

A Strategic Action Plan to Improve an Integrated Family Planning and HIV Service: Using Multiple Nominal Groups to Ensure Stakeholder Involvement

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Introduction: The World Health Organization recommends that family planning be integrated in HIV services, to improve service offering and uptake; stakeholder involvement is crucial. The purpose of this manuscript is to share the utilization of nominal group technique (NGT) and multiple group analysis as a vehicle to ensure stakeholder involvement in the development of a strategic action plan to improve the implementation of integrated services in Ethiopia.

Methods: A qualitative research design, employing a NGT, was applied as data-gathering method to develop a strategic action plan for facilitating the integration of family planning and HIV services. NGT was used to ensure the equal involvement of stakeholders in the development thereof. Twenty-four programme managers in Addis Ababa, Ethiopia – experts in family planning and HIV/AIDS programmes, working in 10 sub-city health departments – participated in the nominal groups to identify the strategies to be included in an action plan development to facilitate integrated services.

Results: The first nominal group's participants identified 12 themes, derived from the 21 categories generated from 34 individual ideas. The second group identified nine themes, from 16 categories, generated from 30 individually ideas. A multiple group analysis utilizing the findings from both groups revealed the top five most important themes (leadership and management, capacity building, implementing policies and guidelines, advocacy/awareness and infrastructure) that were selected to be included in a strategic action plan to integrated family planning and HIV services in Ethiopia.

Discussion: The strategic action plan developed by the researcher who took into account the findings from the multiple group analysis was validated in a face-to-face validation meeting by all the relevant stakeholder's participation. Stakeholder involvement, utilizing different nominal groups and conducting multiple nominal group analysis ensured ownership of the strategic action plan as those involved in the development, will be the individuals to implement in Ethiopia.

Keywords: strategic action plan, nominal group technique, stakeholder involvement

Background

The World Health Organization (WHO) recommends family planning be integrated in HIV services, to improve both the service offering and its uptake.¹ It is evident that where such integration is available at the facility level, it is useful for delivering both family planning and HIV services effectively in sub-Saharan African countries.² Integrated family planning and HIV services are offered in Ethiopia, although not to the extent as required by Ministry of Health and stakeholders.¹³ One of the factors contributing to the successful integration of family planning and HIV services is the development of a comprehensive strategic action plan³ and not only desktop reviews and consultations.¹⁴

A strategic action plan, a useful tool for successfully implementing any intervention, guideline or policy, can be defined as a recognised set of activities or broad plans of action which serve to achieve a specific goal,⁴ the purpose of such a plan being to determine where and what is required to achieve the desired outcomes.⁵ Specific actions need to be formulated and taken, to achieve longer-term goals. Stakeholder engagement has a major impact on the development and success of any strategic action

plan, and the operationalisation thereof.⁵ For that reason, it is vital that the relevant stakeholders be involved, as they are the ultimate actors driving the implementation of the plan.⁵

Stakeholders operating in the context of family planning and HIV services were involved in the development of a strategic action plan in Ethiopia. The process planning model, as modified by Lubbe and Roets (2014), was used to guide the multiple nominal group data analysis process in the course of developing a strategic action plan to facilitate the implementation of integrated family planning and HIV services.⁶ This study reflects and share how more than one nominal group, with a multiple group analysis to combine and prioritize the findings of all groups, can be useful in the development of a strategic action plan to ensure equal participation and a voice to every individual stakeholder who participates. This method can be beneficial and very effective to be added to existing practices of desk reviews and consultative meetings in Ethiopia.

The Aim

The aim of this article is to share the results of stakeholder involvement in the development of a strategic action plan, in the context of integrating family planning and HIV services. Multiple nominal groups were used, to afford each member an equal voice, as a stakeholder participant, in the development process.

Methods

Research Setting

The study was conducted in Addis Ababa, Ethiopia. The city has 10 administrative sub-cities, each with a health department to support over 900 public and private health facilities, serving a population of approximately five million inhabitants.⁷

Research Design

A qualitative research was conducted, in which data were gathered by means of the nominal group technique (NGT),⁸ a process that allows for the identification and prioritization of problems or challenges, and the development of joint solutions by between 3 and 12 participants.⁸ In this study, 24 programme managers (stakeholders) participated in one of two group sessions which normally lasted between 2 and 2.5 hours.⁹ The NGT is commonly referred to as a problem-exploration and consensus-seeking method, that allows individual participants, from very diverse groupings, to generate and present a number of ideas, without any limitations or negative consequences, as part of the data-gathering process.⁹

NGT, which is suitable for qualitative data collection, balances the influence of all participants – including the researcher.¹⁰ Thus, each stakeholder has an equal voice, until consensus is reached. The participants were experts in family planning and HIV/AIDS programmes and service delivery, and employed in sub-city health departments. It is also useful for generating a large number of ideas individually and silently, within a relatively short time.^{9,10} That process contributes to immediate problem-solving or idea-generation, and serves to determine priorities through a consensus method – something deemed highly suitable in the context of health-care services.⁸

Multiple nominal group data gathering allow data collection from more than one group of participants to be analysed, ensuring that the opinions of all participants can be incorporated.¹¹ Before commencement with the nominal group discussions, the inputs of several clients who received family planning and HIV services, were shared with the participants by means of a power point presentation,³ ensuring that the participants were familiar with the opinions of the clients utilising integrated services in Ethiopia¹³ in the period prior to data gathering.³

Unit of Analysis

All 24 programme managers (stakeholder participants), who served as the unit of analysis, were invited from 10 sub-cities (one family planning and one HIV programme manager from each sub-city), from the Addis Ababa City Administration Health Bureau (AACAHB) and the Ministry of Health (MoH) (two family planning and two HIV programme managers) to participate in the nominal group discussions, thus all-inclusive sampling applied.

