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Strategic Planning in Honduras

A Case Study

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Country background

With a total population of 7.4 million, a Human Development Index¹ (HDI) of 117 over 177, GDP per capita of \$3553 (in purchasing power parity terms), and HIV prevalence of 0.7%² [0.4%-1.1%] in 2007³, Honduras is the country second-most affected by HIV/AIDS in Central America. It has defined its epidemic as bimodal; i.e. generalized in the Atlantic coast and concentrated mostly among men who have sex with men (MSM), commercial sex workers (CSW), and the Garifuna⁴ Population. Based on the UNGASS⁵ progress report, HIV prevalence among these groups is almost ten times higher than among pregnant woman.

Honduras has over the years received technical assistance in strategic planning development. The first plan, not costed, was developed for the period 1998-2002 (PENSIDA), while the second, developed for the period 2003-2007 (PENSIDA-II), was costed at USD 24.6 million.

In 2003, during the implementation of PENSIDA-II, Honduras became one of the first recipients⁶ of the Global Fund⁷ and instantly doubled its financial commitment⁸ to USD 57.8 million (USD 11.6 million per year).

With technical assistance from partners, the ABC⁹ and Goals models application^{10,11} were developed to i) determine how to optimize the allocation of resources among HIV prevention interventions (The World Bank, 2003); and ii) assess the impact of PENSIDA-II on HIV incidence, estimate coverage, measure achievable goals, and determine if available financial resources were sufficient to reverse the spread of HIV (Policy Project, 2004). These modeling exercises provided relevant information that was not previously available to policy makers.

For the optimization of resource allocation, a key conclusion from the ABC model was that “a substantial dent on the epidemic could be achieved if funds were appropriately channeled. Investing in condom distribution, condom social marketing, and IEC for high risk populations (CSW, MSM and prisoners) could avert twice as many infections than investing in the other nine interventions”. Another conclusion was that “seeking to reach a greater proportion of the high

¹ http://hdrstats.undp.org/2008/countries/country_fact_sheets/cty_fs_HND.html

² In the North Coast, HIV prevalence is 0.91% [0.57% - 1.85%] against 0.59% [0.37% - 1.2%] in other areas of the country.

³ <http://www.unaids.org/en/CountryResponses/Countries/honduras.asp>

⁴ The Garifuna population is estimated at 50,000 or about 1% of total population

⁵ http://data.unaids.org/pub/Report/2008/honduras_2008_country_progressreport_sp_es.pdf

⁶ For Round 1, a total of USD 33.8 million has been disbursed since 2003 out of maximum funding approval of USD 52.4 million

⁷ <http://theglobalfund.org/programs/grant/?compid=937&grantid=45&lang=en&CountryId=HND>

⁸ It included: the original PENSIDA II budget of USD 25 million, the newly approved Global Fund proposal of USD 24 million, and additional Government and donor commitments of USD 9 million

⁹ The ABC model, developed by the World Bank, is designed to identify the optimal allocation of HIV prevention resources among programs targeting different population groups. The methodology is based on “No Time to Lose” which is referred to as the core model, and follows that of a classic maximization problem which can be expressed as: how does one maximize the number of new infections prevented given a production function for HIV prevention and a resource constraint (World Bank, 2003)?

¹⁰ The Goals model, developed under the Horizons project of USAID, is intended to assist planners in understanding the effects of funding levels and allocation patterns on program impact. It can help planners understand how funding levels and patterns can lead to reductions in HIV incidence and prevalence and improved coverage of treatment, care and support programs. It does not, however, calculate the “optimum” allocation pattern or recommend a specific allocation of resources between prevention, care and mitigation (Stover, 2003).

¹¹ <http://futuresinstitute.org/pages/resources.aspx>

risk groups paid off in terms of the total number of infections that could be averted” (World Bank, 2003).

For funding levels and patterns leading to reductions in HIV incidence and improved coverage, the Goals Model exercise estimated that, based on the capacity of the country to deliver services to key populations, at least USD 122 million dollars, or twice the amount of financial commitments, (54% for prevention¹² interventions, 32% for integrated care, and 14% for policy, administration, research, monitoring and evaluation), or USD 25 million per year, was needed for the implementation of PENSIDA-II (Policy Project, 2004).

Informed by the successes and failures of PENSIDA-II, Honduras started the planning of the third National Strategic Plan (PENSIDA-III 2008-2012).

