list. You may be asking, 'why do an action plan on strengths?' Reflecting on your strengths and coming up with ways to keep them strong will also help you identify strategies for your areas for improvement.

Specific competencies

- Completing a self-assessment of skills
- Developing a list of managerial strengths
- Developing a list of managerial areas for improvements
- Developing an action plan

Suggested Forms to Use

- Self-assessment form
- Action plan
Figure 14: Self-assessment form

Reflect on what you do well and list at least three qualities you consider strengths

Strengths:
1. __________________________________________________________________________________________
   __________________________________________________________________________________________
2. __________________________________________________________________________________________
   __________________________________________________________________________________________
3. __________________________________________________________________________________________
   __________________________________________________________________________________________

Reflect on what you would like to do better and list at least three areas for improvements

Areas for improvement
1. __________________________________________________________________________________________
   __________________________________________________________________________________________
2. __________________________________________________________________________________________
   __________________________________________________________________________________________
3. __________________________________________________________________________________________
   __________________________________________________________________________________________

Action plan

Review your lists you made regarding your strengths and areas for improvements. For each of the strengths and areas for improvement, specifically identify what you will do to either maintain them or improve upon them

Action steps: _____________________________________________________________________________________

Strengths: _____________________________________________________________________________________

For strength #1, I will continue to: _____________________________________________________________________________________

For strength #2, I will continue to: _____________________________________________________________________________________
CHAPTER 11 PROGRAMME ADMINISTRATION

For strength #3, I will continue to: ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Areas for improvement

For areas for improvement you will want to develop action steps or goals that are Specific, Measureable, Attainable, Realistic and Time bound (SMART) (i.e., what will you do, how will you know you have reached it, how often and by when will it be complete)

Area for improvement #1: ____________________________________________

What do I want to improve on?
________________________________________________________________________

How am I going to do things different?
________________________________________________________________________

How often will I do this new behaviour?
________________________________________________________________________

By when will I complete what I am trying to accomplish?
________________________________________________________________________

How will I know I have achieved what I wanted to do?
________________________________________________________________________

Area for improvement #2: ____________________________________________

What do I want to improve on?
________________________________________________________________________

How am I going to do things different?
________________________________________________________________________

How often will I do this new behaviour?
________________________________________________________________________

By when will I complete what I am trying to accomplish?
________________________________________________________________________
How will I know I have achieved what I wanted to do?

_________________________________________________________________________________________________

Area for Improvement #3:  

__________________________________________________________________________

What do I want to improve on?

_________________________________________________________________________________________________

How am I going to do things different?

_________________________________________________________________________________________________

How often will I do this new behaviour?

_________________________________________________________________________________________________

By when will I complete what I am trying to accomplish?

_________________________________________________________________________________________________

How will I know I have achieved what I wanted to do?

_________________________________________________________________________________________________
Team work

It is likely that much of the work in your office is completed by a group of people. It then is important to pay attention to the kind of relationships these people have at work. You want people to have good working relationships, and desire that people can directly communicate with each other in as open a manner as possible. The goal is to make this group of people work together in a cooperative fashion so that the task at hand is completed.

You may want to identify a person who would take the leadership role that you can charge with guiding the completion of the task. The job of this person is not to do the task themselves but rather for them to delegate responsibly and provide follow up on assignments that are made. You will want to check-in with your designated leader to assess how progress is proceeding. Provide your task leader with both support and feedback about how they are handling or addressing the assigned task.

Core competencies

- Knowledge of team work
- Dynamics of groups, especially the different roles that may emerge
- Knowledge of effective delegation
- Agenda development
- Conducting effective meetings

Supervision

Managers are charged with supervising their employees. Supervision is about providing guidance and regular feedback that encourages the employee's professional growth. Supervision is conducted formally and informally. An effective supervisor designates a regular time to meet with an employee and discuss issues both important to the employee and the supervisor. In fact, a written agenda is important to have so as to remember to discuss important and/or urgent matters. The regular meeting time should be set to happen at least once a month but can be done weekly as well. You will want to set the frequency of your meeting according to how much guidance is wanted or you want to provide. You will want to have a supervision session with each employee, even high performing employees. Having a scheduled time that is uninterrupted will let your employees know that this time is reserved for them and no other tasks.

Supervision sessions should be documented. At least list the items discussed and any action to be taken that was agreed upon. You would then be able to check on the progress made on the task in your subsequent meeting with the employee. In addition to these supervision sessions, make the time to observe your employees doing their job. Direct observations will provide you with examples of how an employee chooses to address tasks and how they go about completing them. Supervision should be considered as an opportunity to help staff grow professionally in their job.