All-inclusive sampling was done and all participants who volunteered and provided informed consent to join in either of the two nominal groups prior to commencement of data gathering.

Data Collection

The AACAHB agreed to assist with the organising and booking of two conference rooms a month prior to the agreed date, so that the multiple nominal group sessions could have been conducted at a pre-arranged venue. Two nominal group discussions were conducted, one on 26 and the other on 28 October 2016 at two hotels in Addis Ababa. The nominal group discussions were part of a large study, conducted in multiple phases with the aim to address service integration in Ethiopia, and therefore the nominal groups were conducted in 2016 after the initial data gathering to obtain information from the clients as stakeholders was completed.³ The validation meeting was completed in 2017 where after the strategic action plan was developed.

The two nominal groups were organized based on the participants' geographical location as well as the areas the experts were working, but included participants from sub-city, regional and national level to ensure representation. One facilitator convened both sessions. The time, date and venue were shared electronically with the participants. The first group participants were from five sub-cities and the second from the other five sub-cities.

Although the two nominal groups were conducted separately, they adhered to the same key steps required when conducting a nominal group as a data gathering technique as described¹¹:

- Step 1: Introduction of stakeholders and opening of the session
- Step 2: Participants silently generate ideas, in writing
- Step 3: Round-robin recording of ideas
- Step 4: Serial discussion of the ideas
- Step 5: Vote to select the most important ideas
- Step 6: Discussion of the selected ideas

Trustworthiness

Trustworthiness, which refers to the degree of confidence qualitative researchers have in their data, is assessed using the criteria of credibility, dependability, confirmability, transferability, and authenticity. The researcher was the primary facilitator of the nominal group sessions, and the active participation of the stakeholders ensured the credibility and dependability of the findings. The researcher categorised ideas, cross-checked the data and was flexible in terms of ensuring the neutrality of the data collection and confirmability. Since the study was all-inclusive of the relevant stakeholders, that ensured the transferability of the findings to similar research areas.

Ethics

Ethical clearance was obtained from the custodian university, and an approval and letter of support to conduct the research were received from the AACAHB. The family health sub-process owner at the latter facility acted as gatekeeper, tasked with recruiting all the nominal group participants, disseminating the information letter and consent forms, and arranging dates and venues which suited all the parties involved. The participants were informed that their participation was voluntary, and that they were free to leave the study at any stage, without fear of being penalised. The researcher made available an information letter and consent form, informing the participants of the purpose of the nominal group, and all the participants signed and returned the consent forms for safekeeping by the facilitator.

Results

The data gathered from each nominal group were analysed thematically within the individual groups, to ensure that each stakeholder's voice was heard and incorporated in the subsequent analysis. Themes were identified and ranked. The data were subsequently analysed by the researcher and co-coder, who applied the step-by-step procedure for multiple group analysis,¹¹ making use of electronic formats to simplify the steps.

Voted Themes

During analysis, the stakeholders were actively involved in grouping individual ideas into categories and themes, facilitated by the facilitator. As described in [Table 1](#), the first nominal group's participants identified 12 themes from

Table 1 Ranked Themes, Nominal Group 1

Serial Number	Themes	Individual Scores Given by Stakeholders (0–5)	Total Score (0–60)
Theme 1	Capacity building	5,5,5,5,5,5,4,4,4,4,4	55
Theme 2	Implementing policies and guidelines	5,5,4,4,3,2,2,1	25
Theme 3	Infrastructure	5,3,3,3,2,2,1	19
Theme 4	Advocacy/awareness	5,3,3,1,5	17
Theme 5	Monitoring and evaluation	4,3,2,1,1,1,3	15
Theme 6	Leadership and management	4,3,2,1,2	12
Theme 7	Partnership	3,2,2,1,2	10
Theme 8	Service	4,2,2	8
Theme 9	Referral	3,3,1	7
Theme 10	Human resources	4	4
Theme 11	Male involvement	4	4
Theme 12	Research	1,1,1	3

21 categories, from a list of 34 individual ideas that were generated. The second group developed nine themes, derived from 16 categories, formulated from a list of 30 individually generated ideas as mentioned in Table 2.

The score allocated by each stakeholder, for each generated theme, ranged from 0 (minimum) to 5 (maximum). The facilitator added each individual's score for each theme, and calculated the total (minimum 0; maximum 60). Thereafter, a ranking was awarded from highest to lowest, based on the value of the total calculated score.