Strategic Planning Process in Honduras

The Honduran Government realized that it needed technical support to facilitate the process of formulating a new strategic framework. In the summer of 2006, the Minister of Finance and the Minister of Health therefore requested the assistance of the World Bank to support the process of formulating its new HIV/AIDS strategy (PENSIDA III 2008-2012). The request particularly focused on the need to develop a strategic plan which was evidence-informed and focused on the achievement and monitoring of measurable results. This would entail: (i) learning about the epidemic; (ii) learning about the results achieved by the national response, and (iii) learning about the cost of the new strategy and the available resources. Assistance was to be provided by ASAP (AIDS Strategy and Action Plan), a new UNAIDS program managed by the World Bank Global HIV/AIDS Program, while at the country level the thematic group on HIV/AIDS led by UNAIDS would support and contribute to the effort. The approach was to be participatory so as to ensure that Honduras’ civil society and government ministries would work together with the technical assistance that was to be provided.

The Department of STI/HIV/AIDS of the Ministry of Health, as a key stakeholder and focal institution, followed up on the daily tasks of the planning process while the National AIDS Commission (CONASIDA) coordinated the engagement of various government ministries and civil society in the response to HIV/AIDS.

ASAP and the Government of Honduras agreed that the process had to be led by national authorities (to follow-up, take ownership, and make decisions), that a strategic planning team¹³ had to be created (to ensure that the strategy was sound, to set the boundaries between perception and evidence, and to keep the interest of pressure groups in check), that a road map with key milestones had to be elaborated and implemented (to assign responsibilities to key institutions and provide a warning system when assignments were not being implemented), that quality had to be assured from beginning to end (to ensure that robust synthesis data and information were utilized in the planning), that weekly communications between national stakeholders and ASAP

¹² 7% for vulnerable populations

¹³ The Strategic Planning team included national stakeholders lead by National Program Coordinator Mayté Paredes, coordinated by CONASIDA director Xiomara Bú, and assisted by Liliana Mejía, Rudy Rosales de Molinero, Elsa Palou, Vilma Montoya, Karia Zepeda, Iris Padilla, Juan Ramón Gradelhy, Maria Teresa González, Mirna Aguilar, Lícida Bautista, Emilia Alduvin, Andersy Moncada, Odalys García, Irma Mendoza, and Jeffrey Barahona Perdomo; Rosalia Rodríguez-García, and Marcelo Bortman from the World Bank; María Tallarico and Jose Antonio Izazola from UNAIDS; and ASAP consultants Stephen Forsythe, Daniel Aran, and Eric Gaillard. Cesar Nuñez, Regional UNAIDS Coordinator provided useful insights.

had to be maintained (to provide guidelines, resolve technical problems, and ensure that the road map agreed upon was being implemented), and that periodic assessment between ASAP leadership and the government took place to reinforce the engagement of highest level national stakeholders.

National leadership and availability of human resources

In September 2006, a critical path of key activities and a time table was developed for a two phase deployment process. The first focused on the completion of an epidemiological synthesis study and the second on the completion of a results-based strategic plan.

The Health Secretariat organized a national workshop to launch the strategic planning process. During the workshop, key stakeholders agreed that the process would be driven by Honduran authorities, would be consistent with the three ones, and the emphasis would be on capacity building and not be donor driven. Thus, PENSIDA-III was developed with the firm engagement and leadership of national authorities, who, with guidance from ASAP, took ownership of the process, implemented the road map, coordinated stakeholders (international and national), assured input quality from beginning to end, and delivered a validated and evidence informed result oriented product (PENSIDA-III).

However, right from the beginning, the Health Secretariat admitted to having neither financial resources to hire long term consultants nor enough national staff to dedicate to the process. In close collaboration with CONASIDA, a technical working group composed of multisectoral stakeholders including government officials, academics, civil society, PLHA, MSM/Gay/Lesbian associations, and others, was created to accompany the process during the entire phase of strategic plan development. The technical working group was lead by the National HIV/AIDS Program of the Health Secretariat and assisted by ASAP consultants, and other bi-lateral and multi-lateral agencies. UNAIDS was critical in leading stakeholders throughout the process.