Core competencies

- Knowledge of effective supervision
- Active listening
- Providing feedback in a behaviourally descriptive way
- Establishing goals for growth
- Documenting supervisory sessions
- Assisting staff develop plans of action

Activities

- Develop a form that allows you to record the topics discussed; action steps to be taken and signature spaces for acknowledgement of discussion and agreed upon action
- Role play supervisory session that includes active listening, providing feedback and developing an action plan

Suggested Forms

- Supervisory form
Figure 15: Supervisory form

Issue: _____________________________________________________________

______________________________________________________________

Action Item: _____________________________________________________________

______________________________________________________________

Issue: _____________________________________________________________

______________________________________________________________

Action Item: _____________________________________________________________

______________________________________________________________

Issue: _____________________________________________________________

______________________________________________________________

Action Item: _____________________________________________________________

______________________________________________________________

Issue: _____________________________________________________________

______________________________________________________________

Action Item: _____________________________________________________________

______________________________________________________________

Staff signature: _____________________ Date: _______

Supervisor signature: ________________ Date: ______
**Staff development**

Assure that staff have at least one staff development event on a regular basis, besides the regular supervision sessions, they can participate in. Identify opportunities like conferences or meetings that would help development of a particular skill set or expertise. You could also ask your staff to develop a list of events that they might participate in and ask them to explain how their participation would directly help with their professional development.

Additionally, you will want to conduct an annual skills audit to determine if any critical skill is lacking among your staff. A sample skills audit is included in the appendix for your reference. If you have a form you can substitute that would be fine. The important issue is for you to know if your staff has the skills to do their job and identify if there is any critical skill lacking that needs to be developed.

**Core competencies**

- Identifying expertise and/or skill set important to doing the work

**Suggested Form**

- Skills audit (See Appendix A)

**Budget and resource management**

Managers are routinely asked to help develop programme budgets. It will be important to know how much the current level of activities cost in terms of funds for the programmes to be implemented and in terms of the staff necessary to carry out the tasks. You will also want to anticipate growth or additional expenses for emergencies that may arise.

**Core competencies**

- Develops and presents a budget
- Manages programmes within budget constraints
- Applies budget processes
- Develops strategies for determining budget priorities
- Monitors programme performance
- Prepares proposals for funding from external sources
- Applies basic human relations skills to the management of organisations, motivation of personnel and resolution of conflicts
- Manages information systems for collection, retrieval and use of data for decision-making
- Negotiates and develops contracts and other documents for the provision of population-based services
- Conducts cost-effectiveness, cost-benefit and cost-utility analyses

**Communication**

Managers should maintain contact with both their supervisor and the staff they supervise. In communicating with staff you supervise make sure they completely understand your requests. Likewise make sure you are clear about what your supervisor has requested. If not, ask questions and get clarification. Do not walk away guessing about what people have said or what they are expecting from you. Notify your supervisor or a senior staff member immediately of any problems or when issues are not resolved. This is particularly important to do if the media or other agencies are involved. Do not let your supervisor learn about the problem from another source other than you. Establish written communication protocols that inform staff which departmental staff are to be informed of incidents. Preferably managers would be the first point of contact, however, this is sometimes not possible so staff should have clear guidance about who to call and/or e-mail in the event that something needs immediate attention.
Core competencies

• Communicating verbally in a clear and comprehensible manner
• Communicating in writing in a clear and comprehensible manner
• Being aware of expected communication protocol

Activities

• Develop urgent communication protocol
• Develop directory of phone numbers that can be distributed

Suggested Form

• Urgent communication protocol

Figure 16: Urgent communication protocol

In the event that there is an urgent matter in which management staff have to be reached please call the following numbers in the order they are listed and inform them of the situation:

Secretariat: ________________________________________________________________________________

Administrator: _______________________________________________________________________________

Programme Director: __________________________________________________________________________

Direct Supervisor: ____________________________________________________________________________

Rules and regulations

Know what the rules and regulations are that are critical in conducting your job. If at all possible, make sure you have copies of these documents. Some rules are non-negotiable and everyone needs to adhere to them. Identify what these rules are, learn them and follow them. The website for the Department of Public Service and Administration has a document archive tab which lists acts, policies and regulations. Health departments will want to review this site so as to know what may affect you.

Core competencies

• Know relevant rules and regulations
• Know where you can go to reference them
• Adhere to the rules and regulations

Departmental policies

Know what policies your department has that relate to your position. If at all possible, make sure you have copies of these policies. Some policies are meant to be followed as they are written and others are more flexible. Know which ones need to be strictly adhered to, learn them and follow them. If you have questions about a policy get clarification and offer the clarification to your employees if it is helpful.
Core competencies

- Know relevant policies
- Know where you can go to reference them
- Adhere to the policies that apply to you

Staff roles and responsibilities

Every staff member should know what they are expected to do and by what standards they will be evaluated. A written job description that clearly and specifically identifies an employee’s duties and responsibilities should exist for each position within the organisation. If written job descriptions do not exist you could start by writing your own first and determine if it is what you are actually doing or think you should be doing. Be sure to discuss the job description with your supervisor to see if there is agreement.

Additionally, you will want to provide your staff with written feedback on their performance on at least an annual basis. A performance evaluation should be available from your agency. If not, a suggested form is included for your consideration.