To combine the findings derived from both nominal groups (ie, the opinions of all cadres of stakeholders), a multiple group analysis was conducted. This allowed for the identification of the five most important themes, as the focus of the strategic action plan. The top five ranked themes from each group were used, and, as described by Roets and Lubbe (2015),¹¹ all the steps of multiple group analysis were followed, namely: 1) create an initial spread sheet on an MS Word document; 2) record individual themes, place categories and ideas under each theme; 4) identify the top five themes from each nominal group; 5) do a content analysis of the data; 6) calculate the combined ranking to gain a consolidated and prioritised list; and 7) finalise the ranking. Based on the final ranking, complete multiple group analysis revealed the five themes voted for as the most important, in the following order: leadership and management, capacity building, implementation of policies and guidelines, advocacy/awareness, and infrastructure (see Table 3).

Development of a Strategic Action Plan

A strategy is a general plan of action for achieving predetermined goals.⁴ In this context, it is the strategic action plan, based on the five strategies prioritised after the multiple group analysis, which seeks to facilitate integrated family planning and HIV services. It was crucial to develop a plan based on participants' unanimous agreement, to ensure ownership and enhance implementation success. As mentioned in Figure 1, the process planning model describes a

Table 2 Ranked Themes, Nominal Group 2

Serial Number	Themes	Individual Scores Given by Stakeholders (0–5)	Total Score (0–60)
Theme 1	Implementing policies and guidelines	2,5,5,5,5,5,5,5,5,5,5	57
Theme 2	Leadership and management	1,1,2,2,2,3,3,4,4,4,5,5	36
Theme 3	Capacity building	1,1,2,2,3,3,3,4,4,4,5	32
Theme 4	Fiscal resources	1,1,2,2,3,3,3,4,4,4	27
Theme 5	Medical resources	1,2,2,3,3,4	15
Theme 6	Advocacy/awareness	1,3,3,4	11
Theme 7	Monitoring and evaluation	1,1,1,1,2,2	8
Theme 8	Partnership	4	4
Theme 9	Referral	0	0

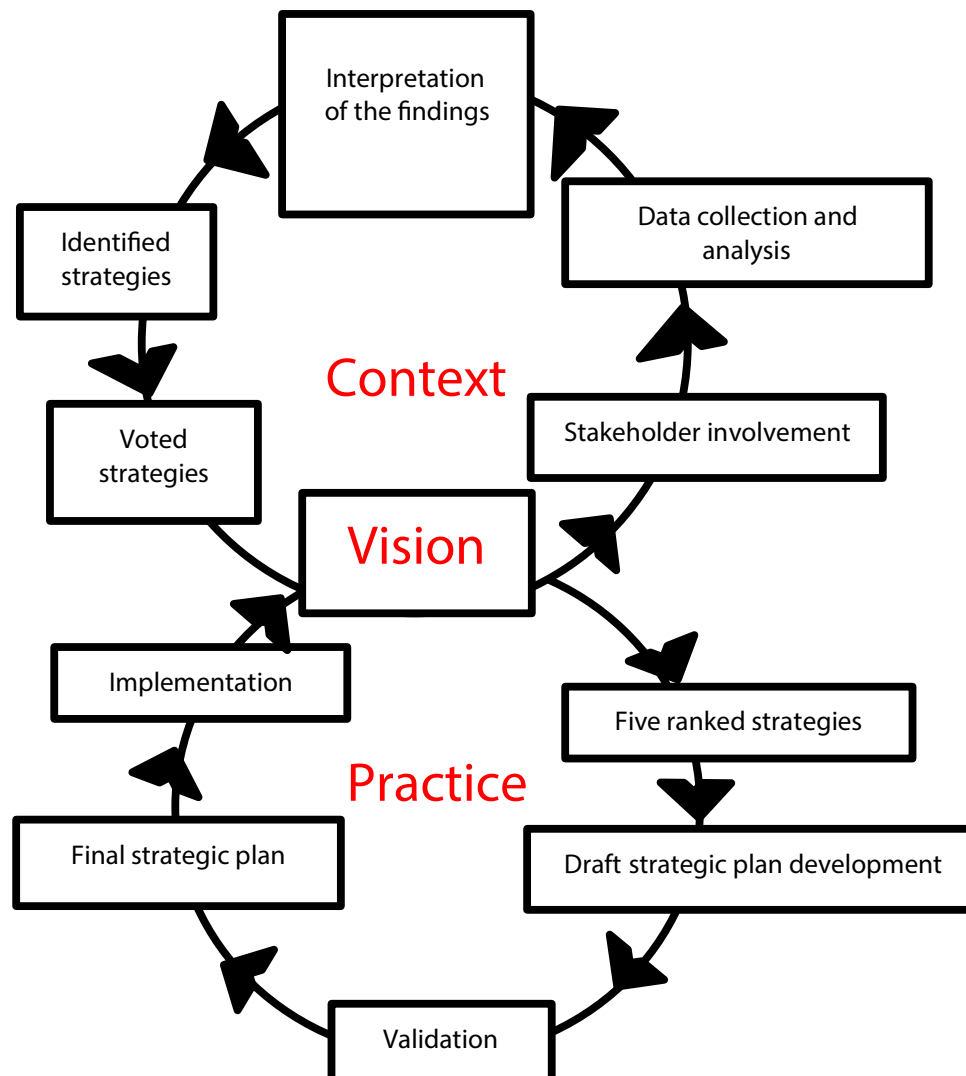
Table 3 Final Top Five Themes as Strategies

Order of Priority	Five Themes Voted as the Most Important Priorities
1	Leadership and management
2	Capacity building
3	Implementing policies and guidelines
4	Advocacy/awareness
5	Infrastructure

cyclical process of planning, taking action, observing, reflecting and, as a result, revising the plan for a new cycle of action research, which can be developed on the basis of quantitative as well as qualitative data.¹²

The key steps of the process planning model, developed by Ortrun, were applied in the process of strategic action plan development.¹² Forming the basis thereof were the top five strategies (themes) identified after multiple group analysis, as well as the available literature on the development of a strategic action plan.