Guided by the driving principles of knowledge transfer and participatory planning, technical support married “process” and “products” during the preparation process of the new strategy. The technical support team applied several tools that had been recently developed by GHAP for the purpose of strengthening strategic planning as well as existing tools for costing (Resource Needs Model) and spending assessments (developed by UNAIDS). These were customized to fit Honduras’ needs, letting the government state the challenges and propose their preferred way to address them. The key tools were:

- 1) ASAP Strategy Result Cycle (road map) (Rodriguez-Garcia and Kusek, 2007) to define each critical step, key milestones, expected products, and contribution of key stakeholders in their specific technical areas of expertise (evidence building, result formulation with corresponding interventions, costing, monitoring and evaluation, impact assessment).¹⁴
- 2) ASAP Self Assessment Tool (World Bank, 2007b) to evaluate the strength and weaknesses observed during the development process of PENSIDA-II,
- 3) Evidence strengthening template to synthesize baseline data;

¹⁴ R.Rodriguez-Garcia and J. Kusek, Planning and Managing for HIV/AIDS Results. World Bank Global HIV/AIDS Program.

- 4) Evidence informed result framework template to develop focused strategies, define critical programs, and assign responsibilities to implementing actors;
- 5) Epidemiological software (Workbook, Mode of Transmission, Spectrum)¹⁵ to replicate the dynamic of demographic characteristics, of HIV prevalence and trends, and assess the weight of key groups on new infections,
- 6) Financial software (National AIDS Spending Assessment [NASA-MEGAS],¹⁶ and Resource Needs [RNM]¹⁷) to estimate national spending assessments from national aids accounts, and cost expected results.

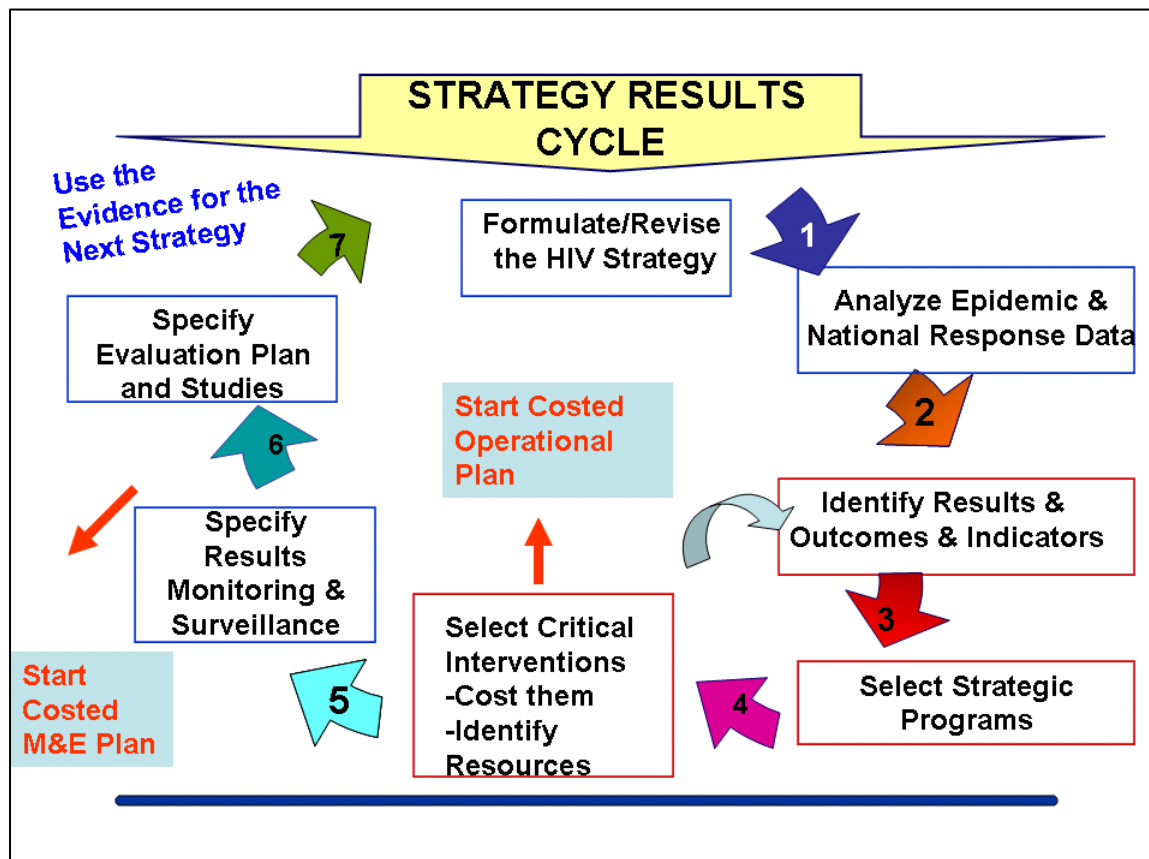
With “knowledge transfer” as a vehicle, the technical support team introduced the “Strategy Results Cycle” to counterparts and stakeholders as a tool for planning and formulating the strategy. The phases reflect a logical approach to improving strategic planning and performance (Figure 1).