Core competencies

- Acquire your job description. If it does not exist, then develop one
- Assure that other staff also have written job descriptions that clearly and specifically identify job expectations
- Review job descriptions with staff and assure that there is agreement with them

Suggested Forms

- Job description

A job description is a written statement of the duties, key responsibilities and other particulars, e.g. the title of the job, the purpose of the job, resources required, supervision necessary etc., of a job. It describes what a jobholder does and why it is done.

The Public Service Regulations (I/III/I1.2) requires a job description to include the main objectives of the post, the inherent requirements of the job as well as the requirements for promotion or progression to the next salary range. A job description should therefore indicate the output expected from a specific job, the competencies (job specifications) that an incumbent should have to successfully achieve the required output as well as a possible career path.

- Performance evaluation
Figure 17: Job description template

Job Information Summary
- Job Title
- PERSAL Component Code
- Post Number
- Current Jobholder
- CORE
- Post Level/Salary Range
- Remuneration
- Location
- Component
- Reports To

Purpose

Dimensions
- Organisational Chart/Organogram

Key Responsibilities

Communication and Working Relations

Working Conditions

Material and Equipment Used

Competency Profile

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and training</td>
<td>Minimum qualification and training required registration / enrolment. E.g. 3 Year tertiary qualification in HR or Practical in-service training and practical demonstration of knowledge and skills</td>
<td>Additional appropriate qualifications or training</td>
</tr>
<tr>
<td>Relevant experience</td>
<td>Period and type of experience required E.g. 2 Years management experience</td>
<td>(e.g. public sector experience)</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Indicate broad and specific knowledge required E.g. Personnel evaluation procedures / Human resource management practices</td>
<td>(e.g. awareness and understanding of cultural climate within the public service)</td>
</tr>
<tr>
<td>Skills</td>
<td>Indicate the skill and where possible the level required/desired (e.g. analytical skills or basic numeracy skills)</td>
<td>Indicate the skill and where possible the level required/desired (e.g. analytical skills or basic numeracy skills)</td>
</tr>
<tr>
<td>Values/attitudes</td>
<td>(e.g. loyal, trustworthy)</td>
<td>(e.g. enthusiastic)</td>
</tr>
</tbody>
</table>

Career pathing

Agreement

Approval
CHAPTER 11 PROGRAMME ADMINISTRATION

Figure 18: Annual performance evaluation

Employee:
Reviewer:
Date:

Strengths and accomplishments:

Training and conferences completed:

Areas for improvement:

Areas for growth and how growth will be achieved:

Specific goals and objectives:

Summary comments:

Signatures:

______________________________  __________
Supervisor     Date

______________________________  ___________
Staff      Date
Office management

Programme offices more often than not have administrative assistants whose jobs include keeping the supplies and materials for the office. Assistants are also tasked with assuring that office equipment are working properly and if not, getting the necessary technical help. If there is not an administrative assistant assigned to your office make sure you specifically identify tasks to keep the office running smoothly in other people’s job descriptions or hire an assistant.

You will also want to be knowledgeable of the contents of any memoranda of understanding when the department is co-located with another organisation. Communication with the other organisation’s director and/or manager is crucial to maintaining a good working relationship. Identify who in the other organisation is the contact person to address concerns and/or issues.

All files related to a programme should be reasonably secured at all times. Printed and electronic files with sensitive information and all files with financial information must be kept under lock and key. Do not leave sensitive written materials on the desk or in open areas. Know when it is appropriate to release information before releasing any.

Core competencies

• Develop or acquire a list of the routine logistical matters that provide your staff the items necessary for them to do their work
• Inventory equipment and working condition
• Know terms of lease or space sharing

Reports

Know what written reports are expected to be created and submitted. Know what the format of the report should be and what topics should be covered. For more regular and routine reports, develop a monthly calendar where you identify the due dates of all reports to be completed. For grants or annual reports organise a team of staff that will be responsible for completing the report. Make sure this team develops a timetable and that important markers like first and final draft are noted. Always identify the primary person that will be taking the lead in guiding completion of a report.

Core competencies

• Know what reports are expected to be submitted
• Know when reports are to be turned in
• Know the format specifics of the report
• Know what grants have to be developed and when they are due
• Develop calendars that assist with tracing writing assignments

Professional etiquette

You will want to conduct yourself in a professional manner and likewise request that your staff also behave professionally. If there are any behaviours and/or actions not considered appropriate, make sure that all staff are aware of this standard. Behaviours and actions are open to interpretation. Remember that you are representing yourself, and your department.
CHAPTER 11 PROGRAMME ADMINISTRATION

Core competencies

- Know what is expected in terms of behavioural conduct
- Communicate expectations to all staff
- Develop written code of conduct that specifically identifies behavioural expectations

Suggested Form

- Code of professional conduct

Figure 19: Code of professional conduct

Professional conduct and behaviour is expected of all staff. Some points to consider:

- Exercise good judgment. Keep in mind that there are behaviours and actions that are considered inappropriate.
- Be aware of any traditional expectations and any consequence if not observed.
- Be aware of legal offenses and follow the law.
- Remember that you are representing yourself, your secretariat and the government.
- List other behaviours you want your staff to demonstrate.