The model not only contributed to the design of the strategic action plan, but also established a common understanding of the planning process, to achieve specific goals and objectives, as described by Ortrun.¹² Three main

**Figure 1** The process planning model.

Note: Adapted with permission from Lubbe JC, Van Tonder SP, Roets L & Wilkinson, AC. Student recruitment in private nursing education institutions in South Africa. University of the Free State. 2012: 21-22. <http://hdl.handle.net/11660/8211>.¹⁵

components – the vision, context and practices, along with several stages and cycles – were applied in the development process.

Vision: The first component of the process planning model is that of vision-building exercises and questionnaire development.¹² In this context, the vision was to identify and vote for strategies which would facilitate the implementation of integrated family planning and HIV services by nominal groups who helped guide the development of a strategic action plan.

Context: The context included stakeholder data analysis, and identifying and voting for the most important strategies¹² which formed the basis for the development of the strategic action plan.

Practice: Planning for improved practice included an analysis of the situation and the organisational problem or “thematic concern” which had to be shared and “owned” by program officers (as stakeholders). Planning had to be followed by a discussion, and agreement on the aims, objectives, desired outcomes, and the strategic plan (what had to be done, by whom, how, when), as well as an evaluation of the strategies and methods to be used.¹² The thematic concern in the context of this study was facilitating the implementation of integrated family planning and HIV services at the public health centre level. The stakeholders involved not only had to identify and vote for the priority strategies, they also helped to develop the strategic action plan. The themes identified under each strategy/theme that the stakeholders voted for, and wished to see incorporated in the plan. A draft strategic action plan was developed, taking into account all the analysed data as well as the relevant literature, following which it was validated by means of multiple nominal group sessions (see Figure 2).

Validation of Strategic Action Plan

The purpose of the validation process was to create an opportunity for the stakeholders to share their inputs in respect of the draft strategic action plan (the plan developed before the validation meeting), thus to agree with or disagree with the content, contributing to the refinement of the final and approved plan, ensuring accuracy and representation of all

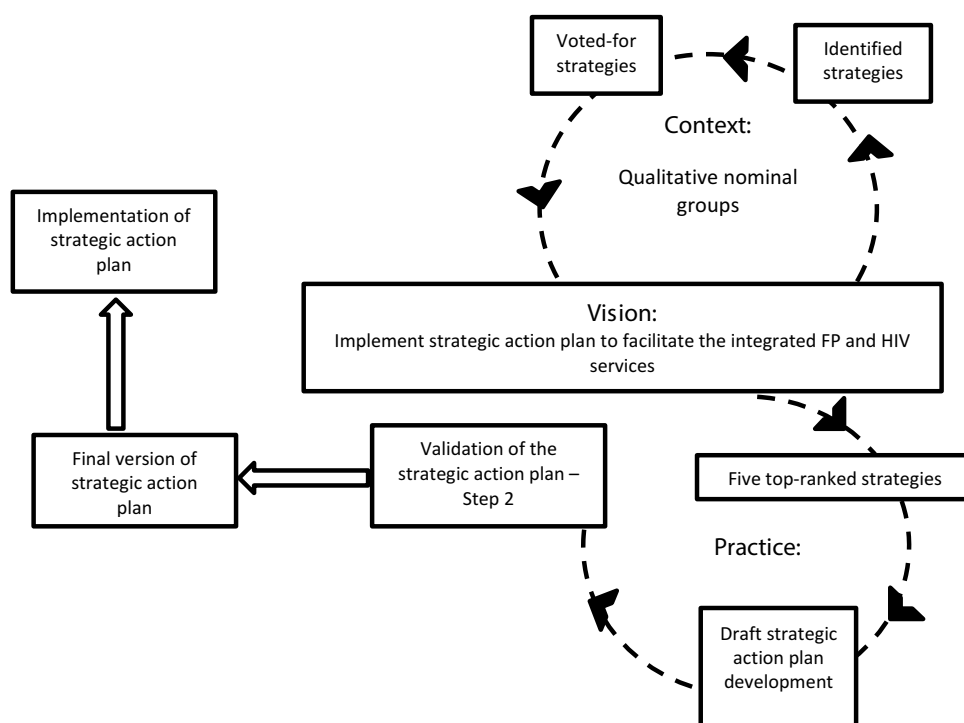


Figure 2 Overview of the strategic action plan development process.