¹⁵ http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi_software2007.asp

¹⁶ <http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp>

¹⁷ <http://futuresinstitute.org/pages/resources.aspx>

Figure 1: Road Map for Strategic Planning and Programming



Source: R.Rodriguez-Garcia and J. Kusek, (2007) Planning and Managing for HIV/AIDS Results. World Bank Global HIV/AIDS Program.

As part of the assessment of accomplishments and failures of PENSIDA II, the national team was asked to complete a Self Assessment Tool (SAT) designed to evaluate a country's national HIV/AIDS strategic plan by responding to a set of 55 questions in 12 programmatic areas.¹⁸ Each of the 12 programmatic areas covered by the SAT was then evaluated and the results were discussed.

Knowledge transfer was also used in the costing and spending analysis. The Resources Needs Model, which has been widely used, applies a combination of information from four areas (unit cost, size of population, current coverage levels, and planned coverage levels) to estimate the resource need for the new strategy in Honduras. The costing of PENSIDA III was based on the priorities identified in the strategy and was consistent with universal access targets and the MDGs.

¹⁸ The 12 programmatic areas are: Epidemic and Response Synthesis and Interpretation, Participatory process, Evaluation of Current Response, Results-Focused Planning, Results-Based Monitoring and Evaluation, Planned Approaches and Interventions, Prioritization, Financing/Resources/Budgets and Costing, Capacity and Constraints, Management and Coordination, Policy Environment and Action Plans. www.worldbank.org/asap.

The analysis of 2006 spending on HIV/AIDS provided essential information on spending. Unlike the methodology of the National Health Accounts, the National Spending Assessment (NASA) provides an estimate of spending not only by government, but also by households. This was done by applying the methodology and templates developed by UNAIDS, which traces financial streams to quantify national HIV/AIDS spending. Such information is essential for addressing issues of equity and financial burden. It also provides an important benchmark against which the increase in resources needed for PENSIDA III can be judged.

Solid analytical foundation

Once national leadership was secured, and human resources and development tools identified, the Health Secretariat organized regular workshops and working sessions to ensure the participation and engagement of multisectoral stakeholders, brainstorm on achieved results, assess the policy environment, maximize the use of development tools, guarantee the support of partners providing technical assistance (statisticians, epidemiologists, modelers, analysts, economists, etc.) and quality assurance during the evidence strengthening cycle, analysis, strategic planning and costing development.

The participatory process was particularly important during the analysis of the response, which started immediately after the launching of PENSIDA-III development. Although two hundred and thirty nine (239) individual stakeholders attended at least one workshop or working session, at least fifty five (55) key actors from forty seven (47) institutions remained actively involved and engaged during the entire process. To tackle multiple fronts at the same time, the Health Secretariat assigned technical tasks to specific areas of interest working groups.

The first priority was to strengthen the evidence.

National stakeholders, guided by ASAP consultants, designed a study plan/protocol specifying how data would be collected and analyzed for the epidemiological synthesis study in order to address the epidemiological-social profile of the national epidemic, determine HIV determinants derived from national evidence but as perceived by neighboring countries as well, and estimate spending assessment from national AIDS account. Relevant publications¹⁹ about HIV/AIDS in Honduras were identified, financial data collected, and their results quantified and summarized in a template.

The analysis of epidemiological data revealed that knowledge about HIV/AIDS was low among PLHA;²⁰ epidemiological evidence was available for only five groups²¹ out of nine identified as most at risk. Prevalence of sexually transmitted infections (STI) was relatively high and condom use too low to have an impact among these groups, and intravenous drugs were used by some MSM and CSW.

¹⁹ Biological and behavioral surveillance reports, epidemiological studies, and statistical data on service delivery from health information systems (blood safety, PMTCT, integrated care and support, condom distribution, etc.)

