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Strategic Plan 2002 - 2005

The Australasian Society for
HIV Medicine Incorporated
349 Crown Street,
Surry Hills, NSW, Australia
www.ashm.org.au
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Contents

Foreword

This strategic plan indicates where the Society wants to be in 3 years time and how we intend to get there.

In 2002, more than twenty years after HIV infection began to have an impact, Australasia is in a more fortunate situation regarding the HIV epidemic than much of the world. A combination of good public policy, prevention strategies and geographical isolation has insulated us from the worst of the epidemic. However, the new millennium has brought with it a number of challenges. The very success of our treatments and our prevention strategy means there is an alarming sense that the epidemic is no longer a threat, with signs that HIV risk behaviours are on the rise in the most 'at risk' communities. In our region, there are rapidly growing HIV epidemics in countries with which we have increasing communications. The history of the epidemic tells us that we are unlikely to be insulated forever.

The success of our response to HIV has seen declining infection rates, and a linking of the strategic response to the so-called 'related diseases' of viral hepatitis and sexually transmitted infections. The importance of these conditions varies among the communities that ASHM serves, and in addition other conditions such as mental health, substance abuse, and poverty may be equally relevant in the clinical management of people with HIV. For this reason, ASHM has decided to use the term 'related conditions' to cover the range of infectious and other diseases and social conditions which play a role in the acquisition and management of HIV.

This strategic plan comes at a time of some uncertainty in Australia's response to AIDS, with an ongoing review of its national HIV/AIDS strategy and its national HIV research centres. ASHM is seen as a central partner in Australia's response to HIV/AIDS and rightly has a place at the table in the formulation of the policy response.

In Australia, a unique approach to the responses to the epidemic, involving a formal partnership between science, medicine, government and community has evolved. While sometimes producing tensions, this partnership has been important in producing an effective policy response to HIV.

This strategic plan provides an overall guiding strategy as to how we will progress from here. The plan is structured in a hierarchical manner, with the Society's purpose paramount, because this guides all its activities.

This plan identifies 4 key areas where we want to achieve results over 2002-2005:

- information;
- education and training;
- policy development and advocacy;
- governance and management of the Society.

As the peak body for HIV related health professionals and scientists, ASHM is in a strong position to influence the further development of Australia's and New Zealand's responses to HIV and related conditions in the coming years.

Andrew Grulich

President

Our purpose

Our vision, mission and values reflect our special role and unique contribution in the management and prevention of HIV and related conditions.

ASHM's vision

To be the leading provider of information and education on human immunodeficiency virus (HIV) and related conditions to health care workers in the region, drawing on a commitment to the health and well-being of individuals and whole populations, the knowledge and skills of experts in HIV and related conditions, and the highest standards of professional practice.

ASHM's mission

ASHM is the representative professional body for medical practitioners and other health practitioners in Australia and New Zealand who work in the fields of HIV and related conditions.

ASHM provides a number of distinct, but inter-related, services for and to the health industry in Australia, New Zealand and neighbouring countries. Those are:

- provision of health and medical/scientific information on HIV and related conditions
- provision of health and medical/scientific education and training about HIV and related conditions
- development and advocacy of policy on clinical practice, professional affairs and public policy issues about HIV and related conditions.

ASHM's values

ASHM is committed to the principles of the *Ottawa charter for health promotion* and *Jakarta declaration on leading health promotion into the 21st century* as well as the highest standards of ethical conduct as practised by the medical, scientific and health care professions.

As an organisation, ASHM is committed to providing goods and services to our customers, and working with stakeholders, in ways that:

- ensure that our practices are informed by the best available scientific evidence;
- respect cultural differences and diversity, including the mores of indigenous peoples;
- respect the choices and privacy of consumers and confidentiality of consumer information;
- redress social inequities;
- strengthen ties with infected populations;
- allow for transparency in our decision-making processes, based on a robust internal democracy; and
- reflect best practise in quality management.

Our history

A group of physicians formed ASHM in Sydney in 1988 (with the name Australian Society of AIDS Physicians, until 1989). They were responding to the difficulties in managing the growing HIV epidemic in Australasia. The Society's initial focus was on the needs of physicians and it was a source or clearinghouse of information about the virus and efforts to combat it.

Over time the Society began using its expert base to provide information about HIV to general practitioners and others involved in the care and management of HIV. While broadening its work, the Society maintained its specialist expertise. Because of the small number of people involved in HIV basic, clinical, epidemiological and social research internationally, and the social and political circumstances around the epidemic and public health policy in Australasia, local experts played an international role. They also fostered involvement and capacity-building among new clinicians, researchers, basic scientists, health sector managers and policymakers in the HIV and related health sectors.