Note: Adapted with permission from Lubbe JC, Van Tonder SP, Roets L & Wilkinson, AC. Student recruitment in private nursing education institutions in South Africa. University of the Free State. 2012: 21-22. <http://hdl.handle.net/11660/8211>.¹⁵

stakeholders. The process ensured that stakeholders took ownership of, and took responsibility for the final strategic action plan.

All 24 stakeholders were invited to participate in the validation meeting, and an extremely positive response rate of 87.5% was achieved. Only three participants were not available, but the AACAHB sent deputy programme managers as replacements. The validation meeting took place on a date, at a time and in a venue agreed on by all parties that was conducted on June 28, 2017.

The validation meeting followed a structured process, including a welcoming address, and an overview of the purpose and responsibilities of every individual participant. The facilitator shared with participants a hard copy of the strategies identified during the nominal group sessions (as informed by the background of evidence received from patients), a printed copy of the draft strategic action plan, as well as the validation guide. The facilitator explained that the validation meeting would entail two sessions:

- Session 1

In the first session, the draft strategic action plan was shared during a 15-minute PowerPoint presentation.⁴

- Session 2

During the second session, the stakeholders were allowed 30 minutes to review and comment on the draft plan. They had to agree or disagree with every action, add their individual suggestions, and comment in the spaces provided on the hard copy, using a validation guide. Thereafter, the participants were divided into five groups, each of which was allocated one of the five voted strategies. The group members added and combined all their suggestions using the validation guide, and presented their combined responses in a plenary session.

All five groups' suggestions were then captured on a flip chart. The researcher acted as scribe and captured all suggestions on a laptop, projecting the information on a screen to allow the participants to verify the accuracy thereof. The participants' suggestions were added to the respective components of the draft plan by each small group, and the final strategic action plan was amended in the plenary session, once consensus had been reached. Only then was the final strategic action plan ready for implementation (see Table 4).

Implementation of a Strategic Action Plan

The strategic action plan, like all other developed plans, will only be effective if developed by, and shared with the appropriate stakeholders who are responsible for the implementation thereof. All the relevant stakeholders participated in the development process, and the AACAHB was actively involved by providing support for the nominal group discussions and validation meeting.

The MoH and AACAHB are free to incorporate the strategic plan in their policy and strategic documents, to secure the implementation thereof, since all stakeholders involved in HIV and family planning services, including patients (as the community to serve), were engaged and participated in one way or another.

The integration of family planning and HIV services should serve to increase the uptake and use of such services, and ultimately improve maternal and child health in Ethiopia. This validated action plan may even be adapted or adopted for implementation in similar contexts, where the need exists to improve maternal and child health.

Limitations

The study was conducted in Addis Ababa city, and it may not be representative of other parts of the country where integrated family planning and HIV services should also be improved.

All relevant stakeholders were involved in the development of the strategic action plan and will be responsible for the implementation thereof. However, the actions specify aspects relevant to budgeting and finances that will take longer than what is stated in the relevant periods.

Table 4 Strategic Action Plan for Integrated FP and HIV Services

Strategy	Actions	Method	Responsible Party/Parties	Time-Frame
Leadership and management	Increase the salary scale and benefit packages for technical and administrative staff of the public health centre, sub-city and AACAHB	1. Assess the current salary scales and benefit packages in other governmental and non-governmental organisations 2. Use the above findings to write a motivation to secure the budget 3. Adjust the salary and other benefit packages of technical and administrative staff public health centre, sub-city and AACAHB	Human resources, along with the finance and administration departments at the public health centres, sub-cities, AACAHB and Ministry Of Health (MoH)	Once, and repeat every 5 years
	Organise awards ceremonies for service providers delivering outstanding performance, to motivate others	1. Organise annual awards ceremony 2. Nominate awardees with outstanding performance at the public health centre level 3. Present the award to winners at the end of the fiscal year	Human resource department, along with supervisors of service providers at the public health centres, sub-city offices and AACAHB	Annually
	Organise retreat programmes for all staff working at public health centres, sub-cities and AACAHB, to manage burnout syndrome	1. Establish ad hoc committee in each sub-city health office (ten sub-cities and one for AACAHB) 2. Arrange the venue agreed on for the retreat programme by sub-city and AACAHB 3. Prepare budget breakdown, secure budget for the retreat programme for 10 sub-cities and AACAHB 4. Invite all staff of public health centre, sub-cities and AACAHB to participate in retreat programme 5. Conduct retreat programme at each sub-city level (ten sessions) and one session for AACAHB	Ad hoc committee in each sub-city, in coordination with Human resource department at the public health centres, sub-cities, AACAHB and MoH Head of AACAHB to approve budget	Annually