²⁰ Among PLHA, 20% of male and 16% of female (PLHA) declared having an STI in the last 12 months, and less than 40% of male and less than 65% of female declared having used a condom in the last sexual contact (Secretaria de Salud, 2007b)

²¹ PLHA, MSM, CSW, Garifuna, and pregnant women

The analysis of strategic plans developed by Central American countries, including Honduras, revealed that four key groups (CSW, MSM, prisoners and youth) out of eleven identified by the different countries were always targeted.

The analysis derived from modeling²² applications revealed that, although HIV prevalence decreased among MSM;²³ CSW;²⁴ Garifunas;²⁵ and pregnant women;²⁶ the source of more than half of new infections²⁷ arose out of sexual contacts among CSW, their clients, sexual partners of their clients; MSM;²⁸ Garifunas; and intravenous drug users (CONASIDA, 2007).

The analysis of national AIDS spending assessments (NASA) revealed that a total of USD 17.5 million dollars (Per capita: PPP \$5.49 or USD 2.39) was disbursed in 2006²⁹, out of which 58% was financed by international donors, 24% by the public sector, and 18% by the private sector. About half of the cost was spent on prevention (50.3%). Within prevention, condom distribution (public sector and commercial) accounted for 28% of the costs, STI treatment among women (14%), VCT (11%), out of school youth (11%), PLHA (2.2%), MSM (2.2%); F-CSW and their clients (2.2%), and M-CSW and their clients (1.9%) (Secretaría de Salud, 2007a). Recent evidence also suggested that HIV prevalence had been contained among the general population and among most at risk groups.

The analysis of the response, which was done by reviewing four areas: the objectives; the actions, the successes and the failures of PENSIDA-II (Secretaría de Salud, 2007b) showed impressive results. In addition to the capacity of Honduras to estimate its need (yearly budget increased from USD 5 million in 2003, to USD 25 million in 2004) and to mobilize resources (from USD 5 million in 2003 to USD 12 million in 2004 and USD 17 million in 2006),³⁰ service delivery of condom distributed, number of people counseled and tested, and number of people on ARV drastically increased in a short period of time. Civil society, including PLHA, was actively involved in the implementation of the HIV/AIDS law. Honduras was getting closer to the “three ones;” national stakeholders were engaged in a unique strategic framework (PENSIDA-III) and CONASIDA was coordinating the response.

However, the analysis derived from the Self Assessment Tool revealed that the stakeholders were not satisfied with the planning process followed for the preparation of PENSIDA-II. They gave a very low score to all ten (10) programmatic components of strategic planning. Not one area received a score higher than 50%.³¹ The weakest components were in monitoring and evaluating (M&E) the response, costing the strategic plan, establishing clear objectives, promoting the capacity of implementers, and designing annual action plans (World Bank, 2007).

²² Workbook, Mode of Transmission, Spectrum

²³ From 13% in 2001 to 10% in 2006

²⁴ From 10% in 2001 to 4.1% in 2006

²⁵ From 8.4% in 1998 to 4.5% in 2006

²⁶ From 1.35% in 1998 to 0.46% in 2004

²⁷ 28% from CSW, their clients, and sexual partners of their clients; 19% from MSM; 5% from Garifunas; and 3% from Intravenous Drug Users

²⁸ 19%

²⁹ 1.7% of health expenditures

³⁰ The estimated spending assessment of USD 18 million for 2006 was 50% higher than the 2003 estimated yearly financial commitment of USD 12 million, but lower than the estimated USD 25 million needed for the implementation of PENSIDA-II.

³¹ The maximum score that can be obtained is 100%.

The results of the analysis of the situation and of the response were largely discussed and approved by stakeholders and by national authorities.

All the elements were there for the development of PENSIDA-III.

Development of the Strategic Plan

The second priority was to develop the structure of the strategic plan.

Through brainstorming sessions the technical working groups, guided by the ASAP Strategy Results Cycle and road map, through brainstorming sessions, addressed issues related to the technical aspects of strategic planning: how to focus on the evidence and on efforts to reach priority populations; how to monitor and evaluate critical interventions; how to allocate resources to strategic priorities; and how to plan the implementation through action plans?