ASHM began providing education programs in 1990, with funding from the Australian government. The initial program comprised two landmark print publications, *Could it be HIV?* (1994) and *Managing HIV* (1997), which were distributed to all medical practitioners in Australia. In recent years ASHM has produced resources for medical practitioners and health care workers about HIV and viral hepatitis. It runs short training courses on HIV and is expanding a 1-day program on hepatitis C medicine to a short course.

ASHM has run an Australasian conference on HIV since 1989. This has become the primary focal point for presentation of research into HIV from basic science to clinical, epidemiological and social research.

Historically, much of the Society's work has focused on Sydney and New South Wales. This is linked to the intensity of the epidemic there and the preparedness of the Australian and New South Wales governments to purchase services. It has, nevertheless, always maintained a national focus within Australia and involved health care workers from New Zealand.

ASHM began programs focused on the hepatitis C virus (HCV) in 1996. We broadened eligibility for membership in 1997 to all tertiary-trained health care workers involved in HIV and related conditions. The Society has evolved, and continues to evolve, as the nature of the HIV and HCV epidemics, their treatment and public health interventions, have changed, and change.

Our people

ASHM is one of a number of players in that part of the health services industry that deals with HIV and related conditions. Some of those other players/people and entities are consumers or users of goods and services we produce – our customers. Some people and entities can influence how we work because they influence or make decisions in other parts of the HIV and related health sectors, or because they benefit if we play our role well – our stakeholders.

ASHM will work on a *partnership* basis with customers and stakeholders, where this maximizes the effectiveness of health interventions on HIV and related conditions and where this leverages the use of ASHM resources.

Customers

ASHM provides goods and services to a range of governmental agencies, corporate entities in the for-profit and not-for-profit sectors and individuals.

Those customers include:

- ASHM members
- National level government agencies in Australia and New Zealand
- State and territory government agencies in Australia
- Regional/area health authorities
- Medical practitioners in general practice
- Specialist physicians
- Nurses, Dentists and Pharmacists
- Paramedical, education, and other health care workers
- People living with HIV/AIDS and related conditions
- AusAID and NZAID
- NGOs like the Australian Federation of AIDS Organisations and the New Zealand AIDS Foundation
- Associations, colleges and guilds of medical practitioners and other health care workers

Stakeholders

ASHM works with a range of governmental agencies, corporate entities in the for-profit and not-for-profit sectors, and individuals. Our relationship with them can influence what we do. Some of our external stakeholders are partners on specific, collaborative projects.

Those external stakeholders include:

- Ministers for health in Australia and New Zealand
- National government agencies in Australia and New Zealand
- State and territory government agencies in Australia
- Regional/area and district health authorities
- HIV and viral hepatitis health services
- Associations, colleges and guilds of medical, dental and other health care practitioners
- Drug companies and the pharmaceutical industry
- People living with HIV/AIDS and related conditions
- NGOs like the Australian Federation of AIDS Organisations and New Zealand AIDS Foundation
- Advisory bodies to governments in Australia and New Zealand
- University-based researchers
- Mass media

ASHM also has internal stakeholders – our members and employees.

Our organisation

ASHM operates as a membership-based association with a democratic constitution and a high participation by our members in voluntary capacities. We also employ and contract staff and consultants to provide goods and services to our customers.

Governance

The most important person in our Society is the member. Membership is open to individuals. We have some 700 full (voting) and associate (non-voting) members at the beginning of this planning period. Some 40% of members are specialist physicians, some 20% are general practitioners, some 10% are involved in epidemiological or clinical research, some 9% are nurses, and some 7% are pathology/laboratory professionals.

Members input to the Society in various ways. They run it, on a delegated basis to an elected Committee. They oversee its work, as members of standing committees and working parties. They directly undertake its work on various matters, such as writing articles for the *ASHM Journal Club*, speaking at conferences, representing it on external bodies, etc. This participation by members is done on a *voluntary* basis: the Society trades on a *non-profit* basis.

The most important decision-making body is the annual general meeting, which is open to any member. This is held in tandem with our annual conference, to maximize participation. The annual general meeting has, among its important tasks, the writing/amendment of the Constitution and the election of the Committee.

The Committee has legal and fiscal responsibility for the Society's affairs, establishes standing committees and working parties, undertakes strategic management of the Society, establishes the corporate headquarters (Secretariat), and appoints staff to take responsibility for operational matters.