Organise training opportunities in leadership and management for programme officers and family health team from sub-city offices and medical directors and process owners from public health centres	1. Prepare and secure detailed budget for training 2. Prepare agenda for training and training materials/documents 3. Select appropriate participants from all sub-city offices (20 per session) and a total of 20 sessions to train 400 participants (24 programme officers, 58 family health team members, 80 medical directors, 240 process owners/head nurses from public health centres) 4. Select trainers/facilitators, communicate and ensure their agreement 5. Decide on venue and invite participants to attend training 6. Conduct training	Programme officers and heads/deputy heads of sub-cities/AACAHB to approve budget External consultants (experts) to facilitate training	Annually
Recruit dedicated service providers to offer integrated FP and HIV services	1. Allocate adequate budget for new recruitment position 2. Prepare clear job description 3. Advertise and recruit appropriate candidates through competitive process	Human resource department at public health centres, sub-city offices and AACAHB	Annually
Assign service providers to offer integrated FP/HIV services for long-term appointment in FP or HIV service provision	1. Provide orientation before deploying new service providers 2. Deploy new and existing service providers for at least 2 consecutive years' assignment, to provide integrated FP and HIV services (without rotation every 6 months)	Human resource department and process owners/head of public health centres and sub-city offices	Biannually
Develop/revise SOP to create an enabling environment at public health centre level Identify/revise roles of different departments/actors Coordinate among different departments/actors	1. Assess all available policies, guidelines and practices through desk reviews and interviews with service providers in the public health centre, programme officers, managers and other stakeholders 2. Plan to revise existing SOP or develop a new SOP based on findings from the above 3. Revise or develop draft SOP 4. Finalise draft SOP and gain final approval 5. Distribute copies of approved SOP to each public health centre	All representatives of departments from AACAHB and MoH, international and local Non-Governmental Organization (NGOs) working on FP and HIV AACAHB to approve final SOP	Develop once and revise every 3 years
Establish continuous online/face-to-face learning forums to create ownership by all levels of managers	1. Identify topics of learning 2. Select participants from public health centres, sub-cities and AACAHB 3. Select facilitators for learning forum 4. Conduct online/face-to-face meetings every quarter; discuss good practice and challenges in the integrated FP and HIV services 5. Evaluate learning forums	Service providers, programme officers to propose topics of learning Process owners or head/deputy head of public health centres, sub-city health offices to facilitate forum AACAHB to evaluate learning forum	Quarterly by public health centres and sub cities Biannually, in conjunction with AACAHB
Conduct review meeting to improve waiting time of clients at public health centre level	1. Prepare budget breakdown; secure budget for review meeting 2. Prepare agenda for review meeting 3. Decide on venue and invite service providers who work in integrated FP and HIV services, process owners, heads of health centres, programme officers, family health team, head/deputy head of sub-city 4. Conduct review meeting in each sub-city (10 sessions) and discuss how to work efficiently for each consultation (to be completed in <15 min) (shorten waiting time of clients)	Service providers, public health centre heads/ process owners, sub-city heads, programme officers, family health team and AACAHB	Biannually

(Continued)

Table 4 (Continued).

Strategy	Actions	Method	Responsible Party/Parties	Time-Frame
Capacity building	Organise and conduct 1-week ToT (training of trainers) on integrated FP and HIV for service providers	1. Prepare and secure detailed budget for ToT 2. Prepare agenda for training, and training materials 3. Select appropriate participants from selected public health centres (20 per session), total of 10 sessions to train 200 participants from public health centres 4. Select trainers/facilitators; communicate and ensure agreement 5. Decide on venue and invite participants to attend training 6. Conduct training	Programme officers and heads/deputy heads of sub- cities AACAHB to approve budget Programme officers and external consultants to facilitate training	Annually
	Organise and conduct 1-week roll-out training in integrated FP and HIV for service providers	1. Prepare and secure detailed budget for roll-out of training 2. Prepare agenda for training, and training materials 3. Select appropriate participants from public health centres (20 per session), total of 60 sessions, to train 1200 participants from all public health centres in Addis Ababa 4. Select trainers/facilitators; communicate and ensure agreement 5. Decide on venue and invite participants to attend training 6. Conduct training	Programme officers and heads/deputy heads of sub- cities AACAHB to approve budget Trained service providers and programme officers to facilitate training	Biannually
	Engage women in planning, implementation and evaluation of FP and HIV programme, to empower them to make their own choices	1. Nominate female representatives from the WDA 2. Invite representatives to participate in planning sessions, meetings and events 3. Invite representatives to visit public health centres and observe implementation 4. Invite representatives to participate in monitoring and evaluating programmes	Service providers and programme officers at sub-city health offices, and AACAHB WDA	Quarterly
	Provide training for community members such as WDA/Health Development Army (HDA)	1. Prepare and secure detailed budget for training 2. Prepare agenda for training, and training materials 3. Select appropriate participants from villages (30 per session), total of 50 sessions, to train 1500 participants from all 328 villages of Addis Ababa 4. Select trainers or facilitators, communicate and ensure the agreement 5. Decide on venue and invite participants to attend training 6. Conduct training	Programme officers and heads or deputy heads of sub- cities/AACAHB to approve budget Trained service providers and programme officers to facilitate training	Biannually
	Provide training in programme management to build capacity of family health teams at sub-city and AACAHB levels	1. Prepare and secure detailed budget for training 2. Prepare agenda for training, and training materials 3. Select appropriate participants from villages (20 per session), total of three sessions, to train 58 participants from all 10 sub-city health offices 4. Select trainers/facilitators, communicate and ensure agreement 5. Decide on venue, invite participants to attend training 6. Conduct training	Programme officers and heads or deputy heads of sub- cities/AACAHB to approve budget Programme officers and external consultants to facilitate training	Annually
	Organise mentorship programme for service providers	1. Identify topics of learning 2. Select mentees (junior service providers) from public health centres 3. Select volunteer mentors (senior service providers and program officers) for mentorship programme 4. Pair mentees and mentors, conduct mentorship programme through a face-to-face meetings or phone calls every month, for one year 5. Evaluate mentorship program at year end	Service providers, process owners, heads of public health centres and programme officers at sub-city health offices and AACAHB	Annually