I, _________________________, verify that I have read and understand        Printed Name

The Code of Professional Conduct.

____________________________  _________
Signature    Date

HIV & AIDS in the workplace

As you know, HIV & AIDS is a serious matter. Oftentimes government agencies develop guides to assist agencies to plan, implement and monitor appropriate and effective responses to HIV & AIDS within the working environment. The South Africa Republic Department of Public Service and Administration has guidelines for reference. If your agency does not have similar guidelines you are encouraged to prompt initiation of development of such guidelines within your own agency.
For further information

- **People Management**: better knowledge for better practices provides information on effective support and supervision to access the document please refer to http://www.scie-peoplemanagement.org.uk/resource/docPreview.asp?surround=true&lang=1&docID=126.

- A staff supervision policy developed by the Social Work Management Team details the key areas of staff supervision, standards, and staff development. To access this policy, please refer to http://www.shetland.gov.uk/socialwork-health/documents/PL34StaffSupervisionPolicy.pdf.

- An article on how to make teams effective provides twelve tips for successful team building. To read the complete article please refer to http://humanresources.about.com/od/involvementteams/a/twelve_tip_team.htm.

  - A second article focuses on team building, employee empowerment, and employee involvement. To read the complete article please refer to http://humanresources.about.com/od/involvementteams/Team_Building_Employee_Empowerment_Employee_Involvement.htm.

- A leadership development website brings together leadership prospective from across the world. For more information on leadership values and principles, please refer to http://www.leader-values.com/default.asp.

- For more information on managing HIV & AIDS in the work place, please refer to the “Managing HIV & AIDS in the Work Place: Guide for Government Departments,” which was prepared by the South Africa Department of Public Service and Administration. The complete guideline can be found in the resource policy section.
Appendix A:

Skills audit assessment

Name of Department: ...............................................................
Name of institution: ...............................................................
Name of section/division: .....................................................
Date: .............................................................................

Dear Manager/Supervisor,

The management of this Department is committed to the training and development of our employees. We want to render quality services and products to our customers/clients and in order to do so we need competent employees. This means that employees must have the necessary knowledge and skills to perform their jobs competently.

The Department wants to identify the skills gap of employees so that we can provide them with the necessary training. We therefore need your input. We developed this questionnaire to enable you to indicate the skills gaps of employees in your division/section, i.e. the people who report directly to you. The information you provide will be used to identify the priority areas for training in the Department.

The questionnaire has been designed to assist you to determine the training priorities that will address the most important skills gap in your section/division.

The focus of this skills gap is to obtain your input in the following main areas:
- What are the main skills gaps in the section/division? (Answers will indicate the gap between the skills/competency employees currently have, in relation to what they should have);
- What training do employees need in the next year and in the future?; and
- Which learning programmes are recommended to address the skills gaps and build the required competence?

<table>
<thead>
<tr>
<th>Details of the person who completed the questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and surname_________________________________ Job title/Designation________________________</td>
</tr>
<tr>
<td>Personnel number__________________ Section/Division________________________</td>
</tr>
<tr>
<td>Date completed________________________</td>
</tr>
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<table>
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<tr>
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<th>RACE</th>
<th>DISABILITY</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>A</td>
<td>C</td>
<td>W</td>
<td>I</td>
</tr>
</tbody>
</table>

Please complete the questionnaire and return it to the ____ by ____________________

---

The questionnaire has been designed to assist you to determine the training priorities that will address the most important skills gap in your section/division.

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</tr>
<tr>
<td>A</td>
<td>C</td>
<td>W</td>
<td>I</td>
</tr>
</tbody>
</table>

Please complete the questionnaire and return it to the ____ by ____________________
### SKILLS AUDIT PHASE I: DETERMINE SKILLS REQUIREMENTS

<table>
<thead>
<tr>
<th>What are the main priorities in your section/ division?</th>
</tr>
</thead>
</table>

**Strategic objectives**
- What are the strategic objectives of your section/ division?
  - Short term:
  - Long term:

- What services do you render to achieve the objectives?

- What skills are needed in the division/section to achieve its goals and objectives? (classify them according each occupation)

- What staff is needed to fulfil the skills required?

- What staff movements are planned or anticipated over the next three years (e.g. promotions, appointments, resignations, retirements, etc.)?

- What other priorities are there in your section/ division that would indicate a need for new skills and training?
CHAPTER 11 PROGRAMME ADMINISTRATION

---

### Scarce and critical skills gap in your section/ division

<table>
<thead>
<tr>
<th>Scarce skills gap</th>
<th>Critical skills gap</th>
</tr>
</thead>
</table>
| • Are there any occupations in your section/division that can be classified as scarce skills?  
  (These are occupations in which you have difficulty employing people because of a scarcity of qualified and experienced people, or because you cannot attract such people to work in your section/ division/ department. Examples are accountants, engineers, primary school teachers, medical doctors or HR practitioners.) | • Are there any critical skills gaps in your section/division?  
  (These are skills within an occupation that are required to perform a function within that occupation. Examples are English writing skills, writing a business plan, MS Office suite, counselling HIV/AIDS patients, developing a curriculum or conducting disciplinary hearings.) |

### Main performance problems in your section/ division

• What are the main performance problems experienced in your section/ division that can be attributed to a lack of skills?