In a number of jurisdictions, members have relatively informal networks that undertake activities for members there, such as forums with updates from international conferences.

An individual member is a *citizen* of the Society, with rights and obligations that flow from membership in a democratic body. They can also be *customers* of the Society, when they use goods and services we produce (such as newsletters, monographs, website, training courses, etc.).

Management

The Committee has overall responsibility for the Society's affairs, within parameters set by the constitution. The Committee delegates decision-making on many matters to a subset of its members, called the Executive: this consists of the President, Vice President, Treasurer, Secretary and Immediate Past President. The Committee and Executive focus on *strategic management* of the Society, delegating operational management to appointed staff.

At the beginning of this planning period the staff team was headed by an Executive Officer with overall responsibility for *operational management*. The Secretariat's management team consisted of the Executive Officer, the Education Programs Manager and the Information Services and Administration Manager.

Our environment

The environment in which ASHM operates is characterised by ongoing changes in the epidemiological, social and political nature of the HIV epidemic. A severe epidemic of HIV in homosexual men in Australia in the mid to late 1980s was followed by declining infection rates. Infections have plateaued in recent years. The epidemic still predominantly affects gay and other homosexually active men. This is testament to the success of prevention programs initiated early in the epidemic and maintained over the last 20 years. The availability of antiretroviral treatments has resulted in lower death rates and a greater proportion of people living with HIV/AIDS (PLWHA) than at any other time. This might act as a further influence among the already complex issues encountered in the long-term maintenance of behavioural strategies to reduce further transmission of HIV between homosexually-active men.

For doctors and other health care workers, the long-term health effects of living with HIV and the side effects of treatments are evolving challenges. These challenges place a considerable amount of pressure on those providing care and treatment to continually maintain up-to-date knowledge of research and related developments. In the wider community, and to a degree within gay communities, there is a sense that the epidemic is over. Treatments are available, death notices do not occupy pages of community newspapers and there has been no mainstream, public HIV/AIDS awareness campaign for many years.

At a political level, Australia maintains a national response, characterised by the same principles that have informed that response since the early days of the epidemic.

Those are:

- national strategy approach
- partnership model
- health promotion and harm minimisation
- enabling environment
- non-partisan political support
- involvement of affected communities

The fourth National Strategy added the concept of linked strategies to this list. This addition acknowledges the strategic and social linkages between the National HIV/AIDS Strategy, the National Hepatitis C Strategy, the National Indigenous Australian's Sexual Health Strategy and National Illicit Drug Strategies.

The development of the first National Hepatitis C Strategy, 1999-2000 to 2003-2004, recognised the need for national leadership in the response to an epidemic of significant proportion. It also recognised that many of the successes learnt in the HIV/AIDS field, through a national coordinated and collaborative response, could be effectively applied to other epidemics. At the same time, the National Hepatitis C Strategy could not simply be a copy of the HIV/AIDS Strategy, but needed to address hepatitis C in its own right. Further, a first National Hepatitis C Strategy must not be evaluated in the same manner as a fourth National HIV/AIDS Strategy, which has benefited from many years of implementation and refinement.

Some ASHM members have been involved with hepatitis C care for a number of years, and, increasingly, ASHM has responded to the needs of those members. This response has included the Day Course in Hepatitis C Medicine, the publication of *HIV and viral hepatitis: a guide for primary care,* and hepatitis C information supplements for nurses, dentists, ambulance officers and paramedics.

Over the course of the third and fourth national HIV/AIDS strategies, HIV/AIDS has increasingly been framed as a population health issue in the context of sexually transmitted infections and blood borne viruses. These have been addressed in a communicable diseases framework both at the policy level and increasingly in models of prevention and care.

At the time of writing this strategic plan, reviews of the Australian fourth National HIV/AIDS Strategy and first National Hepatitis C Strategy were underway. ASHM believes that the principles underpinning the Australian response to these epidemics to date should be maintained and in some cases strengthened. For example, harm minimisation and enabling environment are areas requiring constant promotion and support in the face of political misrepresentation and community misunderstanding. In order to better meet its objectives and goals, the national hepatitis C response requires greater dedicated funding at both the national and state/territory levels. Efforts to address the HIV/AIDS epidemic under earlier strategies benefited substantially from the allocation of dedicated funding. The Australian government needs to provide leadership, collaboration and coordination at the national level, and the national strategy approach has demonstrated its effectiveness in this regard.