Implementing policies and guidelines	Provide technical support to service providers at public health centres, to understand and implement existing policies and other supporting guidelines	1. Plan for supportive supervision visit 2. Prepare checklists of supervisory visits 3. Conduct supportive supervision visits and provide on-the-job training/ orientation on how to utilise existing policies and guidelines 4. Write report and provide written feedback	Service providers to serve as supervisors Programme officers and deputy/head of sub-city to serve as supervisors at sub-city health offices and AACAHB	Quarterly
	Develop SOP to guide the implementation of policies, and guidelines to facilitate the integration of FP and HIV services	1. Assess all available policies, guidelines and practices through desk reviews and interviews with service providers in the public health centre, programme officers, process owner/heads of public health centres, other stakeholders 2. Develop SOP to guide implementation of existing policies and guidelines at the public health centre level 3. Draft SOP 4. Finalise draft SOP, gain final approval 5. Distribute copies of approved SOP to each public health centre	All representatives of department from AACAHB and MoH, international and local NGOs working in FP and HIV AACAHB to approve final SOP	Develop once, revise every 5 years
	Revise existing curriculum to incorporate integrated FP and HIV services	1. Assess all available curriculum documents in the higher institutions for health students 2. Revise existing curriculum, incorporate integration of FP and HIV services 3. Conduct familiarisation workshops with teachers at health colleges/ universities 4. Finalise revision of the curriculum 5. Print and distribute copies of revised and approved curriculum to health colleges/universities	All representatives from the MoE and MoH, international and local NGOs working in FP and HIV MoE to approve final curriculum MoH and MoE	Revise once, repeat every 5 years
Advocacy/ Awareness	Promote integrated FP and HIV services, using local media in different languages	1. Secure budget and develop messages to be disseminated 2. Pre-test, then update messages 3. Select local media agency and sign work agreement 4. Buy airtime (10 min a month) with selected media agency 5. Disseminate messages twice a week	Programme officers and heads or deputy heads of sub- cities/AACAHB to approve budget Local media agencies to air messages	Monthly
	Develop and distribute tailored BCC materials (posters, leaflets, flyers, brochures, magazines, etc) related to integrated FP and HIV services to communities	1. Secure budget and develop draft BCC materials in different languages 2. Pre-test BCC materials 3. Revise BCC materials, incorporate comments from pre-testing in the community 4. Print BCC materials 5. Distribute BCC materials to public health centre, then clients	Programme officers and heads or deputy heads of sub- cities/AACAHB to approve budget	Develop annually Distribute daily
	Provide interpersonal communication training for service providers, for effective communication	1. Prepare and secure detailed budget for training 2. Prepare agenda for training, and training materials 3. Select appropriate participants from public health centres (20 per session), total of 60 sessions to train 1200 participants working in FP and HIV services 4. Select trainers or facilitators, communicate and reach an agreement 5. Decide on venue, invite participants to attend training 6. Conduct training	Programme officers and heads or deputy heads of sub- cities/AACAHB to approve budget Programme officers and external consultants to facilitate training	Annually

(Continued)

Table 4 (Continued).

Strategy	Actions	Method	Responsible Party/Parties	Time-Frame
	Educate clients to increase awareness regarding integrated FP and HIV services	1. Develop plan and secure budget 2. Do quick formative assessment 3. Develop operational guidelines based on above findings (methodology, target audiences, venue, etc.) 4. Educate clients according to operational guidelines 5. Evaluate outcomes of health education	Programme officers and heads or deputy heads of sub- cities/AACAHB to approve budget	Develop annually Educate daily
	Provide quality counselling to improve clients' knowledge by service providers in integrated FP and HIV services	1. Develop/adapt self-assessment checklist 2. Conduct self-assessment 3. Regularly check to ensure quality of counselling according to standard protocols 4. Provide training on counselling, as per above findings	Service providers to do self-assessment; programme officers to check and provide training	Daily
	Advocate for, and convince higher officials and political leaders about need to integrate FP and HIV services	1. Prepare evidence-based presentations on integrated FP and HIV services 2. Invite higher officials and political leaders for round table discussion 3. Present findings to leaders, discuss the need for integrated FP and HIV services 4. Receive directions from higher officials and politicians	Programme officers and head of AACAHB	Annually
Infrastructure	Prepare adequate room/space at public health centres, to provide integrated FP and HIV services	1. Establish 10 ad-hoc committees by sub-city 2. Observe existing room arrangement at each health centre, suggest possible rearrangements 3. Re-arrange space/rooms for provision of FP and HIV services, based on above suggestion	Public health centre heads and program officers	Annually
	Build extra blocks/rooms or renovate existing infrastructure in public health centres, to facilitate integrated FP and HIV services	1. Decide on design of building 2. Secure budget 3. Provide quotations to contractors through official administrative procedure, select contractor 4. Build new wing/new building 5. Hand over completed blocks/rooms to AACAHB	Administrative department of the public health centre, sub- city and AACAHB to secure budget Heads/deputy heads of sub- cities and AACAHB to approve budget	Once, annual renovations
	Procure necessary medical equipment and supplies for public health centre	1. Identify list of medical equipment and supplies to be procured 2. Secure budget 3. Provide quotations to suppliers through official administrative procedures, select supplier 4. Procure medical equipment and supplies 5. Distribute to public health centres	Procurement committee, programme officers and administrative department of the public health centre, sub-city and AACAHB Heads/deputy heads of sub- cities and AACAHB to approve budget Selected company	Annually
	Repair non-functioning medical equipment in public health centres	1. Identify medical equipment requiring maintenance by sub-city 2. Prepare and secure detailed budget 3. Provide quotations, select company through official administrative procedures 4. Provide maintenance service for non-functioning medical equipment	Program officers and administrative department of the public health centre, sub-city and AACAHB Heads or deputy heads of sub- cities and AACAHB to approve budget Selected company	Annually