### What are the overall training priorities, based on the skills needs identified in the previous sections?  
(Please provide a consolidated list of about 5 to 10, in order of priority.)

<table>
<thead>
<tr>
<th>Which scarce or critical skills does the training priority relate to, if relevant?</th>
<th>Which strategic priority does each training priority relate to?</th>
</tr>
</thead>
</table>

---
# PART 3: CONSOLIDATED LIST OF SKILLS GAP OF EMPLOYEES IN YOUR SECTION/ DIVISION (FOR HRD OFFICE USE ONLY)

Note: Each employee in your section/ division should have completed the Skills audit questionnaire for employees. The list that is required here must be compiled after the manager/ supervisor has worked through and integrated the entire skills audit indicated by the individual employees.

<table>
<thead>
<tr>
<th>LEARNING AREA in which training is required</th>
<th>COMPETENCE that should be developed (i.e. what must the learner know, understand and be able to do at the end of the programme)</th>
<th>TYPE OF LEARNING PROGRAMME that would be most appropriate</th>
<th>NQF LEVEL of the programme (if known)</th>
<th>STRATEGIC TRAINING PRIORITY addressed through this training</th>
<th>NAMES OF PERSONS in your section/ division who require this training</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.g.:</td>
<td>E.g.: Analyse balance sheets - Compile budgets - Keep record of income and expenditure - Apply financial procedures to transactions</td>
<td>It is recommended that you select one of the DoL-approved programmes, i.e. ABET, Articles, Apprenticeship, Internship, Learnership, Skills Programme, non-credit-bearing Short Course, or Work Experience</td>
<td>Indicate the NQF level of the programme, where it is known</td>
<td>Indicate the priority identified in Part 2 above</td>
<td>Write the names of the employees who need this training</td>
</tr>
</tbody>
</table>

Note: insert more rows if required

Thank you for taking the time to complete this questionnaire
Chapter 12 Contract Management

Core competencies

What is contract management?
What is a request for proposal?
Understanding and explaining the bidding process
Identifying the types of contracts and the parts of a contract
Amending or making adjustments to contracts
What is contract monitoring? How do you do it?
Progress reports and site visits
Audits and contract termination

Introduction

Contract management is the management of contracts made with vendors, partners, service providers or employees. A contract is a legally binding agreement between the parties identified in the agreement to fulfil all the terms and conditions outlined in the agreement. A prerequisite requirement for the enforcement of a contract, amongst other things, is the condition that all the parties to the contract accept the terms of the claimed contract.

The contract contains the terms of the agreement, the description of services, the funding level(s) and payment information, as well as other necessary legal language. Again, all parties involved should read and be aware of all information in the contract.

Contract management processes and procedures differ from organisation to organisation; know what the specifics are used by your department in managing its contracts.

Request for proposal

A request for proposal (referred to as a RFP) is an invitation for vendors, through a competitive bidding process, to submit a proposal on a specifically requested product or service.

The submittal of an RFP typically involves the following:
Corporate information including proof of licensure in the jurisdiction
Technical capability
Description of services or goods to be provided
Staffing and service delivery plan
Cost or programme budget

The bidders return a proposal by a set date and time determined by the entity releasing the RFP and is included in the advertisement for the proposal. Late proposals may not be considered. The proposals are used to evaluate the responsiveness of a supplier or vendor. An evaluation committee is named to open the received bid packages and evaluate the responsiveness of the application to the RFP. In some instances, selected bidders may be asked to make a presentation to the evaluation committee. The words procurement and solicitation refer to the same process of inviting companies to bid on opportunities to provide goods and services. The actual document outlining the goods and services may be called any of the following: procurement, solicitation, request for proposal (RFP), request for quotation (RFQ), request for qualifications and quotation (RFQQ) or request for information (RFI), depending on the purpose of the procurement. The document that is sent by the bidder in response to a solicitation is called the bid, the response or the proposal.
Figure 20: Example of proposal from National Department of Health

Bidding process

CALL FOR PROPOSALS
NGO FUNDING 2009/10

The National Department of Health is inviting national NGOs working in the field of HIV/AIDS and TB to apply for funding. NGOs are considered to be national entities if they provide a service in three or more provinces. Funds will be made available to eligible organisations providing any of the following services:

- Community Mobilisation for AIDS competence including Home Base Care
- Support for People Living with HIV (PLHIV).
- Treatment adherence Counselling
- Prevention Programmes viz PMTCT, Youth Life Skills and High Transmission Areas interventions
- Provision of Voluntary Counselling and Testing services
- Governance and Leadership development

Requirements:

- Applicants must be implementing services related to priority areas of the National Strategic Plan 2007-2011 & Comprehensive HIV/AIDS Care, Management and Treatment Plan
- Registration as a Non-profit organisation
- Constitution and a functioning governing board
- Copy of financial policy signed by the Board
- Track record in HIV & AIDS and STI service delivery will be a recommendation.