Prioritization

Some representatives of civil society who were members of technical working groups, through filibuster techniques, outdid the softer voices of those calling for a more focused approach to priority populations. As a consequence of multisectoral participation, the nine³² (9) target groups identified in PENSIDA II were all retained, and eleven (11) more were added, bringing the total to twenty (20)--that is twice higher than any other country in the region. As a compromise, national stakeholders agreed to a prioritization process. The groups were categorized based on the evidence about their size, level of HIV and STI prevalence, estimated cost to reach them, access to services, and known risk factor at the regional or global level. As a consequence, five³³ groups (5) were identified as highly vulnerable, five as at risk³⁴, and twelve as lacking evidence and requiring further investigation (Secretaría de Salud, 2007b).³⁵

Even though Honduras had already developed two previous national strategic plans; stakeholders needed assistance in developing a results oriented national strategic plan. The technical working group, assisted by ASAP, developed the technical skills³⁶ needed for constructing an evidence informed results framework, developing a results-based monitoring and evaluation system, and estimating the cost to implement the actions leading to desired results. The strategy was to provide a very high level of coverage to most at risk populations to further contain the growth of the epidemic among these groups, increase coverage for youth and intravenous drug users, and provide universal access for integrated care,³⁷ without ignoring other programmatic components of strategic planning (CONASIDA, 2007).

A four pronged evidence informed result framework to support strategic planning, inspired by the ASAP Strategy Results Cycle, was organized as follows:

- 7) What is the result that needs to be achieved from the current evidence?
- 8) Which indicator needs to be monitored to evaluate the result?
- 9) Which strategic interventions need to be implemented to achieve the result?
- 10) Which entity is responsible for implementing the intervention?

A results-based monitoring and evaluation plan was developed for continuous refining of the strategy. Each indicator defined in the result framework was further refined and embedded into an M&E framework.

Costing and Resource Analysis

The third priority was to cost the strategy, without which it could not be implemented.

Money is the driving force and the main incentive for stakeholder mobilization. It is therefore not surprising that the costing exercise was closely monitored by national stakeholders to ensure that all the programmatic components of the strategic plan were properly funded.

³² PLHA, Garifuna population, orphans, factory workers, mobile population, uniformed personnel, etc.

³³ PLHA, CSW, MSM, Prisoners, and Garifuna

³⁴ Youth, pregnant women in PMTCT, factory workers, orphans, and uniformed personnel (military, police, night guards)

³⁵ Women (pregnant, victims of violence, lesbians, etc), street children, mobile population, disabled, IDU, etc.

³⁶ A strategic result statement must include an action (increase, decrease, etc.), a focus variable, a specific target population, a specific geographic location; a base line, desired quantitative coverage, and a time frame.

³⁷ ARV, prophylaxis, and treatment of opportunistic infections

The technical working group ensured that the evidence presented in the result framework (baseline and targets³⁸) was used³⁹ as an input for the Resource Needs Model. Few countries have data on unit costs and Honduras does not belong to this group. It was not possible to collect specific data to determine the unit cost of each intervention. The unit cost used to develop the national budget was derived from default values or from the ABC and Goals model applications.

The resource needs for the implementation of PENSIDA-III was estimated to be USD 198 million for the period 2008-2012. This is much higher than the amount estimated by the Goals model for the implementation of PENSIDA-II.⁴⁰ The allocation of resources, based on the coverage defined in the strategic framework, was as follows: 52%⁴¹ for prevention; 20% for integrated care;⁴² 23% for policy, administration, research, monitoring and evaluation; and 5% for orphans and vulnerable children. Within prevention, 32% was allocated to high priority population, 52% to service delivery,⁴³ and 16% to health care.⁴⁴

In the opinion of the national stakeholders, allocating more than 40% of financial resources to the general population was consistent with the epidemic pattern (generalized in the Atlantic coast, and concentrated among CSW, Garifunas, MSM, and prisoners). Available data and estimates confirmed that the response to the HIV epidemic had been effective since its growth had been contained.

Thus, for PENSIDA-II, Honduras estimated its yearly budget at USD 5 million in 2003 and adjusted it at USD 25 million in 2004. For PENSIDA-III, it was estimated that USD 30 million would be required in 2008, and USD 50 million in 2012. There is no national spending assessment (NASA) for 2008, but based on the 2006 estimates of USD 20 million (much less than what was budgeted for 2004), the financial gap could be between USD 10 million and USD 30 million per year for the successful implementation of PENSIDA-III.

Results: The PENSIDA-III

All the elements of the strategic planning were tightly linked in a results chain. First, the evidence provided knowledge about the epidemic, the sources of new infections, and the current allocation of financial resources. Second, the understanding of the epidemic provided the elements for the construction of objectives through result statements. Third, the defined results were embedded into a result framework within which the indicators were constructed. Finally, an M&E plan was developed to monitor and evaluate the indicators; and last, all the elements required for the implementation were costed.