ASHM advocates a continued national strategy response over the next three years with mechanisms to allow for flexibility to address changes and challenges as they arise during this time. One of those challenges is the manner in which Australia responds to the burgeoning epidemic in the surrounding region. For example, the scale and impact of the epidemic in Papua New Guinea is increasingly coming to the attention of donor agencies and health care services in northern Australia. Indonesia is no longer classified as a 'low prevalence' country, but has recently been re classified as having a 'concentrated epidemic' with HIV prevalence of over 5% in certain populations spread throughout the country. There is evidence in Indonesia of an explosive spread of HIV among injecting drug users and rapid spread between commercial sex workers and their clients. From the Western Australian perspective, the HIV/AIDS epidemics in India and African countries provide challenges and opportunities for assistance and input that require careful planning and consultation. The epidemics in neighbouring countries are poised to have an increasing impact on Australia's national response and capacity to provide assistance over the coming years.

In New Zealand the government's response to the HIV epidemic was included in the *Sexual and reproductive health strategy* (2001) and *Integrated approaches to infectious diseases: priorities for action 2002-2006* (2001). This identified refugee communities as the most at risk of heterosexual and mother-to-child transmission, and predicted that risks for men who have sex with men will continue to grow. At the time of preparing this strategic plan the Government was consulting on a discussion paper, *Action on hepatitis C prevention*. ASHM expects that its members in New Zealand will be key agents in implementing the proposed AIDS Action Plan and Hepatitis Action Plan.

The environment in which ASHM works is not static. ASHM needs to be vigilant to maintain its place at the table and to ensure that the New Zealand and Australian governments, and state and territory governments within Australia, continue to recognise the value of partnerships with the health sectors we represent, and with affected populations and health consumers. Any change to this approach would significantly change the environment in which we work.

Opportunities

ASHM faces the new century in a good position. We have a strong membership among the key providers of HIV treatment, care and research – specialists and general practitioners. We have a clear focus on infectious diseases and are able to straddle a number of distinct but related areas of medicine affecting HIV, viral hepatitis and sexually-transmitted infections. We have an excellent track record in delivering quality information and education products, including the flagship Australasian conference. These contribute to capacity-building within the health industry. We have good relations with Australian government health agencies and with those of the two largest Australian states. Organisationally, we have an entrepreneurial and efficient secretariat.

ASHM recognises a need to do better in a number of areas. We need to keep abreast of the changing nature of the HIV epidemic in the region. We need to manage the challenges that flow from HIV being positioned in population health policy (in Australia at least) with viral hepatitis and sexually-transmittable infections: we need to keep a central focus on HIV at the same time as undertaking work around viral hepatitis and sexually-transmittable infections where these intersect with the needs of our clients and stakeholders. We need to ensure our information products (including the annual Australasian conference) remain of the highest quality and relevant to diverse interests within the sector. We need to provide face-to-face education and training services in a greater spread of Australian states and in New Zealand. We need to strengthen ties with governments and public health agencies in New Zealand and in some states and territories within Australia. We need to share our expertise with policy and regulatory agencies in the pharmaceutical, overseas aid and HIV research fields. Organisationally, we need a more stable revenue base, which is less dependent on ad hoc and short-term project funding.

We need to be aware of threats to healthy populations in Australia and New Zealand, such as transmission of hepatitis C virus. And we need to be alert to the fiscal pressures in government responses to HIV and HCV.

Over the next 3 years ASHM will be giving priority to:

- creating new partnerships with sexual health physicians and hepatologists;
- enhancing our presence in New Zealand and nationally in Australia;
- developing appropriate education programs in the region, particularly Papua New Guinea, Indonesia, and East Timor;
- creating new partnerships with nongovernment organisations and government agencies in the overseas aid field.

Future directions

This plan identifies 4 key areas where we want to achieve results over 2002-2005:

- information;
- education and training;
- policy development and advocacy;
- governance and management of the Society itself.

For each of these key result areas there are *outcomes* indicating what the Society seeks to achieve for our customers and stakeholders.

For each outcome there are:

- *strategies* – these are generic groupings of tactics and tasks necessary to make an impact;
- *key performance indicators* – these are tools that we will use as a learning guide to test whether we have got results.

The planning framework is designed in a way that puts deliverables for *customers* upfront (key result areas 1, 2 and 3). Underpinning those are desired achievements in the way the Society is resourced and managed and positioned in the health industry (key result area 4).