How to Apply:

Documentation required from NGOs to be considered for funding by the Department of Health:

- Application form, which is obtainable from National Department of Health Offices and website: www.doh.gov.za
- Business Plan detailing schematic plan and budget for funds requested
- Copy of certificate of registration under the Non-Profit Organisations Act of 1997
- Copy of the NGO’s constitution
- Names of Board Members
- Copy of the NGO’s financial policy (the organisation’s signatories should sign all documents)
- Details of other sources of funding.

Note: All applicants must ensure that they have presented their projects to Provincial (Department of Health) HIV & AIDS and STI Programme Managers within their respective provinces where they are operational. A written confirmation will be required in this regard as proof that the province knows your project. The table below lists names and contact details of Provincial Programme Managers and NGO Programme Co-ordinators.

<table>
<thead>
<tr>
<th>Province</th>
<th>Programme Manager</th>
<th>Contact Details</th>
<th>Contact Person</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>Ms B Smuts, Southern Life Centre, 8 Riebeeck St, Cape Town</td>
<td>Tel: (021) 483-5751 Fax: (021) 483-6033</td>
<td>Ms J Arendse</td>
<td>Tel: (021) 918-1545 Fax: (021) 918-1521</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>Mrs G Nogodula, Bishop Hospital Nurse’s Home, HIV/AIDS Building, Bisho 5602</td>
<td>Fax: (040) 609-4292</td>
<td>Ms N Zulu</td>
<td>Tel: 083 378 0449 Fax: (040) 609-4292</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>Ms N Mazibuko, Kimberly Hospital, Du Toit Span Road, Kimberley</td>
<td>Tel: (053) 830-0524 Fax: (053) 830-0655</td>
<td>Ms M Motlhaudi</td>
<td>Tel: (053) 830-0621 Fax: (053) 830-0655</td>
</tr>
<tr>
<td>North West Province</td>
<td>Mr C Lebeloe, 29 Main Street, Mafikeng</td>
<td>Tel: (018) 397-2601 Fax: 086 621 9000</td>
<td>Ms L Molefe</td>
<td>Tel: (018) 397-2686 Fax: (018) 397-2675</td>
</tr>
<tr>
<td>Gauteng</td>
<td>Dr D Moloi, 37 Sauer Street, Gauteng</td>
<td>Tel: (011) 355-3393 Fax: (011) 355-3297</td>
<td>Mr W Mashaba</td>
<td>Tel: (011) 355-3388 Fax: 086 658 6787</td>
</tr>
<tr>
<td>Limpopo</td>
<td>Dr MW Shilumane, Office 108, Jan Modeman Building, Polokwane</td>
<td>Tel: (015) 290-9266 Fax: (015) 291-3402</td>
<td>Ms C Jackson</td>
<td>Tel: (015) 290-9000 Fax: (015) 291-3402</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>Ms Z Madonsela, Government Boulevard/Complex, Building, Nelspruit</td>
<td>Tel: (013) 766-3045 Fax: (013) 766-3470</td>
<td>Mr M Vumase</td>
<td>Tel: (013) 766-3256 Fax: (013) 766-3469</td>
</tr>
<tr>
<td>Free State</td>
<td>Ms P Shai-Mhatu, HIV/AIDS Programme, BopheloHouse, Bloemfontein</td>
<td>Tel: (051) 408-1413 Fax: (051) 408-1961</td>
<td>Ms C Mokobe</td>
<td>Tel: (051) 408-1639 Fax: (051) 408-1961</td>
</tr>
<tr>
<td>KZN</td>
<td>Dr SSS Buthelezi, Natalia Building, Langalabalele Street, Pietermaritzburg 3201</td>
<td>Tel: (033) 395-2197/2112 Fax: (033) 342-9427</td>
<td>Mr R Phili</td>
<td>Tel: (033) 341-4001 Fax: 086 610 2012</td>
</tr>
</tbody>
</table>

Enquiries can be directed to Mr GC Bonnecew at tel. (012) 312-0136/7, fax: (012) 312-0921/3155, mobile no: 082 440 5118. A briefing session will be held on 11 December 2008 @ 10:00.

Venue: National Department of Health offices, HTI Building, Impilo 1 Boardroom, Prinsloo Street (opp State Theatre), Pretoria.

Closing date: 6 January 2009 @ 12:00.

PROPOSALS RECEIVED AFTER THE CLOSING DATE WILL NOT BE CONSIDERED.

Proposals must be forwarded for the attention of Ms V Lekoto, National Department of Health, Private Bag X828, Pretoria 0001 or can be hand-delivered at Room 1605, Hallmark Building, Proes street, Pretoria. Tel: (012) 312-0137.