All the various components of the strategic planning process were assembled together and packaged into PENSIDA-III. The new strategic plan was validated at the national level through regional workshops and subsequently by National Authorities. It was officially launched on December 1st 2007.

³⁸ Workgroup discussions planned for the highest level of coverage that was feasible: 80% for the Garifuna population, 75% for MSM, 80% for “prisoners”, 93% for CSW, 80% for PMTCT, 100% for blood safety, etc.

³⁹ This technical working group is the same that developed the National AIDS Account estimates (MEGAS) for 2006

⁴⁰ The amount estimated by the Goals Model for the implementation of PENSIDA-II was USD 122 Million.

⁴¹ The amount allocated to prevention under PENSIDA-II was 54%.

⁴² The amount allocated to integrated care under PENSIDA-II was 32%

⁴³ Condom distribution, STI treatment, VCT, PMTCT, and IEC

⁴⁴ Blood safety, PEP, and Universal Precaution

Today, Honduras is among the few countries in the Americas with a strategic plan that is informed by evidence, costed, and focused on measurable results.

Lessons and Recommendations

There are lessons learned from the Honduras Strategic Planning process.

National leadership is essential for effective knowledge transfer. Stakeholder mobilization is driven by resource mobilization requirements of proposals and not by long term strategic planning. Various competing interests require the attention of national authorities, forcing them to tackle multiple fronts at the same time, while they lack the resources to hire full time high level assistants. The natural tendency is to push the work to consultants usually provided by financial partners. Thus, the presence of a determined coordinator who takes ownership of the process, who has the authority to make decisions, the vision and the time to achieve, and who understands that technical assistance provided by partners has an end, is essential in developing a strategic plan that reflects the reality of the country.

Participatory process is essential but it takes time and has a cost. It requires negotiating skills, and sometimes leads to negotiated solutions that are not necessarily cost effective. For example, certain groups might be included in the strategy even though there is no evidence to support their vulnerability or assess their risk of infections. The key lesson learned is that effective participation needs to have a goal and a product that every one works together to achieve. This is the only way one can move from rhetoric to engagement.

Evidence is critical to strategic planning. Countries need to develop a culture of evidence to ensure that the planning process is sustainable and not just strengthened to satisfy the financial demand of donors during proposal development. More and better focused efforts ought to be made to fill the knowledge gaps that still handicaps a more effective use of resources and improved programming. For example, during implementation of PENSIDA-II, evidence building was not a priority, and the impact of interventions was difficult to measure because the M&E system was not linked to the strategy. Out of seventy four (74) priority indicators, only forty four (44) were measured, and most had no baseline. In five-ten years, all countries in the region should have established baselines for all key populations and a systematic approach to measurement, evaluation and analysis, both of programmatic and financial data to inform policy-makers.

Challenges of multisectoral implementation: While countries further build their evidence base, they need to focus on a few indicators which they implement and monitor. They must also be prepared to face unforeseen situations and adapt to a changing global environment. Even if the strategic process is inclusive and attempts to engage all actors in the national response, implementing the national plan requires continuous engagement of multisectoral actors, and this is difficult to maintain. For example, in Honduras, the policy environment toward some vulnerable groups such as lesbians, gays, transsexuals and bisexuals (LGTB) needs improvement. The LGTB association Arcoiris said that “Honduras, like the rest of Central America has many laws and a very good constitution, but is slow in enforcing those laws. We, as LGTB, are a minority group confronted by injustice, discrimination, stigma, and homophobia.” The National Program has identified problems in covering the Garifuna population because the

unit cost of intervention was underestimated. Some of the weakest components identified in the SAT, such as developing annual action plans are lagging behind.

Prioritization is difficult: Even in a concentrated epidemic where the priority should be to focus on the most at risk population, it is nearly impossible to ignore the other programmatic components of service delivery such as blood safety, safe medical injections, universal precaution, prevention of mother to child transmission, voluntary counseling and testing, integrated care, etc. The multi sectoral aspect of strategic planning and increased participation of civil society increase the pressure to enlarge the number of priority groups and to develop interventions that are not in harmony with the epidemic. The more participation there is the more effort there needs to be in prioritizing and maintaining a balance between focusing on interventions that are more cost effective and sustaining social equity.

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