KRA 1 Information	Outcomes – what we want to achieve	Strategies – how we will do it	Performance indicators – how we review progress
	1.1 The annual conference, as our flagship information product, maintains state of the art relevance to all sectors of the responses to HIV/AIDS, viral hepatitis and related conditions in Australia and New Zealand, and its management is improved in effectiveness and efficiency	Manage key aspects of conference in-house. Improve tools for participants' feedback. Diversify and increase conference revenues. Promote conference to basic sciences and junior researchers.	Economies in cost achieved. More usable customer feedback. Higher revenues from a wider spread of sources. Increased attendance from targeted groups.
	1.2 Development and distribution of print information	Publish monographs and booklets on HIV, HCV and related conditions. Summarize and review key journal articles for clinical practice. Publish a directory of HIV, hepatitis and related services.	New titles produced on HIV therapeutics, HIV basic science and pathogenesis. Production of journal supplements. *AHSM Journal Club* published on a 2-monthly basis. *Directory of HIV, hepatitis and related services* published annually.
	1.3 Development and distribution of electronic information	Publish online versions of print products. Produce videos on specific HIV, HCV and sexual health matters as needed. Update on-line Positive Information for Patients through links to relevant sites.	Print products are published on website. New videos produced in key areas, for example for Indigenous Australians.
	1.4 Our membership is kept informed with current information on HIV and related conditions	Produce and distribute specific services to members that enhance access to current information on HIV and related conditions.	*ASHM News, ASHM Newsheet,* ASHM e-News are produced regularly.
	1.5 Our information products are marketed better (see KRA 2.7)	Adopt an integrated marketing plan for our information and education products. Align marketing of products to corporate image and membership base.	Marketing plan developed, implemented and evaluated.

KRA 2 Education and training	Outcomes – what we want to achieve	Strategies – how we will do it	Performance indicators – how we review progress
	2.1 HIV and viral hepatitis education is accessible for specialists, GPs and other health care workers in all Australian states/territories and New Zealand	Manage and conduct face-to-face courses. Manage and conduct distance education. Manage and conduct web-based education.	Number, geographic penetration, attendances, and participant feedback.
	2.2 Education programs that allow qualification for accreditation of community-based HIV S100 prescribers and HCV s100 prescribers are developed (see KRA 3.4)	Maintain and update training courses and materials in line with current HIV/AIDS and HCV knowledge.	Number of courses, geographic penetration, attendances, and accreditations. The prescriber base maintained.
	2.3 HIV/viral hepatitis/STI resources for GPs and other health care workers promoted and available in all Australian states/territories	Promote HIV/viral hepatitis/STI resources at conferences, forums etc.	Number distributed.
	2.4 Education services in HIV/HCV are extended to developing countries; collaboration with regional countries in addressing needs for HIV/AIDS and HCV education services is enhanced.	Establish links with HIV/AIDS, HCV care and prevention providers in regional countries. Approach aid NGOs to form partnerships for tenders to AusAID, NZAID, etc. Consider seeking accreditation with AusAID.	Partnerships are established. Accreditation with AusAID considered and sought, if appropriate.
	2.5 The development of a Graduate Diploma in HIV Medicine is explored	Establish a working group for this project. Open qualification to other disciplines. Establish alliance with a university or universities Coordinate and market to universities and training providers to look at possibilities within undergraduate courses.	Extent of membership involvement in developing Graduate Diploma.
	2.6 Our education products are marketed better (see KRA 1.5)	Adopt an integrated marketing plan for our education and information products. Align marketing to corporate image and membership base.	Marketing plan developed, implemented and evaluated.

KRA 3 Policy and advocacy	Outcomes – what we want to achieve	Strategies – how we will do it	Performance indicators – how we review progress
	3.1 Public policies on HIV and related conditions in Australia and New Zealand are shaped by ASHM's policies	Utilise members' interests and expertise better. Establish ad hoc issue-based subcommittees as needed. Lodge evidence-based submissions to governmental inquiries. Use health industry media and mass media to report ASHM policy positions.	Policy function more focused. Database of members' interests and expertise developed and used. Subcommittees established. Submissions lodged strategically to maximize impact on inquiries. ASHM policy positions reported in mass media and industry publications. ASHM positioned on Australian and New Zealand national HIV and hepatitis policy-making committees.
	3.2 National standards for HIV continuing medical education (CME) in Australia reflect best practice	Review and update HIV CME standards as required.	Updated national standards for Australian HIV CME are adopted.
	3.3 Development of national standards for HCV continuing medical education (CME) in Australia	Develop HCV CME in conjunction with NSW HCV s100 prescriber pilot project.	National standards for Australian HCV CME are developed.
	3.4 Development of national standards for accreditation (initial and continued) of HIV s100 prescribers and HCV s100 prescribers in Australia (see KRA 2.2)	Manage accreditation systems in jurisdictions where negotiated with public health authorities. Review and update accreditation standards and processes as required.	National accreditation system adopted in Australia.
	3.5 Public policies on HIV-related issues in developing countries are informed by ASHM's experience and expertise	Assist value-adding aid projects in the region.	ASHM's experience and expertise assist HIV responses in developing countries.