1 The NGO Funding 2009/10 call for proposal issued by the National Department of Health can be accessed at http://www.doh.gov.za/docs/ngofunding-f.html
The bidding process often begins with the HIV & AIDS apparatus issuing an announcement that it intends to issue an RFP, many times this solicitation for services will be competitive. This means that existing as well as new service providers will be eligible to apply for funding by submitting a proposal or application in response to the RFP. The HIV & AIDS apparatus may decide to hold a bidders meeting or conference open to all entities wishing to submit a proposal. This bidder’s conference is used to review the RFP and provide clarification. There are often rules and regulations about how a bidder’s conference will be conducted, such as making public the proceedings of the conference. You will want to know and familiarise yourself with this guidance.

Once proposals are submitted then they will need to be reviewed and evaluated. Usually, the criteria and procedures for evaluating proposals are decided ahead of time and then implemented uniformly. It is suggested that tools be developed that will easily allow components and contents of the proposal to be evaluated. Remember that any and all written evaluation regarding a proposal may be subject to review by the applicants.

**Types of contracts**
Contracts can be of many types such as purchasing contracts, partnership agreements and many others.

A purchasing contract is a contract between a company (the buyer) and a supplier who is promising to sell products and/or services.

A partnership agreement may be a contract which formally establishes the terms of a partnership between two legal entities such that they regard each other as ‘partners’ in a commercial arrangement. You will want to know what kind of contracts the HIV & AIDS apparatus issues and the rules and regulations that guide them.

**Parts of the contract**
Contracts usually are composed of a narrative part that specifically details the terms of an agreement (i.e. what service will be provided, when, in what areas and by which staff) and the proposed budget which provides a detailed line item budget identifying salaries, equipment costs and operating costs. There will also be assurances or declarations that are required to be part of the contract and included as attachments.

You will want to know what the HIV & AIDS apparatus requires to be included in its contracts so that they are complete and considered legitimate.
Modifying contracts

There may be occasions where what is agreed in a contract needs to be changed or amended later. A number of bases may be used to support a subsequent change, so that the whole contract remains enforceable under the new arrangement.

A change may be based on:

- A mutual agreement of both parties to vary the contract, outside the framework of the existing contract. This would be an independent basis for changing the contract.
- A unilateral decision to vary the contract, contemplated and allowed for by the existing contract. This would normally have notice periods for fairness and often the right of the other to cease the contractual relationship. Be careful that any one-way imposition of change is contractually justified, otherwise it may be interpreted as a repudiation of the original contract, enabling the other party to terminate the contract and seek damages.
- A bilateral decision to vary the contract, within the variation or change control process outlined in the existing contract. These are often called “change control provisions.”

It will be important for you to know what changes or amendments the HIV & AIDS apparatus in your jurisdiction is allowed to issue.

Payments

Usually, the terms of payment are outlined in the contract. The service provider will likely need to submit invoices as well as programmatic reports in order to receive payment. Many HIV & AIDS apparatus issue payment on a quarterly basis or every three months. Service providers will want to be aware of the frequency of payment and if advance payment is allowed.

Equipment

More often than not, equipment purchases such as computers, printers, office furniture are allowed. However, the service provider will need to specify the equipment and include it in their proposed budget. The HIV & AIDS apparatus will likely have an inventory process by which any purchased equipment even by contracted service providers are considered to belong to the jurisdiction and thus equipment description and serial numbers will need to be reported. Usually, the approval process for purchasing equipment as well as the disposal process for discarding or replacing equipment is outlined in the contract.

Contract monitoring

The governmental HIV & AIDS apparatus should establish guidelines by which to evaluate, monitor and provide technical assistance through programme reviews to contracting agencies to ensure the delivery of appropriate services.

To fulfil the requirements of monitoring and reporting programme performance, the governmental HIV & AIDS apparatus should assess programme compliance and the quality, quantity and appropriateness of services being delivered by conducting on-site programme reviews. Staff responsible for programme monitoring should prioritise programme reviews annually by applying a risk assessment. An example of a risk assessment tool is attached for consideration.

Risk assessment

HIV & AIDS programmes should establish risk assessment tools to evaluate contractors before prioritizing them. Such assessments tools will consider elements important to successful contractor administrative and programme performance. For example:

- Stable, ongoing programming
- Correction of problems identified in past reviews
- High level of compliance with programme standards
- Appropriate staffing patterns
- Accurate and timely reports
- Meeting programme objectives
- Quality documentation systems
- Timely resolution of client complaints

A priority rating system could be used to establish the frequency staff will conduct programme reviews of contracting agencies. A priority rating should not be construed as a predictor of success or failure; it is simply a gauge for staff to determine the need for programme monitoring and technical assistance for each contract.

- Priority 1: contracting agencies scheduled to be reviewed within the next six (6) months, based on programme defined risk
- Priority 2: contracting agencies scheduled to be reviewed within the next twelve (12) months, based on programme defined risk
- Priority 3: contracting agencies scheduled to be reviewed within the next twenty-four (24) months, based on programme defined risk

Timelines

The governmental apparatus is responsible for developing procedures for conducting programme reviews. Procedures should clearly indicate the time lines in which reviews will be completed. The timelines should correspond with the priority time frames identified above.