Abbreviations: AACAHB, Addis Ababa City Administration Health Bureau; MoH, Ministry of Health; SOP, Standard Operation Procedure; BCC, Behavioral Change Communication; WDA, Women development Army; FP, Family Planning; HIV, Human Immunodeficiency Virus; MoE, Ministry of Education.

Conclusion

It is important to involve all relevant stakeholders in strategic action plan development. Utilizing multiple nominal group techniques, ensure equal opportunities for each individual participant, despite position or rank, to participate enhancing taking ownership, ultimately enhancing implementation possibilities. Multiple group analysis of the obtained data allow for voting and prioritizing of the most important strategies that have to be addressed in a strategic action plan. The multiple nominal group technique, deemed by all participants as a very effective way to involve stakeholders in Ethiopia, can be utilized in developing countries with similar context. A strategic action plan is not static; thus, follow-up studies can be done to assess implementation, identify challenges and recommend changes.

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Disclosure

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References

1. Ford N, Newman M, Malumo S, Chitembo L, Gaffield ME. Integrating sexual and reproductive health services within HIV services: WHO guidance. *Front Glob Women's Health*. 2021;2:735281. doi:10.3389/fgwh.2021.735281
2. Kanyangarara M, Sakyi K, Laar A. Availability of integrated family planning services in HIV care and support sites in sub-saharan Africa: a secondary analysis of national health facility surveys. *Reprod Health*. 2019;16(1):60. doi:10.1186/s12978-019-0713-x
3. Mekonnen DA, Roets L. Integrating HIV and family planning services: the pros and cons. *HIV/AIDS*. 2020;12:879–886. doi:10.2147/HIV.S281997
4. Nickols F. *Strategy, Strategic Management, Strategic Planning and Strategic Thinking Howard*. OH: Distance Consulting LLC; 2016.
5. Holtgrave DR, Valdiserri RO, Kalichman SC, Del Rio C, Thompson M. Core elements of a national Covid-19 strategy: lessons learned from the US national HIV/aids strategy. *AIDS Behav*. 2020;24(12):3279–3282. doi:10.1007/s10461-020-03045-3
6. Lubbe I, Roets L, Van Tonder F. Student recruitment: a framework developed through a multi-phased, multi-method process planning approach. *Afr J Online*. 2014;12(2):6396–6419.
7. Addis Ababa City Administration Health Bureau. *Annual Report 2019*. Addis Ababa: AACAHB; 2019:17.
8. McMillan S, King M, Tully M. How to use the nominal group and delphi techniques. *Int J Clin Pharm*. 2016;38:655–662. doi:10.1007/s11096-016-0257-x
9. De Vos AS, Strydom H, Fouché CB, Delport CSL, editors. *Research at Grass Roots for the Social Sciences and Human Service Professions*. 4th ed. Pretoria: Van Schaik; 2011.
10. Van de Ven H, Delbecq L. The Nominal Group as a research instrument for exploratory health studies. *Am J Public Health*. 1972;62(3):337–342. doi:10.2105/AJPH.62.3.337
11. Roets L, Lubbe I. Power imbalances in research: a step-by-step illustration of an adapted multiple group analysis. *J Int Arts Sci*. 2015;8(5):151–164.
12. Ortrun Z. A model for designing action learning and action research programmes. *J Action Learn Res*. 2002;9(4):143–149.
13. Demissie DB, Mmusi-Phetoe R. Integration of family planning services with HIV treatment for women of reproductive age attending ART clinic in Oromia regional state, Ethiopia. *Reprod Health*. 2021;18(1):102. doi:10.1186/s12978-021-01157-0
14. Rono J, Kamau L, Mangwana J, et al. A policy analysis of policies and strategic plans on maternal, newborn and child health in Ethiopia. *Int J Equity Health*. 2022;73(1):22.
15. Lubbe JC, Van Tonder SP, Roets L & Wilkinson, AC. Student recruitment in private nursing education institutions in South Africa. University of the Free State. 2012: 21–22. <http://hdl.handle.net/11660/8211>.

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