KRA 4 Governance and management	Outcomes – what we want to achieve	Strategies – how we will do it	Performance indicators – how we review progress
	4.1 Our revenue base is more secure and more diverse	Expand the range of funded projects. Secure funding from other corporate sources. Establish a foundation/fund for tax–deductible gifts. Implement tighter expenditure control and cost recovery	Grants for more diverse range of projects. Revenue from corporate strategic partners and sponsors increased. Foundation/fund established. Economies achieved and true costs recovered.
	4.2 Our membership is larger	Promote membership through a range of activities in New Zealand and regional countries among new researchers, physicians, graduates, etc.	Increased membership.
	4.3 Involvement by members in the Society is greater	Refocus standing committees to projects. Establish ad hoc subcommittees on specific issues as appropriate.	Increased participation by members on working parties, subcommittees, and through contributions to publications.
	4.4 The national Committee has a more clearly defined role in setting directions for the Society, its continued development and relevance.	Hold regular meetings, including increased opportunities for face-to-face meetings.	Committee teleconferences held monthly; at least two face-to-face meetings (one at annual conference) held each year.
	4.5 Internal structures and information flow are improved	Finalize *Internal policies and procedures manual*. Introduce quality systems in office management.	ISO-9001:2000 certification attained, if appropriate.
	4.6 Legal basis of the Society as a corporate entity remains appropriate to its scope	Consider whether alternative corporate forms would enhance accountability and efficiency.	Alternative corporate forms investigated and corporate legal status changed if appropriate.
	4.7 Ties with international and regional bodies are stronger (see KRA 2.5)	Prioritise international matters in programming the 2003 conference. Establish syndicates with NGOs for tenders to AusAID. Enhance relations with international organisations.	2003 conference program highlights regional/global issues. Strategic partnerships established with overseas aid NGOs. A visible presence at the IAS Basic Science Conference 2005 achieved.
	4.8 ASHM's secretariat facilities are enhanced	Consolidate office accommodation in current premise. Establish out posted projects in cities other than Sydney where partnerships and funding allow.	Current office space in refurbished and grouped. Projects are out posted in cities other than Sydney where possible (e.g. Melbourne).

Our planning

The Society's planning framework consists of a number of elements:

- planning; and
- performance monitoring and review (evaluation), which help us with future planning.

Each of these is conducted over different time dimensions. Our strategic plan runs for 3 years, and annual business plans are designed to achieve the long-term goals of the strategic plan. A project plan runs for the term of the project. Each is conducted for a different component of the organization. Our strategic plan and business plans focus on the whole organisation. A project plan focuses on a specific project.

This planning document is a *strategic plan*, that is, it deals with 'big picture' issues, and at a level of generality that is flexible enough to allow for operational decisions (including those that deviate from it) in accord with the Society's usual democratic decision-making processes. Because of the overarching nature of the planning framework and the 3-year timeframe, operational matters like specific outputs, allocation of specific resources and project timeframes are not included in this document.

Within the framework of the strategic plan the Society will also prepare subordinate plans, namely:

- a *business plan* for the society as a whole, with a focus on the work of the secretariat, which identifies the intended outputs from the Society's work – on an annual basis, for each of the financial years in the 3-year planning period; and
- a *project plan* for each project – on a lifecycle basis as appropriate (for example, 2 years or 6 months depending on the period of funding), or an *action plan* for particular areas of work that cover multiple projects (for example, our international work).

Those plans address operational matters like specific outputs, allocation of specific resources and project timeframes not included in this document.

This strategic plan will be used to guide the Society's ongoing business and project development, and to report back to members and stakeholders.

ashm
Australasian Society for HIV Medicine Inc

The Australasian Society for HIV Medicine Inc
LMB 5057, Darlinghurst, NSW 1300, Australia
Web: www.ashm.org.au
Email: ashm@ashm.org.au
Phone: 61 2 9368 2700
Fax: 61 2 9380 6882