Monitoring tools

Programme review monitoring tools must be developed for documenting findings, recommendations and the quality of performance of contractors.

Completion of reviews and notification of findings

Monitoring tools should be completed and distributed to the contracting organisation by an established time frame after the review is conducted. Notification to the contractor must include the expected completion and distribution date of the report. A summary of findings and recommendations should be provided to all appropriate staff.

Progress reports

Reports describing the implementation of programme activities and/or the progress being made in fulfilling service goals will be required to be submitted to the HIV & AIDS apparatus. The format to be used will be specified ahead of time and many times it is one of the attachments to a contract. Timeliness is critical as this reflects on an organisationís capacity and ability to write reports and do so in an accurate and prompt fashion.

Progress reports usually are to be submitted on a monthly and/or quarterly basis. The frequency of the report should be specified and if at all possible a calendar with due dates should be developed. The HIV & AIDS apparatus may also require an annual report and if so, the format and requested content should be clear and available to all funded service providers.

Site visits

Staff will make site visits to programmes where they will primarily observe the activities being implemented but may also request a meeting with other parts of organisation implementing the service activities. Usually, site visits will be conducted using a checklist of tasks to complete while visiting a service provider. This list may be specific to a programme and outline in detail what is to be observed and assessed. Staff will likely be required to write a report of their visit and include in the provider file.
Audits

Audits are usually conducted by the fiscal office of the HIV/AIDS apparatus to determine if a service provider is using the funds appropriately. Someone with an accounting background and experience will be the one to do an audit so as to accurately assess the agencies financial viability to continue to operate.

Contract termination

The terms for contract termination are included in a contract’s terms of agreement. These terms are clear in defining the conditions and situations that would necessitate terminating a contract. Contracts are often terminated within the specified time period stated in the contract.

For further information

The NASTAD Botswana program has developed a series of forms and procedures for implementing partners. In the resource policy section, there are sample forms, including: funding agreement, implementing partner contract orientation checklist and funding procedures.

For the department of health to measure organisational capacity, NASTAD South Africa conducted a NGO audit of ten NGOs/CBOs in Northern Cape. Please find the NGO Audit: Capacity-building Assessment in the resource community involvement section.

Included in the resource policy section is an organisational capacity assessment tool that can be used or adapted for your specific department of health.

From the U.S. state government perspective, contract management is a critical issue, the state of Texas publishes its contract guide online, which can be accessed at http://www.window.state.tx.us/procurement/pub/contractguide/.

Risk assessment tools can be used by funding agencies to determine the level of risk for specific contractors. Each department may have its own policies and procedures to measure risk. For an additional resource please find a risk assessment tool and guide for use in the resource policy section.

The NGO funding 2009/10 call for proposal issued by the National Department of Health can be accessed http://www.doh.gov.za/docs/ngofunding-f.html
Introduction

As stated in the NSP 2007–2011, the costs implications to address the four priority areas and goals could balloon to 20 percent of the health budget. One means of addressing the increased cost burdens is to pursue creative financing arrangements by entering into a partnership with key international donors (e.g., Global Fund to Fight HIV/AIDS, TB and Malaria, PEPFAR and the EU) as well as engage with the private health sector and business.

Within South Africa there are a multitude of donor funding agencies and partners, both international and local, involved in HIV & AIDS programmes. These organisations are committing both human and financial resources to combat the HIV epidemic in South Africa and work with national and provincial departments of health as well as local community-based organisations.

As managers within the HIV & AIDS Directorate in the provincial department of health, one role will be coordinating donors as well as managing partners. Each department has developed its own policies and procedures on identifying donors, coordinating donors, and overseeing provincial partners.

Donors and partners can help advance the mission of the provincial department of health and HIV & AIDS and STI Directorate to strengthen and expand prevention programmes, increase enrolment numbers for ART and provide the necessary support programmes, including support groups and home-based care. Each department of health and staff need to periodically review the protocols and policies for coordinating donors and partners within the respective province.

Potential activities

- Quarterly partner meetings
- Regular site visits

Key donor organisations

- Irish Aid (http://www.irishaid.gov.ie/south_africa.asp)

For further information

- NASTAD developed a resource guide on international HIV & AIDS funding agencies, please find the “Global HIV/AIDS: A Primer on the Donor Community Updated Edition,” in the online resource policy section.
- PEPFAR South Africa has released FY2009 provincial activity reports for the majority of provinces; these can serve as a guide for provincial-level programmes, and identify all PEPFAR-funded organisations operating within the respective provinces. These FY2009 provincial activity reports can be found in the online resource policy section.
For all resources discussed in this toolkit, please visit the NASTAD Global Program Resource Materials Section (http://www.nastad.org/programs/globalAIDS/globalAIDSresoursematerials.aspx)